Department of Health and Human Services
Division of Vocational Rehabilitation Services

INDEPENDENT LIVING SERVICES PROGRAM

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CASEWORK & SERVICE DELIVERY POLICY MANUAL

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TABLE OF CONTENTS

TABLE OF CONTENTS 2

MANUAL INTRODUCTION 8

CHARGE AND PURPOSE OF THE NORTH CAROLINA DIVISION OF VOCATIONAL REHABILITATION SERVICES 9

CHAPTER ONE: PROGRAM ADMINISTRATION 10

Section 1-1: Introduction 10
- 1-1-1: Policy Development and Consultation 10
- 1-1-2: Audit-Federal 13
- 1-1-3: Provision of Services to Employees or to Members of Their Immediate Family 13
- 1-1-4: Transportation of Clients-Liability 14

Section 1-2: Records Management 14
- 1-2-1: Record of Service Transfers 15
- 1-2-2: Responsibilities of the Transferring Counselor 15
- 1-2-3: Responsibilities of the Receiving Counselor 16
- 1-2-4: Retention/Disposal of Records of Service 16
- 1-2-5: Annual Review of Closed Records of Service 17
- 1-2-6: Annual Verification of Records of Service 19

Section 1-3: Confidentiality of Records 19
- 1-3-1: General Provisions 19
- 1-3-2: Requests for Client Information 21
- 1-3-3: Release of Confidential Information *With* the Consent of the Client 23
- 1-3-4: Release of Confidential Information *Without* the Consent of the Client 24
- 1-3-5: Subpoenas 25

Section 1-4: Client Assistance Program (CAP) 26

Section 1-5: Client (and Applicant) Appeals of Division Decisions Including Administrative Reviews and Mediation 27

Section 1-6: Social Security Work Incentives 36

Section 1-7: Implications of Section 504 and Americans with Disabilities Act (ADA) 36

Section 1-8: Nondiscrimination 37
- 1-8-1: Disability Group 37
- 1-8-2: Age 37
- 1-8-3: Residence 37

Section 1-9: Identification and Verification 38
- 1-9-1: Social Security Numbers 38
- 1-9-2: Citizenship and Employment Eligibility 38

Section 1-10: Repossession, Storage, and Disposal of Equipment 39

Section 1-11: Case Service Authorizations 39

Section 1-12: Invoice Processing 40
- 1-12-1: Vendor Signatures 40
- 1-12-2: Additional Information Required on Invoices 42

Section 1-13: VR/IL Concurrent Records of Service 46

Section 1-14: Client Signatures 48

Section 1-15: Imprest Cash Fund 49

Section 1-16: Vendor Review and Certification 50
1-16-1: General Provisions 50
1-16-2: Acupuncturists 52
1-16-3: Chiropractors 53
1-16-4: Day Care 53
1-16-5: Dentists 53
1-16-6: Driver Rehabilitation Specialists 53
1-16-7: Hearing Aid Vendors 54
1-16-8: Massage and Bodywork Therapists 54
1-16-9: Medical Specialists 54
1-16-10: Occupational Therapists 54
1-16-11: Opticians 55
1-16-12: Optometrists 55
1-16-13: Podiatrists 55
1-16-14: Prosthetists and Orthotists 55
1-16-15: Psychologists 55
1-16-16: Sign Language Interpreters 55
1-16-17: Speech and Language Pathologists and Audiologists 56

Section 1-17: Medical Consultation 56

Section 1-18: Subrogation Rights: Assignment of Reimbursement 57

Section 1-19: Supervisor Approval 58
1-19-1: Rehabilitation Counselor I and Rehabilitation Counselor Trainee 59

Section 1-20: Applicant/Client Informed Choice 60

CHAPTER TWO: NATURE AND SCOPE OF SERVICES *62*

Section 2-1: Nature of Independent Living Rehabilitation Services 62

Section 2-2: Scope of Services 62
2-2-1: Substantial Services 63
2-2-2: Major Independent Living Services 63
2-2-3: Support Services 64
2-2-4: Timeliness of Services 64
2-2-5: Policy Exceptions 64

Section 2-3: IL Equipment 64
2-3-1: Appliances 68
2-3-2: Assistive Technology Devices 68
2-3-3: Computers 69
2-3-4: Durable Medical Equipment 70
2-3-5: Procedures to Purchase Durable Medical Supplies 75
2-3-6: Furniture and/or Furnishings 76
2-3-7: Recreation Equipment 77
2-3-8: Telecommunicative Devices 77
2-3-9: Procedures to Purchase Other Equipment 79
2-3-10: Equipment Repairs 82

Section 2-4: Assistive Technology Services 83

Section 2-5: Communication Services 83
2-5-1: Foreign Language 83
2-5-2: Interpreting Services (Sign Language and Oral) 84

2-5-3: Reader Services 86

Section 2-6: Counseling and Guidance 86

Section 2-7: Driver Evaluation and Training 86

Section 2-8: Information and Referral 87

Section 2-9: Maintenance 88
2-9-1: Personal Needs 88

Section 2-10: Modifications 88
2-10-1: Residence Modifications 89
2-10-2: Vehicle Modifications 96
2-10-3: Worksite Modifications 99

Section 2-11: Personal Assistance Services 101
2-11-1: Vocational Rehabilitation Program 101
2-11-2: Independent Living Program 105
2-11-3: Suspension and Termination from Personal Assistance Services 113

Section 2-12: Physical Restoration 114
2-12-1: Chiropractic Services 114
2-12-2: Hearing Aids 115
2-12-3: Orthotics 116
2-12-4: Prosthetics 117

Section 2-13: Recreational and Social Services 119

Section 2-14: Rehabilitation Technology 120
2-14-1: Rehabilitation Engineering 120

Section 2-15: Services to Family Members 121

Section 2-16: Transportation 121
2-16-1: Public Conveyance 122
2-16-2: Private Conveyance 122
2-16-3: Personal Care Assistants and Escorts 122
2-16-4: Permanent Relocation and Moving Expenses 122

Section 2-17: Vehicles 123
2-17-1: Vehicle Purchases 123
2-17-2: Vehicle Repairs 123

CHAPTER THREE: PRELIMINARY ASSESSMENT 124

Section 3-1: Timelines for Eligibility Determination 124

Section 3-2: Use of Existing Information 124

Section 3-3: IL Case Status Codes and Definitions 125

Section 3-4: Referral and Application Process 125
3-4-1: Availability for Services 125
3-4-2: Referrals 126
3-4-3: Timeliness of the Application Process 127
3-4-4: Procedures to Enter Applicant Status 127
3-4-5: Procedures to Exit Applicant Status 128

Section 3-5: Determination of Impairments 128
3-5-1: Primary and Secondary Impairments 128
3-5-2: Physical Conditions 128
3-5-3: Psychological/Psychiatric Conditions 129

3-5-4: Shelf Life 131
3-5-5: Special Conditions 132

Section 3-6: Eligibility for Independent Living 133
3-6-1: Eligibility Criteria 133
3-6-2: Significant Disability 133
3-6-3: Functional Improvement 134
3-6-4: Presumption of Eligibility 135
3-6-5: Record of Service Documentation 135

Section 3-7: Priority of Services 136
3-7-1: Definitions 136
3-7-2: Employment Priority 136
3-7-3: Utilization of Resources 136

Section 3-8: Financial Need and Client Resources 137
3-8-1: Financial Needs Survey 137
3-8-2: SSI and SSDI Recipients 148
3-8-3: Comparable Benefits 148

CHAPTER FOUR: REHABILITATION NEEDS ASSESSMENT 155

Section 4-1: Comprehensive Assessment 155

Section 4-2: Record of Service Documentation 156

CHAPTER FIVE: REHABILITATION PROGRAM 157

Section 5-1: IL Service Plan and General Information 157
5-1-1: Signatures 157
5-1-2: Progress Review 157
5-1-3: Annual Reviews 157
5-1-4: Amendments 157
5-1-5: Revisions 158

Section 5-2: Development of the IL Service Plan 158
5-2-1: Identification of the Overall IL Service Plan Objective 158
5-2-2: IL Service Plan Goals 159
5-2-3: Independent Living Services 160
5-2-4: Counselor Comments 160
5-2-5: Responsibilities of Clients and DVRS 161
5-2-6: Comparable Benefits 161

CHAPTER SIX: RECORD OF SERVICE OUTCOMES 162

Section 6-1: Successful Outcome After IL Service Plan-Case Status Code 26 162
6-1-1: Closure Standards 162
6-1-2: Client Notification 162
6-1-3: Record of Service Documentation 162

Section 6-2: Outcome During Preliminary Assessment-Case Status Code 08 163
6-2-1: Closure Standards 163
6-2-2: Client Notification 163
6-2-3: Record of Service Documentation 163

Section 6-3: Outcome Prior to Implementation of the IL Service Plan-Case Status Code 30 163
6-3-1: Closure Standards 163
6-3-2: Client Notification 164
6-3-3: Record of Service Documentation 164

Section 6-4: Unsuccessful Outcome after Implementation of the IL Service Plan- Case Status Code 28 **164**
6-4-1: Closure Standards 164
6-4-2: Client Notification 164
6-4-3: Record of Service Documentation 164
6-4-4: IL Progress and Closure Report 165

Section 6-5: Closure Retrievals **166**
6-5-1: Retrieval of Status 26 Closures 166
6-5-2: Retrieval of All Other Closures 166

CHAPTER SEVEN: POST-CLOSURE SERVICES ***167***

Section 7-1: Post-Closure Services-Case Status Code 32 **167**
7-1-1: Procedure to Enter Post-Closure Services 167
7-1-2: Post-Closure Amendment to IL Service Plan 167

Section 7-2: Termination of Post-Closure Services-Case Status 34 **168**
7-2-1: Termination Standards 168
7-2-2: Client Notification 168
7-2-3: Record of Service Documentation 168

CHAPTER EIGHT: CENTERS FOR INDEPENDENT LIVING (CIL) ***169***

Section 8-1: Definition of a CIL **169**

Section 8-2: Utilization of a CIL **169**

APPENDIX ***170***

AgrAbility **171**

Attention-Deficit/Hyperactivity Disorder (ADD/ADHD) **174**

Auxiliary Aids & Services **176**

Blind & Visually Impaired **177**

Borderline Intellectual Functioning **178**

Chronic Fatigue (CFS) **179**

Chronic Pain **180**

Cochlear Implants **183**

Dental Impairments **185**

Driver Evaluation & Training Services: Procedures for Obtaining Driving Evaluation When Adaptive Driving Equipment Is Involved **186**

DSM-5 **188**

Durable Medical Equipment: Purchase Procedures - Chart A **191**

Durable Medical Equipment: Purchase Procedures - Chart B **192**

Hearing Disabilities **193**

HIV/AIDS **196**

IL Closure Process Guide **200**

IL Federal Service Definitions **202**

Intellectual Disability 204

Learning Disability 205

Morbid Obesity – Determination of Impairment and Functional Capacity Limitations for Eligibility 208

Non-Medical Equipment: Purchase Procedures – Chart A 210

Non-Medical Equipment: Purchase Procedures – Chart B 211

North Carolina Achieving a Better Life Experience (NC ABLE) 212

Personal Assistance Definitions & Resources 213

Referral - Script 216

Rehabilitation Counselor II (RCII) Process 217

Residence Modification General Guidelines 222

Substance Abuse 224

INDEX *225*

MANUAL INTRODUCTION

All policies stated in this manual are effective July 1, 2010 and replace Independent Living Rehabilitation Program policy and procedural information issued for Volume I prior to this date. Subsequent revisions of this Volume will have a revision date. Unless otherwise specified, all policies relate to the Independent Living Rehabilitation Program.

This manual is divided into chapters based on the rehabilitation process of the Independent Living Rehabilitation Program (IL) of the North Carolina Division of Vocational Rehabilitation Services. Each chapter is divided into sections with many sections divided further into subsections. Each chapter, section, and subsection is numbered to provide for easy location of specific topics. A Table of Contents and an Index identifying the location of each topic is also provided.

An Appendix is provided which gives the reader general information and guidance on topics supporting the rehabilitation process.

CHARGE AND PURPOSE OF THE NORTH CAROLINA DIVISION OF VOCATIONAL REHABILITATION SERVICES

Our Charge:

North Carolinians with disabilities will live and work in the communities of their choice with economic and other supports available to help them achieve and maintain optimal self-sufficiency and independence.

Our Purpose:

To promote employment and independence for people with disabilities through customer partnership and community leadership.

CHAPTER ONE: PROGRAM ADMINISTRATION

Section 1-1: Introduction

Enabling Legislation

Federal Legislation and Administration
Title I and Chapter I of Title VII of the Rehabilitation Act of 1973, Public Law 93-112, as amended by Public Laws 93-516, 95-602, 98-221, 99-506, 100-630, 102-569, 103-73, and 105-220.

The Vocational Rehabilitation Program and the Independent Living Program are administered by the Rehabilitation Services Administration in the U. S. Department of Education.

State Legislation and Administration
N. C. General Statutes 143-545.1.

The Department of Health and Human Services is required to establish and operate these programs under the administration of the Division of Vocational Rehabilitation Services in collaboration with the Division of Services for the Blind which conducts Vocational Rehabilitation and Independent Living programs for individuals who are blind or visually impaired under Chapter III of the General Statutes.

State Plans

To be eligible to receive Federal funds for its programs, the State must have a State Plan for Vocational Rehabilitation Services with a Supplement for Supported Employment Services and a State Plan for Independent Living that meet Federal requirements.

[The Rehabilitation Act of 1973 (P.L. 93-112) as amended through 1998; G.S. 143-545.1]

1-1-1: Policy Development and Consultation

The Division of Vocational Rehabilitation Services shall seek and consider in connection with general policy development and implementation the views of:

A. Current and former clients or, as appropriate, their parents, guardians or other representatives;
B. Providers of vocational rehabilitation and independent living services;
C. The State Rehabilitation Council;

D. The Statewide Independent Living Council;
E. Representatives of business and industry and other employers;
F. Numerous advocacy and consumer organizations;
G. Other councils, commissions, associations, agencies, and departments concerned with issues related to individuals with disabilities; AND
H. Committees representing counselors, members of the regional rehabilitation centers, and other professional groups.

Implementation of this policy shall involve the use of numerous mechanisms to seek such views including, but not limited to the following:

- STATE AND STRATEGIC PLAN PUBLIC MEETINGS throughout the State, after appropriate and sufficient notice (usually thirty days), to allow interested individuals and groups an opportunity to comment on the Vocational Rehabilitation and Independent Living State Plans and the Division's Strategic Plan and to participate in the formulation of policies governing the provision of service established through these plans as required by the Federal Vocational Rehabilitation Law.

- PUBLIC RULE-MAKING HEARINGS which are required by the State's Administrative Procedure Act, G.S. 150B, prior to the adoption of policies or procedures that affect the public and that are not already established in either State or Federal laws or rules. These rule-making hearings involve a lengthy process that involves 30-day notices, submission and analysis of fiscal impact of the policies by the Office of State Budget and Management and review by the Governor's Office, an Administrative Rules Review Committee, and the Joint Legislative Administrative Procedures Oversight Committee. This law also provides legal avenues for court review of statutory authority for policies and procedural safeguards for the public.

- ADVICE AND COLLABORATION WITH THE STATEWIDE INDEPENDENT LIVING COUNCIL: Federal law requires the Division and the Division of Services for the Blind to jointly develop and sign the Independent Living State Plan with the Statewide Independent Living Council, and to secure the involvement of this Council in the development of the Strategic Plan. The Independent Living Council is required by Federal law; and in North Carolina, the Governor appoints its 29 members some of whom represent the Division of Services for the Blind.

- INVOLVEMENT OF THE CLIENT ASSISTANCE PROGRAM (CAP) in policy development. The Director of CAP is a member of the Division's Management Team and has the opportunity to participate in initial discussions as policy is being developed. In addition, the Director is a member of the State Rehabilitation Council and regularly attends meetings of the Statewide Independent Living Council, thus representing client interests in policy

development through these two bodies as well as public hearings. CAP is also able, through its involvement in the Division's administrative review/appeals process, to identify problematic policy issues and call these to the attention of the Division Director.

- CONDUCTING FOCUS GROUPS: These groups are a source of stakeholders' participation in policy development, particularly in identifying areas of concern related to existing or needed policies. Focus groups are conducted under the direction of local unit offices and represent grass-roots involvement in policy development.

- DIRECTOR'S INFORMAL CONSULTATION WITH CONSUMER AND ADVOCACY GROUPS: The Division Director periodically holds informal meetings with leaders of various consumer and advocacy groups to solicit their concerns about needed policies or policy changes. These meetings usually relate to significant service-delivery issues such as order of selection for services or issues that would be appropriate for the State or Strategic Plans.

- NORTH CAROLINA ASSOCIATION OF REHABILITATION FACILITIES: The Division Director or his designee meets with the executive committee of this group (which represents community rehabilitation programs) at their regularly scheduled meetings and occasionally, as the need arises, will request special meetings with them. These meetings provide an opportunity for the group to have input into policy development and change.

- COUNSELOR ADVISORY COMMITTEE (CAC): The Counselor Advisory Committee is a group of representatives elected by counselors from all the unit offices and facilities across the State. It meets at least three times a year with the Assistant Director for Program Operations and other supervisory and management staff as appropriate. Ideas, needs, feelings, and client-related issues from the Committee are presented to the Division Director through the Assistant Director. Many of the issues raised by this group result in policy studies and possible changes.

- CONTACT WITH OTHER ORGANIZATIONS, AGENCIES, ASSOCIATIONS, COUNCILS, AND COMMISSIONS: The Division maintains formal contact with approximately 50-75 groups other than those specifically described in this policy. In some instances, the Division has formal representation on such bodies. In other instances, information is routinely exchanged through informal contact, formal correspondence, public hearing notices, and newsletters. The Division has a mailing list of approximately 600 groups and individuals who receive all hearing notices and all proposed rules in addition to hearing notices regarding the two State Plans and the Strategic Plan.

- SPECIAL STUDIES AND SURVEYS are used to solicit direct consumer input

that assists in evaluating the Division's delivery of services and the policies guiding that service delivery.

- THE CONSUMER SATISFACTION SURVEY CONDUCTED BY THE STATE REHABILITATION COUNCIL is used to evaluate the effectiveness of, and consumer satisfaction with, rehabilitation services received through the Division's Title I program. It is sent to all clients who received services from the general Vocational Rehabilitation program and whose cases have been closed within 60 days of their case closure. Review and analysis of these survey results provide information that can assist in evaluating Division policy and implementation of such policy.

- THE INDEPENDENT LIVING REHABILITATION PROGRAM SATISFACTION SURVEY is a similar survey used by the Independent Living Program. It is sent to all consumers in the Independent Living program who have achieved their Independent Living goals within 30 days of the closure of the consumer's case. Results of these surveys can also assist in evaluating policy and its implementation.

- THE POST-CLOSURE FOLLOW-UP STUDY is an ongoing study in which a sample of individuals whose cases were closed successfully is contacted 12 months after their cases are closed. Current work status, earnings, and client views regarding services are assessed by means of a survey form. This information is also useful in evaluating policy and its long-range implications.

[34 C.F.R.361.20; 34 C.F.R.364.20; I.L. State Plan Section 2.3]

1-1-2: Audit-Federal

The Department of Education requires that State Vocational Rehabilitation Division records including client files be retained for three years. Therefore, Federal auditors when auditing the Division, review active client files or records which have been closed no longer than three years. The Division by State statute retains closed case files until notified by the Office of the Controller that cases closed in a specific year are scheduled for disposition. Refer to policy in 1-2-4.

1-1-3: Provision of Services to Employees or to Members of Their Immediate Family

Policy does not prevent rehabilitation services from being provided to an applicant or client with a disability who is an employee or relative of an employee. Counselors should not complete Division documents or issue authorizations for any services for a family member, relative, or division employee without following the requirements set forth in this policy.

An immediate family member is defined as an employee's spouse, parent, sibling, child, grandparent, grandchild, aunt, uncle, and first cousins by either blood or marriage. Step and in-law relationships within these categories are also included as are others who may be living in the same household but unrelated. An employee is defined as anyone currently on Division payroll.

In the instance of an employee's family member or an employee, a neutral counselor or supervisor shall be asked to complete the preliminary assessment and forward such to the Regional Director or designee who will make the eligibility decision and issue the IL Eligibility Decision. The Regional Director or designee will then appoint a neutral counselor, working in a different unit office from the family member, to develop the rehabilitation program and provide services.

1-1-4: Transportation of Clients-Liability

A Division employee who has a motor vehicle accident while transporting a client in the employee's personal vehicle and injures the client is wholly liable, if the Division employee is found negligent. Even though the individual is a State employee and is engaged in State business at the time, this fact does not alter the liability issue.

If the client sustains injury while being transported in a State owned vehicle, and the Division employee is found negligent, liability insurance carried by the State would be available to help satisfy any allowed claim. Allowed claims in excess of State provided coverage become the employee's responsibility. Unless one's policy contains special provisions to cover such, it is our understanding liability insurance carried by the Division employee would not offer coverage when an accident involves a State owned vehicle.

When authorizing a third party to provide transportation for our clients, the counselor should confirm that the individual authorized has a valid driver's license, unless a commercially licensed person or firm is the authorized carrier.

Should a Division employee be involved in any accident on the job which involves a client and/or a State owned vehicle, the employee's supervisor or the state office should be immediately notified.

[Attorney General Ruling]

Section 1-2: Records Management

All Division records of service must be maintained in a neat and orderly fashion which allows easy access to information regarding the client. Client records must be stored in locked file cabinets in each office and should not be removed from the office unless great care is taken to assure confidentiality of client information and should not be left unattended.

1-2-1: Record of Service Transfers

The transfer of client records of service should occur when another counselor is in a better position to develop or continue the rehabilitation program. Records should be transferred on the following conditions:

A. When an applicant/client has permanently located in a geographical area not served by the original counselor and a substantial amount of time is required to develop or complete the rehabilitation program;
B. When the applicant/client could best be served by a specialized counselor in the same geographical area, and if it is in the client's best interest;
C. When a client is being discharged from a facility and the facility does not have an assigned counselor to ensure completion of the rehabilitation process; OR
D. At client request and management discretion, a client's record may be transferred to another counselor when communication and rapport between a client and counselor is not at a level appropriate to assure successful completion of the rehabilitation program.

1-2-2: Responsibilities of the Transferring Counselor

1. The transferring counselor should contact the receiving counselor to notify of the potential case transfer.

2. Ensure the case record is in proper order and complete for the phase of the rehabilitation process. Records should be up-to-date regarding the client's address and telephone number along with an additional current contact name and phone number.

3. Notify the client of the IL office address and phone number for their new location. This should be done via letter with a copy maintained in the client record. The letter should include the receiving counselor's name and the client's requirement to contact the new office within 60 days.

4. It is the responsibility of the client/Parent/Guardian or representative to contact the receiving office within 60 days.

5. The transferring counselor should contact the receiving counselor **AND** client if confirmation of contact has not occurred within 30 days.

6. If contact is not made by the client/parent/guardian or representative within 60 days the transferring counselor may, with Unit Manager approval, close the case unsuccessfully.

1-2-3: Responsibilities of the Receiving Counselor

1. Once client/parent/guardian or representative contact has been made, the receiving counselor must contact the transferring counselor within 5 working days, to request transfer of the case.

2. Upon receipt of the transfer, the receiving counselor will review the case. Casework errors should be documented in case notes. If significant errors are found the case should be staffed with the Unit Manager to determine appropriate action.

   If there appears to be an error in eligibility the case should be staffed with the QDS who will consult with the Chief of Policy.

3. The receiving counselor should arrange to meet the client as soon as possible but at least within 30 days of receipt of the transfer.

[34 CFR 361.39]

Revised 7-1-2013

[34 CFR 361.38 (Protection, use and release of personal information)]

1-2-4: Retention/Disposal of Records of Service

The Department of Health and Human Services and State Department of Cultural Resources, Division of Archives and History have agreed to a schedule for retention and disposition of records for the Division of Vocational Rehabilitation Services.

The following records are subject to the schedule of retention and disposition provided by the Office of the Controller. A predefined period of time cannot be used as a record disposition date. Staff will receive the schedule for purging and destroying records on a semiannual basis from the Chief Operations Officer. Records must be retained in the office until staff is notified that records closed during a specific year are scheduled for disposition. In addition, all records with litigation, appeals, and financial or other local issues pending when disposition is scheduled must be retained until those issues are completely resolved.

ACTIVE RECORDS OF SERVICE: Includes referral information, client data sheets, client survey forms, authorizations, eligibility/ineligibility decision, rehabilitation plans and amendments, financial statements, medical reports, case notes, and related documents and correspondence. Remove the record of service from active files once the record has been closed.

CLOSED RECORDS OF SERVICE: Includes case records closed from any active status.

INELIGIBLE RECORDS OF SERVICE: Included in this category are those records of applicants who were not accepted for services.

PURCHASE ORDERS AND INVOICES

In addition, please retain and dispose of the following records as follows:

- CLIENT MASTER LIST: Keep in office two years, and then destroy.
- GENERAL OFFICE FILES: Includes applications for employment, personnel files, general memoranda, equipment inventory lists, purchase orders and invoices for supplies and equipment. These files should be arranged alphabetically by subject.
- EQUIPMENT INVENTORY LISTS AND GENERAL MEMORANDA: Keep until obsolete, then destroy

[Chapter l2l and l32 of the General Statutes of North Carolina]

1-2-5: Annual Review of Closed Records of Service

The Division is required by Federal law and regulations to conduct periodic reviews of certain categories of ineligibility determinations for applicants and clients. The review of ineligibility determinations applies to applicants who were determined ineligible, on the basis of assessments, which indicated they could not be expected to reach the rehabilitation goal due to the severity of the disability or unfavorable medical prognosis. The following policies apply as appropriate in the respective instances:

Client's Record of Service Closed as Ineligible Due to Unfavorable Medical Prognosis or Disability Too Severe

Clients closed as ineligible in case status code 58, 78, or 80 because the disability is too severe or there is an unfavorable medical prognosis (IL reason code 85) will be reviewed within 12 months to determine if circumstances resulting in the ineligibility decision have changed to the degree that the decision can be reversed. State office staff for the IL program will automatically conduct this initial review. Subsequent reviews will be conducted only upon request of the applicant.

The Program Policy, Planning, and Evaluation Services section or the IL program staff will mail a letter during the ninth month following the date of closure informing the applicant of their right to a review. This letter will also explain why the record was closed. A copy of this letter will be forwarded to the counselor currently serving the caseload from which the applicant was closed. This letter is

designed to provide the applicant with a clear understanding of, and an opportunity for, review.

The letter will explain:

A. The Division's review responsibility;

B. That if the applicant feels employment/independence is now or in the near future a possibility, then the applicant should contact the counselor/office noted in the correspondence; AND

C. That if the applicant is uncertain of the future, contact in subsequent years may be requested.

If the applicant does not respond by the thirteenth month after closure, then the following options are available:

A. If the letter is returned (i.e., moved - no forwarding address; occupant unknown, etc.), the Division will have made a reasonable attempt to provide the initial review and the applicant's name will be dropped from any future follow-up list. Upon receipt of the returned letter from the postal service, the Program Policy, Planning, and Evaluation Services Section or the IL program will send the letter to the counselor. The letter will be filed in the applicant's case record.

OR

B. If the applicant fails to make contact by the thirteenth month, the applicant will be dropped from the list for future contact. The counselor shall document on the copy of the letter that no contact occurred and file the letter in the record of service.

If the applicant makes contact, the counselor should respond and interview the applicant and provide the assessments necessary to make a determination of eligibility based on current data. The applicant's other option would be to request a review the following year. Should either of these situations occur, the counselor must note at the bottom of the file copy of the letter one of the following:

- *Contact - case record requires no further consideration.*
- *Contact - case placed in 52 and subsequently placed in 60 (as appropriate). Counselor should identify the previous and new VR/IL number.*
- *Contact - case placed in 52 and not accepted (58).*
- *Counselor should identify the old and new IL number.*
- *Contact - applicant unable to participate in a rehabilitation program leading to work or independence - requests follow-up next year. (This will automatically establish a review the following year.)*

The IL counselor should notify the IL program staff. The copy of the letter should be filed in the new record. This step is very important in that it allows the Division to document compliance with the Act.

The situation may arise when a record of service was closed 58, 78, or 80 for reason code 85 but is later referred or otherwise opened. IL staff should notify the IL program staff in the state office. This mechanism will prevent a follow-up letter being mailed during subsequent reviews.

[34 CFR 364.53]

1-2-6: Annual Verification of Records of Service

Each year the Regional Director will coordinate a "hands-on" comparison of the *Client Master List* with client records in each unit. This includes inactive and active records of service based on the *Client Master List.* The Regional Director will report to the Section Chief of Program Policy, Planning, and Evaluation or the Chief of Community Services by August 31 the results of the review. Every effort should be made to account for misplaced client records of service. Lost records of service should be reported to the Chief of Policy, as appropriate, for reconstruction purposes.

[34 CFR 361.39 and 34 CFR 361.49]

Section 1-3: Confidentiality of Records

All Division records of service will be maintained in a confidential manner as described in this section.

1-3-1: General Provisions

The Division, through its units and facilities, shall maintain a record on all clients receiving services from the Division. All records shall be of a confidential nature and shall not be made available to the general public. Except as required or allowed in this policy, no information obtained concerning a client served by the Division may be disclosed by the Division without the consent of that client. The Division will not contract with vendors who require, as a condition of admission, the disclosure of health or disability information which is not necessary to achieve health, safety, or programmatic objectives. For example, residential programs are not legally seen as settings that should require HIV disease related information for health and safety reasons. In situations when such disclosure is necessary, the Division will require that the vendor have in place policies which assure that such information will be used and disclosed only as necessary to achieve those purposes. If the information concerns a minor, the consent of a parent or guardian must also be obtained. After a client has reached the age of l8 years, the records of that client may be disclosed only with the

consent of that client, or, if the client is incompetent, the client's guardian. Furthermore, whenever consent or action is required of a client, the client's representative, if properly authorized, may give such consent or take such action.

Except as provided in this policy, each Division client shall have full access to all records which contain information regarding the client. A parent or guardian of a minor shall also have full access to the information contained in the records of that minor. All clients, representatives, service providers, cooperating agencies, and interested persons shall be informed of the confidentiality of client personal information and the conditions for accessing and releasing this information.

All applicants/clients or their representatives must be informed about the Division's need to collect personal information and the policies governing its use. The Division shall inform clients of the following:

A. Identification of the Rehabilitation Act as the authority under which information is collected;
B. The principal purposes for which the Division intends to use or release the information;
C. That the applicant/client’s provision of any information is mandatory if such information is necessary to determine eligibility, to plan rehabilitation goals, objectives, and services, and to accomplish the rehabilitation program. Failure to provide such information will result in delay or denial of services. Information which is not crucial or pertinent to the rehabilitation program would be deemed voluntary and would not affect provision of services if not provided by the client;
D. Identification of other agencies to whom information may be released along with the types of information so released; AND
E. Of those situations when the Division requires or does not require informed written consent of the client before information may be released.

All explanations to applicants/clients and their representatives about policies and procedures affecting confidential information must be in the applicant/client's primary language or must be through appropriate modes of communication for those individuals who rely on special modes of communication.

All confidential information acquired by the Division is the property of the Division and shall remain so, and all contracts, grants, agreements, and other documents entered into by the Division shall so provide. The Division shall maintain in its records only such information about a client as is relevant and necessary to accomplish any purpose of the Division required by statute or rule. No information in the case record shall be removed, destroyed, or altered for purposes of avoiding compliance with this policy. Whenever the Division makes a disclosure to any person or entity other than the client, the disclosed material shall be stamped with a *CONFIDENTIAL INFORMATION* stamp or accompanied by a letter containing the following statement**:** *THIS IS CONFIDENTIAL INFORMATION FROM THE RECORDS OF THE NORTH CAROLINA DIVISION OF*

VOCATIONAL REHABILITATION SERVICES. FEDERAL LAW AND REGULATIONS PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION WITHOUT THE INFORMED WRITTEN CONSENT OF THE CLIENT TO WHOM THIS INFORMATION PERTAINS.

The original file may not be removed from the control of the Division, but must be viewed in the office in the presence of a Division staff member. All other responses to requests requiring personal information shall be provided through photocopies. There will be no charge for the sharing of copies to individuals, agencies or organizations which require copies for the benefit of the client's rehabilitation program. Otherwise, photocopies are $ .25 per page.

A client may submit a written request to add, delete, or amend information contained in the case record. The Unit Manager/Facility Director shall make a decision whether to amend the record. If the record is to be amended, the Division shall:

A. Amend any portion of the record which is not accurate, relevant, timely, or complete by making appropriate notations on the record; OR
B. Insert corrective material into the file.

If the decision is made not to amend the record, the Division shall inform the client in writing of the decision, the reason for such decision, and the procedures for the client placing statements into the record.

1-3-2: Requests for Client Information

All requests for information shall be in writing. The consent for disclosure shall contain:

A. The name of the client;
B. The name or title of the person or organization to whom the disclosure is to be made;
C. The extent or nature of the information to be disclosed;
D. A statement that the consent is subject to revocation at any time;
E. The date on which the consent is signed; AND
F. The signature of the client.

When a requested record has been identified and is available, the Division shall notify the party requesting the information as to where and when the record is available for inspection or that copies will be available and will be sent by mail. The notification shall also advise the requesting party of any applicable fees.

If a requested record cannot be released or located from the information supplied or is known to have been destroyed or otherwise disposed of, the party requesting the information shall be so notified. A response denying a written request for a record shall be in writing and shall include:

A. The identity of the person responsible for the denial; AND
B. A reference to the specific law or regulations authorizing withholding of the record with a brief explanation of how the regulations or law applies to the information being withheld.

When confidential information is released or release is denied, the counselor releasing it or denying the release shall place an entry in the Case Notes stating:

A. The name of the person to whom it was given or by whom requested, if the request is denied;
B. The date the information was released;
C. The documents released or reviewed; AND
D. The reason for such release or denial.

Disability Determination Section

Regulations of the Social Security Disability Insurance (SSDI) Beneficiaries and Supplemental Security Income (SSI) program authorize the disclosure of information about the claimant by the Disability Determination Section (DDS) and the Social Security Administration. Likewise, the regulations authorize this Division to disclose client information to these parties for the purpose of disability determination; which includes the appeals process when claimants are denied benefits.

Releasing records to Disability Determination
During the application process for SSI and SSDI benefits, the claimant must authorize the Disability Determination Section and the Social Security Administration to collect any medical records or other information about the disability from physicians, hospitals, agencies, or other organizations. This signed release by the client meets the requirements set forth in the Division policy, and authorizes the counselor, when requested by the Disability Determination Section or the Social Security Administration, to forward copies of medical records or other information about the client's disability for the purposes of disability determination.

Requesting records from Disability Determination
DDS can release some disability related reports to VR with a written consent. The consent must:

(1) include the name, Social Security number, and date of birth of the individual
(2) be signed, and dated by the individual
(3) specifically authorize the NC DDS to release records
(4) specify the information to be disclosed
(5) state the purpose for which the information is to be disclosed
(6) specify to whom the records may be disclosed.

DDS will only release copies of the signed Consultative Examination (CE) Form to VR. Draft copies will not be released. These documents should contain specific information about the client's disability for use in determining eligibility and rehabilitation service planning.

Revised 6/1/2019

Process for Requesting records from DDS:

- VR staff should fax requests for CE reports with a properly executed consent to the DDS fax at 800-804-5509. (DDS requests that VR NOT call in advance.)
- DDS will handle all VR requests on Thursdays and one of the following responses will be provided via fax:
    - A fax cover with the signed CE report attached
    - A note indicating that there are no reports available
    - A note indicating the claim is no longer within DDS jurisdiction and any inquiries should be sent to the servicing Social Security Field Office

1-3-3: Release of Confidential Information *With* the Consent of the Client

When the client requests that information be released to another individual, Division or organization, the Division upon receiving the informed written consent of the client, shall release to such other individual, Division or organization for its program purposes only that information which may be released to the client, and only to the extent that the other individual, Division or organization demonstrates that the information requested is necessary for its program. Information which is determined by the Division to be harmful to the client shall be released only when the other individual, agency, or organization assures the Division that the information will be used only for purposes for which it is being provided and will not be further released to the client. When a client requests release of confidential information to the client, parent, guardian, or representative, all confidential information contained in the client's file may be inspected and copied with the exceptions as noted below:

- On rare occasions, certain information obtained from another organization is restricted from further re-disclosure. Such information is generally so marked and the Division will honor such restrictions by directing the client to the original source. (Most agencies and organizations, including the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and the Social Security Administration, permit re-disclosure with client consent).

- Any information including medical or psychological information, which, in the judgment of the counselor may be harmful to the client, may not be released to the client. If the client is a minor, it may be released to the client's parent, guardian, representative, or to a physician or licensed psychologist. Some

information is so sensitive and potentially harmful that the counselor shall seek consultation with the Assistant Director for Program Operations or the Section Chief of Program Policy, Planning, and Evaluation before responding to the request. When releasing such information, the Division shall caution the party receiving the information that it may be harmful to the client and; therefore, the receiving party is responsible for the use of the information.

1-3-4: Release of Confidential Information *Without* the Consent of the Client

An employee may, in the course of providing rehabilitation services, disclose confidential information without the consent of the client to other Division employees. The Division may authorize the release of confidential information to an organization, agency, or individual engaged in audit, evaluation, research, only for purposes directly connected with the administration of the program or for purposes which would significantly improve the quality of life for individuals with disabilities. Inquiries of this nature should be directed to the Section Chief of Program Policy, Planning, and Evaluation. Before participating in such activities, the Division will require assurance that:

A. The information will be used only for the purposes for which it is being provided;
B. The information will be released only to persons officially connected with the audit, evaluation or research;
C. The information will not be released to the client;
D. The information will be managed in a manner to safeguard confidentiality; AND
E. The final product will not reveal any personal identifying information without the informed written consent of the client.

The Division may share confidential information on a need-to-know basis with its trainees, interns, and volunteers, who shall be bound by Division policy concerning confidentiality in the same manner as employees.

Confidential information must also be released without consent in the following situations:

A. In order to protect the client or others when the client poses a threat to his or her safety or the safety of others;
B. If required by Federal law;
C. In response to investigations in connection with law enforcement, fraud, or abuse. This includes routine sharing of demographic information as required by DHHS to support Child Protective Service investigations; AND
D. In response to court order.

Revised 9/1/2015

Periodically, the Division will receive requests for client information from attorneys in Workers' Compensation cases, who will not present consent for release, but will assert that Workers' Compensation information is not privileged under N. C. Law. G. S. 97-27 does state that information from physicians and surgeons who examine injured workers shall not be privileged. However, the Division must require client consent because Federal law and regulation *(34 CFR 36l.49)* must prevail in this situation.

1-3-5: Subpoenas

A subpoena is a court order to either appear and testify at trial or at a deposition or to produce documents (a subpoena duces tecum). The subpoena itself does not obviate or overrule the confidentiality regulations dealing with client records and, therefore, client confidentiality may be invoked in certain circumstances as set forth below when a subpoena seeks to elicit confidential client information. This is applicable to either testimony given at a trial or deposition or the production of documents.

An employee who receives a subpoena must send a copy of the subpoena via encrypted email to the Chief of Policy/Policy Office with a copy to the respective Regional Director and Division Director as soon as possible upon receipt. The Chief of Policy is responsible for forwarding the subpoena to NC DHHS legal counsel. The employee shall also notify the Chief of Policy/ DHHS legal counsel as to whether necessary client consent has been given, in writing, for the release of information, including confidential client information. Division of Vocational Rehabilitation Services staff must not respond to subpoena requests without receiving specific instructions from the Chief of Policy/Policy Office in coordination with NC DHHS legal counsel.

Subpoena to appear/testify:
If consent has been given, the employee shall appear according to the terms of the subpoena at the direction of DHHS legal counsel. If no client consent has been given, DHHS legal counsel will inform the court and issuing parties of the requirements of the law and regulations concerning confidentiality; the employee shall testify or produce documents in this circumstance only upon judicial order compelling production.

Subpoena to produce documents:
Upon receipt of a subpoena for the production of documents, if client consent has been given, the production of requested documents shall occur at the direction of DHHS legal counsel. If no client consent has been obtained, written objection to the production of documents should be served on the attorney or such other person designated in the subpoena by DHHS legal counsel. This written objection, prepared by or under the direction of DHHS legal counsel, should state the specific grounds objected to, such as protection of privileged or confidential matters. If the subpoena is issued from Federal Court, the written objection to production must be served within 14 days after service of the subpoena, or before the specified time for compliance if less than 14 days.

If the subpoena is issued from a North Carolina state court, the written objection to production must be within 10 days after service of the subpoena, or before the specified time for compliance if less than 10 days. The written objection to production of documents should read as follows: "Pursuant to Rule 45(c)(3) of the North Carolina Rules of Civil Procedure [Federal Rules of Civil Procedure Rule 45(d) should be substituted if the action is filed in Federal court], the Division of Vocational Rehabilitation Services, North Carolina Department of Health and Human Services, objects to the inspection or copying of the documents designated in the subpoena directed thereto on the grounds that the documents are privileged and confidential pursuant to 34 CFR 361.49." Upon service of the written objection, the employee is relieved of the duty to produce the documents until a court order compelling production of the documents is issued. The burden is on the party issuing the subpoena to obtain a court order to compel production.

On occasion, certain information which the Division received from another source may be restricted from further disclosure by the original source. That information is generally so marked when the Division receives it and the Division should honor the restrictions on re-disclosing. After consulting with the Chief of Policy/Policy Office, the Division should respond to subpoenas for such information by directing the person issuing the subpoena to the original source. If the subpoena requires a court appearance, the employee shall consult with the Chief of Policy/Policy Office who will obtain guidance from DHHS legal counsel.

An employee may testify without client consent about general information concerning the Division, such as services available and eligibility criteria.

Revised 1/3/2017

Section 1-4: Client Assistance Program (CAP)

The CAP, as mandated by 1984 Amendments to the Rehabilitation Act of 1973, was developed to assist individuals with disabilities with resolving concerns related to accessing rehabilitation services. Services available through CAP include:

- Assistance to consumers in resolving concerns related to the application for and the provision of or denial of services.
- Explanation to consumers of rehabilitation policies and procedures.
- Education for consumers on their right to due process (requesting an Administrative Review and/or an Appeals Hearing).
- Provision of legal consultation if required in those cases which reach the Appeals Hearing level of the appeal process (in these cases, CAP is empowered to contract with private attorneys for this service).
- Provision of information/referral services to individuals with disabilities seeking information about independent living, vocational rehabilitation, and other rehabilitation programs.

Each applicant for services must receive *The Agreement of Understanding with the North Carolina Division of Vocational Rehabilitation Services and Applicants for Services* and a CAP brochure. When working with an individual with known or suspected limited reading skills, this information must be thoroughly reviewed to assure full understanding of the CAP.

CAP places a strong emphasis on early intervention and on the use of mediation and negotiation strategies to resolve the consumer's concern at the local or regional level whenever possible.

The CAP Director must be notified immediately upon receipt of a consumer request for an Administrative Review and/or an Appeals Hearing. The CAP director is also involved in the review and development of Division policy and procedures.

A signed consent form is required before verbal and/or written communication can take place between the CAP advocate and the counselor/field staff. The CAP representative should provide this consent form to counselors/field staff at the time of the initial contact. This consent form shall be maintained in the case file. If the counselor initiates contact, a consent form is available under VR client templates, Form & Templates on the Agency Resources page on the Intranet. This consent form should be provided to the CAP advocate.

[34 CFR 370]

Section 1-5: Client (and Applicant) Appeals of Division Decisions Including Administrative Reviews and Mediation

The Division provides a procedure through which any individual receiving or applying for services from the Division who is dissatisfied with any determinations made by the Division concerning the provision of services may request a timely review of those determinations. This policy applies to the Independent Living Program as well as to the Vocational Rehabilitation Program. The applicant/client has the right to an appeals hearing before an impartial hearing officer within 45 days of the Division's receipt of a written request for an appeals hearing. The applicant/client also has the option of seeking resolution of the issue through mediation and/or an administrative review prior to an appeals hearing, but these procedures cannot be required. Division staff will assist applicant/clients with their written request for administrative reviews, mediation, or appeals hearings. Assistance with the resolution of their problems is also available through the Client Assistance Program (CAP).

At the time of application for services, when the IL Service Plan is developed, and when

services are being reduced, suspended or terminated, all applicant/clients shall be given written information informing them:

A. That they have a right to an appeals hearing when they are dissatisfied with any determination(s) made by the Division that affects the provision of services;
B. That they have the option of seeking resolution of the issue through an administrative review prior to an appeals hearing;
C. That mediation may be available to resolve their issues if the Division agrees to it;
D. That the Rehabilitation Counselor, Appeals Coordinator, or other designated staff of the Division will assist them in preparation of the written request for an administrative review mediation and/or appeals hearing.
E. Of the name and address of the appropriate Regional Director to whom the request shall be submitted; AND
F. That they may receive assistance with the resolution of their problems through the Client Assistance Program (CAP).

The counselor shall review this information with the applicant/client in a manner that is understandable to the individual. The applicant/client's signature on *Form ILRP-1001* for IL applicants confirms that this information was provided and explained. All applicants shall be given a copy of this information.

Request for Administrative Review, Mediation and Appeals Hearing

When any applicant for or an individual receiving services wishes to request an administrative review mediation and an appeals hearing or only an appeals hearing the applicant/client shall submit a written request to the appropriate Regional Director. The request shall indicate if the applicant/client is requesting an administrative review, mediation, and an appeals hearing to be scheduled concurrently; an administrative review and an appeals hearing to be scheduled concurrently; or only an appeals hearing. The request shall contain the following information:

A. The name, address and telephone number of the applicant/client; AND
B. A concise statement of the determination(s) made by the rehabilitation staff for which an administrative review, mediation and/or appeals hearing are being requested and the manner in which the person's rights, duties or privileges have been affected by the determination(s).

The Division shall not suspend, reduce or terminate services being provided to a client under an IL Service Plan pending final resolution of the issue through mediation, an administrative review or an appeals hearing unless the applicant/client or the applicant/client's representative so requests, or the Division has evidence that the services have been obtained through misrepresentation, fraud, collusion, or criminal conduct on the part of the applicant/client.

Response to Request

A. Upon receipt of a request for an appeals hearing the Regional Director shall immediately forward the original request to the Section Chief of Program Policy, Planning, and Evaluation who will arrange for the Appeals Coordinator to provide the applicant/client with information about the possibility of mediation (if mediation has been requested) and appoint a hearing officer to conduct the appeals hearing;

B. If the applicant/client has requested an administrative review in addition to the appeals hearing, the Regional Director shall:

1. Make a decision to conduct the administrative review or appoint a designee to conduct the administrative review who:
   (a) Has had no previous involvement in the issues currently in controversy;
   (b) Can conduct the administrative review in an unbiased way; AND
   (c) Has a broad working knowledge of the Division's policy, rules, Federal regulations governing the program, and the State Plan for Vocational Rehabilitation Services or the State Plan for Independent Living Services (as appropriate).

AND

2. Proceed with, or direct the designee to proceed with an administrative review according to the provisions of this policy;

C. The Regional Director shall send the applicant/client written acknowledgment of receipt of the request and inform the applicant/client that additional information will be sent regarding the possibility of mediation (if mediation has been requested) and the administrative review and/or appeals hearing (see SCHEDULING, NOTICE OF, AND CONDUCTING ADMINISTRATIVE REVIEW below). If this information is available, it can be included in the letter of acknowledgment;

AND

D. The Regional Director shall provide the Client Assistance Program (CAP), if assisting the applicant/client with the case, and the Appeals Coordinator with a copy of the request and the response to the request.

Scheduling, Notice Of, and Conducting Administrative Review

If an administrative review is to be conducted, the Regional Director or designee shall:

1. Set a date, time, and place for the administrative review;
2. Send written notification by certified mail to the applicant or client and the

parent(s), guardian, or representative, as appropriate, of the date, time, and place for the administrative review at least five days prior to the administrative review

3. Advise the applicant or client in the written notice:

   (a) That additional information will be sent regarding mediation if mediation has been requested;
   (b) That arrangements will be made for a hearing officer to conduct an appeals hearing if the matter is not resolved in the administrative review or mediation; AND
   (c) That the applicant or client will also receive a written notice from the hearing officer regarding the formal appeals hearing which will be held after the administrative review and mediation (if mediation is scheduled);

AND

4. Notify the Director of the Client Assistance Program (CAP) and other individuals to be involved in the administrative review of the request and the date, time and place for the administrative review. This notification may be by phone or in writing.

Prior to the administrative review the Regional Director or designee shall review all previous decisions and casework related to the applicant or client and seek whatever consultation, explanation, documentation, or other information that is deemed necessary, utilizing the Division's CAP Director as appropriate.

The administrative review must be conducted within 15 days of receipt of the original request. Within five working days of the administrative review the Regional Director or designee shall make a decision and notify the applicant or client and others using the following procedures:

1. Compiling a written report of the administrative review outlining the purposes of the administrative review the participants, the decision that was reached, and the rationale for the decision;
2. Sending the written report containing the decision to the applicant or client by certified mail with return receipt requested, with a copy being placed in the applicant/client's official case record, and copies being forwarded to the Appeals Coordinator and the CAP Director (if CAP is involved), and
3. Providing instructions to the applicant or client of steps that may be taken in response to the decision and the deadline for the responses.

A form indicating agreement with the decision and requesting that the hearing (and mediation if scheduled) be canceled shall be included for the applicant/client's signature if the applicant/client agrees with the decision. If the

applicant/client is satisfied with the decision resulting from the administrative review, the applicant/client shall sign the form and return it to the Regional Director within five days of receipt of the decision. The Regional Director shall inform the Appeals Coordinator of the request to cancel the hearing immediately and forward the form to both the Appeals Coordinator and the Chief of Policy for submission to the hearing officer. If the Regional Director does not hear from the applicant or client within the five days indicated, it is recommended that the Regional Director contact the applicant or client to verify that the person does understand the procedures and does wish to proceed with the formal appeals hearing.

Administrative Review by Section Chief of Program, Policy, Planning and Evaluation

In situations where the issue currently in dispute involves action taken by the central office of the Division, the Section Chief for Program Policy, Planning, and Evaluation or designee shall be responsible for the duties related to the administrative reviews that are prescribed for the Regional Director in this policy.

Appointment of Hearing Officer

Upon receipt of the applicant/client's request for an appeals hearing from the Regional Director, the Section Chief for Program Policy, Planning, and Evaluation shall contact the Appeals Coordinator for the appointment of a qualified mediator (if mediation has been agreed upon by the applicant/ client and the Division) and an impartial hearing officer. The hearing officer will be selected on a random basis without replacement from the pool of qualified hearing officers who meet the requirements of the Rehabilitation Act and have been approved by the Division and the State Rehabilitation Council. This is done concurrently with the scheduling of an administrative review (if one has been requested) in order to meet the 45-day deadline required by the Rehabilitation Act.

[10 NCAC 20B .0206]

Mediation

The Appeals Coordinator will inform the applicant/client in writing that the issue may be resolved through mediation prior to the appeals hearing (and usually after the administrative review, if one is scheduled) if both the applicant/client and the Division agree to mediation. The Division Director will make the decision regarding the Division's participation in mediation.

If both parties agree to mediation, the Coordinator will make arrangements for an impartial mediator from the Division's list of qualified mediators to conduct the mediation. (A qualified mediator must be an individual who has been Certified by the N.C. Dispute Resolution Commission or approved by the Mediation Network of North Carolina. The mediator also must be knowledgeable about Vocational

Rehabilitation law and regulations.)

The Coordinator will make arrangements for the mediation to be conducted in a location that is convenient to both parties. The mediation will be scheduled so that the appeals hearing can be conducted within the required 45-day time frame if possible. If this schedule is not possible, the appeals hearing may be delayed if both parties sign a written agreement for a specific extension of time. The Coordinator will send both parties written confirmation of the mediation: the time and place, the mediator's name, and any instructions relating to the process.

Both parties will sign a statement prior to the mediation agreeing to keep all discussions occurring during the mediation confidential. If an agreement is reached during the mediation, it must be in writing and signed by both parties. The written agreement may be submitted as documentation during the appeals hearing and any subsequent court actions. However, discussions, proposed settlements, and other information not reflected in the mediation agreement must be kept confidential, but evidence that is otherwise discoverable shall not be inadmissible merely because it is presented or discussed during mediation.

The Division will pay for the expenses involved in the mediation process.

Scheduling and Notice of Formal Appeals Hearing

The hearing officer shall schedule the formal appeals hearing to be held within 45 days of the original request by the applicant/client. The hearing officer shall provide the applicant/client and the Division written notice of the date, time and place of the hearing and the issue(s) to be considered at least 10 days prior to the hearing. A copy of the notice shall also be sent to CAP if CAP is assisting the applicant/client. The notice shall state:

A. The procedures to be followed in the hearing;
B. The particular sections of the statutes, Federal regulations, State rules, and State Plan involved;
C. The rights of the applicant or client to present additional evidence, information**,** and witnesses to the hearing officer, to be represented by counsel or other appropriate advocate, and to examine all witnesses and other relevant sources of information and evidence;
D. That the hearing officer shall extend the time for the hearing if the parties jointly agree to a specific extension of time and submit a written statement to that effect to the hearing officer; AND
E. That the hearing may be canceled if the matter is resolved in an administrative review or through other negotiations including mediation

Notice shall be given personally or by certified mail. If given by certified mail, the date of notification shall be the delivery date appearing on the return receipt. If

the hearing officer does not receive a written request from the applicant/client that the hearing be canceled, the hearing shall be conducted as scheduled unless negotiations produce a settlement that is satisfactory to both parties prior to the hearing. If the hearing is canceled, the hearing officer shall send the applicant/client and the Division written notice of the cancellation in the same manner as required for notice of the hearing. A copy of the notice of cancellation shall be sent to CAP if it is involved.

Procedures Governing Hearing

The appeals hearing shall be conducted according to the provisions of Federal Regulation 34 C.F.R. 361.57(b)(l)-(4) and (12) and (c) and according to the provisions of Division rules in 10A NCAC 89B .0212 through .0222 and .0225.

Hearing Officer's Decision

Within 30 days of the completion of the hearing, the hearing officer shall make a decision based on the provisions of the approved State Plan and the Rehabilitation Act (this would include Federal and State Regulations and Division policy that are consistent with the State Plan and the Rehabilitation Act) and provide the applicant/client or, if appropriate, the applicant/client's parent, guardian, or other representative, and to the Division Director, with a full written report of the findings and grounds for the decision. The decision shall be given to the applicant/client and the Division Director personally or by certified mail. If given by certified mail, the delivery date appearing on the return receipt shall be delivery date of record.

The impartial hearing officer's decision is the final decision unless a review by the Secretary of DHHS is requested by either party or one of the parties brings a civil action for review by the courts of the decision.

Review and Final Decision by Secretary of DHHS or Designee

Either party (the applicant/client or the Division Director) may request a review of the hearing officer's decision by the Secretary of the Department of Health and Human Services within 20 days of the receipt of the decision.

The Secretary may delegate the responsibility for reviewing the hearing officer's decision to another employee of the Department but shall not delegate the responsibility to any officer or employee of the Division.

The reviewing official shall send written notification of the review to both parties and allow the submission of additional evidence as required by the Rehabilitation Act. The written notice must be given personally or by certified mail. If given by certified mail, the delivery date appearing on the return receipt shall be the delivery date of record.

The reviewing official's review shall be based on the following standards of

review:

- Decisions that are neither arbitrary, capricious, an abuse of discretion, or otherwise unreasonable.
- Decision supported by substantial evidence and consistent with facts and applicable Federal and State policy.
- Decisions reflecting appropriate and adequate interpretation to such factors as:
  - (a) The Statute and Regulations as they apply to specific issue(s) in question;
  - (b) The State Plan as it applies to the specific issue(s) in question;
  - (c) Division rules as they apply to the specific issue(s) in question;
  - (d) Key portions of conflicting testimony;
  - (e) Division options in the delivery of services where such options are permissible under the Federal Statute; AND
  - (f) Restrictions in the Federal Statute with regard to such supportive services as maintenance and transportation.

The reviewing official shall not overturn or modify a decision, or part of a decision, of an impartial hearing officer that supports the position of the applicant/client unless the reviewing official concludes, based on clear and convincing evidence, that the decision of the independent hearing officer is clearly erroneous on the basis of being contrary to the approved State Plan or Federal or State Law, including rules and regulations and Division policy that are consistent with Federal Law.

Within 30 days of the Secretary's receipt of the request to review the impartial hearing officer's decision, the reviewing official shall make a final decision and provide a full report in writing of the decision, including the findings and grounds for the final decision, to the applicant or client; or, if appropriate, the applicant/client's parent, guardian, or other representative; and the Division Director. The final decision shall be given to both parties personally or by certified mail. If given by certified mail, the delivery date appearing on the return receipt shall be the delivery date of record.

The Division Director shall forward a copy of the final decision to the Section Chief for Program Policy, Planning, and Evaluation, the CAP Director, the Regional Director, and the applicant's or client's representative, as appropriate. A copy shall also be included in the applicant/client's official case record.

Copies of all final decisions must also be submitted to the State Rehabilitation Council but in a manner that ensures that all identifying information of applicant/clients is kept confidential.

Implementation of Decision

The final decision issued by the impartial hearing officer or the reviewing official

shall be implemented regardless of whether a party has filed a civil action in the case. That implementation will stand pending a final decision in any civil action.

Extensions of Time

Reasonable time extensions may be granted for the various steps in these procedures for good cause shown at the request of a party or at the request of both parties except for:

- The time for continuation of services during the administrative review, mediation, and the appeals hearing unless the applicant/client requests that services be stopped or unless there is evidence that services have been obtained through misrepresentation, fraud, collusion, or criminal misconduct on the part of the applicant/client
- The 45-day time for conducting the appeals hearing which may be extended only when the Appeals Coordinator or the hearing officer extends the hearing for a specific period of time upon a written request of both parties
- The 10-day time for issuance of the written notice of the formal appeals hearing
- The 20-day time frame for requesting a review of the hearing officer's decision
- The 30-day time for the reviewing official's issuance of a final decision.

When an extension of time is being granted by the person conducting the administrative review or meditation or by the hearing officer, consideration shall be given to the effect of the extension on deadlines for other steps in the administrative review and appeals process.

Record

The official records of appeals hearings shall be maintained in the central office of the Division by the Section Chief for Program Policy, Planning, and Evaluation.

Any person wishing to examine a hearing record shall submit a written request to the Section Chief for Program Policy, Planning, and Evaluation in sufficient time to allow the record to be prepared for inspection, including the removal of confidential material.

Transcripts

Any person desiring a transcript of all or part of an appeals hearing shall contact the office of the Section Chief for Program Policy, Planning, and Evaluation. A fee to cover the cost of preparing the transcript shall be charged, and the party may be required to pay the fee in advance of receipt of the transcript. The transcript may be edited to remove confidential material.

Civil Action

Any party (the applicant/client or the Division) aggrieved by a final decision may

bring a civil action for review of such decision by a State Court of competent jurisdiction or in a United States district court of competent jurisdiction.

The party seeking judicial review in a State court must file a petition in Superior Court of Wake County or in the superior court of the county where the person resides within 30 days after the person is served with a written copy of the decision. Court review in a United States district court will be governed by the Federal laws applicable to such situations.

[CFR. 361.57; 10A NCAC 89B Section. 0200; 1998 Amendments to the Rehabilitation Act, Section 7(16) and Section 102(c)

Section 1-6: Social Security Work Incentives

Individuals receiving SSI and/or SSDI are offered a variety of work incentives and programs which may have little or no impact on their benefits. These incentives are explained in SSA publication No. 64-030 entitled A Summary Guide to Social Security and Supplemental Security Income Work Incentives For People With Disabilities.

The Social Security Act no longer provides for suspension of benefits to those SSDI beneficiaries and SSI recipients who refuse, without "good cause," to accept Vocational Rehabilitation (VR) services.

Section 1-7: Implications of Section 504 and Americans with Disabilities Act (ADA)

It is the policy of this Division that full compliance with the requirements set forth under Section 504 of the Rehabilitation Act of 1973, as amended (PL 93-112) will be maintained in all areas of programming, and services provision. The Division will implement all necessary procedures set forth in 45 CFR, Part 84, to assure full compliance with the requirements by the required dates. All policies and procedures relative to provision of services, employment, and programming within the Division will be carried out with due consideration to these requirements. The Program Policy, Planning, and Evaluation Section should be consulted on compliance issues related to client services. The Director of Human Resources is designated as the responsible party for assuring compliance with employment requirements under this Section.

[Section 504, Rehabilitation Act of 1973, as Amended; 45 CFR 84; 29 USC 706]

Section 1-8: Nondiscrimination

All policies are applied without regard to sex, race, age, creed, color, national origin or type of disability of the individual applying for service.

[34 CFR 364.41]

1-8-1: Disability Group

No individual will be found ineligible for services or be restricted from Division services on the basis of the type of disability.

1-8-2: Age

There is no upper or lower age limit which will, in and of itself, result in a finding of ineligibility for any individual who otherwise meets the basic eligibility criteria. It is clear that the Rehabilitation Act is directed to the rehabilitation of individuals for employment or independent living. While it is clear that some services may be initiated prior to the current employable age (in North Carolina) of sixteen years old, these individuals are not likely to be employable or be able to live independently. An individualized rehabilitation program may not be appropriate until a later age.

1-8-3: Residence

No state residency requirement can be imposed which excludes from services any individual who is otherwise eligible unless the individual comes to North Carolina for the sole purpose of becoming a client of the Division.

Individuals may be served by two different State vocational rehabilitation programs as long as services are not duplicated. The counselor should have the applicant sign a release of information giving permission to obtain records from the State vocational rehabilitation program of the individual's previous residence. Communication with the joining state will be crucial in assuring that the needs of the consumer are being met and that services are not being duplicated. This also assures that both states receive credit for the successful closure.

34 CFR 361.50(b)(2) RSA-TAC-12-04

Section 1-9: Identification and Verification

1-9-1: Social Security Numbers

A social security number is required on each applicant for or client of rehabilitation services prior to closing client records in case status codes 58, 76, 78 or 80. Should an applicant/client lose his/her number or have never applied for a social security number, counselors have the responsibility for assisting the applicant/client in completing the appropriate request for either a duplicate card or an original from the Social Security Administration. The disability benefits verification process used at application for services can be used to verify the existence of an SSN when an applicant cannot locate or cannot remember his/her SSN as long as the individual can provide the name, date of birth, race, ethnicity, and primary language associated with the SSN. Services should not be delayed pending issuance and/or receipt of the social security number unless the counselor has information contrary to the requirements noted in 1-9-2.

1-9-2: Citizenship and Employment Eligibility

The Immigration Reform and Control Act of 1986 (IRCA) was passed to control unauthorized immigration to the United States. The Immigration Reform and Control Act made all U.S. employers responsible to verify the employment eligibility and identity of all employees hired to work in the United States after November 6, 1986. To implement the law, employers are required to complete Employment Eligibility Verification forms (Form I-9) for all employees, including U.S. citizens.

Citizens of the U.S. include persons born in Puerto Rico, Guam, the U.S. Virgin Islands, and the Northern Mariana Islands. Nationals of the U.S. include persons born in American Samoa, including Swains Island.

Appropriate documentation to establish identity is required prior to VR/IL eligibility and the delivery of services. Documents which are acceptable are listed on Immigration and Naturalization Service Form I-9. The current version of this form may be found at:

http://uscis.gov

Visual verification of allowable documents is required in all cases in which a valid SSN is not produced. Visual examples of the allowable documentation required for employment verification may be referenced in the section on “acceptable documents for verifying employment verification” of the *Handbook for Employers: Instructions for completing Form I-9* found at:

http://www.uscis.gov/files/form/m-274.pdf

Section 1-10: Repossession, Storage, and Disposal of Equipment

The counselor should repossess equipment purchased for clients when the equipment is not being used for the intended purpose and it is unlikely that the equipment will be used for such in the foreseeable future or for reasons as specified on the DVR-1015. When equipment costing more than $500 is repossessed, the Counselor should consult with the Purchasing Manager on disposal of the equipment and arrangements for storage. In some cases, repossessed equipment may be of use to another client. The equipment should be safely stored until reassignment is made. In other situations, equipment may not be feasibly transferred to another client because of the customization or general condition of the equipment. The Purchasing Manager can advise on the disposition of equipment in such cases. If necessary, the Unit Manager may designate staff to pick up and safely transport repossessed equipment to another location. The Unit Manager should arrange for the transportation of equipment items that staff cannot safely move by contacting the Assistant Regional Director.

Repossessed equipment that might be of use to another client may be stored locally or in a regional storage area or in the purchasing section of the state office. If such storage space is not available, the Purchasing Manager and/or Assistant Regional Director should be consulted regarding other options for storage of the equipment.

Section 1-11: Case Service Authorizations

Case service authorizations must be issued prior to or on the effective date of the service being authorized. While it is allowable to issue a verbal authorization in times of emergency situations, written authorization must be issued within three days of the verbal authorization to cover the service. The intent is to assure the vendor and the clients are aware of the service(s) being authorized. Services not authorized should not be purchased. Any retroactive authorization exceeding seven days must be approved by the Supervisor except for required ancillary services associated with surgical procedures that are routinely authorized.

All claims must be received by DVRS within 365 days of the last date of service in order to be accepted for processing and payment. Claims received after 365 days of the last date of service must be approved by the Unit Manager. Claims received after two years from the last date of service must be approved by Fiscal Services.

When authorizing medical services, including durable medical equipment, comparable benefits such as private health insurance, Medicaid or Medicare must be noted, if applicable in the section named “Less Resources.” Additionally, the service description section on the authorization form can be used to provide further instructions to the vendor regarding the use of comparable benefits. When a comparable benefit has been ruled out, is no longer available or the Chief of Policy has approved waiving the usage

of the comparable benefit, written documentation to explain the action is required in the case file.

If the client is required to pay for a portion of the service being authorized, as noted in Excess Income Applied on the Financial Needs Survey, the authorization should note the specific amount the client must pay. Arrangements for payment should be made by the client and vendor when the VR authorization is issued

Definitions:

Pre-Planned Authorization: An authorization issued to a vendor for services to the client in statuses 02 and 10 prior to the development of the IL Service Plan.

Planned Authorization: An authorization issued to a vendor for services to the client in status 12 or 32 upon the development of the IL Service Plan.

Authorization to Client: An authorization issued directly to the client, in either a pre-plan or planned status, such as for transportation funds in advance of an appointment or for allowing the client to be reimbursed by the Division.

Revised 1/1/2019

Section 1-12: Invoice Processing

In order to meet Federal requirements regarding authorization for services, rates of payments, and determination of comparable benefits, the Division requires the submission of an invoice for any service provided to a client that is consistent with the corresponding authorization for services. Invoices must be submitted on forms specified in this policy and found on the automated case management system along with required supportive information. Other required information includes client name, inclusive dates of service, complete description of service, vendor name, vendor address, and the counselor's approval in BEAM.

Revised 2/2/2016

1-12-1: Vendor Signatures

Medical Invoices - Signatures on File - (Medical Vendors only)
An electronic or manual signature on medical, dental and pharmacy claim forms is a required field; however, the claim can be processed if the following is true: if a

physician, supplier, or authorized person's signature is missing, an authorization must be on file either electronic or paper or the signature field contains a computer generated signature.

Revised 4/1/2015

Vendor Invoice: Vendor signatures are not required on vendor invoices. Invoices must specifically document the invoiced amount, the service, the equipment, the training etc. Examples of documentation include but are not limited to:

- Packing Slips and receipts that detail the item or service and the cost
- Cash register or other sales receipts
- Invoice on letterhead with itemized list
- Invoices for copying Medical Records
- Computer generated invoices that identify the name of the company, date and itemized list of purchases

Case Service Invoice: Vendor signatures are required on the Division's case service invoice form when it is the only submitted documentation and none of the above documentation is available; or for authorizations to clients.

Invoices are to be submitted on one of the following required invoice forms:

1. Vendor Invoice – Invoice provided by the vendor. Acceptable invoices must include the Vendor's Name, a detailed description of the service, the cost, the date(s) of service, and the client's name.

2. Case Service Invoice - This is the general purpose invoice used by the Division in place of an invoice provided by a vendor or when an authorization is done directly to a client. These invoices must include client name, a detailed description of the service, the cost, and the date(s) of service.

3. Medical Invoice - Health Insurance Claim Form CMS 1500 used for speech, hearing, orthotic, anesthesia, radiological, DME, ambulatory surgery, physician services, home health and other services. These invoices should include the Employer Identification Number (EIN) per Federal Standards as noted in the claim instructions.

4. Dental Invoice - Used for dental services. These invoices should include the EIN per Federal Standards as noted in the claim instructions.

5. Eyeglass Invoice - Used for eyeglass billing. Should be DVRS Agency form from Nash Optical or Health Insurance Claim Form CMS 1500 from all other vendors.

6. Pharmacy Invoice - Used for over-the-counter and prescription medications and

others. These invoices should include the EIN per Federal Standards as noted in the claim instructions.

7. Hospital Invoices – UB04 used for inpatient and outpatient services and some Home Health services. These invoices should include the EIN per Federal Standards as noted in the claim instructions.

Revised: 5/1/2016

1-12-2: Additional Information Required on Invoices

Authorization Adjustments: Any authorization adjustments in excess of 10% must be electronically approved by the adjuster's supervisor.

DME Invoices - the Division will pay up to the State Contract Rate for DME after all other resources and comparable benefits have been utilized, when the purchase occurs on State Term Contract. If the DME is not purchased on State Contract, the Division will pay the "low bid" amount when bids are required. Refer to Section 2-5- for procedures to purchase DME as well as exceptions/waivers to the purchasing process.

All Durable Medical Equipment vendors are required to file for any available medical comparable benefits as "assigned" on the invoice form, so that any payment from the benefit goes directly to the vendor. The Division can only invoice for the portions of the purchase not covered by the comparable benefit (as supported by the EOB). The Subrogation Rights Form shall not be used in lieu of this procedure.

[Special Note on Lift Chairs: In the purchase of lift chairs, it is universally understood that Medicare and Medicaid pays for the lift motor mechanism only, and not for the chair/frame itself. Medicaid will pay as secondary co-pay only if Medicare is the primary insurance. Medicaid will not pay as a solitary benefit on this item. Accordingly, staff shall not invoice for the lift motor mechanism unless presented with a Medicare EOB showing a denial of the claim. However, staff may invoice for the chair/frame without delay since Medicare nor Medicaid covers. The Division would deem this as an acceptable business practice and accounting of the comparable benefit.]

Dental Invoices*:* Require the same information as medical claims, but the procedure codes are paid according to American Dental Association (ADA) codes. Preventive procedures should not be authorized: if invoiced without adequate justification, these procedures will not be considered for payment.

Eyeglass Invoices*:* Eyeglasses Ordering/Claim Forms require much the same information as a medical claim but the amounts paid are according to manufacturer invoice costs. The optometrist or ophthalmologist should complete and sign the invoice or have a signature on file. Detailed instructions for the purchase and payment of eyeglasses are on the reverse side of each page of the eyeglass invoice.

Housing Placement and Assistance Invoices*:* Included in this category are home furnishings and the invoice must be accompanied by an itemized list of purchases.

Housing and Transportation Modification Invoices*:* Should have itemized bills attached and bills for payment must also have the engineer's signature indicating inspection and approval.

Maintenance Invoices*:* Must indicate which services are being sponsored (meals, room, or both). Meals should not exceed actual cost or State per diem rates, whichever is less. Invoices for room and board must not exceed the allowable rates as specified in Volume V.

Medical Invoices*:* At this time, only a Current Procedural Terminology (CPT) code is required to determine appropriate payment. If a code is not available or there is no listed rate, additional details may be requested. Seek pre-approval from the Chief of Policy when there is no listed rate. Additional supporting information may sometimes be requested to confirm or assure proper payment. Preventive procedures will be removed from the invoice unless appropriate justification is received.

Other Services*:* Allowed services must be itemized either on the case service invoice or on an approved invoice. The following are examples:

- **Equipment Invoices** must be itemized Equipment purchased for training falls under normal equipment policy.

- **Imprest Cash Fund Invoices** must be itemized relevant to the service being provided. For example, imprest checks which are to be used for maintenance services should provide the same information required for other maintenance invoices. If the imprest cash is written to the client then the Case Service Invoice should be used and must be signed by the client, if the imprest cash is written to a vendor then the vendors invoice must be included (if the vendor chooses to utilize the Agency's Case Service Invoice, the vendor must also sign it). The authorization will need to contain the justification for use the imprest cash and must contain the electronic signatures of both the counselor and the manager as well as the physical signature of the client. Receipts indicating that funds were used for the amounts and purposes intended should be forwarded with the invoice whenever possible.

Personal Assistance Service Invoices*:* Should be submitted directly to the Fiscal Intermediary.

Pharmacy Invoices*:* Invoices must have the prescription number, the brand or generic name, whether it's brand or generic (B = brand; G = generic), the National Drug Code (NDC) number, Dispense as Written (DAW) code, strength, the concentration of drug per unit, the quantity of drug dispensed (e.g., number of tabs, caps ml, cc. oz.), the date the prescription order was actually filled and amount billed for each drug.

Revised 4/1/2015

Prosthetic and Orthotic Invoices: Should be itemized with a complete CPT code and description of the service provided. Fees for items not found in the fee schedule should receive prior approval from the policy office.

Psychological Services Invoices: Must indicate the assessment level as specified in Volume V. Psychotherapy invoices must include the number of sessions and the length of each session. Neuropsychological invoices must reflect the amount of time and be within the limits stated in Volume V. All invoices submitted by psychologists are reviewed to assure the providers are on the Approved Panel of Psychologists

Speech Therapy Invoices: Must include length of each session and number of sessions.

Technological Aids and Device Invoices: Invoices for environmental control units, augmentative communication devices, etc., must be accompanied by an itemized list of items purchased.

Transportation Invoices*:* Must list number of miles and rate per mile. Invoices for public conveyance must note the number of rides or whether the invoice is for a multiple ride ticket, monthly bus pass or a book of bus tickets. All invoices should reflect the actual dates the travel is to or has taken place in. If invoices are completed in this manner, an attached receipt is unnecessary.

Revised 1/1/2017

Invoice Numbering Convention: If the vendor provides an invoice number, you are required to use that number. Occasionally invoices are received that do not have an invoice number. BEAM requires an invoice number for payment. For invoices that do not already have an invoice number, use the authorization number (less the A#), the letter "P" and, the payment number. Additionally, even though Vendor Client Number is not a REQUIRED field, you should begin entering the client's first initial and last name in this space. If the vendor has any identifying client number such as a student ID or account number, you should always include that so the vendor can easily apply our

payments to the correct client accounts.

> EXAMPLE: Creating a payment for authorization AA1999999A1 (this number appears on the screen so you can easily see it), the invoice number would be AA1999999P1 (Notice that the A1 was dropped and replaced with the P). If this was for rent and this was the 5th time a payment approval was created for rent the invoice number would be AA1999999P5. If you cannot remember what payment number it is, BEAM will not let you duplicate an invoice number and will generate an error that it has already been used and you just use the next number in sequence until it accepts the digit(s).

NOTE: This invoice number must be written at the top of the bill so that payment approval and invoice can be matched at the Controller's Office during payment.

Revised 4/1/2015

Comparable Benefits:

- When comparable benefits are listed on the authorization form, they must be clearly addressed on the invoice. Because of the variety of invoice forms received, there is no single area for comparable benefits to be noted. For example, if medical insurance is listed on the authorization as a comparable benefit, the counselor must indicate either the amount of the payment and specify the procedure(s) for which the payment is to be applied towards, or indicate denial of benefit. The insurance denial letter or payment stub must be forwarded with the invoice.
- If a legal settlement is pending, the counselor shall review the financial situation with the attorney and advise the state office of the current status of the legal action when submitting the invoice for payment. An Assignment of Reimbursement should be attached to the invoice, when appropriate, in order to expedite the payment process.
- If Medicare is the comparable benefit, a copy of the Explanation of Benefit (EOB) is required prior to payment.
- Division funds cannot be used to complement or supplement a comparable benefit that pays at the Medicaid rate. If a comparable benefit pays more than the allowable state established rate, the Division is unable to contribute any payment towards the cost of the service. Invoices with Medicaid as the comparable benefit should not be forwarded for processing until Medicaid status is ascertained.
- If a comparable benefit exists for equipment or items subject to payment at a competitive bid or contract rate, VR will pay the difference between the bid/contract rate and comparable benefit payment amount, including a co-pay or co-insurance.
  NOTE: See Sub-Section 3-8-3: Comparable Benefits, for requirements and procedures when a comparable benefit is waived.

Revised 6/1/2016

Methodology for Paying Medical/Pharmacy Claims: Effective July 1, 2014, the non-pharmacy Medicaid rates are defined as the reimbursement rates in effect for the specific date-of-service paid on a specific date. Likewise, the pharmacy rates are defined as the reimbursement rates and dispensing fees in effect for the specific date-of-service paid on a specific date. DVRS will not recoup and repay claims when Medicaid reimbursement rates are changed retroactively.

4/1/2015

Prior Approval Of Unusual Charges: Any service which appears excessive, not normally provided, non-routine or out-of-the-ordinary must be accompanied by documentation of prior approval by the Chief of Policy.

Revised 4/1/2015

Request For Review: Request for review of the amount of payment for a service should be submitted in writing to Case Service Accounting at dvr.m.fiscalservices@dhhs.nc.gov. The request should include the, case service authorization number and any reports or justification that can be provided to help in the review for possible additional payment.

Weekly Check-Write: Vendor payments are processed weekly on Monday night. Payments issued to vendors are computer-generated check or electronic draft. Careful review should be made comparing the invoice to the authorization prior to submission of the invoice for payment processing, this will help assure all information is in agreement and the proper vendor is paid for services in a timely manner. Any discrepancies will result in delay of payment. Rejected billing will be returned for corrective action and resubmission of payment processing.

[34 CFR 361.50; 361.53]

Revised 7/1/2014

Section 1-13: VR/IL Concurrent Records of Service

The 1992 Amendments to the 1973 Rehabilitation Act strongly emphasize coordination and collaboration between the Vocational Rehabilitation Program and the Independent Living Rehabilitation Program in order to assure that clients with significant disabilities are able to access those services necessary to complete their rehabilitation program.

Coordination of rehabilitation planning between the Vocational Rehabilitation (VR) Program and the Independent Living Rehabilitation (IL) Program is essential if the client is to achieve a successful vocational and independent living outcome.

Joint VR/IL cases should be considered whenever there are rehabilitation needs and goals that can appropriately and collaboratively be met by both programs for clients who are at a minimum significantly disabled. Joint planning should occur early in the rehabilitation process or as soon as it is determined that the client must access both programs in order to have a successful employment and independent living outcome. The VR and IL counselors must closely collaborate in planning services so that IL related services are authorized through appropriate IL case service budgets and vocationally related services are sponsored via the appropriate VR case service budget. IL policy and maximum limits prevail whenever IL funds are utilized. VR policy and maximum limits prevail whenever VR funds are utilized. Under no circumstances should either program identify the other as the responsible party without prior coordination and agreement with the other program.

The VR and IL counselor must designate which counselor will be the primary point of contact for all projects requiring State Office approval (Chief of Policy, Purchasing Manager, etc.) and the designee will be identified on the client data package.

In concurrent records of service,

The VR counselor will:

1. Identify that independent living services may be needed 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 IL services.

3. Notify the client that the IL program will determine eligibility for the Independent Living Rehabilitation Program.

4. Complete an IPE or IPE Amendment upon the IL counselor's determination of eligibility, selecting the service of Information and Referral to IL and outlining in the detail section the IL services that are to be coordinated by the IL program. If VR funded services are planned, the service(s) must be added to the IPE and the appropriate financial need category must be selected; if applicable, obtain verification of the client's eligibility for SSI/SSDI or complete the Financial Needs Survey. The IPE should include the statements – All services funded by VR will be terminated when the VR case is closed. All services funded by IL will be terminated when the IL case is closed.

5. All established VR closure standards apply to concurrent records of service.

6. Maintain all fiscal information (authorizations; bids or price quotes; invoices) in the VR case file for VR funded services, in keeping with the record retention schedule.

The IL counselor will:

1. Identify that vocational rehabilitation services may be needed for the individual to complete their Independent Living Service Plan (ILSP).

2. Contact the VR Office to staff the case with the appropriate VR counselor.

3. Notify the client that the VR program will determine eligibility for the Vocational Rehabilitation Program.

4. Complete an ILSP or ILSP Amendment upon the VR counselor's determination of eligibility, selecting the service of Information and Referral to VR and outlining in the detail section the VR services that are to be coordinated and/or provided by the VR program. If VR funded services are planned, the appropriate financial need category must be selected and the Financial Needs Survey must be completed or, if applicable obtain verification of the client's eligibility for SSI/SSDI. Include the statement on the ILSP – All services funded by IL will be terminated when the IL case is closed. All services funded by VR will be terminated when the VR case is closed.

5. All established IL closure standards apply to concurrent records of service.

6. Maintain all fiscal information (authorizations; bids or price quotes; invoices) in the IL case file for IL funded services in keeping with the record retention schedule.

[The 1992 Amendments to the Rehabilitation Act of 1973, Section 10]

Revised 8/1/2015

Section 1-14: Client Signatures

Clients are required to sign many Division forms to either affirm their participation in developing the form or that they received a particular document from the counselor. Signatures may be of the individual or, if appropriate, a parent, family member, guardian, advocate, or an authorized representative of the individual. If the individual with a disability has not yet reached the eighteenth birthday and is not a legally

emancipated minor, then additional signatures must be secured. If the individual is under eighteen and has been adjudicated a ward of the State, then an adult who is involved with the individual must sign required documents. Specific requirements are noted in appropriate polices.

In the electronic case management system, dating a signature for the individual signifies that the individual has signed a hard copy of the document. A signature should not be dated in the electronic case management system until the individual has signed the particular document.

Revised 7/1/2014

Section 1-15: Imprest Cash Fund

The imprest cash (V-STIF Account) fund is a fixed sum of money available to meet emergency service delivery needs of clients. This fund is to be used for client services only. The fund should not be used to circumvent Division vendor approval requirements, bidding procedures, or used to provide any service that is subject to rates not established by the Division. At the beginning of each state fiscal year, each VR program unit office which requests an imprest cash fund is allocated a fixed amount of funds out of this budget. This budgeted amount remains constant until approval is received from Fiscal Services. Unit managers, or designee, must maintain the local fund in relation to expenses and reimbursements. Under no circumstances is the local fund to show a negative balance without prior permission from Fiscal Services.

Imprest cash can be used in either pre-planned or planned statuses. Refer to 1-11 Authorizations for explanation of the three different types of authorizations.

Procedure for Use of Imprest Cash Fund

1. In pre-planned status (02, 10)
    - If the vendor is the client, select “Authorization to Client”
    - If the vendor is not the client, select “Pre-planned authorization”
    - Proceed to step 3

2. In planned statuses (12, 18) the authorization cannot be issued until the service is added to the plan.
    - Add the service to the plan.
    - If the vendor is the client select “Authorization to Client”
    - If the vendor is not the client select “Planned Authorization”
    - Proceed to step 3

3. For either pre-planned or planned authorizations as described above, the service description field on the authorization must include a full detailed justification for the use of Imprest Cash. Check the Imprest Cash box toward the bottom of the authorization. Once this is checked, a field will appear to enter the Imprest Cash check number.

4. The authorization will then need two approvals one by the counselor and then the second approval from the supervisor. (Once the authorization has both approvals, Positive Pay will pick up the Imprest check and upload overnight. This means checks are not available for deposit or cashing until the day after the authorization is approved. If your client must cash or deposit the check the same day, please contact your financial analyst or email dvr.m.fiscalservices@dhhs.nc.gov to get the check uploaded to positive pay.)

5. After the counselor and Supervisor's electronic approvals are on the authorization, the client will need to physically **sign and date** the printed and approved Imprest authorization to show that the check was received.

6. A payment approval should be created. The payment approval, the signed and dated CSI (for authorization to client) or vendor invoice (see Section 1-12: Invoice Processing), any back up documentation and a copy of the authorization should be electronically submitted to the Controller's Office for reimbursement to the STIF account. All original documents with signatures should be kept in the unit Imprest Cash Fund files.

7. A copy of the Imprest authorization with all three signatures as described in step number five should be retained with the check copy. Also, supporting documentation such as payment approval, copy of the signed CSI or vendor invoice, receipts, mileage reports, etc. would be kept with these copies as well.

8. Once the field obtains all the necessary documentation for reimbursement, the payment approval is made on the authorization then is approved by the field in the Payments – Ready for Review PDQ. Once approved through this PDQ, the Controller's Office will process the reimbursement resulting in the payment back to the imprest account.

[Budget Manual 5.3 - Fiscal Policies and Regulations, Imprest Cash Fund]

Rev.: 7/1/2017

Section 1-16: Vendor Review and Certification

1-16-1: General Provisions

Each year a training session on nondiscrimination compliance/vendor reviews is held for the Assistant Regional Directors (ARDs). The ARDs conduct similar sessions for regional management teams who in turn train counselors and other appropriate staff. Designated Division staff are responsible for conducting on-site vendor reviews of all in-state vendors being considered for utilization during the rehabilitation process.

An appropriate vendor review form must be signed by the reviewer and the unit manager. This form must also include the signature of the vendor indicating that the vendor is in compliance with all nondiscrimination legislation. The form is then sent to the Assistant Regional Director (ARD) for signature. The Assistant Regional Director (ARD) reviews the vendor information and if there are no nondiscrimination compliance issues or accessibility/communication compliance issues, sends it to the state office. If there are problems in one of the above areas, the ARD will attempt to resolve them and will contact the Section Chief for Program Policy, Planning and Evaluation if there are difficulties in remedying some nondiscrimination compliance/ accessibility issues. The Section Chief for Program Policy, Planning and Evaluation may approve a plan, containing specific time lines for the correction of the problem, under which the vendor may be conditionally approved. The Section Chief for Program Policy, Planning and Evaluation approves, conditionally approves, or denies approval and notifies the vendor. The Chief sends a copy of the approval or conditional approval or denial letter to the appropriate Counselor, Unit Manager, ARD and upon approval adds the vendor to the vendor compliance list.

Authorizations to a vendor will not be accepted prior to approval of that vendor by the Section Chief for Program Policy, Planning and Evaluation. New vendors also sign a statement on the *Form DVR-0304*, *Form DVR-0308*, and *Form DVR-0309* vendor forms indicating that the vendor will not charge the client if an authorization from the agency has been accepted unless the amount for such service charge or payment is previously known to and approved by the Division. Approval is made for these limited situations by the Assistant Director for Fiscal Services and is not subject to negotiation by field staff.

A W-9 must be attached to vendor review applications in order for the vendor application to be processed. A *DVR-0306* is not required for any vendors who have completed one of the four vendor review forms listed below.

The following vendor review forms can be obtained on the Division of Vocational Rehabilitation Services Intranet Website:

- *Form DVR-0303, Boarding Facility-On-Site*
- *Form DVR-0304, Miscellaneous Vendor Review-On-Site*
- *Form DVR-0308, Application for Vendorship of Professionals-On Site*
- *Form DVR-0309, Application for Corporate Group of Professionals-On Site*
- *Form DVR-0306, Certificate of Nondiscrimination Compliance.*

Private interpreting agencies must be reviewed utilizing *DVR-0304, Miscellaneous Vendor Review-On Site*; however, a vendor review is not required for individual

interpreters.

A computerized *Vendor Compliance List* is maintained for information purposes and as a tool to delete the names of vendors not utilized. Questions should be directed to the ARDs or the Section Chief for Program Policy, Planning and Evaluation.

Although an on-site vendor review is not required, a *DVR-0306* must be signed by the following types of vendors:

- Day care programs
- Transportation vendors, i.e., taxi companies, and bus lines, etc.
- Vehicle modifications and repair vendors
- Building contractors (licensed general contractors are preferred). State law requires that persons, firms, or corporations constructing projects costing $30,000 or more to be licensed with the Licensing Board for General Contractors.

Vendors must indicate compliance with all Federal laws related to nondiscrimination based on race or national origin, sex, age, or disability by signing a vendor form. If, at any time, a staff member finds that an approved vendor is not in compliance with the nondiscrimination legislation, it is the staff member's responsibility to discuss the matter with the unit manager and document the concern in writing. The vendor will be offered the opportunity to correct the problem. Should the correction not be made, a report must be sent to the ARD who will review the matter and forward recommendations to the Section Chief for Program Policy, Planning and Evaluation. Any vendor who is in violation of nondiscrimination legislation will receive a letter from the Section Chief for Program Policy, Planning and Evaluation advising the vendor that it has been removed from the approved vendor compliance list and of action required of the vendor prior to consideration for reinstatement with the Division.

The Division may cease to utilize any facility or program when the Division determines that a facility or program fails to meet the individualized rehabilitation needs of Vocational Rehabilitation clients. The Unit Manager must investigate and advise the vendor of the concerns of the Division, and the two parties must agree upon a plan to correct them. Should the vendor fail to make the necessary improvements, the Unit Manager will forward recommendations to the ARD to remove the vendor from the approved list. The ARD will review and, if in agreement forward such recommendations to the Section Chief for Program Policy, Planning and Evaluation who will remove the vendor from the vendor compliance list.

[10A NCAC 89C .0402; Vocational Rehabilitation Act of 1973, as amended; Civil Rights Act of 1964; 10A NCAC 89C .0403 and 10A NCAC 89D .0101 through – 34 C.F.R .364.55; State Plan, Section 4.9(c)]

1-16-2: Acupuncturists

These vendors must be licensed by the N. C. Acupuncture Licensing Board. They must complete a *DVR-0304* and be approved by the Section Chief for Program Policy, Planning and Evaluation.

1-16-3: Chiropractors

These vendors must be licensed by the N. C. Board of Chiropractic Examiners. They must complete a *DVR-0304* and be approved by the Section Chief for Program Policy, Planning and Evaluation.

1-16-4: Day Care

Counselors may authorize only to such businesses that are licensed or registered by the North Carolina Department of Health and Human Services, Division of Child Development. The day care center should display the license or registration certificate. Before authorizing day care services, the counselor must obtain the license or registration number. A notation of the licensure or registration must be entered in the case record. Comparable benefits must be used when available. The day care programs must complete a *DVR-0306*. Questions regarding day care services should be directed to the Section Chief for Program Policy, Planning and Evaluation.

1-16-5: Dentists

Dentists must be approved by the N.C. State Board of Dental Examiners. A DVR-0308 must be completed and approved by the Section Chief for Program Policy, Planning and Evaluation.

[10A NCAC 89D .0302]

1-16-6: Driver Rehabilitation Specialists

The driver rehabilitation specialist (DRS) is an individual who is licensed, trained, and experienced in evaluating the driving abilities of individuals with disabilities. The DRS must be proficient in the application and operation of modified driving equipment as well as in driver evaluation and training tools. In order to purchase driver evaluation or driver training services, the Division requires a DRS to possess the following minimum qualifications:

A. Current certification as a Certified Driver Rehabilitation Specialist (CDRS); AND
B. Current licensing or registration of one or more of the following credentials: NC Licensed Occupational Therapist (OT/L), NC Licensed Physical Therapist (PT),

Registered Kinesiotherapist (RKT), or NC Licensed Recreational Therapist (LRT); AND

C. A minimum of one (1) year, documented, full-time experience in one or more of the services defined in this section to individuals with disabilities consistent with the population they wish to serve.

OR

A. Current licensing or registration of one or more of the following credentials: NC Licensed Occupational Therapist (OT/L), NC Licensed Physical Therapist (PT), Registered Kinesiotherapist (RKT), or NC Licensed Recreational Therapist (LRT); AND

B. A minimum of three (3) years documented full time experience in one or more of the services defined in this section to individuals with disabilities consistent with the population they wish to serve.

1-16-7: Hearing Aid Vendors

Such vendors must sign a Letter of Agreement with the Division indicating acceptance of payment rates and other requirements. They must be licensed by the N.C. State Hearing Aid Dealers and Fitters Licensing Board. These vendors must also complete a *DVR-0304* and be approved by the Section Chief for Program Policy, Planning and Evaluation in the State Office.

[10A NCAC 89D .0306]

1-16-8: Massage and Bodywork Therapists

These vendors may render services prescribed by a physician. Therapists must be in compliance with any local ordinance that pertains to such vendors and must be licensed by the North Carolina Board of Massage and Bodywork Therapy. These vendors must complete a *DVR-0304* and be approved by the Section Chief for Program Policy, Planning and Evaluation.

1-16-9: Medical Specialists

A medical specialist must be certified in a specialty recognized by the American Board of Medical Specialists or eligible for certification through post-graduate education, and must be a member of the staff of a hospital approved for participation in the DVRS program. Physicians wishing to provide services should complete the vendor review *Form DVR-0308* or *DVR-0309*, which must be approved by the Section Chief for Program Policy, Planning and Evaluation.

[10A NCAC 89D .0302]

1-16-10: Occupational Therapists

These vendors must be licensed by the N. C. Board of Occupational Therapy. They must complete the *DVR-0304* and be approved by the Section Chief for Program Policy Planning and Evaluation.

[10A NCAC 89D .0302]

1-16-11: Opticians

These vendors must be licensed by the N.C. State Board of Opticians. They must complete the *DVR-0304* and be approved by the Section Chief for Program Policy, Planning and Evaluation.

1-16-12: Optometrists

These vendors must be licensed by the N. C. State Board of Examiners in Optometry. They must complete the *DVR-0308* and be approved by the Section Chief for Program Policy, Planning and Evaluation.

1-16-13: Podiatrists

These vendors must be licensed by the N.C. Board of Podiatry Examiners. They must complete a *DVR-0308* and be approved by the Section Chief for Program Policy, Planning and Evaluation.

1-16-14: Prosthetists and Orthotists

The American Board for Certification in Prosthetics must certify these vendors, indicating that the shop meets the Board's various standards. These vendors must complete a DVR-0304, and the form must be approved by the Section Chief for Program Policy, Planning and Evaluation.

[10A NCAC 89D .0307]

1-16-15: Psychologists

The N. C. Psychology Board must license psychologists providing services as VR vendors, and the Section Chief for Program Policy, Planning and Evaluation must approve a *DVR-0308*. In addition to the above, Masters level Psychological Associates also must provide evidence of an active supervisory contract.

[10A NCAC 89D .0304]

1-16-16: Sign Language Interpreters

These vendors must be licensed by the NC Interpreter Transliterator Licensure Board requirements. See Section 2-4-2 for additional information.

1-16-17: Speech and Language Pathologists and Audiologists

Such vendors must be licensed by the N.C. Board of Examiners for Speech and Language Pathology and Audiology. They must complete a *DVR-0304* and be approved by the Section Chief for Program Policy, Planning and Evaluation.

[10A NCAC 89D .0205]

Section 1-17: Medical Consultation

The North Carolina Division of Vocational Rehabilitation Services employs a Medical Consultant/physician to provide medical consultation services to all unit offices. Consultation is often necessary to interpret, clarify, expedite, and make decisions regarding medical aspects of the case. It remains the counselor's responsibility to determine eligibility, provide/arrange for all appropriate services and set employment objectives. All counselors must have access to medical consultation to aid them in proper decision-making and to keep informed concerning current diagnostic and treatment methods. The responsibilities of the Medical Consultant are as follows:

1. Interpret medical terms and medical information on clients;
2. Clarify and explain physicians' reports in terms of client disability;
3. Assess the adequacy of medical information and advise on the need for specialist consultation or further medical evaluation;
4. Advise on nature and extent of functional impediments and improvement from proposed interventions;
5. Advise on likelihood of residual impediments after treatment;
6. Assess medical prognosis related to rehabilitation potential;
7. Provide staff education regarding disease or injury and current methods of treatment; and
8. Serve as liaison with colleagues in the medical community.

Medical situations which must be staffed with the Medical Consultant include those in which:

- A second opinion regarding chronic pain or chronic fatigue syndrome is considered desirable;
- Differentiation of an acute versus chronic condition is difficult;
- Unusual studies or treatment are involved;
- Severe disabilities render an eligibility determination difficult to establish, e.g.

head injury, spinal cord injury, stroke, and chronic progressive conditions such as MD and MS;
- An elective hospital admission under VR sponsorship is requested when preadmission certification has been denied for a Medicaid recipient;
- There is question as to the appropriate level of care or reasonable length of stay for specific procedures or conditions;
- Require more than 7 days diagnostic hospitalization; or questions arise regarding inpatient -vs. - outpatient services or treatment.

[Rehabilitation Services Manual 540.01 - 540.08]

Revised 11/15/2013

Section 1-18: Subrogation Rights: Assignment of Reimbursement

Subrogation rights legally allow the Division to recoup funds spent in the vocational rehabilitation or independent living rehabilitation of clients who may eventually be compensated for their injury(ies) by another third party. *Form DVR-0104, Subrogation Rights: Assignment of Reimbursement,* must be completed and dispensed prior to the provision of any rehabilitation service which is subject to financial eligibility, and there is a likelihood of future litigated or negotiated compensation from another source. Once *Form DVR-0104* is appropriately completed and dispensed, the Division may sponsor rehabilitation services. At such time a settlement is reached, the Division must reclaim its expenditure. *Form DVR-0104* must be completed under the following circumstances:

- The disability was caused by a personal injury in which an insurance settlement is pending.
- The disability resulted from an occupational injury which is subject to workers' compensation insurance requirements. Since the applicant/client has a right to appeal a denied claim, an Assignment of Reimbursement should be secured when the original claim is denied.
- The applicant/client has health insurance which pays directly to the applicant/client; it is the client's responsibility to notify the counselor of any funds received.
- Any other situation when there is pending litigation regarding the applicant/client's disabling condition.

The individual applying for services must sign the form after it is fully completed. If the applicant is under eighteen, then the parent, guardian, or other legally recognized individual must also sign the form. Failure to sign constitutes failure to cooperate in the Division's legal responsibility to use comparable benefits and financial eligibility requirements thus negating eligibility to receive services based on these contingencies. The form must be notarized. Failure on the counselor's part to fully complete and accurately dispense the form will impede, if not negate, the Division's ability to recoup these funds. Completed forms mailed to the insurance carrier, employer, and attorney must be sent by certified mail.

When requested to supply financial information for settlement purposes, counselors should contact the Business Services Coordinator in the State Office Fiscal Services Section for this information which will be communicated to the responsible party as settlement is in progress. In addition, all negotiations for partial settlements with the Division must also be referred to the contact noted above. There are two conditions under which the Division will entertain such requests. These are:

A. When there is insufficient money to pay the total Division expenditure leading to a pro rata settlement among all parties having claims against the settlement, AND
B. When the partial settlement would offset future Division expenditures in completing the IPE.

[Rehabilitation Act of 1973, as amended; Federal Rehabilitation Manual, Chapter 2515; 34 CFR 361.63 NC General Statute 143-547]

Section 1-19: Supervisor Approval

Many casework decisions require oversight and approval by a Supervisor. A Supervisor is defined as a Counselor in Charge (CIC), Assistant Unit Manager (AUM), Casework Advisor, Unit Manager (UM) and Facility Director (FD). Supervisors may approve casework decisions in their designated unit at the direction of the Unit Manager. CIC, AUM and Casework Advisors should not approve their own work if it requires additional approvals.

The following require Supervisor approval:

- All successful closures (case status code 26)
- Any revisions of the case record (as covered under *SECTION 1-3: CONFIDENTIALITY OF RECORDS*)
- Out-of-state services
- Justification for purchase of equipment outside of the state contract
- All requests for exceptions to maximum rates and fees as determined by Division policy (Supervisor must approve prior to submitting to the Chief of Policy for approval)
- Exceptions to use of comparable benefits
- Cases involving excess financial resources and extenuating circumstances as determined by completing the Financial Needs Survey
- Any exception to the requirements for verification of income or verification of payment of allowed deductions on the Financial Needs Survey
- Retroactive authorizations exceeding 7 days except for ancillary services associated with surgical procedures
- Case service invoices for authorizations exceeding 365 days from date of service

- Imprest Cash Authorizations **
- Case Service Invoice authorization adjustments of 10% or more of the initially authorized amount
- Equipment purchases in excess of $500.00 *
- Power Wheelchairs/Scooters *
- Residence modifications *
- Vehicle modifications *
- Vehicle repairs in excess of Division rates **
- In-home maintenance *
- Personal care assistance in excess of 28 hours per week
- Extension beyond 6 months for sponsorship of medically managed weight loss program
- Purchase of prescription pain medications considered controlled substances in excess of three prescriptions**
- Permanent relocation and moving expenses *

* These services require electronic approval by the Supervisor at the time they are added to the IL Service Plan.

** These services require electronic approval by the Supervisor at the time they are authorized.

Revised 10/22/2014

1-19-1: Rehabilitation Counselor I and Rehabilitation Counselor Trainee

In addition to the requirements at the beginning of this Section, those individuals who have not yet achieved Rehabilitation Counselor II status must have the following casework and service delivery forms approved by the Supervisor:

- Eligibility Decision
- Ineligibility Decision
- IL Service Plan, Amendments
- IL Service Plan closure documents
- Case service authorizations and all authorization revisions with the following exception:

    - Following a six-month period of service as a counselor, the counselor's Manager has the discretion to request the BEAM system administrator to enable a specific counselor to be granted the ability to authorize services and authorization revisions up to and including $500 without requiring supervisory approval. This does not apply to services and activities requiring approval beyond supervisory approval. The BEAM system administrator will maintain a record of such requests for audit purposes.

When requesting the change, it is recommended for the Manager to copy the Regional Director and the appropriate Quality Development Specialist to notify them of the change so that this information can be noted during case reviews.

Revised 2/1/2015

Section 1-20: Applicant/Client Informed Choice

Informed choice is an ongoing process and partnership with an applicant or client which provides the individual with the opportunity to make decisions and selections regarding their options and methods to secure these services. The ability of the applicant/client to choose, based on a factual knowledge that reveals all available options, and the potential implication of the individual's selection, is instrumental in the successful completion of the rehabilitation program. Division staff will provide the opportunity for applicant/clients to participate in their rehabilitation program by providing information or assisting in the acquisition of information necessary for the individual to make informed decisions throughout the rehabilitation process. Division staff will provide, through the most appropriate means of communication for the applicant/client to make informed decisions throughout the rehabilitation process. Division staff will provide, through the most appropriate means of communication for the applicant/client, information concerning the availability and scope of the various choice, the manner in which decisions may be exercised, and the availability of support services for those applicant/clients who because of their disability need assistance in exercising their options.

Application Phase

The assessment for determining eligibility must be conducted consistent with the applicant's needs and choices. When necessary to provide evaluation services in order to complete the assessment, staff will provide the applicant information necessary to make a choice regarding the service, service provider, and methods to procure the service. Services will be provided consistent with the applicant's informed choice.

Plan Development

Staff will provide clients with information necessary to make decisions regarding alternative goals, objectives, services, service providers and methods to procure services or assist in the acquisition of information necessary to make these informed decisions. Information related to cost, accessibility, and duration potential services will also be provided along with information regarding qualifications of service providers, types of services offered by those providers,

and the degree to which services are provided in and integrated setting. Such information will come from state; regional; or locally maintained lists; referrals to other individuals or groups in order to get information, and information related to qualifications and certifications of potential service providers.

Service Delivery

Services will be provided consistent with the full input of the individual applying for or receiving services.

Independence Outcome

The independence outcome will be consistent with the client's informed choice as noted on the IL Service Plan, original or amended.

While working to honor client choices in service planning and delivery, Division staff will apply resources in the most accountable and efficient manner. Only those services necessary to complete the rehabilitation program will be provided by the Division.

[1998 Amendments to the Rehabilitation Act of 1973 Sec.102(b)(2)(B, 34 CFR 361.52, 34 CRF 364.52)]

CHAPTER TWO: NATURE AND SCOPE OF SERVICES

Section 2-1: Nature of Independent Living Rehabilitation Services

The purpose of the Independent Living Rehabilitation Program (IL) is to promote the integration and inclusion of individuals with significant disabilities in the community. The IL program has a priority focus on those individuals with significant disabilities who can manage or learn to manage on their own in the community with services from the program. The IL Program assists eligible individuals with significant disabilities to obtain services to assist with deinstitutionalization, the prevention of institutionalization, achieving community living, and/or employment transition to the Vocational Rehabilitation Services program. The program does not establish or operate permanent living facilities or manage supervised living arrangements, but does strive to facilitate the independence of many who might otherwise be placed in such settings and, perhaps, have less opportunity to realize their fullest potential. The IL program works collaboratively with community resources with emphasis given to coordination and use of those resources to conserve state funds. The provision of services is dependent and contingent upon and subject to the appropriation, allocation, and availability of funds to the IL rehabilitation program.

Section 2-2: Scope of Services

The scope of rehabilitation services available to an individual is determined by the services required by that individual in order to reach the IL goal. All services provided must be directly related to the achievement of the goal established in concert between the client and the Counselor. The client is to play an instrumental role in determining the services received and the source from which these services are received. The Counselor's role is to assure that the client is aware of the service providers and how to access those services; and to provide the services which are within the Division's purview that have been planned with the client. Counseling and guidance is important to maintain a counseling relationship throughout the rehabilitation process, in order to assist individuals to secure needed services from other agencies, and to advise individuals about client assistance programs. The analysis of the impairment data is a crucial step in making the decision regarding service delivery. This analysis and development must occur as soon as possible in the rehabilitation process. The Counselor‘s commitment and negotiation/counseling skills are important in developing the IL Service Plan, in partnership with the client, to achieve the balance of substantial services.

All services planned and provided must be documented in the client's record of service. Counselors are encouraged to use forms which are part of the IL Service Plan system for documentation of services after the development of the rehabilitation plan and to provide clients copies of this documentation. All services listed in this chapter are

available for planning towards the accomplishment of the rehabilitation goal. Some services are subject to the financial need, comparable benefits or both, and are so noted. The distinction is specific to the service being provided not the case status code or where the individual is in the rehabilitation process.

[34 CFR 364.4]

Revised 7/1/2014

2-2-1: Substantial Services

A substantial service is any major independent living service that is provided within a supportive counseling and guidance relationship and contributes significantly to the individual‘s successful independent living outcome.

Substantial services are further defined as those services that are required by the individual in order to relocate from an institution to community-based living or avoiding institutionalization as long as possible; to improve the ability to live more independently in the home, family, and/or community; or to engage in or maintain employment and that contribute to the successful outcome such that the outcome could not have been achieved without the services. Required services are identified during the analysis of the information that precedes the development of the IL Service Plan. The services are provided to meet a specific rehabilitation need identified by the client and the counselor. Only those services that are required to achieve the rehabilitation goal(s) and the overall IL objective are to be provided.

Revised 7/1/2014

2-2-2: Major Independent Living Services

The major independent living services consist of the following:

- Counseling and Guidance *(refers to substantial counseling and guidance as opposed to that which is simply supportive in nature)*
- Physical Restoration of Impairments (that meet eligibility criteria)
- Personal Assistance Services
- Information and Referral (*for the purposes of transition to Vocational Rehabilitation or other program services required to meet the overall IL objective*)
- Rehabilitation Technology – Engineer services, vehicle modifications, residence modifications

Revised 4/24/2014

2-2-3: Support Services

Support services serve an important purpose by allowing the individual to participate in and benefit from a major service on the IL Service Plan. Support services provided alone do not constitute major services, and must only be provided in conjunction with a major service. Examples of support services include evaluations for personal assistance, rehab engineering assessments, transportation and maintenance.

Revised 7/1/2014

2-2-4: Timeliness of Services

Services must be initiated at the earliest time the service is available and that the client is prepared and available to participate. Delivery of substantial services should be documented within 90 days of initiation. If the substantial service has not been initiated within 90 days of the projected initiation date the circumstances requiring the delay must be documented on a progress review.

Revised 02/01/2018

2-2-5: Policy Exceptions

CROSS REFERENCE: **Section 1-19, Supervisor Approval**

Exceptions to the policies concerning the provision of services must be approved by the Chief of Policy, unless approval is specifically delegated to the Unit Manager. This includes requests to exceed Division maximums, time limits, and other service selection criteria. The rationale for the exception must be submitted to the Chief of Policy to be reviewed. The Program Specialist for Independent Living will be consulted as needed.

Revised 7/1/2014

Section 2-3: IL Equipment

Definitions:

Equipment - any item that can be utilized by a client as part of their IL Service Plan. Equipment is usually considered transferrable, meaning it can be relocated with the client if there is a change in the vocational setting or the living situation. Examples are numerous for items related to a job placement, retention or small business support. Items can range from something as basic as a table or task chair to something more complex like an entire workstation or specialty power equipment.

Examples regarding home accessibility include large items such as Platform/Porch Lifts, Ceiling Lifts, and Stair Lifts, or smaller items such as Door Openers or electric locks. Assistive Devices /Equipment may have certain Durable Medical Equipment classifications (i.e. wheelchairs, shower chairs, etc.) or they can be related to electronics, such as an augmentative communication (Aug. Com.) device, computers or an Environmental Control Unit (ECU) or Electronic Aid to Daily Living (EADL).

Assistive Technology Device - An assistive technology device is any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capacities of individuals with disabilities.

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 by risking immediate loss of employment or severely increasing the risk of institutionalization. There must be written justification in the case record to explain the extraordinary 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 Client data packet.

Client Data Packet – Information required by the Chief of Policy and Purchasing staff in order to approve equipment purchases and carry out purchasing procedures when applicable. The client data 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 equipment 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.

NOTE: *A checklist for each type of request has been created and is located on the DVRS Intranet* ***Forms*** *Page under* ***VR Client Templates****. The checklist must be completed and included with the client data packet.*

Rev. 11/9/15

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 Client data 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.

Purchase of Equipment

These services involve the provision of all equipment required for the IL Service Plan including devices or durable medical equipment such as TTYs, wheelchairs, Hoyer lifts, or assistance to obtain these services from other sources. For purposes of safety, risk containment and general best practices the Rehabilitation Engineer must be involved if the equipment is to be modified to accommodate the individual's disability. Equipment should not be used by Division staff for their personal use and it should not be stored at the private residence of Division employees. Such services are subject to both financial needs criteria and comparable benefits.

Equipment may be purchased under the following conditions:

A. The client has the knowledge to use or can be trained to use the equipment;
B. The equipment is required to meet the client's independent living goal and will be used by the client towards completion of the IL Service Plan; AND
C. The client has the resources to safely store, insure, and adequately maintain the equipment.

Equipment Security Agreement

The counselor is responsible for completing the Acknowledgement/Equipment Security Agreement (*DVR-1015)* for any equipment costing $500 or more upon receipt of the equipment. This form must be maintained in the case record with all required signatures completed. This security agreement will remain in effect until the Division at the Supervisor's request dissolves the agreement. Such request should not be made until the equipment has been used for at least 5 years or unless unusual circumstances necessitate release of Equipment.

State Term Contract

All equipment that costs more than $100 or exceeds the cost of the minimum order for the state term contract STC) must be purchased from the STC unless approved by the Chief of Policy. Also, see Medicare subsection within section 2-3-4 Procedures to Purchase Durable Medical Equipment (DME) for exceptions based on possible applicability of Medicare DMEPOS.

Information regarding vendors who have been awarded STC is available through the State Purchase and Contract Web Site.
To utilize the website:

1. Log on to the Purchasing Site: www.doa.state.nc.us/PandC/
2. Select Term Contract Link.
3. Utilize the "Term Contract Alphabetical/Key Word Listing" link.

4. Select an appropriate Alphabetical letter representative of a key word for the equipment to be purchased.
5. On each contract site review the information available regarding scope of contract, discounts, and details for placing an order.
6. Note the minimum order information. (Usually #5 on the contract).

In addition, any item provided by the NC Department of Corrections (Correction Enterprises) must be obtained from this source. (http://correctionenterprises.com). Items/services available from Correction Enterprises would primarily be office furniture, printing and eyeglasses (Nash Optical).

Counselors are required to check the STC for availability of needed equipment. The Division's purchasing section is available to help counselors determine if the equipment is on the STC.

Revised 7/1/2014

2-3-1: Appliances

The IL program may assist with the purchase of appliances for purposes of deinstitutionalization, first time relocation to accessible housing, or to overcome environmental barriers related to functional limitations. The need for appliances must be related to the individual's functional limitations as documented in the case record by the appropriate specialist. The provision of basic appliances may include:

- Microwave
- Window air condition unit
- Washer and Dryer
- Refrigerator

The purchase of these items is sometimes necessary to assist an IL client in maintaining or regaining independence and is subject to the individual's financial need and comparable benefits.

Procedures to purchase appliances are detailed in Section 2-3-9: Procedures to Purchase Other Equipment.

2-3-2: Assistive Technology Devices

The provision of this service is subject to the individual's financial need and comparable benefits. Procedures to purchase AT devices are detailed in Section 2-3-3 under Procedures for Purchasing Computer Systems, Assistive Technology and Software in excess of $500. Procedures to purchase AT devices under $500 are detailed in Section 2-3-9: Procedures to Purchase Other Equipment.

[The 1992 Amendments to the Rehabilitation Act of 1973, Sec. 103 (13); 34 CFR 364.4; 34 CFR 361.5]

Revised 7/1/2014

2-3-3: Computers

The Division will participate in the purchase of computers if assistive technology is required by the client for purposes of augmentative communication, environmental controls, or when voice recognition or equivalent adaptive input devices are required for the individual to complete the IL Service Plan. The Chief of Policy must approve the entire system including computer and assistive technology.

Division assistance will be limited to $500.00 for software unless the software is required in one of the cases named above. The Division will not purchase upgrades or improved versions of assistive technology following the initial purchase, unless the individual can no longer use the device because of a significant change in their disability. The Chief of Policy must approve exceptions.

Computers and **Assistive Technology** such as adaptive software, hardware, augmentative communication, Environmental Control Units (ECUs) or Electronic Aids to Daily Living (EADL), voice recognition, or equivalent adaptive input devices may be purchased when they are required for the individual to access or participate in his/her rehabilitation program according to the conditions listed above. This service is subject to financial need. The Counselor, Rehabilitation Engineer or Assistive Technologist should assess the client‘s individualized need for assistive technology based on his/her functional capacities and the technology‘s projected benefit to his/her capabilities. Adequate planning should be provided to ensure that there is compatibility between all system components.

The Chief of Policy must approve:

- Assistive technology requested to support an individual‘s independent living goal when the assistive technology equipment recommended by a Rehabilitation Engineer or Assistive Technologist exceeds $500.
- A computer system (i.e., personal computer (pc) with pre-installed software, etc.) that exceeds the Volume V rate and is required to support an individual’s access or participation in the rehabilitation program.
- Specialized software that exceeds $500 and is required for the individual to complete the IL Service Plan.

Procedures for Purchasing Computer Systems, Assistive Technology and Software in excess of $500 (see below):

1. The Counselor verifies that the Financial Needs Survey is current and valid, or completes a new FNS to document that the client meets financial need for this service.

2. The Counselor completes the Computer/Assistive Technology Client Data Checklist (most current as available via VR intranet) and sends via fax, mail, or email to the Chief of Policy at dvr.m.policyoffice@dhhs.nc.gov.

3. The Counselor will receive an approval or denial letter. If approved, the DVR Purchasing Agent will be instructed to begin the purchasing process and contact the Counselor.

4. Once Purchasing has received the request, the Purchasing Agent will obtain quotes based on the items requested. Once the Purchasing Agent receives the quotes they will ask the Counselor to add the vendor(s) and the cost(s) to the plan in BEAM. The Counselor is to email the Purchasing Agent once this process is complete. At that time the Purchasing Agent will issue the purchase order to the vendor and complete the RFQ and authorization in BEAM. Computers shall be delivered to a VR office so that the Counselor can assure that the client receives the computer and so that all paperwork is appropriately processed. Exceptions can be made under certain circumstances and this must be presented to the Purchasing Agent prior to placement of order. The packing slips and invoices should be submitted along with the authorization, payment approval form to Fiscal Services for payment.

[10A NCAC 89C .0305]

2-3-4: Durable Medical Equipment

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

In order to purchase DME the counselor must establish the need for DME and obtain an evaluation for specifications. If a DME Convenience Contract is in effect, covered DME services may be expedited with higher quality control through applicable contract terms and conditions as compared with the normal required competitive bidding process.

When purchasing wheelchairs, a Seating and Mobility Evaluation should be obtained from an independent source, such as a wheelchair/seating clinic at a rehabilitation center/hospital employing staff who are Occupational or Physical Therapists qualified as Seating and Mobility Specialists. This evaluation team is to include a qualified wheelchair and seating technology specialist (RESNA ATP or ATS):

- When the DME Convenience Contract is to be used, the evaluation team is to include the contract provider's ATP or ATS qualified wheelchair and seating technology specialist
- If no clinic is available or would result in significant service delay, the counselor should use the DME Convenience Contract provider, or other provider that has

staff qualified with Assistive Technology Professional (ATP) or Seating and Mobility Specialist (SMS) 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 and specifications to the vendor when the vendor is filing with a comparable benefit first. Individual DME items costing ≤ $500 that are part of a turnkey Residential Modification project (i.e. standard tub benches, stationary shower chairs, fold-down seats, etc.) DO NOT require a prescription in order to be purchased. A Rehabilitation Engineer's recommendation is sufficient for these basic off-the-shelf items, and will all be bid out as a Residential Modification. For individual DME items > $500, or anything customized (i.e. rolling shower chairs or tilt-in-space chairs), a prescription is required, and applicable DME Purchasing guidelines must be followed.

DME Convenience Contract

A DME Convenience Contract has been established for VR/IL. Although this is not a mandatory contract, Counselors are strongly encouraged to utilize this contract in order to expedite service delivery and as a cost savings to the Division. The Division's Purchasing section is available to help determine if the equipment is available on the Convenience Contract. There is no minimum order if the item exists on the contract.

If the DME is available on the Convenience Contract, but there is a reason to purchase from a non-contract vendor, follow the procedures for purchasing off-contract through competitive bid processes. The Counselor should document the rationale for not purchasing from the Convenience Contract.

Details regarding approved vendors, available items and coverage areas are available on the Contract and related guidance materials located on the VR Intranet FORMS Page, DME Convenience Contract Resources Section. Counselors may purchase from any of the approved vendors who provide the specific equipment within the zone coverage areas.

DME available on the DME Convenience Contract – Purchase Procedures

(see Appendix Entry: 'Durable Medical Equipment: Purchase Procedures – Chart A')

Obtain a quote from the selected DME Convenience Contract vendor that lists (1) the manufacturer's suggested retail price (MSRP) as documented on the manufacturer's order form when available (strongly preferred) or alternately the price quote obtained from the manufacturer; (2) the percent discount applied to the MSRP; and (3) the final price quote with discounts applied.

Cost ≤ $500:

1. No further approvals are required on the IL Service Plan. Add the on-contract service to the IL Service Plan, including the price quote for the equipment.

2. Counselor issues an authorization to the Convenience Contract vendor at the contracted amount which includes shipping, delivery and set-up charges.

Cost > $500 - ≤ $10,000:

1. Supervisor approval is required on the IL Service Plan. If approved, add the on-contract service to the IL Service Plan, including the price quote for the equipment.
2. Counselor issues an authorization to the Convenience Contract vendor for the price quote which includes shipping, delivery and set-up charges.

Cost > $10,000:

1. For equipment estimated to cost >$10,000 the counselor shall assemble and submit a Client Data Packet using the Checklist: DME/Equipment/ECU/Prosthetic/Orthotic (available via the VR Intranet) to the Chief of Policy for review and approval.
2. If approved, the Chief of Policy will notify the counselor. The counselor adds the on-contract equipment service to the IL Service Plan, including the Convenience Contract vendor and the price quote for the equipment.
3. The IL Service Plan or amendment will be approved by the Chief of Policy in BEAM.
4. Counselor will issue the authorization to the Convenience Contract vendor at the contracted amount which includes shipping, delivery and set-up charges.

NOTES:

- If durable medical equipment is needed as part of the preliminary or comprehensive assessment the same approval thresholds apply. Approval, if required occurs on the pre-planned authorization.

- Even when purchasing items on contract – waiving comparable benefits requires prior approval from the Chief of Policy

- **Regardless of the cost of the equipment, the following documents must be submitted to Fiscal Services (or via encrypted email:** dvr.m.FiscalServices@dhhs.nc.gov**) in order to facilitate accurate payment processing:**

    - **Invoice**

    - **Authorization**

    - **Payment Approval Form**

    - **Quote Documentation Form DVR-1033 (available via VR Intranet) with the following attachments:**

- 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 by the DME Convenience Contract provider
- The DME Convenience Contract provider's final price quote with discounts applied

- 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 Convenience Contract amount.
- If client does not have comparable benefits, then the vendor bills VR for full contracted amount.

Revised: 3/1/2016

DME NOT available on the DME Convenience Contract – Purchase Procedures
(see Appendix Entry: 'Durable Medical Equipment: Purchase Procedures – Chart B')

Estimated Cost ≤$500:

1. Verify that the item(s) are not available on the Convenience Contract. Determine the estimated cost of the equipment.
2. If the estimated cost is ≤$500 the counselor must obtain a quote. A faxed or written quote on the vendor's letterhead is preferred to prevent any miscommunication and to comply with fiscal auditing procedures. If it is not possible to obtain a written quote, a verbal quote may be accepted and documented on the Quote Documentation Form DVR-1033 (new via intranet10/2014). The quote must be maintained in the case record.
3. Add the "off- contract" equipment service to the IL Service Plan and record the awarded vendor and the price quote.

4. No further approvals are required. The counselor can issue the authorization. The RFQ is not required for items in this purchase category ≤$500.

Estimated Cost >$500 - ≤ $2500:

1. Verify that the item(s) are not available on the Convenience Contract. Determine the estimated cost of the equipment.
2. If the estimated cost is > $500 - ≤ $2500 the counselor completes the bid process. A minimum of three (3) written competitive quotations must be obtained 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.
3. When the bids are received add the off-contract equipment service to the IL Service Plan, include the awarded vendor and the price quote for the equipment.
4. Supervisor approval is required. After obtaining approval the counselor can issue the authorization to the awarded vendor and complete the RFQ.

Estimated Cost > $2500:

1. Verify that the item(s) are not available on the Convenience Contract. Determine the estimated cost of the equipment.
2. For equipment estimated to cost >$2500 the counselor shall assemble and submit a service justification packet (see Section 2-5: Equipment – Definitions) to the Chief of Policy for review and approval.
3. If approved, a formal bid process will be completed by DVRS State Purchasing Section.
4. When the bids are received purchasing will notify the counselor to add the "off-contract" equipment service to the IL Service Plan, including the awarded vendor and the price quote for the equipment.
5. The IL Service Plan or amendment will be approved by the Chief of Policy in BEAM.
6. DVRS State Purchasing Section will initiate the RFQ process and issue the authorization.

NOTES:

- **Regardless of the cost of the equipment, the following documents must be submitted to Fiscal Services (or via encrypted email: dvr.m.FiscalServices@dhhs.nc.gov) in order to facilitate accurate payment processing:**
    - **Invoice**
    - **Authorization**

- **Payment Approval Form**
- **Quote Documentation Form DVR-1033 (available via VR Intranet) with the following attachment:**
    - Awarded Written Quote as competitively obtained on vendor's form, letterhead, or completed bid form **(if the item costs ≥$500)**

- If multiple pieces of equipment are being purchased from the same vendor, AND the total amount exceeds $2500, Chief of Policy approval is required.
- If durable medical equipment is needed as part of the preliminary or comprehensive assessment the same approval thresholds and bidding procedures apply. Approval, if required, occurs on the pre-planned authorization.

Revised: 3/1/2016

2-3-5: Procedures to Purchase Durable Medical Supplies

The provision of this service is subject to the individual's financial need and comparable benefits. Counselors should follow procedures for DME **NOT** on the DME Convenience Contract for the purchase of all Durable Medical Supplies.

Revised: 3/1/2016

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 3-8-3 Comparable Benefits). Additionally, see SECTION 1-11 Case Service Authorizations, 1-12: 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 vendors 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 (vendors and physicians) 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.

Revised 7/1/2014

2-3-6: Furniture and/or Furnishings

The IL program may assist with the purchase of furniture and/or furnishings for purposes of deinstitutionalization, first time relocation to accessible housing, or to overcome environmental barriers due to a change in functional limitation. A basic furniture package may include:

- Small Couch or loveseat, or chair
- Small Coffee or End table
- Small Dinette Table with maximum of four chairs.
- One Twin, Full, or Queen Size bed with mattress and box spring.
- Chest of Drawers or Dresser
- One Nightstand

A basic furnishing package may include the following:

- 2 sets sheets
- Mattress cover
- 2 Pillows

- 1 Comforter or Bedspread
- 1 Blanket
- 1 bedside lamp
- 2 Bath towels, 2 hand towels, 2 washcloths,
- 1 shower liner and hooks
- 1 living room lamp
- Maximum set of 4 plates, 4 bowls, 4 mugs, 4 glasses, 4 sets of utensils
- 1 basic set of pots and pans, cooking utensils, mixing bowls

The provision of this service is subject to the individual's financial need and comparable benefits. Procedures to purchase furniture and/or furnishings are detailed in Section 2-3-9 Procedures to Purchase Other Equipment.

2-3-7: Recreation Equipment

The IL program may assist with the purchase of recreation equipment when recreational services are being provided to support a goal on the IL Service Plan. The provision of this service is subject to the individual's financial need and comparable benefits. Procedures to purchase recreation equipment are detailed in Section 2-3-9 Procedures to Purchase Other Equipment.

2-3-8: Telecommunicative Devices

The Division will evaluate the needs of all eligible sensory impaired clients for telecommunications, sensory, and other technological aids and devices. These services include the widest range of electronic or assistive listening devices that are available and have demonstrated an ability to aid a person's chances of going to work or living more independently. Assistive listening devices include hardware devices, FM systems, loops, infra-red devices, direct audio input hearing aids, telephone aids and speech assistance devices. Such services are subject to an individual's financial need and comparable benefits, when available. Individuals needing Assistive Listening Device (ALD) or Speech Communication Device systems should be referred to the North Carolina Assistive Technology Program (NCATP) for consultation services. The NCATP staff will assess the individual's needs and will provide a written report with recommendations. The counselor should submit a referral for services and authorization to the North Carolina Assistive Technology Program. Contact the North Carolina Assistive Technology Program's administrative office at 919-233-7075 or obtain referral form and rate information at www.ncatp.org, click on "make a referral" and follow the steps listed.

Requirements for purchasing such devices are as follows:

A. The client must have a telephone or be able to afford the cost of telephone installation, monthly bill and maintenance in order to receive assistance with assistive devices requiring a telephone.
B. Text Telephones-Teletypewriters (TTYs) and other assistive devices costing $500 or more require an Equipment Security Agreement form.

Assistive Listening Devices for Students in Post-secondary Education
The Division can encourage educational institutions to provide assistive listening devices for students who are deaf and hard of hearing. Most students who use a hearing aid have difficulty understanding speech due to background noise. Hearing aids have a tendency to enhance all sounds at the same time, thereby drowning out the sounds of speech.

Several amplification systems are available to improve hearing ability in large areas, such as lecture halls and auditoriums, as well as in interpersonal situations (group discussions, and instructor conferences). These systems work by delivering the speaker‘s voice directly to the ear (with or without personal hearing aids), thus overcoming the negative effects of noise, distance, and echo, thereby improving understanding ability. It is the educational institution‘s responsibility to provide these large FM systems.

Assistive listening devices for students in post-secondary educational programs should not be purchased without a recommendation from the North Carolina Assistive Technology Program (NCATP) and counselor documentation that such a system is not available from the educational institution for use by the student. The Counselor should make a referral and submit an authorization to the North Carolina Assistive Technology Program for services rendered. Referral form and rates can be found at www.ncatp.org or by contacting the North Carolina Assistive Technology Program at 919-233-7075.

The NCATP Consultant will contact the client, the postsecondary institution, and involve appropriate vendors prior to completing a written report and making recommendations. Equipment may be purchased under the following conditions:

A. The device is required for the student to achieve the academic goal and is part of the IPE; AND
B. The device is mobile and can be used in a work environment after obtaining the degree.

Equipment Distribution Service (EDS): The Division of Services for the Deaf and Hard of Hearing (DSDHH) has an Equipment Distribution Service, which provides access to telecommunications devices for people who are Deaf, Hard of Hearing, Deaf-Blind, and Speech Impaired but have difficulty affording these devices.

Types of Devices Available through EDS: (Please verify equipment with DSDHH by visiting their website at http://www.ncdhhs.gov/dsdhh/services/deaf.htm.)

- Amplified telephones with adjustable ringer volume
- Signaling devices that use sound, lights, and/or vibration to alert you to environment sounds such as the telephone ringing
- VCO(Voice Carry Over) telephones allow you to speak to the other person and read what they are saying
- Single Hearing aid with telecoil switch
- TTYs(teletypers) allow you to type and read telephone conversations
- Large Visual Display TTYs for individuals with vision impairments
- Braille TTYs provide a print out in Braille
- Specific telephones for people with speech impairment such as voice controlled remote and outgoing voice amplification
- HCO (Hearing Carry Over) telephones allow you to hear what is being said while typing your message
- Electronic speech aids: artificial larynx, stutter inhibitors and Augmentative and Alternate Communication devices

In addition the EDS Hearing Aid Program provides one (1) hearing aid that allows individuals with hearing loss to communicate on the telephone using a hearing aid telecoil (T-coil). The goal is to provide equal access through use of the telephone. Devices are free to qualified individuals.

Types of Hearing Aids Available Through EDS Hearing Aid Program: (one hearing aid per person)

- Digital Hearing Aid
- Analog Hearing Aid
- Behind the Ear Hearing Aid

EDS is NOT considered a comparable benefit. However, individuals determined to be ineligible for IL services should be referred to EDS when appropriate. DSDHH may have a waiting list for services based on funding.

[Section 103(a) (11); 10 NCAC 89C.0310; State Plan, section 12;)

2-3-9: Procedures to Purchase Other Equipment

CROSS REFERENCE: **Durable Medical Equipment and Supplies for IL*;* Section 1-19, Supervisor Approval; Section 2-12-2, Hearing Aids**

Procedures for Purchase of Non-Medical Equipment available on State Term Contract (STC) *(see Appendix Entry: 'Non-Medical Equipment: Purchase Procedures – Chart A')*

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.

Cost ≤ $500:

1. No further approvals are required on the IL Service Plan. Add the "on-contract" service to the IL Service Plan, including the price quote for the equipment.
2. Counselor issues an authorization to the STC vendor at the contracted amount which includes shipping, delivery and set-up charges.

Cost > $500 - ≤ $2500:

1. Supervisor approval is required on the IL Service Plan. If approved, add the "on-contract" service to the L Service Plan, including the quoted cost of the equipment.
2. Counselor issues an authorization to the STC vendor at the contracted amount which includes shipping, delivery and set-up charges.

Cost > $2500:

1. The counselor shall assemble and submit a client data packet (see Section 2-3: Equipment – Definitions) to the Chief of Policy for review and approval.
2. If approved, the Chief of Policy will notify the counselor. The counselor adds the on-contract equipment service to the IL Service Plan, including the STC vendor and price quote for the equipment.
3. The IL Service Plan or amendment will then be approved by the Chief of Policy in BEAM.
4. The counselor issues the authorization to the STC vendor at the contracted amount which includes shipping, delivery and set-up charges.

Revised: 10/22/2014

NOTE: Regardless of the cost of the equipment, the following documents must be submitted to Fiscal Services in order to facilitate accurate payment processing:

- **Invoice**
- **Authorization**
- **Payment Approval Form**
- **Quote Documentation Form DVR-1033 (new 10/2014 via intranet)**

- **Written quote when available**

Procedures for Purchase of Non-Medical Equipment NOT available on State Term Contract (STC) *(see Appendix Entry: 'Non-Medical Equipment: Purchase Procedures – Chart B')*

Estimated Cost ≤$500:

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

2. If the estimated cost is ≤$500 the counselor must obtain a quote. A faxed or written quote on the vendor's letterhead is preferred to prevent any miscommunication and to comply with fiscal auditing procedures. If it is not possible to obtain a written quote, a verbal quote may be accepted, and documented on Quote Documentation Form DVR-1033 (new via intranet 10/2014) The quote must be maintained in the case record.

3. Add the "off- contract" equipment service to the IL Service Plan and record the awarded vendor and price quote.

4. No further approvals are required. The counselor can issue the authorization. The RFQ is not required for items in this purchase category ≤$500.

Estimated Cost > $500 - ≤ $2500:

1. Verify that the item(s) are not available on the State Term Contract. Determine the estimated cost of the equipment.
2. If the estimated cost is >$500 - ≤ $2500 the counselor completes the bid process. A minimum of three (3) written competitive quotations must be obtained as part of the bid process. The quotes must be maintained in the case record.
3. When the bids are received add the "off-contract" equipment service to the IL Service Plan, including the awarded vendor and the price quote for the equipment.
4. Supervisor approval is required. After obtaining approval, the counselor can issue the authorization to the winning bidder and complete the RFQ

Estimated Cost > $2500:

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 counselor shall assemble and submit a client data packet (see Section 2-5: Equipment – Definitions) to the Chief of Policy for review and approval.
3. If approved, a formal bid process will be completed by DVRS State Purchasing

Section.

4. When the bids are received, purchasing will notify the counselor to add the off-contract equipment service to the IL Service Plan, including the awarded vendor and the price quote for the equipment.
5. The IL Service Plan or amendment will be approved by the Chief of Policy in BEAM.
6. DVRS State Purchasing Section will initiate the RFQ process and issue the authorization.

NOTE: **Regardless of the cost of the equipment, the following documents must be submitted to Fiscal Services in order to facilitate accurate payment processing:**

- **Invoice**
- **Authorization**
- **Payment Approval Form**
- **Quote Documentation Form DVR-1033 (new 10/2014 via intranet)**
- **Written quote when available.**

- If multiple pieces of equipment are being purchased from the same vendor AND the total amount exceeds $2500, Chief of Policy approval is required.
- If equipment is needed as part of the preliminary or comprehensive assessment the same approval thresholds and bidding procedures apply. Approval, if required, occurs on the pre-planned authorization.

Revised: 10/22/2014

2-3-10: Equipment Repairs

Equipment repairs may be sponsored if such repairs are required in order to complete the rehabilitation program or as part of a post-closure plan. Repairs up to seven hundred fifty dollars ($750) require only one quote from a reputable service vendor. Repairs exceeding seven hundred fifty dollars ($750) require obtaining three quotes, with the low quote being accepted and approved by the supervisor. Approval by the Chief of Policy is required for repairs exceeding two thousand five hundred dollars ($2500). When authorizing repairs, counselors should be cognizant of the cost of the repairs in relation to the value of the equipment being repaired. This service is subject to financial need and comparable benefits.

Revised 4/1/2015

Section 2-4: Assistive Technology Services

This service is defined as any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device. The provision of this service is subject to the individual's financial need and comparable benefits.

[34 CFR 364.4; 34 CFR 361.5]

Section 2-5: Communication Services

These services are provided to enable the client to better communicate with other people. These services include, but are not limited to, foreign language translator and interpreter services, interpreter services (sign language & oral), tactile interpreter services for individuals who are deaf and blind, cued speech services, Braille training, reader services and training in use of communication equipment. Communication accessibility may be required at any time during the rehabilitation process in order to allow the individual to have access to all rehabilitation services.

2-5-1: Foreign Language

Title VI of the Civil Rights Act of 1964 is the Federal Law that protects individuals from discrimination on the basis of their race, color, or national origin in all programs that receive Federal Financial Assistance. Title VI requires linguistic accessibility to health and human services. Therefore foreign language interpreters/translators will be sponsored at any time during the rehabilitation process when the applicant/client is unable to understand either verbal or written information presented by the Division.

The U. S. Office for Civil Rights has interpreted Title VI to require all recipients/agencies receiving federal funds to implement the following specific guidelines:

A. The Counselor is responsible for determining the client's preferred language and providing a qualified foreign language interpreter/translator at the earliest possible opportunity before or after the initial contact with the Division.

B. IL forms are available in Spanish for individuals with Limited English Proficiency (LEP). The Counselor may contact the Specialist for the Deaf and Hard of Hearing/Communicative Disorders for assistance in locating a qualified interpreter/translator for Spanish.

C. Interpreters/Translators for all languages must be qualified and trained with demonstrated proficiency in both English and the native language of the client. The Membership Directory of the Carolina Association of Translators and Interpreters is available at: https://catiweb.org/; however, it is not required that all qualified interpreters/translators be listed in this directory.

D. IL must offer translation services at no cost to the person with Limited English Proficient (LEP). Rates for foreign language interpreting services are listed in Volume V. The Unit Manager/Facility Director can approve exceptions. A minimum of two-hours will be authorized per session. Such services are not subject to the financial need criteria; however, comparable benefits must be used when available.

E. Interpreter/Translator services must not be authorized to a member of the consumer's family. Minors (age 18 or under) shall not be used to interpret.

F. Information to verify identity and employment eligibility is in Section 1-9.

2-5-2: Interpreting Services (Sign Language and Oral)

The Americans with Disabilities Act (ADA) has set our sights on removing the barriers that deny individuals with disabilities an equal opportunity to share in and contribute to the vitality of American life. The ADA means access to jobs, public accommodations, government services (VR & IL), public transportation, and telecommunications – in other words, full participation in, and access to, all aspects of society (Dunne, 1990).

IL Counselors may obtain an assessment from a Rehabilitation Counselor for the Deaf to determine a client's mode of communication to ensure than an appropriate interpreter is employed to meet the client's communication needs before diagnostic and evaluation services are begun or anytime throughout the rehabilitation process. Such services are not subject to the financial need criteria; however, comparable benefits must be used when available. The assessment for determining eligibility and rehabilitation needs should determine the client's ability to communicate, and the IL Service Plan should note any potential need for interpreting services.

The Division may also provide sign language instruction for clients who are deaf on an individual or group basis when this service is an essential part of the IPE. Interpreters may be provided during the appeals, mediation, and administrative review process.

All freelance interpreters and private interpreting agencies utilized by the NCDVRS must be licensed by the North Carolina Interpreters and Transliterators Licensure Board. Educational Interpreters utilized by NCDVRS must be licensed by the Board or meet the certification requirements established by the National Registry of Interpreters for the Deaf. (See Volume V for rates for interpreting services).

The following types of interpreting services may be used:

A. Sign language interpreting – ASL, signed English, or pidgin, the interpreter "visually" relays the spoken word to the student in whatever sign system is agreed upon.

B. Oral interpreting – the interpreter 'mouths' the words spoken for the deaf or hard of hearing student. Sign language may sometimes be used as filler.

C. Tactile interpreting – is used by deaf-blind students who need to 'feel' the formation of signs that the interpreter is making. The student places their hands on the interpreter's hands while interpreting. Some students can also use on-the-palm printing.

D. Low-vision interpreting – is used by deaf/low-vision students who cannot see the interpreter from a distance. The interpreter and student face each other at a closer distance to enable the student to see the interpretation.

Payment for Freelance Interpreters (See Educational Interpreting, Special Programs – Deaf Students)

The Division has adopted the guidelines and the pay scale established by the Department of Health and Human Services' Approved Interpreters List. The Division has an ascending pay scale as delineated in Volume V for licensed interpreters, private interpreting agencies, and educational interpreters.

- The counselor should utilize an interpreter with full state license when possible.
- Normal reimbursement rates will apply during weekdays between the hours of 7:00 am to 5:00 p.m. During all other times and days, and during State recognized holidays, reimbursement will be at the rate of one and one-half times the normal rate.
- Time and one-half will also apply to last minute or emergency requests with twenty-four (24) hours or less notice.
- Interpreters will be paid for a minimum of two hours per assignment.
- Mileage may be authorized at the allowable OSBM rates for State employees.
- Per diem expenses may be authorized at the allowable rates for State Employees with advance approval from the counselor or the unit manager.

Independent Living and Interpreting Services

IL staff serving Consumers who are deaf should contact the Program Specialist for the Deaf and Hard of Hearing in the State Office for consultation and/or instructions on how to authorize for interpreting services.

[34 CFR 364.4; NCAC 89C 0308]

2-5-3: Reader Services

Generally if a client needs reader services, the Division of Services for the Blind will serve this client and provide these services. However, if a client served by IL needs reader services, contact the Program Specialist for the Deaf and Communicative Disorders for assistance. Such services are not subject to the financial need criteria; however, comparable benefits must be used when available.

Section 2-6: Counseling and Guidance

These services cover an array of counseling and guidance issues for Division clients that could be general, or specific and substantive in scope. Services in this category are not subject to financial need or comparable benefits. Supportive "counseling and guidance" is an integral part of any rehabilitation program and may be provided at any time during the rehabilitation process. Counseling and guidance provided as a substantial service is distinct from the general or supportive counseling relationship that exists between the counselor and client. The guidance and counseling planned must be anticipated to result in a functional change in the client's primary IL objective and must be accompanied by other rehabilitation services.

The following are examples of guidance and counseling interventions:

- Helping the individual understand their diagnosis/impairment and functional limitations
- Assisting the individual in dealing with and adjusting to the emotional issues surrounding their disability
- Liaison or interventions with medical providers to facilitate individual's treatment and meet medical needs
- Discussion and exploration of an individual's strengths, interests, and abilities in relation to the recommendations from assessment data and other case information

Section 2-7: Driver Evaluation and Training

CROSS REFERENCE: **Section 2-14, Rehabilitation Technology; Section 1-16-6, Driver Rehabilitation Specialists; Appendix Entry-Counselor's Driver Evaluation and Training Process**

Handbook: Counselors shall utilize the "Counselor's Driving Evaluation and Training Process" located on the intranet.

Driver evaluation and training may be sponsored for those clients who require such training in order to obtain a driver's license. If the individual has never had a license, had the license revoked, or cannot get the license renewed due to the development of a disability, it may be necessary to secure both evaluation and training prior to getting a license.

Individuals who have cognitive, visual, or other physical impediments with questionable driving ability or restrictions must receive such evaluation and training prior to the Division agreeing to purchase and/or modify a vehicle. Any individual requesting driving control modifications, including hand controls and left foot accelerators, must complete a driving evaluation prior to modifications to their vehicle, except when all three of the following conditions are met generally for purposes of providing replacement equipment:

A. The individual has previous and current experience driving with driving control modifications; AND
B. The individual's disability is stable; AND
C. The individual is requesting functionally equivalent modifications.

The evaluation must be conducted by a driver rehabilitation specialist, an individual who is licensed, trained, and experienced in evaluating individuals with specific disabilities. Individuals who have never had a driver's license are required to pass the written and eye examinations and to obtain either a driver's permit or a "Restricted Driving Permit" prior to participating in an in-vehicle evaluation or training. Financial need and comparable benefits must be determined prior to the initiation of the training phase.

[34 CFR 361.42(a)(16)]

Section 2-8: Information and Referral

This service includes those activities designed to coordinate services and benefits available in the community. Referrals to public programs can include Vocational Rehabilitation, other DHHS Divisions and agencies, Medicaid, housing authorities, and social services. Referrals to private programs can include Centers for Independent Living, civic organizations, religious organizations, home health agencies, and private contractors. Services in this category are neither subject to financial need nor comparable benefits.

[34 CFR 364.4]

Section 2-9: Maintenance

Maintenance means monetary support provided for those expenses such as food, shelter and clothing that are in excess of the normal expenses of the individual, and that are necessitated by the individual's participation in an assessment for determining rehabilitation needs or while receiving services under an IL Service Plan. Maintenance is not intended to pay for those living expenses that exist irrespective of the individual's involvement with rehabilitation. Rather maintenance is a limited service designed to assist the individual with meeting the additional costs incurred while participating in a rehabilitation program. Financial need must be determined except in those situations when maintenance is required in support of an assessment service required to determine eligibility or rehabilitation needs. Comparable benefits must be used when available. Maintenance services include:

- Basic payments while client is in travel status to obtain services
- Basic payments (room, board, incidentals) for increased independence in situations such as deinstitutionalization or a move to accessible and/or affordable housing.

NOTE: Unit Managers must review and sign all case service authorizations for maintenance when the client lives in their home or in the home of a family member. All exceptions to the Division's maximum limits for maintenance must be approved, in advance, by the Chief of Policy.

2-9-1: Personal Needs

Personal needs means monetary support provided for personal hygiene items that are necessitated by the individual's participation in an assessment for determining eligibility and rehab needs or while receiving services under an ILSP. Personal needs should only be provided on a short term basis, and are not intended to pay for expenses that exist irrespective of the individual's involvement with a rehabilitation program. This service is subject to financial need except in situations when the service is required in support of an assessment service required to determine eligibility or rehab needs. Comparable benefits must be used when available. Rates are listed in Volume V. All exceptions to the Division's maximum limits for personal needs must be approved in advance by the Chief of Policy.

Section 2-10: Modifications

In order to assist an individual in increasing their independence, the Division may assist with modifications of the home, vehicle, or in joint cases with VR where there is an employment goal, workplace modifications. All modifications are subject to the individual's financial need and comparable benefits. The Chief of Policy is responsible

for approving all modification projects exceeding Unit Manager approval maximum rates and involving Division funds. In joint cases where modifications of any type are being funded out of VR funds, VR policy prevails.

2-10-1: Residence Modifications

Cross Reference: **Section 3-8-3: Comparable Benefits**
Appendix Entry – Residence Modification General Guidelines

Residence modifications may be considered when the goal of modifying the residence is to enhance the individual's independence in relation to community integration and/or employment. All residence modifications are subject to the individual's financial need and comparable benefits. Regardless of the residence type, modifications costing ≤ $500 require a Rehabilitation Engineer's recommendation and one written price quote. Residence Modifications > $500 require Unit manager approval up to the maximum threshold for the residence type. The Chief of Policy is responsible for approving all modification projects exceeding Unit Manager approval maximum rates and involving Division funds. In joint cases where residence modifications are being funded out of VR funds, VR policy prevails.

FORMS

FORM DVR-0197, REQUEST FOR RESIDENCE MODIFICATION:
The form which must be completed by the Counselor and signed by the property owner and client for all residence modifications involving Division funds regardless of the cost of the project. The purpose of this form is to assure that the client and property owner are fully aware of the specifications and proposed modifications. If, during the review process, the originally recommended modifications are altered, a new *Form DVR-0197* must be completed with appropriate signatures.

NC DVRS INFORMAL CONSTRUCTION CONTRACT:
This agency-specific document is to be consistently used in compliance with its accompanying instructions when bidding out jobs or obtaining quotes for ALL residential modifications exceeding $500. Use of this contract format, its terms and conditions and approved procedures improves the agency's protections and effectiveness regarding the procurement process for residential modification services.

FORM DVR-7007, ENGINEER CHANGE REQUEST:
This form must be completed by the Rehabilitation Engineer if the residence modification project is deemed unacceptable or incomplete. The Rehabilitation Engineer will consult with the Unit Manager, Counselor, client, and contractor to resolve the situation. The Policy Office is also an available resource for seeking resolution if a solution cannot be reached. If there are additional costs involved, an official price quote

will be obtained from the contractor on letterhead or in an email and documented on this form. The additional costs will be added to the original bid amount to arrive at an adjusted total amount. If the original project was handled locally and the adjusted amount remains within the local purchasing delegation for the residence type, the Unit Manager will approve and sign the form. If the original project required Policy Office approval, the Policy Office will approve and sign the form. If the adjusted amount exceeds $12,000 the Policy Office and the Purchasing Office will approve and sign the form.

FORM DVR - 7011, BID TABULATION SHEET & AWARD RECOMMENDATION: This form must be completed to document solicitation of at least 3 bids, bid responses, and award recommendations and shall be retained within the case file.

Division Maximum Rates for Residence Modifications

Per Client

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. A project, for purposes of this policy, shall be defined as the group of all planned modifications foreseen to occur at a residence necessary to enable an individual to obtain their IL Service Plan goals. A project may not be subdivided or bid in "phases" to circumvent the Agency policy maximums per residential type unless prior approval to subdivide has been provided by the Chief of Policy.

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 residence 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.

Cost Per Project Based on Residence Type and the Approval Process

A limit of $12,000.00 per project shall be placed on modification projects when the residence is owned by the client or client's immediate family. If the cost per project is estimated to exceed $12,000, a *Residence Modification Client Data Packet* is to be submitted to the Chief of Policy for approval *(please include the* **Client Data Packet Checklist** *with all requests; the checklist is located on the*

DVRS Intranet FORMS page under the VR Client Templates section). If approved, the Purchasing Office is responsible for bidding and purchasing residential modifications exceeding $12,000.

Client / Immediate Family-Owned Residence (Site Built)			
If Estimated CUMULATIVE VR/IL Expenditures per case are:	**Current Project Estimate is:**	**Approval By:**	**Bid (or re-bid) and Purchased by:**
<$12,000	≤$12,000	Unit Manager or designee	Unit Manager or designee
>$12,000	≤$12,000	Chief of Policy	Unit Manager or designee
>$12,000	>$12,000	Chief of Policy	Purchasing Manager (PM)—Note: Must be Bid and Purchased by PM.

Modifications to a mobile home owned by the client or the client's immediate family shall not exceed $8,500.00 per client per project**.**

Client/Immediate Family-Owned Residence (Mobile Home)			
If Estimated CUMULATIVE VR/IL Expenditures per case are:	**Current Project Estimate is:**	**Approval By:**	**Bid (or re-bid) and Purchased by:**
<$12,000	≤$8,500	Unit Manager or designee	Unit Manager or designee
<$12,000	$8,501 - $12,000	Chief of Policy	Unit Manager or designee
>$12,000	>$12,000	Chief of Policy	Purchasing Manager—Note: Must be Bid and Purchased by PM.

Modifications on rented or leased residences shall not exceed $5,500.00 per project.

Rental Property, Including Mobile Homes, Apartments or Multi-Family Dwellings			
If Estimated Cumulative VR/IL Expenditures per case are:	**Current Project Estimate is:**	**Approval By:**	**Bid (or re-bid) and Purchased by:**
<$12,000	≤$5,500	Unit Manager or designee	Unit Manager or designee
<$12,000	$5,501 - $12,000	Chief of Policy	Unit Manager or designee
>$12,000	>$12,000	Chief of Policy	Purchasing Manager—Note: Must be Bid and Purchased by PM.

Exceptions to these amounts must be approved by the Chief of Policy and are considered on a case-by-case basis. The following list gives some examples of the issues and circumstances that are considered when approving exceptions:

- client's living situation, circumstances, and preferences
- medical necessity and justification
- availability of alternative living situations or solutions
- cost effectiveness of the proposed solutions
- risks to the client's safety and health and independence
- cost of unforeseen structural damage needing repair(s) as part of the primary modification
- total cost of residential modification projects over the life of the case
- counselor's assessment of the stability of the situation and the projected client benefits

Comparable Benefits

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.

When the client has a concurrent record of service for IL and VR with a residence modification as a planned service, the residence modification will be sponsored by the VR case service budget.

CAP/DA Medicaid Waiver Services include home accessibility and must be explored and accessed when available.

Residence Modification Process

1. Review and determine previous client expenditures for Residence Modifications. 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.
2. The Counselor must consult with the Unit Manager regarding the feasibility of the project. If the project is supported by the Unit Manager, the Counselor must involve the Rehabilitation Engineer in discussion about the project.
3. The Rehabilitation Engineer must visit and evaluate the site to determine the feasibility of the project. Residence modifications shall be directed only at the issues of accessibility and will directly address the disability-related needs. They shall be the most technically appropriate, cost effective, and safe modifications that meet a client's independent living needs regarding living independently and, as applicable, supporting their vocational goals.
4. The Rehabilitation Engineer will then consult with the Counselor and client, develop the project specifications and provide a report to the Counselor along with an estimated cost of the project.
5. Procedures for bidding and approval required will depend on the estimated cost.
    a. If the estimated cost does not exceed allowable limits the project is bid out using policy procedures and NCDVRS Informal Construction Contract, then awarded by the Unit Office.
    b. If the project is bid locally and the bid responses exceed allowable limits, a Residence Modification Data Packet shall be submitted to the Chief of Policy for approval.
    c. If the project estimate exceeds allowable limits based on the type of residence, a Residence Modification Data Packet shall be submitted to the Chief of Policy for approval.

Bid and Award Process

1. The NC DVRS Informal Construction Contract template shall consistently be used for all residential modification projects exceeding $500.
2. It shall be the best practice of each office to bid to a minimum of 4-5 qualified contractors who are interested and actively bidding on the Agency's projects located within the project's vicinity. Proof of solicitation of at least 3 bids is required and documentation of this shall be retained within the case file using **Form DVR – 7011 Bid Tabulation Sheet & Award Recommendation** document recording solicitations, bid responses, and award recommendations.
3. For any projects exceeding $12,000, Purchasing policy requires the following documents to be uploaded into the client's electronic case file: 1) Documentation related to the bid solicitation and any Addendums, 2) **Form DVR - 7011 Bid Tabulation Sheet & Award Recommendation** document, and 3) Signed winning Bid Proposal Details and Contract pages.
4. Bids may be **SENT** TO CONTRACTORS via regular mail, or electronically via fax or e-mail (encrypted). Conducting business via e-mail with safeguards in place to protect client information can be an efficient and preferred method of conducting business. When e-mailing bid packages, it is imperative to exclude from bid specifications the client's name (case identifier is ok), age, phone number, specific address (city is allowed), or other personal identifying information components that can be used to identify an individual's identity as per HIPAA guidelines.
5. Bids shall be sent out for a MINIMUM of 14 calendar days. The bidding period may be extended at the discretion of the local office with an official notification Bid Addendum sent to all vendors.
6. ANY significant inquiries or clarifications regarding the engineering specifications or the terms and conditions must be communicated in writing to all the vendors equally with a Bid Addendum.
7. Bids **RECEIVED** FROM CONTRACTORS must be a hard copy as part of the sealed bid response. This can be received via regular mail or physically dropped off at the location indicated on the bid solicitation.
8. Bids shall have time/date stamped (or noted) upon receipt at the local office.
9. Only bids received by the closing date with the vendor's signature and business information will be considered valid. All bid responses, the number received and from whom are to be kept internally confidential until the bids are opened.
10. Bids shall only be opened in the presence of at least two Agency staff witnesses and documented with signatures and retained in the case file.
11. Receipt of 3 bid response offers at first opening is not required, but highly encouraged. A valid bid is one that meets the bidding process deadline and all

terms, specifications, scope, and engineering criteria including any applicable urged and cautioned site visit requirements. A “No Bid” is not considered a valid bid.

12. The vendor who submits the low bid that meets the project specifications and all other bidding and qualifying requirements is generally awarded the project. Any exceptions (i.e. going with the next lowest bid, etc.) must be approved by the Assistant Regional Director and the justification(s) must be documented in the case file. The Assistant Regional Director is encouraged to consult the Policy Office or Purchasing if further consultation is required.

    a. <u>If only 1 valid bid response is received and it is within the project estimate and Agency policy maximums per residence type, then it will be handled locally</u>.
    **** As noted above, proof of solicitation of at least 3 bids is required and documentation of this shall be retained within the case file.**

    b. <u>If only 1 valid bid response is received and it is **above** the project estimate but still within Agency policy maximum per residence type, then the Assistant Regional Director must review and approve with justification documented in the case file.</u>
    **** As noted above, proof of solicitation of at least 3 bids is required and documentation of this shall be retained within the case file, including any justification to exceed the original project estimate.**

    c. <u>If only 1 valid bid response is received and it is **above** the project estimate and it is **above** the Agency policy maximum per residence type, then a Client Data Packet must be submitted to Chief of Policy for consideration.</u>
    **** As noted above, proof of solicitation of at least 3 bids is required and documentation of this shall be retained within the case file, including any justification to exceed the original project estimate.**

13. The bid price shall be valid for a period of 120 days beyond the bid opening date. Any withdrawal of the offer shall be made in writing, effective upon receipt by the Agency.

14. A contract package shall be sent to the vendor/contractor. This is a package of information prepared by the Unit Office or the Purchasing Office authorizing the vendor to proceed with the project. Included in this package are:

    - The case service authorization (or purchase order if issued by the Purchasing Office if the accepted bid exceeds $12,000)
    - A copy of the bid from the selected vendor/contractor;
    - A copy of the modification specifications; AND
    - A cover letter authorizing the vendor/contractor to proceed with the project

Payment Approval Process

1. The vendor/contractor will complete the project and send the invoice to the Rehabilitation Engineer.
2. The Rehabilitation Engineer will visit the work site to assure that all project specifications have been followed in a satisfactory manner. When the project is approved, the Rehabilitation Engineer will sign the contractor's invoice and forward it to the Counselor.
3. If the project is deemed unacceptable or incomplete, the Rehabilitation Engineer will consult with the Unit Manager, Counselor, client, and contractor to resolve the situation. The Policy Office is also an available resource for seeking resolution if a solution cannot be reached. If there are additional costs involved, an official price quote will be obtained from the contractor on letterhead or in an email and documented/approved on **Form DVR-7007, Engineer Change Request**.
4. The Counselor will attach a copy of the contractor's invoice to the payment approval and authorization and submit for payment.

2-10-2: Vehicle Modifications

In order to assist an individual in increasing their independence or maintaining or obtaining employment, the Division may assist with modifications of the vehicle. Individuals for whom such modifications are considered must have been determined eligible for VR/IL services. All modifications are subject to the individual's financial need and comparable benefits. The rehabilitation engineer shall be involved in all modification projects involving Division funds. The engineer may be involved with developing specifications using drawings and sketches as well as developing project cost estimates for the Division. The Purchasing Manager is responsible for developing and reviewing the bid specifications. An engineer is required to be present for delivery of all vehicle modifications.

The IL program may assist with the modification of a participant/family-owned or leased-to-purchase vehicle in order to enhance the participant's ability to function independently in the family or to actively participate in the community. Modifications may be considered for participants enrolled in secondary school.

The VR program may assist with modifications to a client/family-owned or leased-to-purchase vehicle for employment purposes or to assist with commuting problems while the individual is enrolled in a college training program where there are no or limited on-campus living facilities or if transportation is required as part of the training curriculum. Modifications shall not be considered for clients enrolled in secondary school.

The Chief of Policy reviews and approves all vehicle modifications estimated to exceed $500. The Division will only contribute financially towards vehicle modifications that are recommended by the rehabilitation engineer. Prior to the Division's participation, a thorough analysis of the individual's transportation needs must be conducted and other options, such as public conveyance or conveyance by a family member or other support person, must be considered and used when available. This analysis shall be included as a part of the Client Data Package.

DEFINITIONS

VEHICLE: For the purposes of this policy, vehicle includes automobiles, trucks, and vans. Motorcycles, mopeds, and golf carts do not fit this definition. When modifying used vehicles, Counselors should be cognizant of the cost of the modifications versus the value of the vehicle.

DMV REVIEW: A review conducted by the Policy Office for the purpose of obtaining information regarding the status of the vehicle operator's driver's license. Vehicle modifications and insurance require this review. Individuals with poor driving records and infractions will not be provided assistance with vehicle modifications, vehicle purchases, or vehicle insurance.

CLIENT DATA PACKET: A packet of information prepared by the Counselor and submitted to the Chief of Policy for review. For all vehicle modifications that exceed $500, the packet is submitted to the Chief of Policy for casework/policy review. The packet then goes to the Rehabilitation Specialist for technical review. If the estimated amount is within the approval authority of the Supervisor, then the Supervisor should review the case record with particular emphasis on this information generally required in the client data packet. **The required components of the Client Data Packet are specific to the type of modification and are found in the applicable Client Data Packet Checklist. These checklists are located on the DVRS Intranet 'FORMS' page, under the 'VR Client Templates' section.**

BID PROCESS: All bids should be neatly prepared on the contractor's stationary or the Division's bid form with the vendor's full name, address, and itemized costs. To be considered valid, the bid must be signed and dated by the vendor. Bids should identify each part of the project and have the cost of each along with the total cost clearly stated. Bids are to be opened with at least two (2) Division staff present; and ALL bids are to be opened at the same time with the lowest bid being signed by at least two (2) of the Division staff present.

VENDOR SELECTION: The process, as defined by the Division of Purchase and Contract, is the same for all modification projects regardless of the cost and must be followed. The Counselor, along with assistance from the Rehabilitation Engineer, is responsible for initiating this process and must canvass the local area to assure all

potential and interested vendors are offered the opportunity to bid on each project. Sufficient bids should be solicited to assure that a minimum of three (3) competitive bids are returned. Only those bids returned by the closing date will be considered valid. The vendor who submits the low bid that meets specifications within the deadline noted on the bid is generally selected to complete the project. This process must be strictly followed unless otherwise approved by the Regional Director.

CONTRACT PACKAGE: This is a package of information prepared by the Unit Office or the Purchasing office and sent to the vendor authorizing the vendor to proceed with the project. Included in this package are:

- The case service authorization (or purchase order if issued by the Purchasing Manager signed by the Supervisor and/or the Purchasing Manager if the accepted bid exceeds the maximum amount allowable for the Supervisor to authorize);
- A copy of the bid from the selected vendor;
- A copy of the modification specifications; AND
- A cover letter authorizing the vendor to proceed with the project.

FORMS

FORM DVR-0196, REQUEST FOR VEHICLE MODIFICATION: This form is intended to inform the client and vehicle owner of the specifications and proposed modifications, that the Division is not responsible for removal of the proposed modifications, that the Division may reclaim modifications if it is determined that they are no longer needed by the client, that the Division is not responsible for restoring the property to its original condition, and to fully indemnify the Division as a result of the modifications. If, during the review process, the originally recommended modifications are altered, then a new *Form DVR-0196* must be completed.

FORM DVR-7001, VEHICLE INSPECTION SHEET: This form must be completed and signed by an ASE Certified mechanic when modifications to used vehicles are being considered. All used vehicles being considered for modifications must be evaluated with an emphasis on safety and “life expectancy” of the vehicle. Recommended repairs may be authorized by the Counselor while general maintenance and “upkeep” items must be supplied by the client.

Proof of Insurance

The consumer must provide proof of collision and comprehensive insurance for the vehicle and adaptive equipment prior to the adaptive equipment being purchased. If the vehicle is involved in an accident, the Division considers insurance to be a comparable benefit in sponsoring repairs or replacements.

Maximum Rates for Vehicle Modifications

The IL program may support vehicle modification projects that are estimated to be equal to or less than $7000.00:

A. for vehicles that are newer than 10 years or have less than 120,000 miles; OR

B. that can be easily transferred to another vehicle if need be or can be installed in a vehicle not limited to the previous age/mile limit, provided the vehicle passes both the rehabilitation engineer's inspection and the DVR-7001 inspection with an estimated additional useful life of 5 years.

The Chief of Policy must approve any exception to the maximum limits stated above.

VEHICLE MODIFICATION PROCESS

Est. Cost	Steps
≤ 500.00	1. Approved by Supervisor
	2. Engineer reviews, develops specifications, and estimates
	3. Bid process by counselor
	4. Vendor selection by counselor
	5. Contract package by the Supervisor
	6. Rehabilitation engineer approves completed project
	7. Counselor forwards vendor invoice with payment approval and authorization for payment

Est. Cost	Steps
> 500.00	1. Supervisor consult
	2. Engineer reviews, develops specifications, and estimates
	3. Submit Client Data Packet to Chief of Policy for policy/casework compliance. Then the Rehabilitation Specialist for technical review of project.
	4. Approved by Chief of Policy
	5. Bid process by Purchasing Manager
	6. Vendor selection by Purchasing Manager
	7. Contract package by Purchasing Manager
	8. Rehabilitation engineer approves completed project
	9. Rehabilitation engineer initials vendor invoice and forwards to Counselor
	10. Counselor forwards vendor invoice with payment approval and authorization for payment

2-10-3: Worksite Modifications

The IL program may only sponsor worksite modifications when there is a joint VR/IL case and when VR funds are utilized. The goal of modifying the job or work site is the suitable placement of a client, including clients who are self-employed, and the successful conclusion of a rehabilitation program by increasing job accessibility, reducing mental demand, reducing physical demand, alleviating physical distress, alleviating mental/emotional stress, increasing energy conservation, improving quality,

or reducing dependency. Placement equipment is not included in this policy and should not be counted in calculating the cost of job and work site modifications. The employer and/or owner of the property to be modified must review the modification plans and understand the changes the Division is proposing. The client, the employer, and/or the property owner must also understand that the Division can remove certain Division-purchased free-standing equipment when it is no longer needed at the job site. The Division will not be responsible for expenses incurred for changes not needed to accommodate persons with disabilities. *Form DVR-0191, Request for Worksite Modification,* must be signed by the property owner to free the Division from responsibility of the expense of restoring any property or equipment to its previous condition if the client is no longer employed at that site.

Maximum Rates for Worksite Modifications

A limit of $7000.00 shall be placed on all worksite modification projects. Unit Managers shall approve and oversee the bidding and vendor selection process for projects less than, or equal to, $2500.00, while projects estimated to be greater than $2500.00 must be approved by the Chief of Policy.

Exceptions to the maximum contribution are based on the degree of disability and the cost of modifications and adaptive equipment necessary to complete the rehabilitation program. Individuals whose disability necessitates extensive technological adaptations require more extensive solutions.

WORK SITE MODIFICATION PROCESS

Est. Cost	Steps
≤ 2500.00	1. Approved by Supervisor
	2. Engineer reviews, develops specifications and estimates
	3. Bid process by Counselor
	4. Vendor selection by Counselor
	5. Contract package by Supervisor
	6. Rehabilitation Engineer approves completed project
	7. Rehabilitation Engineer initials vendor invoice and forwards to Counselor
	8. Counselor forwards vendor invoice with payment approval and authorization for payment
Est. Cost	**Steps**
> 2500.00	1. Supervisor consult
	2. Engineer reviews, develops specifications and estimates
	3. Submit Client Data Packet to Chief of Policy for review and approval
	4. Bid Process by Purchasing Manager
	5. Vendor selection by Purchasing Manager
	6. Contract package by Purchasing Manager

	7. Rehabilitation Engineer approves completed project
	8. Rehabilitation Engineer initials vendor invoice and forwards to Counselor
	9. Counselor forwards vendor invoice with payment approval and authorization for payment

Rev. 11/15/2016

[l0A NCAC 89C .0205 and .0206 (Financial Needs Test) and 10A NCAC 89C .0300 , Scope and Nature of Services; 10A NCAC 89C .0316; 34 CFR 364.4]

Section 2-11: Personal Assistance Services

CROSS REFERENCE: **Appendix Entry-Personal Assistance Definitions and Procedures**

Personal assistance is hands on assistance with two (2) or more major activities of daily living (ADL). The Division shall not sponsor chore worker or housekeeping services as a sole service. Housekeeping or chore worker services shall be secondary to the hands on ADL activities and shall not be the only assistance that is needed. Supervision, monitoring, companionship, cuing (reminder or prompting to complete task) and respite services are not considered personal assistance services and shall not be sponsored by the Division.

ADL tasks are basic daily living activities that must be performed to assure or support one's physical well-being. Examples of the major ADL activities include body/oral hygiene, bathing, toileting, dressing, grooming, eating, transferring, and moving about as needed in the environment.

Housekeeping and chore worker activities involve basic activities that help to provide a safe and healthy living environment and promote community inclusion. Examples include cleaning, laundry, preparing meals, shopping, bookwork, and transportation.

Workers that provide ADL and housekeeping/chore worker services do not require any state licensure or certifications.

2-11-1: Vocational Rehabilitation Program

Personal assistance services may be sponsored at any time during the rehabilitation process to enable clients to fully participate in the assessment for determining eligibility and vocational rehabilitation needs, planning, service provision, and employment. It is a

support service which can only be provided in relation to and in support of another vocational rehabilitation service. Sponsorship of this service is not intended to supplant services traditionally provided by the client's family. Personal assistance services are not subject to financial need, but comparable benefits must be utilized when available. Under no circumstance shall the Division sponsor co-pays for personal assistance if the client is utilizing Medicaid or another similar benefit to acquire personal assistance. Personal assistance can be provided by enrolling the VR client in the consumer-directed personal assistance service or by authorizing to Home Health agencies or medical service organizations. When home health care agencies are utilized, the Division shall authorize payment directly to the home health care vendor, and a concurrent case with IL is not opened. **The VR counselor cannot authorize greater than 28 hours per week for personal assistance. Requests to exceed 28 hours per week shall be submitted to the Unit Manager.**

Criteria

In order for a VR client to receive personal assistance services, the individual must be eligible for VR services and determined to be either SD or MSD based on a physical disability with functional limitations in the areas of self-care and/or mobility. The individual must require hands on personal assistance services (PAS) with two (2) or more major activities of daily living in support of one or more of the CORE VR services planned on the Individualized Plan for Employment (IPE).

Concurrent Records of Service

When the counselor and VR client elect to pursue personal assistance by enrolling the client in the consumer-directed PAS, the client 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. If other IL services are required in order to achieve the IL primary objective, then these services should be funded by IL, and IL policies should be applied. However, any services which are related to the achievement of the client's IPE goal should be funded by VR and provided according to VR policies.

Transition of Personal Assistance and Personal Assistance in a Post-Employment Plan

During the comprehensive assessment, the VR Counselor shall consider factors related to the transitioning of personal assistance services. In cases where personal assistance is needed to support training, the counselor shall discuss and document a client's stated needs related to transitions such as school breaks, completion of training, beginning a job search, and job placement. In cases where personal assistance is needed in support of job placement, the

Counselor shall discuss and document any stated needs related to post-employment personal assistance services. This includes a discussion of comparable benefits, including the client's ability to private pay using the client's earned income. When referring a client to IL for coordination of personal assistance, the VR Counselor shall notify the IL counselor of the client's stated needs as related to transitions in personal assistance services so that the IL Counselor may effectively consider the service as part of a plan for independent living. Communication and coordination shall continue throughout service provision regarding personal assistance transitions.

At the point in which the client has achieved all other requirements for a successful employment outcome other than the termination of personal assistance services, the VR Counselor shall coordinate with the IL Counselor to determine whether the client is likely to meet the IL program's financial eligibility to continue personal assistance. If it is unlikely that the individual will qualify for this or other comparable benefits, the VR Counselor may continue to refer the client to the IL program for personal assistance coordination to be paid for out of VR case service funds as part of a VR post-employment plan.

In concurrent records of service,

The VR counselor will:

1. Identify that independent living services may be needed 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 IL services.

3. Notify the client that the IL program will determine eligibility for the Independent Living Rehabilitation Program.

4. Obtain from IL, once available:
   a) IL Eligibility
   b) Supporting medical documentation
   c) Financial Needs Survey for IL funded services

5. Complete an IPE or IPE Amendment upon the IL counselor's determination of eligibility, selecting the service of Information and Referral to IL and outlining in the detail section the IL services that are to be coordinated by the IL program. If VR funded services are planned, the service(s) must be added to the IPE and the appropriate financial need category must be selected; if applicable, obtain verification of the client's eligibility for SSI/SSDI or complete the Financial Needs Survey. The IPE should include the statements – All services funded by VR will

be terminated when the VR case is closed. All services funded by IL will be terminated when the IL case is closed.

6. All established VR closure standards apply to concurrent records of service.

7. Maintain all fiscal information (authorizations; bids or price quotes; invoices) in the VR case file for VR funded services, in keeping with the record retention schedule.

The IL counselor will:

1. Identify that vocational rehabilitation services may be needed for the individual to complete their Independent Living Service Plan (ILSP).

2. Contact the VR Office to staff the case with the appropriate VR counselor.

3. Notify the client that the VR program will determine eligibility for the Vocational Rehabilitation Program.

4. Obtain from VR, once available:
   a) VR Certification of Eligibility
   b) Supporting medical documentation
   c) Financial Needs Survey or Verification of SSI/SSDI for VR funded services

5. Complete an ILSP or ILSP Amendment upon the VR counselor's determination of eligibility, selecting the service of Information and Referral to VR and outlining in the detail section the VR services that are to be coordinated and/or provided by the VR program. If VR funded services are planned, the appropriate financial need category must be selected and the Financial Needs Survey must be completed or, if applicable obtain verification of the client's eligibility for SSI/SSDI. Include the statement on the ILSP – All services funded by IL will be terminated when the IL case is closed. All services funded by VR will be terminated when the VR case is closed.

6. All established IL closure standards apply to concurrent records of service.

7. Maintain all fiscal information (authorizations; bids or price quotes; invoices) in the IL case file for IL funded services in keeping with the record retention schedule.

[The 1992 Amendments to the Rehabilitation Act of 1973, Section 10]

Revised 7/1/2014

2-11-2: Independent Living Program

The Independent Living Rehabilitation Program (ILRP) provides a part-time personal assistance service for those individuals who meet the requirements described in this section. This service is subject to both the individual's financial eligibility and comparable benefits.

Personal assistance is to be a client -driven service. The counselor shall gather data relative to several aspects of personal assistance at the time of application and at closure, in order for the Division to assess the impact of this service.

Revised 4/24/2014

Client Selection for Personal Assistance Service

Due to funding limitations for this service and the often large number of requests received, counselors shall prioritize applicants. Further, an evaluation of the basic personal assistance service needs of the referred client (e.g., hours of assistance needed and availability of other resources including reviewing the other resource's assessment and plan of care) must be secured by the counselor prior to planning personal assistance on the IL Service Plan. Those individuals targeted to receive personal assistance services (in order of priority) are:

1. Individuals currently living in an institution who require personal assistance as part of discharge plan
2. Individuals living independently who, if PAS is not provided, will be placed in an institution within the next 90 days or when there is an elevated risk due to extenuating circumstances
3. Individuals who need personal assistance to remain independent in the community but who are not in immediate danger of being institutionalized OR individuals who are employed and need personal assistance to maintain employment

Evaluation of Individual's Personal Assistance Needs

Once an individual has been identified as a candidate for personal assistance services, the IL counselor shall obtain a personal assistance evaluation in order to determine the client's ability to participate in and benefit from personal assistance. The counselor shall utilize a registered nurse, physical therapist, or occupational therapist to complete the Division's evaluation form by observing the client perform the activities of daily living.

Data gathered by the evaluation should include information related to the following areas:

1. Medical
2. Housing
3. Functional Assessment
4. Social/psychological history
5. Community Resources
6. Community Accessibility
7. IL goals
8. Specific needs for personal assistance
9. Other resources available for personal assistance
10. Number of hours required
11. Availability of personal assistants meeting the applicant's expected qualifications
12. Personal assistance routine and schedule
13. Individual's management skills
14. Emergency back-up plans

Other specialty evaluations, such as psychological evaluations, may be secured when necessary, in order to better determine that the individual satisfies item 13 of the criteria above.

When the evaluation has been completed, a narrative of the results shall be prepared by the evaluator justifying the need for personal assistance services. The evaluator shall not determine the number of hours that the Division will sponsor.

The counselor in consultation with the client will determine the number of hours that is being requested for the Division to sponsor based on the evaluation. The counselor in consultation with the client shall complete a "Personal Assistance Service Needs Check List" specifying the type of personal assistance services that is being requested for the Division to sponsor based on the evaluation. The client's file shall be staffed with the Unit Manager or the Unit Manager's designee for approval of the number of hours and type of personal assistance services that will be sponsored by the Division. The Division shall not sponsor personal assistance services unless all of the hours as recommended on the evaluation are covered by all paid service providers and in-kind providers (family, friends, and volunteers).

The number of personal assistance service hours that the Division will sponsor shall be documented on a Progress Review Note and attached to the evaluation and a copy shall be provided to the client. The counselor shall attach the completed "Personal Assistance Service Needs Check List" to the evaluation and provide a copy to the client and the Division's contract fiscal agent.

Re-evaluation of the Individual's Personal Assistance Needs

If personal assistance services are being provided, the counselor shall continuously monitor the client's personal assistance needs throughout the rehabilitation process with changes documented appropriately. An updated evaluation by a registered nurse, physical therapist, or occupational therapist is required only when there are significant changes in the client's functional capacity and subsequent need(s).

The counselor shall review the most current evaluation with the client at least annually to determine if there are significant changes in the client's functional capacity. If there are no significant changes in the client's functional capacity, the counselor shall document on a new Progress Review Note the status of this review and the number of hours that the client is approved to receive based on the most current evaluation. The Counselor in consultation with the client shall complete a new "Personal Assistance Service Needs Check List" which shall be consistent with the service needs as recommended on the most current evaluation. The Progress Review Note and the new "Personal Assistance Service Needs Check List" shall be attached to the most current evaluation and a copy shall be provided to the client. A copy of the new "Personal Assistance Service Needs Check List" shall be provided to the Division's contract fiscal agent.

If there are significant changes in the client's functional capacity, the counselor shall obtain a new evaluation by a registered nurse, physical therapist, or occupational therapist.

When the new evaluation has been completed, a narrative of the results shall be prepared by the evaluator justifying the need for personal assistance services. The evaluator shall not determine the number of hours that the Division will sponsor.

The counselor in consultation with the client will determine the number of hours that is being requested for the Division to sponsor based on the new evaluation. The counselor in consultation with the client shall complete a new "Personal Assistance Service Needs Check List" specifying the type of personal assistance services that is being requested for the Division to sponsor based on the new evaluation. The client's file shall be staffed with the Unit Manager or the Unit Manager's designee for approval of the number of hours and type of personal assistance services that will be sponsored by the Division. The Division shall not sponsor personal assistance services unless all of the hours as recommended on the new evaluation are covered by all paid service providers and in-kind providers (family, friends, and volunteers).

The number of personal assistance service hours that the Division will sponsor shall be documented on a new Progress Review Note and attached to the new

evaluation and a copy shall be provided to the client. The counselor shall attach the new "Personal Assistance Service Needs Check List" to the new evaluation and provide a copy to the client and the Division's contract fiscal agent.

The maximum number of allowable hours for IL-sponsored personal assistance services shall be determined by the counselor in consultation with the client following a review of the most current personal assistance evaluation, but shall not exceed forty (40) hours per week. Any changes to personal assistance hours as well as changes to an assistant's wage rate must also be approved by the Unit Manager. Approval requests shall briefly describe justification for a change in hours, justification for services in excess of twenty-eight (28) hours, and/or justification for the change in wage rate.

Selection Criteria

Individuals for whom personal assistance services are planned must:

- Be eighteen (18) years of age or older;
- Be intellectually and emotionally capable of directing and managing a personal assistant or capable of doing so after completion of personal assistance management training;
- Hire their personal assistant(s);
- Use the Division's contract fiscal agent;
- Sign Form "*Personal Assistance Services and Reimbursement Agreement" annually or if the hours and/or hourly rate changes.*

Management Training

Personal assistance management training is provided to instruct clients in ways to develop an employer/employee relationship with the individual's personal assistant. Specific topics include identifying one's self-care needs, developing management skills, assertiveness training, recruiting personal assistants, interviewing techniques, hiring and firing and dealing with performance or salary issues.

Annual Evaluation and Client Contact

An annual telephone contact and an annual face-to-face visit will be made by IL staff in order to monitor the client's independent living status and make suggestions or assist with situational changes, if needed. The telephone contact and face-to-face visit will be alternated throughout the calendar year such that the client receives contact twice a year either by phone or in person. During the month that the annual evaluation is conducted, this visit may take the place of the required annual face-to-face visit. A quarterly face-to-face visit may be conducted if the counselor determines that more frequent visits are needed.

The IL Counselor shall continue to explore comparable benefits for personal assistance during the annual evaluation and client contacts (e.g., CAP-DA,

Division of Aging and Adult Services, Division of Medical Assistance). If, during the annual evaluation, the Counselor and client identify comparable benefits for providing personal assistance, the Counselor shall assist the client in exploring these benefits. The client shall notify their IL counselor immediately when they are approved to use a comparable benefit for personal assistance services (e.g., CAP-DA, Division of Aging and Adult Services, Division of Medical Assistance). If the IL Counselor determines that the client is no longer able to manage the IL personal assistance service due to cognitive or mental decline, the IL Counselor must develop a transition plan for the client to begin utilizing another source of personal assistance services. This may include assisting the client in identifying other public programs for the client to contact. In cases where the client becomes too significantly disabled to manage the Division's personal assistance service, yet still requires this type of support, the IL Counselor may authorize time-limited personal assistance to be provided by a home health agency until the client can successfully transition to another public program.

Client as Employer

In the provision of personal assistance services, the IL client shall assume the role of a managing employer. The client's personal assistant(s) will assume the role of employee. DVR Form *"Personal Assistance Services and Reimbursement Agreement"* outlines the client's responsibilities as the managing employer. This form must be signed by the client annually, or when there is a change in the number of hours and/or the wage rate of the personal assistant(s). A copy of the *Personal Assistance Services and Reimbursement Agreement* shall be provided to the client and a copy provided to the Division's contract fiscal agent.

As the managing employer of the personal assistant(s), the IL client controls the terms and conditions of the personal assistant's employment except for the administrative duties performed by the Division's contract fiscal agent as defined in this policy. The client shall use the Division's completed "Personal Assistance Service Needs Check List" when recruiting and determining who to hire as the personal assistant(s). The Division shall only pay for services which are specified on the Division's "Personal Assistance Service Needs Check List." The client is responsible to interview prospective personal assistant(s). If, upon interviewing, the client is unable to identify a personal assistant who meets all of the pre-defined qualifications, the client has the option to train an individual who closely meets the qualifications in those areas in which the individual is deficient. The client may also arrange for family members, or others whom are capable, to provide the training. Prior to hiring the personal assistant, the personal assistant shall sign the consent for a criminal background check provided by the Division's contract fiscal agent. The client shall utilize the criminal background check information provided by the Division's contract fiscal agent when determining if the personal assistant will be hired. The client's counselor will be available for

questions that the client may have during their consideration of personal assistant applicants, but it is the client's responsibility to make the final decision about whom they hire as a personal assistant. The personal assistant(s) hired by the IL client:

- May reside in the same residence as the IL client
- Must be eighteen (18) years of age or older
- Do not require any state licensure or certification

The hourly wage rate for personal assistance services shall be negotiated between the IL counselor and the client prior to hiring the personal assistant. Only one hourly wage rate shall be allowed for an IL client, and that rate shall be used in paying all assistants. A client's assistant(s) shall not be paid at an hourly rate that exceeds the actual hourly expenditures for personal assistance services, and in no instance shall a client's hourly reimbursement rate exceed the current Medicaid rate for personal assistance services.

The IL client shall submit a request in writing to their counselor if they wish to request a change of hours or wage rate. A change of either hours or rate would be contingent upon the availability of Personal Assistance Service funds. The number of hours of personal assistance requested must be consistent with the client's personal assistance evaluation, and the portion being sponsored by DVRS shall not exceed forty (40) hours per week.

DVRS shall not pay for personal assistance hours and/or hourly rate that exceed the number of hours and hourly rate as specified on the most current DVR Form *"Personal Assistance Services and Reimbursement Agreement."* DVRS shall not pay for overtime if the personal assistant works more than forty (40) hours per week. Hours that a personal assistant does not work during the first week of the two-week pay period cannot be carried over to the second week of the pay period.

The IL client's personal assistant shall not be paid for personal assistance services that are not on the DVRS Personal Assistance Service Needs Check List. The personal assistant will not be paid if the service was not provided. This includes times when the client may be in the hospital, or when personal assistance services are provided by another resource.

If the IL client employs more than one personal assistant, no two (2) personal assistants may assist with the client's personal care at the same time. Also, if another agency is providing personal assistance services to the client, the personal assistant(s) funded by DVRS cannot be working at the same time as a personal assistant funded by the outside agency.

Clients who are required to contribute towards the cost of their personal assistance service due to excess income shall include on the timesheet both the

number of hours that the Division will sponsor and the number of hours that the client is required to contribute towards the cost of their personal assistance service. The IL client shall submit the timesheet to the Division's fiscal agent as specified on the payroll calendar and provide a check to the Community Integration Services and Supports (CISS) Administrative Assistant for the amount that the client is required to contribute. The client shall make the check payable to DVRS. The Division's fiscal agent shall pay the personal assistant for both the number of hours that the Division will sponsor and the number of hours that the client is required to contribute towards the cost of their personal assistance service.

If the client fails to pay the required contribution for two (2) consecutive months the counselor should immediately contact the client to discuss the delinquency. The counselor may also communicate with the Chief of Policy to discuss the situation and determine whether a corrective action plan (CAP) is required. If a CAP is required it will be implemented within 30 days. Failure to comply with the CAP may result in suspension or termination. Refer to section 2-11-3.

Revised: 6/1/2018

Personal Assistance by a Home Health Agency

In the rare situation when an IL client temporarily contracts with a home health agency for personal assistance services, the following requirements shall be met in order for Division funds to be used towards this assistance:

- Services shall be negotiated between the client and a vendor, with the counselor serving as a resource person or mediator.
- Authorizations shall not exceed Division maximums (Medicaid rate), and the vendor must agree not to charge fees in excess of this rate.
- Any vendor selected by the client shall be certified by the NC Health Services Regulation.
- Any vendor selected shall be responsible for all employer related expenses.
- The Division shall authorize payment directly to the vendor.
- The vendor shall agree to meet the client's personal assistance needs as defined by the client and the Division, and the client must be able to terminate the agreement without penalty when needs are not being met.

Division's Contract Fiscal Agent

The Division's contract fiscal agent shall process and pay the personal assistants, pay the employer related taxes, complete the employer related paperwork and reporting requirements, conduct a criminal background check including checking the NC Health Care Personnel Registry for each personal assistant and provide Worker's Compensation Insurance coverage for the IL clients enrolled in the personal assistance service. The counselor shall provide

the Division's contract fiscal agent with the client's contact information, social security number, number of personal assistance service hours and hourly rate sponsored by the Division on the "Client Information Sheet" provided by the fiscal agent.

Authorizations

When the counselor authorizes for personal assistance services, the authorization shall cover several types of payments:

- Monthly payment for personal assistant(s) net pay
- Payment for federal and state employer related taxes
- Worker's Compensation Insurance coverage.

The counselor will provide the Division's contract fiscal agent with the completed DVR Form *"Personal Assistance Services and Reimbursement Agreement,"* the "Personal Assistance Needs Check List" and the "Client Information Sheet." The fiscal agent will calculate the authorization amount and provide this information to the counselor within three days of receiving the Client Information Sheet. The counselor will issue the authorization and provide the authorization to the fiscal agent within three days of receiving the authorization amount from the fiscal agent.

For clients who are required to contribute towards their personal assistance service due to excess income, the counselor shall provide the Division's contract fiscal agent with the annual amount that the client is required to contribute and the approved hourly rate for paying their personal assistant(s) on the "Client Information Sheet." The fiscal agent shall calculate the number of hours that the client is required to contribute per week based on the hourly rate and the federal/state taxes. The fiscal agent shall provide the number of hours per week and the semi-monthly amount that the client is required to contribute towards the cost of their personal assistance service to the counselor within three days of receiving the Client Information Sheet.

If the hourly rate or number of hours is increased (after the Chief of Community Integration Services and Supports approval) prior to the expiration date of the authorization, the counselor will provide the Division's contract fiscal agent with the new DVR Form *"Personal Assistance Services and Reimbursement Agreement"* and service dates. The fiscal agent will calculate the new authorization amount and provide this information to the counselor within three days of receiving the client information from the counselor. The counselor will issue a new authorization and provide the new authorization to the fiscal agent within three days of receiving the authorization amount from the fiscal agent.

2-11-3: Suspension and Termination from Personal Assistance Services

All incidences of Client non-compliance with personal assistance policies shall be documented in the case record.

Individuals shall be suspended from receiving personal assistance for the following reasons:

A. Evidence of misuse of funds. Examples of misuse include falsifying the personal assistance service timesheet or misrepresenting personal assistance needs;
B. Failure to cooperate with program staff in efforts to implement policy and procedures pertaining to this service; AND
C. Refusal to sign or conform to the Form *"Personal Assistance Services and Reimbursement Agreement*."

Upon suspension, the Counselor shall contact the IL Program Specialist who will collaborate with the Chief of Policy to identify strategies to be included in a corrective plan for the particular incident of non-compliance. The Counselor shall partner with the client to develop the steps and timeframes required to be included in the corrective action plan. The corrective action plan shall be documented in the case record. The Division shall not pay the client's personal assistant(s) for any personal assistance services provided during the period of suspension. The Counselor shall document the progress of the client in completing the corrective action plan in the case record. The Division shall resume service provision upon completion of the corrective action plan **within** the specified timeframe.

Individuals shall be terminated from receiving personal assistance for any of the following reasons:

- Financial gains to the point that the client can pay the full cost of personal assistance needs as documented on the Financial Needs Survey
- Significant change in the disabling condition, as determined by the personal assistance evaluation, which eliminates the need for this service
- Completion of the IL Service Plan, unless personal assistance is negotiated as an IL post-outcome service
- Identification of a comparable benefit (e.g., CAP-DA, Medicaid, Division of Aging) for this service in a manner compatible with the IL goal
- Relocation out-of-state or IL office service area unless approved by the Independent Living Rehabilitation Program Coordinator and DVR Chief of Policy
- Death or incapacitation that requires institutionalization
- Insufficient case service funds
- Failure to complete the corrective action plan in the specified timeframe
- Continued and repeated incidences of noncompliance that have resulted in two (2) or more suspensions within a two (2) year period of time

The suspension and termination decision must be made in partnership with the client. In cases of death or institutionalization when no executor, Power of Attorney, or guardian exists, the Counselor shall contact the IL Program Specialist, who in consultation with the Chief of Policy can advise on final payment procedures. Should the client disagree with the Division's decision to suspend or terminate personal assistance services due to a breach in the personal assistance agreement, then the counselor must inform the client of the Division's administrative review and appeals process. Record of service documentation is required when personal assistance is suspended or terminated.

[10A NCAC 89C .0316]

Section 2-12: Physical Restoration

CROSS REFERENCE: **Interim Policy and Procedure Directive #04-2007, Physical Restoration and Physical Conditions; Interim Policy and Procedure Directive #05-2007, Secondary Restoration Issues Accompanying a Chronic Impairment**

Physical restoration services are subject to the individual's financial need and comparable benefits. The IL Counselor must seek and utilize all comparable benefits prior to the provision of Physical Restoration Services.(Reference 3:10:3 Comparable Benefits) Such services may be provided as part of the Independent Living Plan to increase independence and enhance quality of life.

2-12-1: Chiropractic Services

The Division may utilize the services of any legally licensed doctor of chiropractic. This service is subject to financial need and comparable benefits. The following conditions must exist:

A. The client has signs or symptoms that are considered by a chiropractic physician to be related to spinal subluxation, and are not shown in the general or special examination to be due to other causes;

B. The client chooses the services of a chiropractic physician for spinal subluxation and/or spinal manipulation; AND

C There are no contraindications to spinal manipulations imposed by disorders other than spinal subluxation.

Chiropractic physicians may not be utilized during the assessment to determine eligibility and vocational rehabilitation needs.

[RSA-PRG-77-5; PL 92-603, Section 275 (Medicaid); G.S. 90-143 and 157.1; NCAC 20C Section .0303; 20D Section .0302]

2-12-2: Hearing Aids

CROSS REFERENCE: **Appendix Entry - Hearing Disabilities; Section 2-3-7 Telecommunicative Devices**

Hearing aids may be sponsored for those clients who meet the eligibility criteria listed in the Hearing Disabilities section of the Appendix and who require such devices to meet the needs of a training program or employment. A hearing aid may be purchased for a primary or secondary disability if the hearing loss meets the criteria for a hearing disability See Appendix – Hearing Disabilities).

The Division will utilize vendors who provide a full range of services including servicing and loaner aids. Physicians who meet this requirement may provide ear, nose and throat (ENT) examinations, hearing evaluations, hearing aid evaluations and may dispense hearing aids (see Volume V for rates). Such services are subject to the individual‘s financial need and comparable benefits, when available. In order to purchase a hearing aid or aids, the counselor will authorize to an otologist and audiologist licensed to practice in the State of North Carolina for an ear, nose, and throat (ENT) exam, hearing evaluation, and a hearing aid evaluation. Medical clearance for fitting of an aid must be obtained from a physician skilled in diseases of the ear (ENT exam). The Division cannot accept a waiver for medical clearance from an audiologist, a physician‘s assistant, a hearing aid dealer, or a family member.

The Division may purchase any kind of hearing aid (behind the ear, in the ear, programmable, or digital) recommended by a licensed audiologist or Board Certified Hearing Aid Specialist. The user‘s hearing aid should be equipped with a telecoil switch (T-coil switch). The _T-switch functions like an antenna, picking up the electromagnetic energy and transferring it to the hearing aid which converts it into sound. With a —T-switch, the consumer will be able to utilize additional assistive technology devices and have access to the telephone. (See Volume V – Hearing Aid Fees)

Purchase of a hearing aid is not subject to equipment purchasing procedures.
Clients are expected to follow the manufacturer‘s directions in using and maintaining a hearing aid. The client is responsible for safe storage of the hearing aid when it is not in use and should pay close attention to the safe handling of the device. Replacement hearing aids will **not** be purchased due to negligence that results in damage or loss.

A hearing aid can be repaired if feasible and cost effective, and the needed repair is not due to negligence. A replacement hearing aid may be purchased when an individual‘s current hearing aid is not sufficient to meet his/her needs due to a rapidly progressive hearing loss (See Appendix – Hearing Disabilities and Section 2-3-7 Telecommunicative Devices – Comparable Benefits).
Rehabilitation Counselors may also approve sponsorship of a replacement hearing aid if the client meets **one** of the following criteria:

A. The client is working and needs a hearing aid to maintain employment (a letter from the supervisor/employer is recommended for establishing the need).
B. The client is not working and his/her current hearing aid is not meeting the communication needs of the client;
C. The client has a documented rapidly progressive hearing loss (see Appendix – Hearing Disabilities).

For exceptions to this policy or extenuating circumstances, please contact the Chief of Policy or the Program Specialist for Deafness and Communicative Disorders.

Revised 11/15/2013

2-12-3: Orthotics

Orthotic devices may be sponsored for clients who require such services in order to complete the rehabilitation program. A prescription from the appropriate medical specialist is required followed by an assessment and quote from a Certified Orthotist (as defined by the American Board for Certification in Orthotics, Prosthetics and Pedorthics).

Purchases and repairs to orthotics are paid based on statewide fees for services established by the Division of Medical Assistance using the prevailing Medicaid rates. Procedures for purchase:

- If the estimated cost is less than or equal to $500
  - an assessment and quote is obtained from a certified orthotist
  - the counselor adds the service to the plan, and documents under *"Counselor Comments"*: "*Sole source of the vendor is warranted in accordance with Waiver section 01 NCAC 05b.1401 because a particular orthotic appliance is needed"*
  - The counselor issues the authorization

- If the estimated cost is greater than $500, but less than or equal to $2500:
  - an assessment and quote is obtained from a certified orthotist
  - the counselor adds the service to the plan, and documents under *"Counselor Comments"*: "*Sole source of the vendor is warranted in accordance with Waiver section 01 NCAC 05b. 1401 because a particular orthotic appliance is needed* "
  - the supervisor approves the plan in the Division's electronic case management system
  - the counselor issues the authorization

- If the estimated cost is $2501 or more:
    - an assessment and quote is obtained from a certified orthotist
    - the counselor submits a client data packet to the Chief of Policy
    - the Chief of Policy reviews and responds with an approval or denial external to the Division's electronic case management system
    - If approved, DVRS State Purchasing will notify the counselor to add the service to the IPE, including the awarded vendor and the amount the counselor puts the service on the plan**,** and documents under *"Counselor Comments": "Sole source of the vendor is warranted* in accordance *with Waiver section 01 NCAC 05b. 1401because a particular orthotic appliance is needed.*
    - the Chief of Policy approves the plan in the Division's electronic case management system
    - The purchasing agent in the Division Purchasing Section issues the authorization

The service is subject to financial need. Comparable benefits are to be used whenever available towards the purchase of orthotic devices. If a comparable benefit provides partial coverage towards a prescribed device, the counselor must consult with the Chief of Policy on how best to apply Division funds in coordination with the comparable benefit towards overall payment of the device.

Outpatient and inpatient gait training (with documented medical need) may be provided.

A replacement orthosis may be considered for purchase when repairs to the existing orthosis are not feasible or cost effective, as determined by a Certified Orthotist. Replacements, as with initial devices, must be prescribed by an appropriate medical specialist. Repairs may be recommended and prescribed by an Orthotist.

[34 CFR 361.4; NCAC 20C, Section .0303]

Revised 7/15/2019

2-12-4: Prosthetics

Prosthetic devices may be sponsored for clients who require such services in order to complete the rehabilitation program. A prescription from the appropriate medical specialist is required followed by an assessment and quote from a Certified Prosthetist (as defined by the American Board for Certification in Orthotics, Prosthetics and Pedorthics).

Purchases and repairs to prosthetics are paid based on statewide fees for services established by the Division of Medical Assistance using the prevailing Medicaid rates.

Procedures for purchase:

- If the estimated cost is less than or equal to $500
  - an assessment and quote is obtained from a certified prosthetist
  - the counselor adds the service to the plan, and documents under *"Counselor Comments"*: "*Sole source of the vendor is warranted in accordance with Waiver section 01 NCAC 05b.1401 because a particular prosthetic appliance is needed"*
  - The counselor issues the authorization

- If the estimated cost is greater than $500, but less than or equal to $2500:
  - an assessment and quote is obtained from a certified prosthetist
  - the counselor adds the service to the plan, and documents under *"Counselor Comments"*: "*Sole source of the vendor is warranted in accordance with Waiver section 01 NCAC 05b. 1401 because a particular prosthetic appliance is needed* "
  - the supervisor approves the plan in the Division's electronic case management system
  - the counselor issues the authorization

- If the estimated cost is $2501 or more:
  - an assessment and quote is obtained from a certified prosthetist
  - the counselor submits a client data packet to the Chief of Policy
  - the Chief of Policy reviews and responds with an approval or denial external to the Division's electronic case management system
  - If approved, DVRS State Purchasing will notify the counselor to add the service to the IPE, including the awarded vendor and the amount the counselor puts the service on the plan**,** and documents under *"Counselor Comments": "Sole source of the vendor is warranted* in accordance with Waiver section 01 NCAC 05b. 1401*because a particular prosthetic appliance is needed.*
  - the Chief of Policy approves the plan in the Division's electronic case management system
  - The purchasing agent in the Division Purchasing Section issues the authorization

The service is subject to financial need. Comparable benefits are to be used whenever available towards the purchase of prosthetic devices. If a comparable benefit provides partial coverage towards a prescribed device, the counselor must consult with the Chief of Policy on how best to apply Division funds in coordination with the comparable benefit towards overall payment of the device.

Outpatient and inpatient gait training (with documented medical need) may be provided.

A replacement prosthesis may be considered for purchase when repairs to the existing prosthesis are not feasible or cost effective, as determined by a Certified Prosthetist. Replacements, as with initial devices, must be prescribed by an appropriate medical specialist. Repairs may be recommended and prescribed by a prosthetist.

[*34 CFR 361.4; NCAC 20C, Section .0303]*

Revised 7/15/2019

Section 2-13: Recreational and Social Services

CROSS REFERENCE: **Subsection 2-3-6, Recreation Equipment**

Recreational Therapy services assist consumers to develop and use leisure in ways that enhance health, functional abilities, community reintegration, independence and overall quality of life. Such services are subject to financial need and comparable benefits. Services include but are not limited to adaptive equipment, sponsorship of initial fitness memberships and leisure activity classes.

[34 CFR 364.4]

[Policy continued on next page]

Section 2-14: Rehabilitation Technology

***CROSS REFERENCE*: Subsection 2-2-2 Major Independent Living Services**
Section 2-3 IL Equipment
Section 2-4 Assistive Technology Services
Section 2-10 Modifications
Subsection 2-14-1 Rehabilitation Engineering

Rehabilitation Technology includes but is not limited to assistive technology devices; repair, customizing, adapting or maintaining assistive technology devices; coordinating and using other therapies and interventions with assistive technology; training and technical assistance to clients, family members, employers, other agencies or rehabilitation professionals; and modifications to vehicle, home, or worksite. As one of the major IL services, assistance with rehabilitation technology becomes a substantial rehabilitation service when it is provided within the supportive counseling and guidance relationship.

2-14-1: Rehabilitation Engineering

CROSS REFERENCE: **Subsection 2-2-1, Substantial Services; Section 2-7, Driver Evaluation and Training; Handbook: Vehicle Modification Guidelines (intranet); Counselor's Driving Evaluation and Training Process (intranet); Vehicle Modification Client Data Package Checklist (intranet); Home Modification Client Data Package Checklist (intranet)**

The term "rehabilitation engineering" means ". . . the systematic application of technologies, engineering methodologies or scientific principles to meet the needs of and address the barriers confronted by individuals with disabilities in areas which include rehabilitation, education, employment, transportation, independent living and recreation." Applicants and clients who are in need of and can benefit from rehabilitation engineering services and devices should be referred to the Rehabilitation Engineer. This includes services and devices which can supplement and enhance individual functions such as adapted computer access, augmentative communication, special seating and mobility, vehicle modifications, and services which can have an impact on the environment, such as accessibility, job re-design, work site modification and residence modification. Other requirements are noted in specific policy statements elsewhere in this manual. The IL program may provide support for those technologies described above, or the technologies may be coordinated through joint VR and IL cases. When VR funds are being utilized for devices, equipment, and modifications, VR policy prevails. A rehabilitation engineering evaluation is not subject to an individual's

financial need; however, devices, equipment and modifications recommended by the engineer are subject to financial need. Rehabilitation engineering services can be provided without consideration of comparable benefits. However, where rehabilitation engineering services are readily available to the individual from other sources, they should be used.

[34 CFR 361.5; 34 CFR 364.4; 10A NCAC 89C .0315]

Revised 4/24/2014

Section 2-15: Services to Family Members

Any rehabilitation service may be provided to a member of the client's immediate family if the service is required in the client's rehabilitation program, is essential to the success of the rehabilitation program and is not readily available through other agencies or resources. Such services are subject to financial need and comparable benefits as if the service was being provided to the client.

[34 CFR 361.42; NCAC 20C, Section .0307; 34 CFR 364.4]

Section 2-16: Transportation

These services include the provision of or arranging for transportation. Transportation may be for the provision of assessment services or services leading to the accomplishment of VR/IL program goals. Public and private transportation services may be provided. Also included is payment for escorts, personal care providers or guides. Transportation services are subject to both financial need and comparable benefits unless transportation is required in conjunction with an assessment service. The mode of transportation should depend upon the circumstances of the individual, the availability and appropriateness of the transportation system, and upon fiscal considerations. The client or client's family should be used to provide transportation whenever possible without cost to the Division. The agency maximum (see Vol. V) should not be exceeded without first receiving approval from the Chief of Policy.

[34 CFR 361.42 (a)(6); 34 CFR 364.4; NCAC 20C, Section .0306]

2-16-1: Public Conveyance

Sponsorship of public conveyance may be sponsored at the rate charged by the vendor. This includes tickets for buses, trains, and other means of public transportation. Taxis may also be used.

2-16-2: Private Conveyance

When a private vehicle is used for transportation, the current Volume V mileage rate will be authorized. *(see Transportation – Volume V)*

2-16-3: Personal Care Assistants and Escorts

Assistant or escort services will usually only be authorized for a client who is significantly disabled. The salary or fee is considered to be a related expense to the transportation of the individual. When assistant or escort services are obtained at no cost to the Division, travel costs and subsistence of the assistant/escort may be sponsored not to exceed State per diem rates. A family member should not be paid for services normally expected of a family member; however, if acting as an assistant or escort causes undue hardship to the family member, reasonable reimbursement may be paid. Authorizations must be issued to the client with the client paying the assistant/escort.

2-16-4: Permanent Relocation and Moving Expenses

Financial assistance for the permanent relocation of a client, or a client and family, may be provided when a move is necessary in order to support the client in transitioning to a primary residence. This assistance may be provided when the primary IL objective is deinstitutionalization or in situations where the individual is moving from a non-accessible residence into an accessible residence to support prevention of institutionalization or community integration. Included in this category are expenses for deposits and other relocation expenses. The Counselor should obtain three competitive bids for total moving costs and submit them to the Unit Manager for approval. The low bid should be accepted.

Section 2-17: Vehicles

2-17-1: Vehicle Purchases

CROSS REFERENCE: **Subsection 2-10-2: Vehicle Modifications**

If the client elects to purchase a vehicle to be modified by the Division, the IL Program may contribute to the cost of the vehicle modifications at the maximums set for the IL Program. The client should only purchase vehicles recommended by the rehabilitation engineer based on the modification requirements of the individual. The Division is not responsible for costs incurred by the client if the rehabilitation engineer was not involved in recommending the vehicle purchased by the client.

[10 NCAC 20C .0316(d); Eff. 2/1/96]

2-17-2: Vehicle Repairs

Vehicle repairs may be authorized in order to assist a client in maintaining independence. At the discretion of the counselor, a request may be made to the policy office to conduct a DMV review before agreeing to sponsorship of repairs. Repairs up to seven hundred fifty dollars ($750.00) require only one quote from a reputable auto service vendor. Repairs exceeding seven hundred fifty dollars ($750.00) will be approved by the Supervisor, and require that three quotes be obtained, with the low quote being accepted. Additionally, review and approval by the Chief of Policy is required for repairs exceeding two thousand five hundred dollars ($2500). When authorizing repairs, Counselors should be cognizant of the estimated value of the vehicle versus the cost of the repairs. General "upkeep" items should not be authorized. Repairs to mopeds and motorcycles will not be sponsored. This service is subject to the individual's financial need and comparable benefits.

Revised: 1/3/2017

[34 CFR 364.4]

CHAPTER THREE: PRELIMINARY ASSESSMENT

The IL program will conduct a preliminary assessment in order to make a determination of eligibility. The IL Preliminary Assessment is necessary to determine whether an individual is eligible for services and to assign the priority for services.

Section 3-1: Timelines for Eligibility Determination

A determination regarding eligibility must be made within a reasonable period of time, not to exceed sixty days from the date the individual submitted an application for services unless exceptional and unforeseen circumstances beyond the control of the Division prevent a determination within sixty (60) days, and the Division and the individual agree to a specific extension of time not to exceed 60 days. In such cases, an **Eligibility Extension** must be completed prior to sixty (60) days from the date of application. The Extension of Eligibility Decision letter must be sent to the individual with a copy maintained in the record of service. The exceptional and unforeseen circumstances beyond the control of the Division along with the specific and agreed upon length of the extension must be documented. If a decision regarding eligibility is not made within the agreed upon timeline, then another **Eligibility Extension** must be completed and the Extension of Eligibility letter issued to the individual. If the applicant refuses to agree to extend the eligibility decision and the data is not available to make the eligibility determination, the application process should be discontinued.

Revised 8/1/2015

[The 1998 Amendments to the Rehabilitation Act of 1973 Sec. 102 (6)(A)(B); 34 CFR 365.30, 365.31; *Eff.8-7-98]*

Section 3-2: Use of Existing Information

Existing medical documentation or other specialist data shall be used for determining eligibility and rehabilitation needs. Counselor discretion is required to determine whether existing information is relevant and sufficient to determine eligibility for services.

If the existing data is not sufficient to describe the current functioning of the individual, then additional assessments must be obtained. The information must be sufficient to document the existence of a <u>significant</u> disability. Second opinions may be secured when a question arises regarding a diagnosis or treatment plan. In addition to medical data, counselor observations, school records, information provided by the applicant or the applicant's family, information used by the Social Security Administration, and determinations made by officials of other agencies may be used to identify limitations to independent living.

[State Plan-Section 7; 1992 Amendments to the Rehabilitation Act of 1973: Section 7(22)(A)(I)(I) and(ii); Section 102(a)(2) and (3); 34 CFR 361.42(c)(1)(2); 34 CFR 364.4z; Eff. 2-11-97]

Section 3-3: IL Case Status Codes and Definitions

For reporting purposes, the following case status codes will be used.

00 Referral
02 Applicant
04 PAS Waiting List
08 Outcome from status code 00 or 02
10 Eligible for Services – IL Service Plan (ILSP) development
12 ILSP developed and signed
18 ILSP implemented
26 Successful Outcome
28 Unsuccessful outcome after services on ILSP are initiated
30 Unsuccessful outcome after eligibility determination but prior to service implementation
32 Post closures services
34 Termination from post closure services
38 Outcome from case status code 04

Revised 7/1/2014

Section 3-4: Referral and Application Process

CROSS REFERENCE: **Appendix Entry-Referral Script**

3-4-1: Availability for Services

In order to become an applicant for services or continue in services, the individual must be available to participate in necessary assessments for purposes of determining eligibility, rehabilitation needs and services. When a criminal records check indicates that the individual is a fugitive from justice (i.e. criminal background check contains instructions to contact law enforcement authorities immediately), the individual will not be considered available for services. Individuals in the following circumstances may not be considered available for participation in services:

- Have current charges with pending court dates or sentencing that would prevent the individual from participating in a program of vocational rehabilitation services (these situations must be staffed with the Unit Manager)
- Cannot/or are unwilling to attend appointments and evaluations

- Are unwilling to participate in essential disability related treatment that will enable an individual to benefit from Division services in terms of an independent living outcome

As a division of North Carolina state government, Vocational Rehabilitation is required to comply with any orders on file with the NC Departments of Justice and/or Departments of Correction for reporting individuals having outstanding warrants to the appropriate authorities.

[The Final Regulations to the 1998 Amendments of the Rehabilitation Act, 34 CFR Part 361, Sec. 361.41 (b) (C) (iii)] [NC General Statutes 14-267 and 14-259]

3-4-2: Referrals

Referrals may be made by any individual, agency, professional, relative or friend; or individuals may self-refer. Once an individual states a desire to apply for IL services, the individual must be provided with sufficient information to aid the individual's decision on further pursuit of services. This will include informing the individual that the Division conducts criminal background checks on all new referrals, including those who are minors. In addition, the Division's confidentiality policy should be explained, including circumstances in which information will be shared with or without the client's consent. Upon completion of the criminal background check and documentation of other necessary referral data, the individual may be scheduled for a group orientation session. A referral form is completed utilizing the form available for Independent Living. Upon completion of the referral process, the individual may be scheduled for an appointment for purposes of taking an IL application. The following information will be documented on the referral form:

- Name
- Date of referral
- Address
- Date of birth
- Telephone number
- Stated impairment
- Stated Independent Living needs
- Referral source
- Directions to residence
- Completion of Criminal Background Check

Circumstances that result in a delay in the application process must be documented on the referral form for individuals who do not complete an application or in the comment section of the completed application. The date of referral must be entered into the database when the application date is entered.

Counselors will work closely with referral sources to establish criteria for appropriate referrals. It is also the counselor's responsibility to educate the referral source that the

individual must consent to a referral to IL to be considered a referral. Individuals who have been referred as a part of a large list of potential referrals will not be considered an official referral. If an individual indicates interest in applying for IL services after they have been contacted by a counselor or other designated staff, the application process must be initiated in an expeditious manner. Independent Living referrals must be initiated as soon as possible after the referral is made based on the priorities for services listed in subsection 3-7.

Revised: 9/1/2015

3-4-3: Timeliness of the Application Process

In order to assure that individuals with disabilities receive services in a timely and equitable manner, the Division shall initiate the application process as soon as possible for each referral. Independent Living must initiate contact based on the priority categories as listed in Section 3-7. Options for initiating the application process are as follows:

- Scheduling an individual intake and counseling session in the office
- Scheduling an individual intake and counseling session at the individual's residence at the time of referral
- Providing a referral packet to an individual who comes to the office and requests services
- A documented telephone call explaining IL services followed by mailing an application packet for the individual to return
- A letter or email with an application and information packet included

3-4-4: Procedures to Enter Applicant Status

The Division must inform each individual of the application requirements and identify the information that must be gathered to process the application. Referral packets mailed or given to the individual to complete must minimally include the following information:

- A cover letter explaining application requirements and advising the individual that their provision of existing information could assist with making a more timely eligibility determination.
- An application for services
- Information regarding client rights, appeals process and CAP
- Information Release Forms
- An explanation of the income verification process and required documents
- Requirement for a Social Security number
- Parent consent form if the individual is under 18

The preliminary assessment begins at the time of application for Division services and terminates at the time an eligibility decision is made. An individual is officially an applicant once the application form is appropriately completed and signed by the individual and/or, as appropriate, the individual's parent, guardian, advocate, or

representative. Individuals who are under age eighteen and are not legally emancipated minors cannot apply for services until the counselor has received signed parental permission. Guardianship issues also must be considered. If an applicant does not speak English or understand verbal or written information or if he or she communicates by sign language, the counselor must arrange for the most appropriate method of communication. Each applicant must be given a copy of the Client Assistance Program brochure. All required signatures must be obtained and maintained on a paper copy of the application in the case record.

3-4-5: Procedures to Exit Applicant Status

To exit the applicant process, the individual's record of service must:

A. Be closed for reasons other than ineligibility;
B. Be closed due to ineligibility; OR
C. Be determined eligible for rehabilitation services.

[1998 Amendments to the Rehabilitation Act of 1973]

Section 3-5: Determination of Impairments

3-5-1: Primary and Secondary Impairments

The primary impairment is the major disabling condition that is most responsible for the client's loss of functional independence. The applicant determined eligible for the Independent Living Rehabilitation Program must have a major disability code regarded as significant. A secondary impairment is any other disabling condition that contributes to, but is not the major source of, the individual's loss of functional independence. A secondary disability may, or may not be, a significant disability.

3-5-2: Physical Conditions

CROSS REFERENCE: **Interim Policy and Procedure Directive #04-2007, Physical Restoration and Physical Conditions**

Physical impairments must be diagnosed by the appropriate medical specialist and should be significant and chronic in nature. "Chronic" would refer to those conditions that are of long duration. "Acute" conditions are generally of short duration, of sudden onset, and should not present residual problems following treatment.

3-5-3: Psychological/Psychiatric Conditions

CROSS REFERENCE: **Appendix Entry-Learning Disability**
Appendix Entry-Intellectual Disability
Appendix Entry-Attention Deficit Disorder
Appendix Entry-Borderline Intellectual Functioning
Appendix Entry-Substance Abuse

Evaluation and diagnosis by the appropriate specialist is required to establish the existence of a mental, emotional, or substance abuse impairment.* Appropriate specialists include:

Attention Deficit Disorder*

- Psychologist
- Licensed Psychological Associate
- Psychiatrist
- Neuropsychologist
- Neuropsychiatrist
- Neurologist
- Pediatrician

Autism/Pervasive Developmental Disorder

- Psychologist
- Licensed Psychological Associate
- Neuropsychologist
- School Psychologist (w/copy of IEP Team Report)
- Neurologist
- Neuropsychiatrist
- Pediatrician
- Borderline Intellectual Functioning**
- Licensed Psychological Associate
- Psychologist

Intellectual Disability, Learning Disability*

- School Psychologist (w/copy of IEP Team Report)
- Psychologist
- Licensed Psychological Associate

Other Mental Health Disorders

- Licensed Professional Counselor
- Licensed Clinical Addictions Specialist
- Licensed Marriage and Family Therapist
- Licensed Clinical Social Worker
- Licensed Psychological Associate
- Psychologist

- Psychiatrist
- Physician associated with Treatment Facility
- ABAM (American Board of Addiction Medicine) Certified Physician

Substance Abuse**

- Psychologist
- Psychiatrist
- Physician associated with a treatment facility
- ABAM (American Board of Addiction Medicine) certified physician
- Licensed Clinical Addictions Specialist
- Licensed Psychological Associate
- Certified Clinical Supervisor (CCS)

***Division staff having any of the above credentials are prohibited from diagnosing and providing treatment to individuals served by the Division of Vocational Rehabilitation Services. For questions about secondary employment contact the Human Resources Section of NC DVR.**

****Refer to the corresponding entry in the appendix for further documentation requirements for establishing the impairment and impediments.**

The condition must be chronic and current. Some individuals with mental health impairments may require evaluation by more than one specialist depending on the complexity of their impairment (e.g. a person with schizophrenia diagnosed by one of the nonmedical specialists may need referral to a psychiatrist for medical management). Counselor discretion is imperative in determining whether existing assessments are sufficient in describing the nature and severity of the individual's impairment. As always, if existing assessments are not sufficiently comprehensive to describe the individual's impairment and current functioning, additional assessments may be obtained.

If the individual falls within a target population group for publicly funded mental health services, the Counselor should use these resources for diagnostic and treatment purposes as long as access to and utilization of these services do not present substantial delays in or difficulty with accessing VR services.

Diagnoses noted as being "by history" are not accepted due to lack of current impediments to employment. Diagnoses with the qualifier "in full sustained remission" should be assessed on an individual case basis and may or may not present current impediments to employment.

For those individuals in school, intellectual disabilities, learning disabilities and autism spectrum disorder must be documented by obtaining a copy of the school psychological and a copy of the IEP (Individualized Education Plan) Team report.

Psychological evaluations from the school systems may be used for the identification of learning disability and may be considered along with data specified in the LD policy (Appendix).

School psychological evaluations may also be used for the identification of an intellectual disability provided the individual is being served by the school system as intellectually disabled as evidenced on the IEP team documentation.

In situations when the school psychologist and the IEP Team do not concur regarding placement for one of these three conditions, the counselor must use the disabling condition that corresponds to the IEP team placement as evidenced on the IEP team report. Other diagnoses, such as emotional or behavioral disorders, require a valid DSM diagnosis (Diagnostic and Statistical Manual of Mental Disorders).

For individuals with intellectual disabilities, it is important that diagnostic information contain comprehensive adaptive behavior test results in the three domain areas: conceptual, social, and practical. Subdomain scores from each core domain should be reported in addition to intelligence test scores to assure that the diagnosis is not only meeting DSM 5 standards, but also to assure cross-agency acceptance of VR-funded psychological evaluations for referral purposes. This is critical to prevent disruption of services such as long term support or other supportive services as funded through LME/MCOs that may be critical to the client's success. If the LME/MCO requires updated adaptive behavior testing or other updated partial/full testing in order to access long term supports it is permissible to sponsor such testing.

Evaluations from other sources such as educational institutions, government agencies, or institutions such as prisons, hospitals, or mental health clinics are considered valid sources of data as long as the evaluation is performed by or under the direction of one or more of the specialists listed above.

Revised 5/1/2017

[34 CFR 361.42]

3-5-4: Shelf Life

The age validity or "shelf life" of an evaluation is dependent upon the impairment and counselor discretion. For the comprehensive assessment, up to date evaluations may be needed to show the current functioning or status of the individual's impairment; however, if the evaluation is for eligibility purposes in establishing the impairment, then the following guidelines for age validity apply:

A. For individuals currently in treatment there is no age requirement on existing data as long as the treatment has been provided by one or more of the specialists listed under 3-5-3 and has been uninterrupted. This would include individuals in correctional facilities who have been in treatment for the duration of their incarceration.

B. For individuals not currently in treatment, if a condition is defined by the DSM-IV-TR as a cognitive disorder, psychotic disorder, or mood disorder, individuals should be reevaluated if the information is more than five years from the date of application for services. Anxiety disorders, personality disorders, and mental and emotional disorders not elsewhere classified, require a reevaluation if the report is older than two years from the date of application for services.

C. For individuals not currently in treatment, if intellectual disability or another pervasive developmental disorder (i.e. autism) has been previously diagnosed and there has been no dramatic change in the client's environment or physical well-being, then there is no age requirement on existing data.

D. For the diagnosis of Borderline Intellectual Functioning (BIF), a psychological evaluation may be considered as current for up to five years from the date of application for services.

E. For individuals not currently in treatment, reports providing the diagnosis of Attention Deficit/Hyperactivity Disorder have a shelf life of three years from the date of application for services.

F. If a learning disability (LD) has been previously diagnosed in a secondary education setting and the individual has been served under an IEP within the past two years, a school psychological evaluation with the IEP team report may be regarded as current for up to five years from the date of application for services. Other provisions specified in the LD policy (appendix) apply. For psychological reports providing the DSM diagnosis of learning disability, the five year shelf life also applies.

G. For individuals not currently in treatment, for purposes of the preliminary assessment, reports providing the diagnosis of substance abuse or dependence can be considered as current within one year of the date of application for services.

3-5-5: Special Conditions

The Division has established criteria to assist counselors in making decisions regarding the existence of an impairment that for some individuals may cause substantial impediments to employment. Service delivery staff should be very familiar with these conditions in order to assure that individuals with disabilities are evaluated consistently and fairly. The appendix contains policy entries addressing criteria the Division has established for the following impairments: Attention Deficit Disorder, Blind and Visually Impaired, Borderline Intellectual Functioning, Chronic Fatigue Syndrome, Chronic Pain, Cochlear Implants (Hearing Impairment), Dental Impairment, Hearing Disabilities, Human Immunodeficiency Virus (HIV Disease), Learning Disability, Intellectual Disability, Substance Abuse.

Section 3-6: Eligibility for Independent Living

3-6-1: Eligibility Criteria

IL services may be provided to an individual:

A. with a significant disability;
B. whose ability to function independently in the home or community, or whose ability to maintain employment is substantially limited;
C. who shall be an active participant in his/her own IL rehabilitation program involved in making meaningful and informed choices about IL goals and objectives;
D. who shall be a full partner and share joint responsibility for planning and implementing his/her IL rehabilitation program; AND
E. for whom the delivery of IL services will:
    - improve or maintain the ability to maximize their independence in the home or community, OR
    - enable employment, OR
    - enable transition to VR.

3-6-2: Significant Disability

The classification of significant disability is based on the degree to which an individual's impairment results in barriers to independent living. The decision regarding significant disability will be documented in the record using the definitions presented in this subsection. Along with the definitions, counselor judgment is essential in determining the perceived degree of difficulty presented by the individualized nature of the disability relative to the extent of counselor time and involvement which will be required to reach the client's goals. The receipt of disability benefits (SSI/SSDI) implies the presence of a disabling condition that seriously limits one or more functional capacities, but does not automatically imply the significance of one's disability for Independent Living.

An individual with a significant disability is a person who:

A. Has a significant physical or mental impairment that seriously limits one or more functional capacities (Communication, Mobility, Self-Care, and/or Sustained Activity) in terms of an independent living outcome. "Seriously limits" means that the lack of functional capacity requires accommodations and/or interventions that cannot be easily achieved and that will be required permanently in order for the individual to achieve a successful independent living outcome,

AND

B. Requires multiple independent living services, whether provided by the Division or another provider, in order to complete an independent living rehabilitation program OR requires a permanent service(s) in the form of rehabilitation technology or personal assistance.

Definitions of Functional Capacity Areas (In order to demonstrate that an individual is "seriously limited," at least one of the following limitations must apply.)

COMMUNICATION:
Communication is the ability to use, give, and/or receive information.

Functional Limitations include:

- Inability to speak intelligibly to people outside of the family
- Inability to communicate in the home or community without accommodations or assistive technology

MOBILITY:
Mobility is the ability to move from place to place.

Functional Limitations include:

- Inability to drive without modifications and/or specialized training
- Inability to climb one flight of stairs or walk 100 yards without pause or without adaptive equipment or personal assistance
- Demonstrated loss of driver's license due to physical impairment

SELF-CARE:
Self-care is the ability to plan and/or perform daily activities.

Functional Limitations include:

- Inability to perform activities of daily living (ADLs) without rehabilitation technology or personal assistance
- Inability to plan and prepare meals
- Inability to use the phone or get help in case of an emergency

SUSTAINED ACTIVITY:
Sustained activity is the ability to perform activities of daily life over a continuous period.

Functional Limitations include:

- Inability to participate in sustained productive activity in the home, community, or workplace without extended restorative rest.

3-6-3: Functional Improvement

The eligibility decision must include projected functional improvements in specified life areas (IL goals); which include self-care, mobility/transportation, communication, community services, educational, information access/technology, personal resource management, and vocational.

Revised 8/1/2015

3-6-4: Presumption of Eligibility

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

Eligibility for IL services is determined individually based on the criteria in Section 3-6-1. There is no presumption of eligibility for Independent Living Services for individuals receiving SSI or SSDI pursuant to title II or title XVI of the Social Security Act.

An individual who is determined eligible for MFP by the Division of Medical Assistance (DMA) is presumed to be eligible for IL services based on the following DMA 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

The MFP Application and Pre-Transition Checklist will suffice for verification of MFP eligibility. These documents must be maintained in the IL case record. 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.

3-6-5: Record of Service Documentation

The IL Eligibility form must be completed on all individuals determined eligible for services. The Eligibility Decision letter must be maintained in the case record and a signed copy given to the client.

The counselor must document:

A. The significant impairment(s) that seriously limits one or more functional capacities (Communication, Mobility, Self-Care, and/or Sustained Activity) in terms of an independent living outcome; AND
B. The multiple independent living services, whether provided by the Division or another provider; OR the rehabilitation technology or personal assistance services required permanently; AND
C. The primary objective; AND
D. The goal areas and ways functioning will be improved with the provision of IL services.

Revised 8/1/2015

Section 3-7: Priority of Services

The categories of service delivery for the IL program in priority order are to:

1. Provide for deinstitutionalization of persons with significant disabilities;
2. Prevent the institutionalization of persons with significant disabilities who are “at risk;”
3. Assist persons with significant disabilities towards community living; AND
4. Assist persons with significant disabilities towards employment transition.

3-7-1: Definitions

Deinstitutionalization: Client is currently living in an institution and needs IL services as part of their discharge plan.

Prevent Institutionalization: Client is currently living outside an institution. Documentation verifies that if IL services are not provided, the individual will be placed in an institution within the next 90 days.

Community Living: Client is currently living outside an institution and requires IL services to maintain and maximize independence. Client is not in immediate danger of being institutionalized.

Employment Transition: Client can benefit from joint IL and VR services to meet goals of independence and employment.

3-7-2: Employment Priority

For clients in need of Personal Assistance Services who have become employed and whose VR case is scheduled to close will be considered a high priority if the services are needed to maintain employment.

3-7-3: Utilization of Resources

Funding, staff resources and time will be prioritized in such a manner to assure that the highest priorities will be served first in accordance with our priority of service categories.

Section 3-8: Financial Need and Client Resources

3-8-1: Financial Needs Survey

The scope of rehabilitation services available to an individual is determined by the services required by that individual in order to reach the IL goal. All services provided must be directly related to the achievement of the goal established in concert between the client and Rehabilitation Counselor.

For IL, financial need must be established prior to the planning and provision of any service subject to financial need.

Services Not Subject to Financial Need

The determination of financial needs is not applicable nor is it necessary to maintain a copy of the Financial Needs Survey in the physical case file for the following services (unless otherwise specified, comparable benefits apply but would be addressed on the IL Service Plan, not on the Financial Needs Survey):

- Assessment (regardless of case status)*
- Guidance and counseling *(not subject to comparable benefits)*
- Consultation and technical assistance provided by Rehabilitation Engineers *(not subject to comparable benefits)*
- Recreational Therapy provided by IL staff
- Referral and collaborative efforts with other agencies
- Personal Assistance services sponsored by VR
- Driver Evaluation
- Foreign Language Interpreter/Translator
- Interpreter Services (Sign Language and Oral)
- Reader Services
- Note takers

Assessment includes any diagnostic/evaluative services provided:

- ***for the purpose of diagnosing or clarifying impairments (including secondary restoration issues) in applicant status (status 02),***
- ***as part of the IL needs assessment (status 10) for the purpose of determining rehabilitation needs,***
- ***in the service delivery statuses for IL for the purpose of further diagnosing, clarifying, or establishing treatment/rehabilitation needs for a primary/secondary impairment, or inter-current illness***
- ***in IL post-outcome (status 32)***

In cases in which the IL Service Plan consists entirely of services from the above list (not subject to financial need), the counselor only addresses the appropriate financial need category (covered below) on the Financial Needs Survey screen.

Services Subject to Financial Need

Determination of financial need is required and the *Financial Needs Survey* must be completed for the following services (Additionally, comparable benefits apply unless specified otherwise.):

- Equipment (including Durable Medical Equipment, IL Equipment, Tele-Communicative Devices, and Equipment Repairs)
- Day Care
- Driver Training
- Residence Modifications
- Purchase of Furniture and Appliances
- Maintenance
- Other Goods and Services
- Personal Assistance Services sponsored by IL
- Physical Restoration (hearing aids, orthotics, prosthetics, podiatry, visual services, chiropractic services, intercurrent illness, drugs and medical supplies, dental services, home health, speech therapy, physical therapy, occupational therapy)
- Recreational and Social Services not provided by IL staff
- Assistive Technology Services
- Vehicle and Worksite Modifications
- Services to Family Members
- Transportation
- Purchase of Vehicle Insurance
- Sponsorship of Vehicle Repairs
- IL Skills Training

If services subject to the financial needs test are being provided, the counselor must continuously monitor financial need throughout the rehabilitation process with changes documented appropriately. Check stubs, State and Federal income tax returns and other information must be requested to document income or other financial resources. State and Federal Income Tax Returns shall be used as a last resort. Counselors are required to request this information routinely when services requiring financial need are being planned or provided. Copies of the documents used for verification must be in the case record.

Copies of all existing financial account statements (checking, savings, money market, debit express cards) for a minimum of 3 months must be obtained from all applicable family members. The financial account statements must be within 6 months of the completion of the FNS and must be consecutive. The amount in the account(s) must be considered as an asset and recorded in Section D – Available Assets. Counselors

are expected to exercise due diligence in an effort to verify the existence of bank accounts. In addition to seeking this information via client report, counselors are advised to review documentation submitted in support of the needs determination for evidence of the existence of financial institution accounts.

If all reasonable efforts have been made, and it has been demonstrated that neither the client nor other applicable family members have accounts at a financial institution, the Bank Account Non-Existence Contract (BANC) form shall be completed. This form must be signed by the client and VR representative. The signed copy should be attached to the printed FNS and retained in the file. The contract remains valid for the life of the current FNS as established in Section F of the FNS.

Revised 11/13/2017

If the individual does not have tax returns or check stubs, he/she will complete a verification form signed by his/her last employer, the individual who supports him/her or the agency representative who processes the individual's public support. A letter from the agency, hospital or individual who can verify income status is an acceptable form of verification. The counselor shall document the income of the client and all applicable family members including wages, SSI/SSDI pensions, commodities sold and other types of income including interest, stock, inheritances, etc. Whenever the financial situation of the individual is unclear, the counselor will consult with the Supervisor who must approve exceptions.

Requirements for Updating the Financial Needs Survey

Financial need, once determined, must be continuously monitored throughout the rehabilitation process. A new *Financial Needs Survey* shall be completed and signed:

- any time there is a significant change in the individual's financial status
- any time services subject to financial need are added to the plan in instances of excess income or extenuating circumstances
  OR
- when the time period established in Section F has expired and services subject to financial need are ongoing.

Any time the *Financial Needs Survey* is completed, income must be verified.

COMPLETION OF THE FINANCIAL NEEDS SURVEY

MEDICAL INSURANCE COVERAGE:

Medical insurance information can be updated in this section if there have been changes to the client's coverage since the time of application.

Determination of Family Unit and Income:
The family shall be determined and the counselor shall gather financial information for applicable family members to complete sections A-D.

A client is considered a family of one if:
A. Client is twenty-three years of age or older **(unmarried, not a tax dependent, and has no dependents)**; **OR**

B. Client is less than twenty-three **AND** one of the following:
   a. Ward of the court;
   b. Emancipated minor;
   c. Honorably discharged Veteran of the US Armed Forces;
   d. Can verify self-supported income and can produce receipts for basic living expenses (to include rent and utilities, medical payments, health insurance premiums, child care expenses, and legally mandated payments) for a minimum of three months.

If the client is married, the client's family shall include:
A. The client's spouse if residing in the same home;
B. The client's children, but not to include step-children; AND
C. Other individuals related to the client by blood, marriage, or adoption **if the other individuals have no income.**

If the client is less than twenty-three years old and is not married, **or** if the client is 23 years of age or older and is being claimed as a dependent by the parents for tax purposes regardless of place of residence, the client's family shall include:

A. Client's parents, not including step-parents;
B. Siblings or half-siblings of the client, but not step-siblings, if the siblings are unmarried and less than 23 years of age;
C. Siblings or half-siblings of the client, but not step-siblings, if the siblings are 23 years of age or older and have no income; AND
D. Other individuals related to the client by blood, marriage, or adoption if the other individuals have no income.

A. MONTHLY RESOURCES

(A1) NET INCOME OF ALL APPLICABLE FAMILY MEMBERS: The name and income of all members of the family unit must be recorded on the Financial Needs Survey If an individual in the family unit has no income to report (i.e. minor children) this must be recorded in this section. Net income is typically considered for the thirty-day period prior to the date of the *Financial Needs Survey*. In situations in which income cannot be determined on that basis, the Counselor should calculate a fair

representation of net monthly income. Pay that occurs in increments other than monthly is calculated as follows: net monthly = biweekly x 2.17; net monthly = weekly x 4.33. Income includes all cash income received from wages, salaries, or self- employment. Net income is computed by subtracting **mandatory** deductions from gross wages. Income does not include cash that minor children earn from babysitting, lawn mowing, or other miscellaneous tasks or gifts. Also, do not include Work Adjustment training earnings or work study as income. Check stubs must be requested to document income. If the individual does not have check stubs, the counselor will obtain a *Wage Verification Form* signed by the current or last employer or a *Source of Support Form* completed by the person who supports the individual, or the agency representative who processes the individual's public support. In lieu of this form, a letter from the agency, hospital or individual whom can verify income status is an acceptable form of verification. Tax forms are acceptable if other documents are unavailable.

The following information shall be captured for each applicable family member:

1. Net Wages

- **Name:** Record the name of the client or family member.
- **Relationship to Client:** Record the relationship of the family member to the client. Choose "self" if the information pertains to the client.
- **Income Documentation:** Select the type of documentation used to verify the client or family member's income information.
- **Wage Details:** Select "net wages" and record this information. Select one or more elective withholdings if these are applicable on the client or family member's income documentation.
- **Frequency of Pay:** Record how often the wages or elective withholdings occur.
- **Amount:** Record the amount of the wages or elective withholdings.

2. Pensions (SSDI, SSI, VA, etc.): Identify and record the total amount of the benefits received by all applicable family unit members. Included in this category are monetary benefits received from public assistance, retirement, and other pension benefits. Others may also apply.

3. Compensation Payments (Unemployment, Workers' Compensation, etc.): Identify and record the total amount of the benefits received by all applicable family unit members.

4. Commodities Sold: Commodities are frequently produced and sold seasonally. The profit (income minus production costs) should be computed on a monthly basis.

5. Other: Identify and record all other available financial resources. Examples are income from stocks, bonds, savings accounts, investments, rentals, alimony, child support, GI Bill training benefits, sick pay, inheritances, life insurance payments, payments from trust funds, etc. Identify the source of the income and the amount.

NOTE: Student loans *are not recorded as income, assets or contributions on the Financial Needs Survey.*

SUBTOTAL (A1): The total of lines 1 through 5.

(A2) ALLOWED DEDUCTIONS: Identify the recurring deductions and record the amount of monthly payments the family unit is making for any family member for the items or services listed below. If recurring deductions vary in amount from month to month, the average of the past three months will be calculated to determine the monthly allowed deductions. **Deductions must be verified by receipts, bill statements and other information.** Documentation that the expense is actually being paid by a member of the family unit is needed as opposed to a verification of the expense with no evidence of payment. Include only those expenses not covered by a third party payer. Copies of the documents used to verify deductions must be in the physical case record. **If it is not possible to verify deductions, the Supervisor must approve exceptions to this requirement.**

1. Medical Expenses: medical expenses, dental expenses, medical supplies, prescription and non-prescription items. Special diets/foods that are related to the individual's disability may be considered. Also included are medical/health insurance premiums, if not already deducted from gross wages. Vision and Dental insurance premiums are allowed; **however, do not deduct optional health insurance premiums including flexible spending accounts, disability, cancer or long term care.**

2. Equipment Expenses: Examples include disability-related clothing, devices and equipment including necessary maintenance of such devices and equipment.

3. Personal Assistance Services (PAS): Examples include domestic, chore, and other attendant-related services required to assist family unit members with activities of daily living and self-care needs. Note: If the client will require personal assistance services to achieve independent living or employment outcome, an assessment of the individual's resources will occur. For Vocational Rehabilitation, personal assistance is not subject to financial need. For both Vocational Rehabilitation and Independent Living programs, comparable benefits must be utilized.

*****NOTE FOR IL PERSONAL ASSISTANCE SERVICES (PAS) ONLY:*** *Clients for whom the IL Program is contributing or is considering contributing toward the cost of PAS, the PAS service must not be counted as an allowed deduction/disability-related expense on the part of the client. See below under Excess Net Monthly Income for further instructions on determining the client's contribution to PAS.*

4. Housing/Vehicle Expenses:

Housing - Payments for additional expenses necessitated by residing in an accessible

residence; payments for specialized equipment in the residence. Examples are auditory alarms, specialized ventilation equipment, etc.

Vehicle - Due to the increased costs associated with purchasing and maintaining adapted vehicles, the Division has developed rates for modified automobiles and vans. If the individual owns or is purchasing a modified vehicle, a monthly deduction is granted, based on the information below:

COST OF MODIFICATION	AUTOMOBILE	VAN
< $1,000.00	$10.00	$149.00
> $1,000.00 but < $6,000	$60.00	$199.00
> $6,000.00	$90.00	$229.00

5. Child Care Expenses: Actual costs not to exceed $175.00 per month per child may be deducted for any child fourteen years old or younger, provided parents or other responsible adults are unavailable or unable to care for a child in the family unit.

6. Post -secondary Training Expenses: Actual costs not to exceed Division-allowed maximums for tuition, fees, books, and maintenance expenses may be deducted for applicable family unit members. Note: Prorate the amount of training expenses to get a monthly amount to report as deduction.

7. Legally Mandated Expenses: Alimony, child support or Social Security reimbursements may be deducted if required of any applicable family member. Other legally mandated payments cannot be deducted.

8. Other: Others may also apply.

TOTAL ALLOWED DEDUCTIONS (A2): This figure represents the total of allowed deductions.

TOTAL MONTHLY RESOURCES (A1 - A2) = (A): This figure represents the individual's total monthly resources.

B. ALLOWABLE NET MONTHLY INCOME: The allowable net monthly income amounts for family size one through eight are listed on the form. Add the amount as indicated on the form per family member for each over eight. The appropriate amount should be recorded as **Total (B)** on the form.

C. EXCESS NET MONTHLY INCOME (A) - (B) = (C): This amount represents the monthly income available from the family unit, which can be applied toward the cost of the rehabilitation program. **Total (C)** represents the excess cash that can be applied toward the cost of the rehabilitation program.

*****NOTE FOR IL PERSONAL SERVICES (PAS) ONLY:*** *Clients for whom the IL*

Program is contributing or is considering contributing toward the cost of PAS, the PAS service must not be counted as an allowed deduction/disability-related expense on the part of the client. The Counselor records net income and family unit size to determine excess monthly income. When the counselor indicates on the Financial Needs Survey that the personal assistance is funded by IL, one half of the excess monthly income figure is exempted and the other half shall be applied as the portion to be assumed by the client in the cost of rehabilitation services. The remaining cost of PAS services are sponsored by the IL Program.

D. AVAILABLE ASSETS:
1. Cash - Includes cash in checking or savings accounts, which exceeds an amount three times the *Allowable Net Monthly Income (B)* for the appropriate family size. Assets may include stocks, bonds, inheritances, lump sum insurance settlements, life insurance proceeds, gifts, or other resources the individual or the individual's family may have readily available to access.

2. Real Property - Such property is an available asset to the extent it can be converted to cash or used as collateral, in a timely manner, to meet the cost of rehabilitation services. The local county tax office can verify property information. Real property, excluding the individual's home site, will be recorded at the fair market value or purchase price; whichever is less, minus the amount owed for mortgages or liens. Any amount over $25,000.00 will be recorded as excess resources. If the residence is in a rural area, home site is defined as the house and land on which the residence is located up to a maximum of one-acre including all buildings on the acre. If the residence is in the city, home site is defined as the family unit's principle place of residence, including the house and lot plus all buildings on the lot.

Total (D) represents the amount of available assets that can be applied towards the cost of the rehabilitation program.

E. CONTRIBUTIONS: Record the total amount of scholarships educational grants, community funds, or other resources that the individual has available to contribute to the rehabilitation program.

Total Contributions: represents the amount of contributions available for the family unit.

F. EXCESS RESOURCES: Complete this section when the amount in **(C), (D), or (E)** is greater than $0.00. The section addressing appropriate time period is the actual length of time for services planned on the rehab program subject to financial need, with three months as the minimum and twelve months as the maximum number of months. For example, restoration services may include the estimated recuperation period, etc., while training services would include the length of the training period.

TOTAL (F) represents the sum of all *Excess Resources* that can be applied toward the

cost of the rehabilitation program.

NOTE: *When the amount (F) is greater than $0.00, the counselor must select "Excess Resources Applied" in section I. The counselor must then identify the services for which the client's resources will be responsible and record the amount the individual is expected to contribute toward the cost of the rehabilitation program. The counselor will record the amount the individual is expected to contribute and an explanation of which service(s)to which the resources will be applied. (See instructions for extenuating circumstances-justification section, below, when part of the client's excess resources will be waived)*

When there are excess resources of any type, Supervisor approval is required on the Financial Needs Survey.

G. ESTIMATED COST OF REHABILITATION PROGRAM: If the amount in **(F)** is greater than $0.00, the counselor will estimate the cost of the entire rehabilitation program during the time period identified under *Excess Resources*. All services being planned on the rehab program should be recorded along with an estimated cost.

Total Cost of Rehab (G)*:* Represents the estimated cost of the rehabilitation program. If *Total (G)* is less than *Total (F)*, the individual does not meet the criteria for the financial need. If *Total (G)* is more than *Total (F)*, the individual does meet the criteria for the financial need and the Division may participate in the cost of certain services. *Total (G)* **-** *Total (F)* represents the *Estimated Agency Expenditure.* The counselor must negotiate the actual amount of Division participation, as all of client's resources must be accounted for in the cost of the rehabilitation program.

> ***NOTE:*** *The supervisor can add additional line items to Section G of a previously completed FNS in order to increase the overall Estimated Agency Expenditure, increasing the total for which the counselor may authorize. Increasing the Estimated Agency Expenditure is limited to situations where the projected cost of the services included in the rehab program on the FNS is exceeded by actual costs. The circumstances must be explained in the Extenuating Circumstance section. The addition of previously unplanned services is not allowed (See* ***Requirements for Updating the Financial needs Survey****). This feature of the electronic case management system renders Policy Directive #2-2014 obsolete.*

Revised 11/9/2015

H. EXTENUATING CIRCUMSTANCES – JUSTIFICATION: This section is provided to allow the counselor to identify other information related to the individual's financial situation that will affect the individual's ability to participate in the cost of the rehabilitation program. If there are extenuating circumstances that prohibit the

individual's application of part or all the excess resources toward the cost of rehabilitation, the Division may waive all or part of these resources. Such circumstances may include: the inability to sell property, the fact that the amount of funds would be so small that it would provide little substantial financial help toward the cost of rehabilitation program, or the fact that the conversion of the excess resources may result in undue delay in proceeding with the rehabilitation program.

NOTE: *If the Division waives* ***only part*** *of the client's excess resources, then this section should be completed as well as the excess resources/comparable benefits section. In this instance, the counselor should select a financial determination category of "Extenuating Circumstances."*

If the individual's monthly resources change during the period of rehabilitation due to an inability to work, this should be recorded in this section. Supervisor Approval on the *Financial Needs Survey* is required for the waiver. Verification of the particular circumstances must be provided by the individual and must be maintained in the record.

The client must pay his/her portion, recorded in Section F *Excess Resources*, directly to the service provider(s) according to the arrangements made between the counselor and client. The Division is unable to accept payment from the client.

In the case of PAS services, the client receiving PAS who is required to contribute towards the cost of their personal assistance service due to excess income will provide a check to the Community Integration Services and Supports (CISS) Administrative Assistant for the amount that the client is required to contribute. The client shall make the check payable to DVRS.

Revised: 06/01/2018

I. FINANCIAL NEED CATEGORIES: Prior to completion of the *IL Service Plan*, one of the following financial need categories must be selected in the Division's electronic case management system. Additionally, the following description of the categories provides instructions regarding:

- the sections to be completed on the *Financial Needs Survey* for each category
- when it is necessary to print the completed *Financial Needs Survey* for signatures and placement in the case file
- when Supervisor approval is necessary

1. Yes-Financial Needs Test Met: Financial need is established to receive services subject to financial need. Sections A - E are completed. The *Financial Needs Survey* must be printed for signatures and placed in the physical case record and maintained in the client's electronic case file.

2. No-Financial Needs Test is Not Met: The client's excess resources exceed the

cost of the rehabilitation program. Sections A-G are completed. The Division will not authorize or sponsor any services subject to financial need. The *Financial Needs Survey* must be printed, with appropriate signatures and placed in the physical case record and maintained in the client's electronic case file.

3. Not Applicable: Services planned are not subject to financial need. It is not necessary to complete any sections on the form, print the form, or obtain any signatures.

4. Extenuating Circumstances: This category is used when:

- income/deductions cannot be verified,
- all or part of the excess resource amount is waived

Sections A-I must be completed. In section H, *Extenuating Circumstances - Justification*, the counselor must explain the specific extenuating circumstances and (if applicable) the impact of waiving the client's contributions in terms of how specific services will be funded. The *Financial Needs Survey* must be completed and printed with appropriate signatures and placed in the physical case record and maintained in the client's electronic case file. Supervisor approval within the Division's electronic case management system is required.

5. Excess Income Applied: Complete Sections A – G. It is not necessary to enter any comments in the *Extenuating Circumstances-Justification* section. Enter amount to be contributed and document details of the contribution on the form. The *Financial Needs Survey* must be completed and printed with appropriate signatures and placed in the physical case record and maintained in the client's electronic case file. Supervisor Approval within the Division's case management system is required.

When the client has excess income to contribute to the cost of the rehabilitation program, the counselor should ensure that the client has the funds available before authorizing for the service. The client is responsible for coordinating payment to the vendor. The authorization issued to the vendor should clearly indicate the amount the client is required to pay directly to the vendor. In no situations should the client issue a check or money order payable to the Division. In addition, the Division should not hold client checks or money orders payable to the vendor. To do so would be a violation of the DHHS Cash Management policy.

The only exception to this practice is for clients receiving Personal Assistance Services through the Fiscal Intermediary who are required to pay a portion of their PAS. In these situations clients send their checks to the Community Integration Section in the state office (refer to Volume VIII 1-11).

Revised: 1/1/2019

SIGNATURES: The counselor and individual must always sign the form once it is completed. The parent, guardian, or other representative must sign the form when appropriate. The signature indicates that the financial information provided is correct and that the individual and/or the appropriate representative participated in the completion of this *Financial Needs Survey*. The Supervisor is required to electronically sign the form in all cases when there are excess resources, including resources that are due to comparable benefits such as educational grants, and when there are extenuating circumstances. The original *Financial Needs Survey* and subsequent updated *Financial Needs Surveys* require the client or other appropriate signature as specified above.

[34 CFR 361.54; 10 NCAC 20C .0205 and .0206; 34 CFR 364.59]

Revised 7/1/2014

3-8-2: SSI and SSDI Recipients

Independent Living will apply a financial needs test for all participants requiring cost services regardless of the source of income. Vocational Rehabilitation will not apply a financial needs test or require the financial participation of any individual who receives Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI). Verification of these benefits must be documented in the case record. Services provided by Vocational Rehabilitation for these individuals must be directly related to the completion of the Individualized Plan for Employment or trial work experience. VR counselors must explore Social Security work incentives with these individuals as a part of the planning and development of the IPE. Comparable benefits must be utilized when available.

[34 CFR 361.54(b)(3)(ii)]

3-8-3: Comparable Benefits

The Division will provide rehabilitation services only when such services are not available from some other source as a comparable benefit or service. Comparable benefits are to be investigated and used for all rehabilitation services except those noted in Chapter 2 in this manual. The specific comparable benefits available to a client are to be recorded on the BEAM Intake form. Updates to comparable benefits should be documented on the relevant intake form throughout the life of the case. These comparable benefits should then carry over to the IL Service Plan with explanation as to how they will be applied to cover costs associated with accomplishing the IL Service Plan. Comparable benefits must be recorded on the IL Service Plan under the COMPARABLE BENEFITS section. **By marking *"none"*, the rehabilitation counselor signifies that comparable benefits have been investigated but are not available for the stated service as evidenced through supporting documentation contained in the file (financial aid denial, Medicaid or Medicare denial/EOB, private health**

insurance denial/EOB, and Chief of Policy approved waiver of comparable benefits). Comparable benefits must also be added to the IL Service Plan whenever new services are added.

If at any time in the rehabilitation process, a comparable benefit is ruled out or is determined to no longer be available to the client; the case should contain documentation from the comparable benefit of the denial. The counselor should remove the comparable benefit from the BEAM Intake form.

[34 CFR 361.53; State Plan Section6.11; Comparable Benefits: 10 NCAC 20C .0204]

NC Tracks – Verification of Comparable Benefits

Verification of Comparable Benefits through NC Tracks is required when the following occur:

- When services subject to financial need and comparable benefits are being planned. This includes ILSP development and when amendments and revisions are completed. See 3-8-1 for a listing of services subject to financial need and comparable benefits
- At any time in the rehab process when there is reason to believe a client has obtained a comparable benefit for services currently being received. For example – PT sessions have been authorized, and the client obtains a comparable benefit
- Prior to submitting medical related, DME or pharmacy invoices for payment that exceed $10,000

Eff. 6/1/2016

Waiving Comparable Benefits

The counselor may request exception to waive usage of comparable benefits in a client's rehabilitation program if accessing the comparable benefit:

- Interrupts or delays the progress of the individual toward achieving the employment or independent living outcome identified in the IPE/IL Service Plan
- Jeopardizes an immediate job placement, or
- Delays in the provision of a service placing the individual at extreme medical

risk. (Extreme medical risk means a probability of substantially increasing functional impairment or death if medical services, including mental health services, are not provided expeditiously. This determination shall be based upon medical evidence provided by an appropriate qualified medical professional. The counselor must continue to seek comparable benefits that might be retroactive and replace Division authorizations.)

These exceptions must have initial review and approval by the Supervisor and final approval by the Chief of Policy. The written rationale with supporting documentation and approval from the Chief of Policy must be filed in the case record.

The Counselor, with no additional approvals, may waive the usage of comparable benefits for diagnostic services if the client is unable to pay the copay or deductible and the service is required for determining eligibility or rehabilitation needs. Justification for this waiver must be documented in the case record. The authorization must indicate that the service is diagnostic and must be signed by the Counselor.

[34 CFR 361.47; NC Administrative Code, Volume II Part B, Subchapter 20C, Sections .0204, .0205, and .0206: State Plan Section 6.3 and Section 6.6] Section 361.53

4/1/2015

The following are examples of comparable benefits; if others are available they should be utilized.

Medicaid

The Division cannot supplant resources available through Medicaid. Therefore, Medicaid eligibility must be verified at the time of application and throughout the rehabilitation process. When appropriate, the counselor should refer the applicant or client to the local DSS for determination of eligibility.
Medicaid may continue for SSI recipients who are disabled and earn over the SSI limits if they cannot afford similar medical care and depend on Medicaid in order to work. A threshold test and Medicaid use test will be applied to the individual situation to determine continuation of Medicaid eligibility (1619B).

The Division, regardless of the individual's financial need, cannot authorize Medicaid deductibles. If the counselor determines the client can meet the deductible, the Division will not contribute toward the cost of the medical services. Individuals who qualify for Medicaid because they are eligible for SSI are not subject to a spend-down.

If the client meets financial need but has a deductible and is unable to meet the deductible thus jeopardizing the ultimate rehabilitation goal, the counselor may request an exception to sponsor the necessary medical services without Medicaid as a comparable benefit. This request must be first reviewed by the Supervisor who, if approves, forwards the request to the Chief of Policy for final review and approval. The

written rationale with supporting documentation and approval from the Chief of Policy must be filed in the case record. The counselor should them remove Medicaid as a comparable benefit from the BEAM Intake Form.

Medicare

Medicare is an available comparable benefit for those individuals who meet the eligibility requirements for this program. If a client has Medicare, the Division cannot invoice for medical services, unless the Medicare EOB shows payment was less than the established Division (Medicaid) rate. The Division's authorization for medical services must denote Medicare accordingly. The Division may sponsor the difference between the Medicare amount and the Division (Medicaid) rate, if any. If the client who meets financial need has Medicare but is unable to access it because of inability to pay required co-pays, thus jeopardizing the ultimate rehabilitation goal, the counselor may request an exception to sponsor the necessary medical services without Medicare as a comparable benefit. This request must be first reviewed by the Supervisor who, if approves, forwards the request to the Chief of Policy for final review and approval. The written rationale with supporting documentation and approval from the Chief of Policy must be filed in the case record. The counselor should them remove Medicare as a comparable benefit from the BEAM Intake form. If the counselor determines the client can pay the Medicare copays, the Division will not contribute toward the cost of the medical services.

Health Insurance

Medical and related health insurance should always be used for any service applicable to the benefit. The counselor must assure that the vendor or the client pursues this benefit prior to payment for a rehabilitation service. The Division cannot process invoices for medical services when a client has health insurance that pays directly to the provider unless the EOB shows that the health insurance did not pay up to the Division's (Medicaid) rate. In such case, the counselor may authorize and invoice for the difference between the health insurance payment and the Division's rate. Health insurance that is specifically set up to pay directly to the individual must be used to offset Division payments, and the counselor must complete a SUBROGATION RIGHTS-ASSIGNMENT OF REIMBURSEMENT FORM. If a client who meets financial need has private health insurance but is unable to access it because of inability to pay required deductibles or copays (thus jeopardizing the ultimate rehabilitation goal), the counselor may request an exception to sponsor the needed medical services without consideration of private health insurance as a comparable benefit**.** This request must be reviewed first by the Supervisor who, if approves, forwards the request to the Chief of Policy for final review and approval. The written rationale with supporting documentation and approval from the Chief of Policy must be filed in the case record. If the exception is approved, the counselor should them remove Medicare as a comparable benefit from the BEAM Intake form.

Workers' Compensation

If Workers' Compensation benefits are available, such benefits must be used prior to

the expenditure of Division funds. If Workers' Compensation eligibility is pending or if there is an undue delay in service provision necessary for rehabilitation, the counselor may authorize services if Subrogation Rights: Assignment of Reimbursement form has been completed. (See section 1-18)

Veterans Affairs

Veterans Affairs is an available comparable benefit for veterans and their spouses who meet the eligibility requirements for this program. Individuals 65 years of age or older who served 90 days of continuous service with one day of service during a war may be eligible for Aid and Attendant Benefits. For more information contact the local Veteran Integrated Service Network at: http://www.visn6.va.gov

Children's Special Health Services

Individuals 21 years old or younger who require medical and related support services, including equipment needed for medical reasons, should apply for services from this resource. More information can be obtained at http://www.dhhs.state.nc.us [See section for children and youth]

Social Security Work Incentives

Social Security work incentive options, Impairment Related Work Expense plans (IRWE) and Plans to Achieve Self-Support (PASS), must be explored and used when applicable. Social Security's PASS Cadre Specialist approves and monitors PASSes.

Money Follows the Person (MFP)

MFP is a federally funded resource to provide housing assistance for individuals who are transitioning from a skilled nursing bed, having been in that bed for a minimum of 90 days, to the community. Individuals must remain Medicaid-eligible to be considered for Money Follows the Person. Individuals approved for this resource are prioritized for CAP-Medicaid services. MFP funds can assist with personal care services, rent deposits, utility deposits, furniture, and other transition-related expenses. MFP is considered a comparable benefit and must be utilized when available. All priority one (deinstitutionalization) clients must be referred to the Division's Housing Transition Specialist to be considered for eligibility for this service. For clients who are utilizing both MFP and DPP funding, available MFP funding must be committed prior to utilizing DPP funds.

NC Housing Finance Agency

The NC Housing Finance Agency is a state and federally funded agency that consists of two programs which may be utilized by the Division's clients. The programs are for individuals who are considered low-income:

- **Displacement Prevention Program (DPP)** is a program that must be utilized as a comparable benefit. DPP assists individuals who are elderly and/or disabled

with modifications and adaptations in order to make the home accessible to individuals. For clients who are utilizing both MFP and DPP funding, available MFP funding must be committed prior to utilizing DPP funds.

- The **Urgent Repair Program** may be used to assist with structural, plumbing, and electrical repairs which may not otherwise be provided by the Division.

Educational Grants

No training services in postsecondary institutions will be sponsored by Division funds unless maximum efforts have been made to secure grant assistance, in whole or in part, from other sources to pay for such training. Awards and scholarships based on merit are excluded as a comparable benefit. (Merit awards or scholarships are defined as awards or scholarships in which at least 50% of the qualifying criteria are based on excellence in academic performance.)

Written evidence (i.e. copy of the application, award/denial letter, etc.) that a client has applied for federal student aid must be included in a client's record of service to document application for comparable benefits prior to the Division's authorization for services. If the client has not provided the Division an award/denial letter from the educational institution prior to the end of the first semester, Vocational Rehabilitation will discontinue financial support until such time this information is provided by the individual. If the client was not eligible for a Pell Grant the first year, the Division will not require the person to reapply unless there has been a significant change in the financial resources of the client or his/her family. The counselor must determine and document if financial resources have changed. If resources have changed, the Division must adjust support if the client receives federal student aid. Pell Grant and/or other federal/state aid (excluding merit awards) must be used for the purchase of tuition and fees, books, supplies, computers, software, assistive technology, room, board, and related training materials in order to demonstrate maximum effort in utilization of comparable benefits prior to using Division funds. The Division cannot designate that financial aid funds be used for in-home maintenance and use Division funds for the above educational expenses.

If a person in a postsecondary institution receives sufficient financial aid to cover the above listed educational expenses, the Division would not authorize training services until the client's entire financial aid is accounted for toward payments for educationally related needs/costs. The counselor must document in the record the type(s) and costs of services for which financial aid is being used.
[CFR 361.48 (f);]

A student can apply on the Internet for a Free Application for Federal Student Aid at http://www.fafsa.ed.gov instead of using a paper form. For more information see the above website or call 1-800-4FED-AID (1-800-433-3243). The on-line process is faster.

If a client is in default of a Title IV loan and denied a PELL Grant, they are not able to

access a comparable benefit. Clients who are in default should be advised to clear their default status by making arrangements to repay the loan. The client is required to provide the documentation of at least three months payments to the lender at a rate approved by the institution.

A determination to provide IL assistance can be made on an individual basis only after careful examination of all of the circumstances involving the default status, including the individual's financial situation, consistent with the intent that IL is the last financial resource for training in institutions of higher education. Default status can be cleared if the holder of the loan certifies for the purpose of reinstating Title IV eligibility that the borrower has made satisfactory arrangements to repay the defaulted loan or the loan is discharged in bankruptcy.

[34 CFR 668.35]
The counselor may request exception to waive usage of comparable benefits in a client's rehabilitation program if accessing the comparable benefit:

- Interrupts or delays the progress of the individual toward achieving the independent living outcome identified in the IL Service Plan
- Jeopardizes an immediate job placement (VR), or
- Delays in the provision of a service placing the individual at extreme medical risk. (Extreme medical risk means a probability of substantially increasing functional impairment or death if medical services, including mental health services, are not provided expeditiously. This determination shall be based upon medical evidence provided by an appropriate qualified medical professional. The counselor must continue to seek comparable benefits that might be retroactive and replace Division authorizations.)

These exceptions must have initial review and approval by the Supervisor, and final approval by the Chief of Policy. The written rational with supporting documentation and approval from the Chief of Policy must be filed in the case record.

[34 CFR 361.47; NC Administrative Code, Volume II Part B, Subchapter 20C, Sections .0204, .0205, and .0206: State Plan Section 6.3 and Section 6.6]

Revised 7/1/2014

CHAPTER FOUR: REHABILITATION NEEDS ASSESSMENT

Section 4-1: Comprehensive Assessment

The purpose of the comprehensive assessment is to develop the IL Service Plan and subsequent amendments. Once eligibility for IL services has been determined, the counselor, along with the client, should jointly identify and prioritize the independent living rehabilitation needs in relation to the development of the IL Service Plan. The comprehensive assessment is conducted either simultaneously with the preliminary assessment or after an individual has been determined eligible for independent living services if additional data are necessary to develop the IL Service Plan. The counselor and eligible individual must be able to identify the overall independent living objective, the goal(s), and the related services which will support the individual towards achieving a successful independent living outcome. The services planned must be anticipated to have a direct impact on the primary objective based on the stated rehabilitation needs. The independent living objective, goal(s), and services will be consistent with the unique strengths, resources, priorities, abilities, capabilities, interests, and informed choice of the individual.

The comprehensive assessment must be limited to a survey of information that is necessary to identify the rehabilitation needs of an eligible individual and to develop the IL Service Plan such as:

- Existing information, including information that is provided by the individual, the family of the individual, and medical providers
- Functional Capacities Evaluation, Physical Therapy Evaluation, Occupational Therapy Evaluation, Personal Assistance Evaluation, Rehabilitation Engineering Evaluation, Assistive Technology Evaluation
- Medical, psychiatric, psychological, and environmental factors that affect the rehabilitation needs of the individual; AND
- Other rehabilitation services used for the purposes described below:

Any rehabilitation service may be provided during the comprehensive assessment to the extent that the service is necessary to achieve the purpose of the assessment, i.e., to identify the rehabilitation needs of the individual and to develop an IL Service Plan that addresses those needs. Such services, when appropriate, should include assistive devices and services and rehabilitation technology. Financial need and comparable benefits must be considered relative to the service being provided. If the service being provided is a diagnostic service, the financial needs test is not required during the comprehensive assessment. Comparable benefits must be utilized for services when available.

[34 CFR 364.52]

Revised 7/1/2014

Section 4-2: Record of Service Documentation

Documentation in the case record must include appraisal and analysis of the comprehensive assessment. All data used to complete the comprehensive assessment must be maintained in the record of service. An analysis of the individual's rehabilitation needs is required and must be completed on the IL Written Rehabilitation Analysis Page (WRAP). The WRAP should not be completed until all comprehensive assessment data has been received.

Components to address on the WRAP include:

- Identification of the significant impairment(s)
- Explanation of Functional Capacity limitations
- Explanation of additional Significant Disability criteria
- Rehabilitation Needs
- Selection of service(s) to meet the rehabilitation need(s)
- Explanation of projected functional improvement (goals)
- Available comparable benefits and resources

Counselors must document the provision of rehabilitation services, including the client's informed choice, necessary to complete this assessment. The analysis on the IL WRAP must form the basis for the independent living objective, goal(s) and services (both major and support services). The IL Service Plan represents the culmination of the comprehensive assessment by documenting the overall independent living objective, goal(s) and the nature and scope of the services required to reach a successful outcome. If there are changes to any information gathered during the comprehensive assessment, including the rehabilitation needs, services or comparable benefits prior to the IL Service Plan, these changes must be documented and explained in the relevant section(s) on the WRAP

8/1/2015

CHAPTER FIVE: REHABILITATION PROGRAM

This chapter contains development and content requirements for the IL Service Plan) for the IL program.

Section 5-1: IL Service Plan and General Information

5-1-1: Signatures

CROSS REFERENCE: **Subsection 1-14, Client Signatures**

The IL Service Plan shall be agreed to and signed by the eligible client, or as appropriate, the client's parent, guardian, or power of attorney for the individual. The IL Service Plan must also be approved and signed by the counselor.

Once all the required signatures have been secured, a copy shall be given to the eligible client and the plan can be implemented.

5-1-2: Progress Review

This is a review conducted on a periodic basis to assess and document the client's progress towards completing the services required to achieve the long-range objective of the plan. This review may occur at any time during the service delivery process as deemed necessary by either the counselor or client. Such reviews should be documented as part of the IL Service Plan. Clients are not required to sign the review but should be given an opportunity to participate in the review and are to receive a typed copy of the review.

5-1-3: Annual Reviews

These reviews are required at least annually from the date of the original plan or subsequent annual review. Clients must be given the opportunity to participate in this review and will receive a typed copy. If the client chooses not to participate, and the annual review is conducted in the absence of the client, there must be documented evidence in the case record that the client was informed of and offered the opportunity to participate.

5-1-4: Amendments

CROSS REFERENCE: **Subsection 2-2-3: Timeliness of Services**
Subsection 2-2-4: Policy Exceptions

Any time there are changes to the IL Service Plan an amendment to the IL Service

Plan is required. Substantive changes require the amendment to be signed by the client or the client's representative, the counselor and supervisor (if required). The following changes are considered substantive and require a client's signature:

- Changes to the Primary Objective
- The deletion of an IL Goal
- Any changes to a major service, including adding, changing or deleting a major service
- Any changes to a vendor providing a major service, including adding, changing or deleting a vendor providing a major service
- The deletion of a support service
- The deletion of a vendor providing a support service
- The addition or deletion of IL as a funding source for a major service
- The addition or deletion of IL as a funding source for a support service.
- These changes shall not take effect until the amendment is agreed to and signed by the client or the client's representative and the counselor. Copies of all amendments, once appropriately signed, will be given to the client.

5-1-5: Revisions

Revisions are defined as non-substantive changes to the IL Service Plan. Clients are not required to sign revisions, but must be given the opportunity to participate in the changes. The following changes are considered non-substantive and do not require a client's signature:

- The addition or change of a Goal
- The addition or change of a support service
- The addition or change of a vendor providing a support service
- The addition or deletion of an external funding source

These changes shall not take effect until the revision is completed. Copies of all revisions will be given to the client.

Revised 7/1/2014

Section 5-2: Development of the IL Service Plan

CROSS REFERENCE: **Subsection 3-7-3: Utilization of Resources**

5-2-1: Identification of the Overall IL Service Plan Objective

Each eligible client accepted for services must identify the overall IL objective(s) so that a comprehensive program of services may be formulated to assist the client in

relocating from an institution to community-based living or avoiding institutionalization for as long as possible; improving the ability to live more independently in the home, family, and/or community; or engaging in or maintaining employment.

5-2-2: IL Service Plan Goals

The IL Service Plan must identify goals in one or more of the general areas listed below. Each goal must have the date the goal is initiated and the date the goal is achieved.

Communication
Goals involving either improvement in a client's ability to understand communication by others (receptive skills), and/or improvement in a client's ability to share communication with others (expressive skills). **Note**: Hearing aids and augmentative communication systems would be included with this goal.

Community Services
Goals that provide for a change in living situations with increased autonomy for the client. This may involve a client's goals related to obtaining/modifying an apartment or house. **Note:** Services to aid in deinstitutionalization, housing placement and assistance, Section 8 or North Carolina Housing Finance Agency (NCHFA) housing, furniture packages, and utility/residence deposits would be included with this goal.

Educational
Goals of an academic or training nature that are expected to improve the client's basic knowledge or increase his/her ability to perform certain skills deemed to increase his/her independence consistent with IL philosophy. **Note:** Recreational Therapy services would be included with this goal.

Information Access/Technology
Goals related to a client obtaining and/or using a computer or other assistive technology, devices, or equipment, also a client's goal of developing skills in using information technology, e.g., emerging computer screen-reading software.

Mobility/Transportation
Goals to improve a client's access to his/her life space, environment, and community. This may occur by improving the client's ability to move, travel, transport himself/herself, or use public transportation. **Note:** Transportation modifications, ingress/egress residence modifications, wheelchairs, orthotics and prosthetics would be included with this goal.

Personal Resource Management
Goals related to a client learning to establish and maintain a personal/family budget, managing a checkbook, and/or obtaining knowledge of available direct and in-direct resources related to income, housing, food, medical, and/or other benefits.

Self-Care
Goals to improve/maintain a client's autonomy with respect to activities of daily living such as personal grooming and cleaning, toileting, meal preparation, shopping, eating, etc. **Note:** Bathroom and/or kitchen modifications, personal assistance services, assistive aids for personal care, and emergency alert systems would be included with this goal.

Vocational
IL goals related to obtaining, maintaining, or advancing in employment. **Note:** This goal alone is not a legitimate goal for the IL program but would be utilized for all joint cases

5-2-3: Independent Living Services

The services planned to achieve the IL goals shall be recorded on the IL Service Plan along with the anticipated initiation date of the service. Services may be provided directly by IL staff, purchased, or brokered by the program from another source or comparable benefit. Any comparable benefit that is to be used to pay for the service should be listed along with the provider.

When adding a service subject to financial need the vendor and cost must be added to the IL Service Plan. If competitive bidding or quotes are required these must be obtained before adding the service to the plan.

If a specific vendor has not been identified when the service is planned, "undetermined" vendor may be recorded on the IL Service Plan. Prior to bill payment the specific vendor will need to be added to the IL Service Plan.

Once a service is completed, the date achieved must be recorded on the plan.

5-2-4: Counselor Comments

Record any relevant comments in this section. If the plan is being revised or amended an explanation of changes should be documented. In addition, the anticipated need for services following a successful outcome must also be addressed.

Revised 8/1/2015

5-2-5: Responsibilities of Clients and DVRS

Information describing the responsibilities of both the Division and the client in meeting the terms and conditions of the IL Service Plan should be recorded.

5-2-6: Comparable Benefits

Record whether comparable benefits are available for services planned on the IL Service Plan. If comparable benefits are available they should be specifically identified and described.

Revised 7/1/2014

CHAPTER SIX: RECORD OF SERVICE OUTCOMES

Section 6-1: Successful Outcome After IL Service Plan-Case Status Code 26

6-1-1: Closure Standards

CROSS REFERENCE: **Subsection 4-1, Comprehensive Assessment**

Clients whose records are closed in this status must meet the following criteria as documented in the case record:

A. The client was appropriately determined eligible for services;
B. Substantial services provided according to the IL Service Plan must have had a direct impact on and contributed to the achievement of the primary IL objective;
C. The independent living outcome(s) is consistent with the client's strengths, resources, priorities, concerns, interests, and informed choice; AND
D. The client and the counselor consider the independent living outcome to be satisfactory and agree that the client has an improved level of independent living functioning and an enhanced involvement within their family, home, and community.

Clients cannot be closed with a successful outcome more than once in the same Federal fiscal year.

NOTE: IL program clients cannot have their records closed successfully (status code 26) from Transition to VR) until the client has been determined eligible for vocational rehabilitation services.

6-1-2: Client Notification

The client is to participate in the decision to close the record to the extent possible.

6-1-3: Record of Service Documentation

Complete the IL Progress and Closure report and the closure document) which should include the reason why it has been determined that the client has achieved the goal(s) and that the client has been informed of the availability and how to access post closure services. The client is to receive a copy.

Revised 7/1/2014

Section 6-2: Outcome During Preliminary Assessment-Case Status Code 08

6-2-1: Closure Standards

Case status code 08 is a means of identifying all persons not accepted for service from applicant status. An annual review will be conducted on all individuals not accepted for service due to ineligibility. The IL program will conduct the initial review with subsequent reviews being initiated by the applicant. *The IL Ineligibility Decision* is required when the applicant's record is closed due to ineligibility reasons—condition became too severe or does not meet the eligibility criteria.

6-2-2: Client Notification

The applicant must be given the opportunity to participate in the decision to close the case unless the applicant is unavailable or the disability is rapidly progressive or terminal. A copy of the *IL Ineligibility Decision* is to be maintained in the applicant's file and a copy sent to the applicant.

6-2-3: Record of Service Documentation

A copy of the *IL Ineligibility Decision* is to be maintained in the applicant's file when case is closed due to ineligibility reasons. The reasons for ineligibility, applicant's input into the decision and review of the appeals process and annual review provisions should be documented. If the record is closed due to reasons other than ineligibility the IL Outcome Decision letter should be completed with documentation of the closure reason.

Revised 7/1/2014

Section 6-3: Outcome Prior to Implementation of the IL Service Plan-Case Status Code 30

6-3-1: Closure Standards

This status is used when a client's record is closed after the client has been determined eligible and an IL Service Plan is on file. If the closure is due to ineligibility, a review, at least annually, of the decision is required. The client is given the opportunity for full consultation in the reconsideration of the decision unless the individual refuses the review, is no longer present in the state, has unknown whereabouts, or has a medical condition that is rapidly progressive or terminal. The Division is responsible for initiating the first review while any subsequent reviews are undertaken at the request of the client. An *IL Ineligibility Decision* is required when the client's record is closed due to ineligibility reasons.

6-3-2: Client Notification

The client must be given the opportunity to participate in the decision to close the case regardless of the reason for closure. If issued, *the IL Ineligibility Decision* is to be sent to the client.

6-3-3: Record of Service Documentation

Documentation explaining why it has been determined that the client could not progress to the point of plan implementation and the views of the client must be maintained in the case record. A copy of the *ILRP-1005, IL Ineligibility Decision,* is to be maintained in the applicant's file when case is closed due to ineligibility reasons. The reasons for ineligibility, applicant's input into the decision and review of the appeals process and annual review provisions should be documented. If the record is closed due to reasons other than ineligibility the IL Outcome Decision letter should be completed with documentation of the closure reason.

Revised 7/1/2014

Section 6-4: Unsuccessful Outcome after Implementation of the IL Service Plan- Case Status Code 28

6-4-1: Closure Standards

This case status code is used to close a client's record after the IL Service Plan has been signed and there must be at least one service initiated which was planned for on the IL Service Plan. If the closure is due to ineligibility, a review, at least annually, of the decision is required. The client is given the opportunity for full consultation in the reconsideration of the decision unless the client refuses the review, is no longer present in the state, has unknown whereabouts, or has a medical condition that is rapidly progressive or terminal. The Division is responsible for initiating the first review while any subsequent reviews are undertaken at the request of the client. *An IL Ineligibility Decision* is required when the client is closed due to ineligibility reasons.

6-4-2: Client Notification

The client must be given the opportunity to participate in the decision to close the case regardless of the reason for closure. If issued, a copy of the *IL Ineligibility Decision* is to be sent to the client.

6-4-3: Record of Service Documentation

Complete the IL Progress and Closure Report and the closure document *IL Other Outcome Letter* stating why it has been determined that the client could not progress to the point of rehabilitation and the views of the client must be included.

Documentation must be part of the IL Service Plan; however since closure for reasons other than ineligibility does not create the need for an IL Service Plan amendment, the client's signature is not required although the client is to receive a copy.

If the record of service is being closed due to ineligibility, the IL Service Plan must be amended to delete planned services which have not been provided and must be signed by the client. If issued, a copy of the *Ineligibility Decision* is to be maintained in the client's file.

Revised 7/1/2014

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6-4-4: IL Progress and Closure Report

Instructions for Documenting Improved Access to Transportation, Health Care Services and Assistive Technology when closing a case in status 26 or 28

This table measures how independent living program services enable clients to overcome barriers to their independence by helping them to access previously unavailable transportation, health care services, and assistive technology.

Please complete the columns in the Access Table as follows:

Column 1 (Client Requires Access) — Select "Y" in the check box if at any time during the rehabilitation process the client required access to previously unavailable (A) Transportation; (B) Health Care Services; and/or (C) Assistive Technology. The lack of transportation, health care services or assistive technology as barriers to reaching one or more of their IL goals may be identified by the client and/or the IL staff.

Column 2 (Consumers Achieving Access) – If the client requires access as indicated by a "Y" in column 1, select "Y" if access was gained to previously unavailable (A) Transportation;
(B) Health Care Services; and/or (C) Assistive Technology as a result of the provision of IL services. Indicate "Y" if access in any of these areas was facilitated through the IL services provided – whether or not such access had been the client's originally stated goal. Any client with a "Y" in this column must also have a "Y" in the column 1.

Access to transportation may be facilitated through information and referral to existing community transportation services that provide specialized services to individuals with disabilities; residence modifications to enable clients to enter and exit the home; vehicle modifications; durable medical or other equipment; prosthetics; and/or personal assistance services.

Access to appropriate health care services may be enhanced through information and referral services to local medical facilities with available interpreters or TDD phone numbers; assistive technology services for clients to better communicate with their doctors; residence modifications to enable clients to enter and exit the home; and/or personal assistance services.

Access to assistive technology may be expanded through information and referral to public and private sector sources of funding or equipment; acquiring assistive technology equipment; and/or skills training on the use of assistive technology.

Note: The term “assistive technology” encompasses a broad range of independent living resources such as daily living, mobility, cognitive and communications aids as well as information technology

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Section 6-5: Closure Retrievals

6-5-1: Retrieval of Status 26 Closures

If a case is closed status 26 and upon additional audit or review is determined not to have met closure standards outlined in 6-1-1 the UM must email a request for the status change to the BEAM system administrator who will change the status from status 26 to the requested status and document the request on the Client Case Note for the status change.

6-5-2: Retrieval of All Other Closures

If after closure to status 08, 28 or 30 a determination is made to change the case status back to an active status or to a different closure status, the UM must email a request for the status change to the BEAM system administrator who will complete the action and document the request on the Client Case Note for the status change.

CHAPTER SEVEN: POST-CLOSURE SERVICES

Section 7-1: Post-Closure Services-Case Status Code 32

Post closure services may be provided to those individuals who meet the following criteria:

A. The individual has successfully achieved the rehabilitation goal(s) and closed in case status code 26;
B. Continued services are needed in order to maintain the goal(s); AND
C. The problem is a continuation of the original rehabilitation need and the solution does not entail the need for a determination of eligibility and IL Service Plan.

The primary purpose of this service is to assist the individual in maintaining the ability to function within the family or community or engage or continue in employment. Personal care services are the most common services rendered during this phase of the rehabilitation process. Services are subject to the same financial eligibility and comparable benefits requirements and described in CHAPTER 2. Should new problems arise that are not a continuation of the original or amended IL Service Plan, the counselor will make a new determination of eligibility while assisting the client in identifying other resources outside the scope of the IL program. Sponsorship of acute medical conditions cannot be provided.

Individuals who may be generally considered candidates for post closure services include:

A. Those whom counselors identify prior to closure that will need services and for whom planning is outlined on the IL Service Plan;
B. When unexpected situations arise after closure and very specific short-term services are required; OR
C. Those in the above group who may need long-term services but the problem is a continuation of the IL Service Plan.

7-1-1: Procedure to Enter Post-Closure Services

Once the decision is made to provide services through post closure rather than opening a new case, the counselor will change the status to case status code 32.

7-1-2: Post-Closure Amendment to IL Service Plan

The counselor and client must jointly amend the original IL Service Plan describing the nature and scope of services planned and how they will be provided. There must be sufficient documentation in the record of service to explain why services are necessary to maintain the individual's goal(s).

Revised 7/1/2014

Section 7-2: Termination of Post-Closure Services-Case Status 34

7-2-1: Termination Standards

Clients terminated from post closure services will have:

A. Been placed in case status code 32;
B. Had a program of services developed outlining the goal and need for post closure services; AND
C. Have completed the plan and maintained the goal or it has been determined that the client is in need of services outside the scope of post closure services and a new application will be evaluated for the development of a new record.

7-2-2: Client Notification

The client is to be involved in the decision to terminate post closure services and is to receive a copy of the Outcome Statement letter summarizing the closure of the post-closure amendment and why services are being terminated.

7-2-3: Record of Service Documentation

When terminating a client from post closure services, it is necessary to document the reason for termination and the client's involvement in the decision. If a new application for services is taken, the new IL# and effective date of the application should be recorded in the *Case Notes.*

Revised 7/1/2014

CHAPTER EIGHT: CENTERS FOR INDEPENDENT LIVING (CIL)

Section 8-1: Definition of a CIL

The purpose of a Center for Independent Living as authorized by Title VII of the Rehabilitation Act amendments is to promote a philosophy of independent living including a philosophy of consumer control, peer support, self-help, self-determination, equal access, and individual and system advocacy to maximize the leadership, empowerment, independence, and productivity of individuals with significant disabilities, and to promote and maximize the integration and full inclusion of individuals with significant disabilities into the mainstream of American society. A center will be designed and operated within local communities by individuals with disabilities, including an assurance that the center will have a board that is the principal governing body of the center and a majority of which must be composed of individuals with significant disabilities.

As per federal regulation, a center for independent living must provide the following independent living CORE services:

- Information and referral services
- IL skills training
- Peer counseling
- Individual and systems advocacy

While these core services are required in the federal regulations, other services may be provided as well based on the interests and development of an individual center.

[34 CFR 364.2, 364.4, and 366.50]

Section 8-2: Utilization of a CIL

Referral service relationships should be developed and maintained between the DVRS Independent Living Rehabilitation Program and the Centers for Independent Living to meet the comprehensive rehabilitation needs of the individual. The nature of the referral will vary depending upon the availability of a local CIL and the services provided by that CIL. In addition to the CORE services available through the CIL, other services may include nursing home transition, transportation and housing assistance, ADL equipment exchange, facilitation of ramp construction, and technology training. Where available, services shall be considered and utilized as comparable benefits when developing the IL Service Plan. Financial need must be determined prior to purchasing services from the CIL.

APPENDIX

Appendix entries are alphabetized by topic heading.

AgrAbility

Rev. 11/1/2017

In an effort to consistently serve farmers and farm workers throughout our state, we have established guidelines and procedures for serving these clients through the AgrAbility Program.

AgrAbility is an initiative sponsored by the U.S. Department of Agriculture and is intended to assist farmers and their family members who have a disability and other health related concerns. The focus is helping farmers who are at risk of losing their farm due to their disability and/or helping farmers who want to enter into a career as a farmer.

NCATP contracted with NC A&T to provide Assistive Technology and farm assessments. AgrAbility, as it pertains to assisting eligible farmers/farm workers, is a collaboration between DVRS and the North Carolina Assistive Technology Program (NCATP). NCATP can provide an evaluation on the farm to identify many of the disability-related assistive technology needs of the farmer/farmworker.

There are three categories of farmers for DVRS Policy consideration:

1. Existing Farmers
2. Farming as a Self-Employment Venture
3. Employment as an Agricultural Worker

Process for DVRS and AgrAbility (NCATP) to work together:

1. Farmer/Farm worker referred to VR for Intake **(See Supplemental Information below this entry).** NCATP may make this referral to VR, but the referral does not have to come from NCATP.
2. Contact the Planner/Evaluator assigned to AgrAbility Cases in the Policy Office (dvr.m.policyoffice@dhhs.nc.gov) - The Planner/Evaluator serves as case tracker/troubleshooter point person for AgrAbility cases, which admittedly can be challenging.
3. If not already working with AgrAbility through NCATP, we recommend referring for resources and assessment services at the appropriate point, ideally in coordination with rehabilitation engineering for joint site visit.

    - The nature of the case (Job Accommodation versus Self-Employment Venture) will direct assessment flow.
    - Self-Employment Ventures will involve the Self-Employment Specialist to help guide through the SEEDS process.

- Job Accommodation cases (existing farmers/farmworkers) will require appropriate equipment or vehicle modification packet to be submitted to the Policy Office.

The Planner/Evaluator will consult with the Policy Office staff and the Rehabilitation Technology Specialist when cases involve equipment or modifications. The Rehabilitation Technology Specialist will work with rehabilitation engineer, counselor, and AgrAbility evaluator to address and help with equipment/modification procurement process. See *Client Data Packet Checklist: AgrAbility Requests* - for documentation requirements. Located on the DVRS Intranet Forms Page:

https://hrdvr03.dvr.dhhs.state.nc.us/division/forms/dvr/forms_templates.htm

Since the financial needs survey can be challenging for such cases, you are strongly encouraged to consult with the Planner/Evaluator and the Policy team prior to making your determination.

Supplemental Information:

Below are some **suggested** points of conversation in talking with consumers who express interest in farming as a vocational goal. These questions may help us determine the viability of farming as a vocational goal, and help the consumer to take a realistic look at this job choice.

Please contact the Planner/Evaluator assigned to AgrAbility cases for guidance/direction early in the process so that these cases can be tracked and shared with the Policy Office.

1. What is your previous farming experience?
2. How long have you worked on this farm?
3. Who owns the farm?
4. What is the nature of your farm? ie crops, cattle, etc.
5. How many acres is the farm?
6. Approximately how many hours per week do you farm?
7. What are your anticipated earnings for the farm?
8. What specific tasks do you perform independently on the farm? Or Describe a typical day on the farm for you.
9. What difficulties/hardships are you currently facing on the farm due to your disability?

10. What assistance do you think you need to alleviate these hardships due to your disability?
11. What supports do you have in maintaining this vocational goal? In other words, is there personnel available to assist with tasks that you are unable to complete independently?
12. Have you had an assessment through NCATP and/or the AgrAbility program?

Attention-Deficit/Hyperactivity Disorder (ADD/ADHD)

ADD/ADHD is a developmental disability with a history of childhood onset that typically results in a chronic and pervasive pattern of impairments in school, social and/or work domains and often in daily adaptive functioning as defined in the DSM-IV. Evaluation and diagnosis by the appropriate specialist is required to establish the existence of a mental, emotional, or substance abuse impairment.

Appropriate specialists include:

- Psychologist
- Licensed Psychological Associate
- Psychiatrist
- Neuropsychologist
- Neuropsychiatrist
- Neurologist
- Pediatrician

IMPAIRMENT
Documentation of ADD/ADHD as an impairment must include the following components:

History
- Onset
- Pervasiveness
- Severity
- Previous/current treatment and response to treatment

Educational/Psychological Assessment
- Aptitudes
- Achievement
- Information Processing

Rule Out Presence of Co-morbid Conditions
While information from the school and medical sources should be included as a component of the assessment, this diagnosis must be based on DSM-IV criteria. Evaluation and diagnosis by a licensed psychologist or psychiatrist is required to establish the existence of mental, emotional or substance abuse impairments. (See Subsection 3-5-3)

SUBSTANTIAL IMPEDIMENT
Emphasis should be on the identification of the impediments to employment caused or created by the impairment. Severity of symptoms is such that ongoing treatment is recommended and, as a result of the impairment, at least one of the following is

present:

- Accommodations required to maintain suitable employment
- Inability to maintain suitable employment
- Poor school attendance, tardiness or inability to follow a schedule and meet deadlines
- School discipline issues due to poor problem solving
- Inability to anticipate consequence of behavior and actions
- Poor interpersonal skills due to lack of social judgment

For students in transition either of the additional indicators that ADD/ADHD is an impediment to employment is required as follows:

- The student's academic performance is below the expected level for the individual based on individual intelligence and achievement scores;

- The student has a history of academic performance being below the expected level prior to treatment and/or accommodations

TREATMENT

Prescription and nonprescription drugs and medical supplies may be provided for those individuals who meet the criteria for the financial needs test when comparable benefits are not available. (See Volume I, subsection 2-16-9) Twenty-four sessions of private psychotherapy may be authorized based on counselor discretion. Additional sessions can be authorized with the approval of the Unit Manager/Facility Director and the Chief of Policy. (See Volume I, subsection 2-13-1)

Revised 10/1/2011

Auxiliary Aids & Services

A public accommodation is required to provide auxiliary aids and services necessary to ensure equal access to the goods, services, facilities, privileges, or accommodations that it offers, unless an undue burden or fundamental alteration would result. A fundamental alteration is a modification that is so significant that it alters the essential nature of the goods, services, facilities, privileges, advantages, or accommodations offered.

This obligation extends only to individuals with disabilities who have physical or mental (impairments) disabilities, such as vision, hearing, or speech (impairments), that substantially limit the ability to communicate. Measures taken to accommodate individuals with other types of disabilities are covered by other title III requirements such as “reasonable modifications” and “alternatives to barrier removal”.

Auxiliary aids and services include a wide range of services and devices that promote effective communication. According to the Americans with Disabilities Act of 1990, Titles I and V, auxiliary aids and services includes:

- Qualified interpreters or other effective methods of making aurally delivered materials available to individuals with hearing (impairments) disabilities
- Note takers
- Computer-aided transcription services
- Telephone handset amplifiers
- Assistive listening devices and systems
- Telephones compatible with hearing aids
- Closed caption decoders
- Open and closed captioning
- Telecommunication devices for deaf persons (TDD);
- Videotext displays
- Exchange of written notes
- Qualified readers, taped texts, or other effective methods of making visually delivered materials available to individuals with visual (impairments) disabilities;
- Brailled materials
- Large print materials
- Computer terminals, speech synthesizers, and communication boards available to individuals with speech (impairments) disabilities
- Acquisition or modification of equipment or devices
- Other similar services and actions

Blind & Visually Impaired

NC DVRS will refer to the Division of Services for the Blind (DSB) the following individuals:

- All persons having 20/200 or worse vision in the better eye with best correction.
- All persons having between 20/100 and 20/200 in the better eye with best correction if the person has been unable to adjust to the loss of vision or if it is felt the individual needs the specialized services of DSB.
- All persons having night blindness, limited field of vision, or a rapidly progressive condition which in the opinion of a qualified eye specialist will reduce vision to 20/200 or less.

NC DVRS may accept individuals noted below as having an impairment:

- Persons having between 20/100 and 20/200 in the better eye with best correction if the individual has adjusted to the loss of vision and functions as a sighted person.
- Persons having between 20/60 and 20/100 in the better eye with best correction.
- Persons who have no vision in one eye with better than 20/100 with best correction in the other eye.
- Persons with a loss of vision with best correction of 25 % or more. Individuals with vision in one eye only are automatically classified as having a 25% loss of vision. Individuals without binocular vision or depth perception are classified as having useful vision in one eye only.

Borderline Intellectual Functioning

This impairment is diagnosed when there are deficits in adaptive behavior associated with an FSIQ measured in the range of 71-84. The adaptive behavior deficits must be identified by the psychologist, teacher, or the individual's family and must be stated or referenced in the psychological report. The psychologist may require such preliminary information about suspected or known behaviors prior to testing in order to establish the diagnosis. It is extremely unlikely that this impairment will ever be coded as SD.

Chronic Fatigue (CFS)

As a chronic condition, CFS represents an impairment which, on an individual basis, may result in substantial impediments to employment. An individual whose fatigue symptoms are not diagnosed as CFS may be determined to have an impairment of a different origin.

Interventions, other than those listed below, are considered experimental and should not be sponsored by the Division.

- An accurate explanation of the condition
- Supportive counseling
- Psychological assistance, including medication as prescribed
- Appropriate nutrition and rest
- Anti-inflammatory agents when joint and muscle pain persist
- An incremental program of increased activity with the aim of maximum increase in function

Chronic Pain

Important in an individual's approach to addressing chronic pain are both realizing that chronic pain may not be able to be totally eliminated and taking responsibility for the best management of any residual pain. In addition, utilizing surgical and other strongly overt approaches to symptom relief may often be avoided through first utilizing more conservative approaches.

Pain is a response of special sensory nerve endings to irritation, pressure, heat, cold, injury, stress, and disease. Emotional and attitudinal factors, previous experiences, other health conditions as well as social cultural and ethnic differences, however, can cause individuals to react differently to pain. Assisting the individuals we serve to assume responsibility not only for complying with specific treatment, but also encouraging the person's adapting an approach which takes a "holistic" or total mind and body approach will greatly enhance the likelihood of a return to a level of significant functioning.

CHRONIC PAIN INTERVENTIONS

Medical and Surgical

A physician experienced in the treatment of chronic pain and who seeks to understand the individualized and personal effect that pain of long duration may have had on the patient is most likely to utilize a comprehensive approach. While involving the psychologist and other team members, the potential influence of the physician in facilitating the consumer's assuming the responsibility for improvement is great. Surgery and other more overt interventions may be reasonable within the context of utilizing appropriate more conservative approaches initially.

Physical Exercise

A physician directed program of exercise to tolerance should be a part of nearly all treatment approaches. Improvement in metabolism and general physical conditioning helps to improve tolerance of residual pain in a variety of ways including reducing depression and subsequently improving sleep patterns. Walking, water exercises, and other personalized interventions have proven to often have a positive impact upon the individual's functional capacity even when residual pain persists.

Psychological

Through a psychological evaluation by a licensed practitioner experienced in assisting chronic pain patients, the individual and the treatment team can more fully learn about and address the role of depression, rewards and secondary gain that may come from having the condition, previous physically and emotionally traumatic experiences, and other factors that may be preventing optimal functioning. The psychologist may recommend specific stress reduction

interventions that assist in demonstrating the linkage between emotions and physical comfort. Problems with alcohol may also be identified and treatment addressed.

The psychologist's involvement with family members may be necessary to explore and surmount features in interpersonal relations that may contribute negatively to effective pain management and functional capacity.

Dietary

Good eating habits contribute to good general conditioning as well as to healing connective tissues damaged by inflammation. The individual may need to utilize a nutritionist for instruction in eating to maximize recovery.

Smoking Cessation

Assisting the individual to stop smoking through physician recommended smoking cessation services is another potential component in the comprehensive approach to pain management.

Alternative Medical Approaches

Alternative medical approaches have been gained increasing acceptance by the medical community during recent years. As with other interventions, the individual is best served when he or she views the treatment as a component in an overall approach to pain reduction and tolerance as opposed to a "cure all."

Recognizing the value of chiropractic treatment, the Agency has allowed the sponsorship of spinal manipulation for many years. When prescribed by a physician and performed by a licensed practitioner, acupuncture may be effective as a component in a comprehensive approach. Biofeedback, again when medically approved and performed by a qualified practitioner, can be effective in pain control and has been sponsored by the Agency for stress reduction. Massage therapy, under the prescription of a physician, when in compliance with any local ordinances that pertain (there is no state licensing), and when performed by a therapist certified by the National Certification Board for Therapeutic Massage and Bodywork is potentially of functional benefit. Since a series of the above listed treatments may need to be repeated should symptoms recur, individualized rehabilitation plans should assist in the client's assuming work activities that will both minimize the chances of pain exacerbation as well as provide the financial means for funding subsequent treatments that may be needed.

While some alternative medical therapies are consistent with physiological principles of western medicine, others are far outside the realm of accepted medical practice. The above mentioned interventions are among those that have had significant acceptance by the medical community in the United States.

The National Institute of Health's Office of Alternative Medicine suggests that, in seeking a provider, one should select someone who is appropriately licensed and accredited who has significant experience in the specific application of the treatment for individual's particular pain treatment need. The provider should be able to offer references of other care providers who have recognized the benefit of the intervention with their patients. The client and practitioner alike need to realize that our sponsorship is for a finite number of treatment sessions and that subsequent treatment sponsorship will depend upon client cooperation, benefit having been realized with additional improvement expected, and progress toward the planned goal of the client's progressing toward being responsible for treatment costs.

The Division acknowledges the reduction of chronic pain that may be associated with many of these treatment modalities and supports short-term sponsorship as part of a total treatment approach under the direction and referral of a medical specialist. In view of the guarded prognosis when organic disease may be absent or insufficient to explain the pain condition, sponsorship of interventions requires diagnosis of the precipitating condition. Vendors must be certified and licensed as appropriate.

(See Volume VIII, Vendor Review and Certification.)

Cochlear Implants

Effective September 1, 1998, Medicaid approved the sponsorship of Cochlear Implants (CI) for children (ages 2-21) but not adults. At this time, Medicaid pays for the physician cost, the implant and hospitalization based on their fee schedule. Medicaid does pay for the speech processor.

The Division of Vocational Rehabilitation is not sponsoring the cochlear implant surgery. However, the counselor can sponsor external replacement parts for the CI such as the speech processor, microphone, coils, etc. for eligible clients with a CI through an approved vendor. The IPE must document this service as a core service under physical restoration that is provided within a supported guidance and counseling relationship. Please refer to Volume V for rates. Any questions regarding CI issues, please contact the Statewide Coordinator for Deafness and Communicative Disorders.

The external replacement parts may only be replaced or repaired by a licensed audiologist who has established a written plan of care that substantiates the need for the replacement or repair of external parts. These parts and rates are listed in Volume V. Upgrades to existing, functioning, replaceable speech processors to achieve aesthetic improvements are not medically necessary and will not be covered.

Although the Division does not sponsor the cochlear implant surgery; the following information is intended to provide Counselors with a general background of knowledge on the procedure. Listed below is a short description of the surgical procedure and process that a client may follow for maximum benefit from the CI. The use of cochlear implantation is still relatively new. The small, snail-shaped electrical devices are surgically implanted in the cochlea, the inner-ear organ that contains nerve endings needed for hearing (under the skin behind the ear). Sound waves enter the microphones, which are then sent via a thin cable to a speech processor that may be worn on a belt or a behind-the-ear model.

The speech processor is a powerful miniature computer that translates incoming sounds into distinct electrical codes. The speech signal is sent back up the same cable, to the headpiece and transmitted across the skin via radio waves to the implanted device. This signal then travels down to the electrode array, which has been positioned within the inner ear and stimulates the auditory nerve. While the implants do not restore normal hearing, they bypass defective parts of the ear and send auditory signals to the brain.

Possible Pre-operative Required Testing for Consumers

A. Hearing Evaluation
B. Speech Discrimination Testing
C. Tympanometry
D. Acoustic Reflex Testing

E. Auditory Brainstem Response Testing (ABR)
F. Promontory Stimulation Test
G. Consultative Pre Cochlear Implant
H. Other tests and/or services as required

Implant Procedure

A. Hospitalization
B. Anesthesiology
C. Radiology
D. Cochlear Implant Devices/System

Post-Operative Activities

A. Audiological (Aural) Rehabilitation–Post Surgery
B. Speech Processor Programming & Therapy
C. Final Testing
D. Other tests and/or services as required

Dental Impairments

Dental impairments create certain difficulties for service delivery staff in determining whether such conditions are severe enough to cause vocationally-related difficulties. Consequently, the Division has developed the following contingencies related to this impairment:

- COSMETIC APPEARANCE – An impairment may be present if the individual encounters rejection in social and employment-related situations due to the severity of the cosmetic appearance.
- CHRONIC DENTAL CARIES or other Severe Dental Problems – An impairment may exist if the condition is so severe that pain and discomfort interferes with normal functioning. Likewise, the impairment may prevent the individual from maintaining control or treatment of another medical condition.

The dentist or other physician must document that either or both of the above conditions are present.

Driver Evaluation & Training Services: Procedures for Obtaining Driving Evaluation When Adaptive Driving Equipment Is Involved

{This appendix insert replaces Policy Directive 04-2004 dated 09/14/2004}

Since September 14, 2004, counselors were directed to utilize one or two specific rehabilitation engineers per region who were to serve as point persons assisting counselors with matching the various driving evaluation providers and their capabilities with the specific needs of the consumer. Additionally, these "designated engineers" also reviewed the driving evaluations for purposes of verifying their compliance with the Division's requirements prior to payment for services rendered. Over the course of that period, we have been able to improve the quality of the driving evaluations purchased and were able to strengthen all staff rehabilitation engineer's ability to provide these services.

Effective April 20, 2007, we are requesting for all counselors who wish to obtain driving evaluations or training for clients involving adaptive equipment to contact the rehabilitation engineer from which they normally obtain all rehabilitation engineering services. They will guide the counselor through the resources, forms and procedures for obtaining these services.

One of the benefits of this new approach is that the rehabilitation engineer with whom the counselor normally partners can remain an integral part of the process from the very moment that a counselor determines that a driving evaluation should be pursued for a given client. It also should be less confusing for counselors to work with the rehabilitation engineer that they normally partner with on all rehabilitation engineering-related matters.
As a reminder, the following types of driver evaluation/training services are NOT included in this process:

- Clinical evaluations for purposes unrelated to adaptive equipment purchases, e.g., cognitive-perceptual types of evaluations often purchased through outpatient rehab centers.

- Driver's training where no adaptive equipment is involved.

Furthermore, when authorizing, utilize the following codes as applicable:
Driver Training (No Adaptive Equipment): D,T 68
Driver Evaluation /Training (With/For Adaptive Equipment): D,T 69
Once the services are provided, the vendor is instructed (via DVR-0229-B) to submit their report, which will consist of a completed DVR-0229-D "Standardized Driving Evaluation /Training Report" and any additional information provided by the evaluator. In order to maintain the level of quality of the information within the reports, the counselor is to immediately send a legible copy of the report, signed case service and vendor invoices to your rehabilitation engineer, who will review and approve for payment via

signature, date and title. Alternatively, your engineer may request corrections to the report from the vendor prior to payment. The engineer will send the final report (if corrections were required) and the signed invoices to the counselor, who will submit the invoices to the controller's office for payment. PROCEDURES FOR OBTAINING DRIVING EVALUATION & TRAINING SERVICES WHEN ADAPTIVE DRIVING EQUIPMENT IS INVOLVED

For future reference, the forms will be available via the following:

- VR Intranet site link: http://hrdvr03.dvr.dhhs.state.nc.us/division/sections/pos/docs/resources.htm

DSM-5

Rev. 5/1/2017

Highlights of Changes from DSM-IV-TR to DSM-5

- Changes were made based on research and clinical studies.

- The multi-axial system of diagnoses is eliminated.

- The chapters are restructured based on the disorders' relatedness to each other and align DSM-5 with ICD-11. The World Health Organization's classification system lists "disorders" in the ICD and bases all "disabilities" on the International Classification of Functioning, Disability, and Health (ICF).

- When using DSM-5 diagnoses, clinicians should note the name of the disorder next to the code listing since some codes are used for multiple disorders. No distinct code yet exists for DSM-5 diagnoses; therefore, dual coding may be provided to account for the lag between DSM-5's publication and official implementation of matching ICD-10-CM codes on October 1, 2014 and ICD-11 to be released in 2015 (currently using ICD-9-CM coding).

- Diagnostic criteria for Intellectual Disability (Intellectual Developmental Disorder) emphasize the need for an assessment of both cognitive capacity (IQ) and adaptive functioning with severity (mild, moderate, severe, profound) being determined by adaptive functioning rather than IQ test scores alone. Adaptive behavioral functioning refers to how well a person meets community standards of personal independence and social responsibility in comparison to others of similar age and sociocultural background. The term intellectual developmental disorder is placed in parentheses to reflect the bridge term for the future link to the ICD system.

- Not Otherwise Specified (NOS) has been eliminated and replaced with "unspecified" and "other specified" to maintain greater concordance with the official International Classification of Diseases (ICD) coding system. In terms of VR policy, a diagnosis of unspecified would be unlikely to have impediments to employment. A thorough analysis of data will be needed to determine whether "other specified" has impediments to employment.

- Substance use disorders are no longer separated into the diagnoses of substance abuse and dependence as in DSM-IV and the DSM-IV diagnosis of polysubstance dependence has been eliminated. The DSM-5 substance use disorder criteria are nearly identical to the DSM-IV substance abuse and dependence criteria combined into a single list, with two exceptions:

    - recurrent legal problems criterion for substance abuse has been deleted from DSM-5; and
    - craving or a strong desire or urge to use a substance criterion has been added in the DSM-5.

- Severity of the DSM-5 substance use disorders is based on the number of criteria endorsed:
    - 2–3 criteria indicate a mild disorder;
    - 4–5 criteria, a moderate disorder; and
    - 6 or more, a severe disorder.

- Substance use disorders in the mild range may not present impediments to employment. Analysis of the data will be critical to accurately determine eligibility for VR services.

- Some specific disorders have been combined, eliminating 28 disorders previously listed in the DSM-IV-TR. Examples include language disorder (combines DSM-IV expressive and mixed receptive-expressive language disorders); specific learning disorder (combines DSM-IV diagnoses of reading disorder, mathematics disorder, disorder of written expression, and learning disorder not otherwise specified); and panic disorder (the former DSM-IV diagnoses of panic disorder with agoraphobia, panic disorder without agoraphobia, and agoraphobia without history of panic disorder are now replaced by two diagnoses, panic disorder and agoraphobia, each with separate criteria).

- Several disorders are now classified on a spectrum including autism and schizophrenia.

- Autism spectrum disorder encompasses the previous DSM-IV autistic disorder (autism), Asperger's disorder, and pervasive developmental disorder not otherwise specified. Levels of symptom severity (mild, moderate, severe) are differentiated in two core domains and both components are required for diagnosis of ASD:

    1. deficits in social communication and social interaction
    2. restricted repetitive behaviors, interests, and activities (RRBs)

- In DSM-5 the schizophrenia spectrum refers to a dimensional approach to rating severity for the core symptoms of schizophrenia. As a result, the DSM-IV subtypes of schizophrenia are eliminated (e.g., paranoid, disorganized, undifferentiated).

- The DSM-IV diagnosis of dementia is incorporated under neurocognitive disorders in the DSM-5 along with diagnostic criteria to distinguish the difference in severity between major and mild cognitive impairment. Criteria for distinct

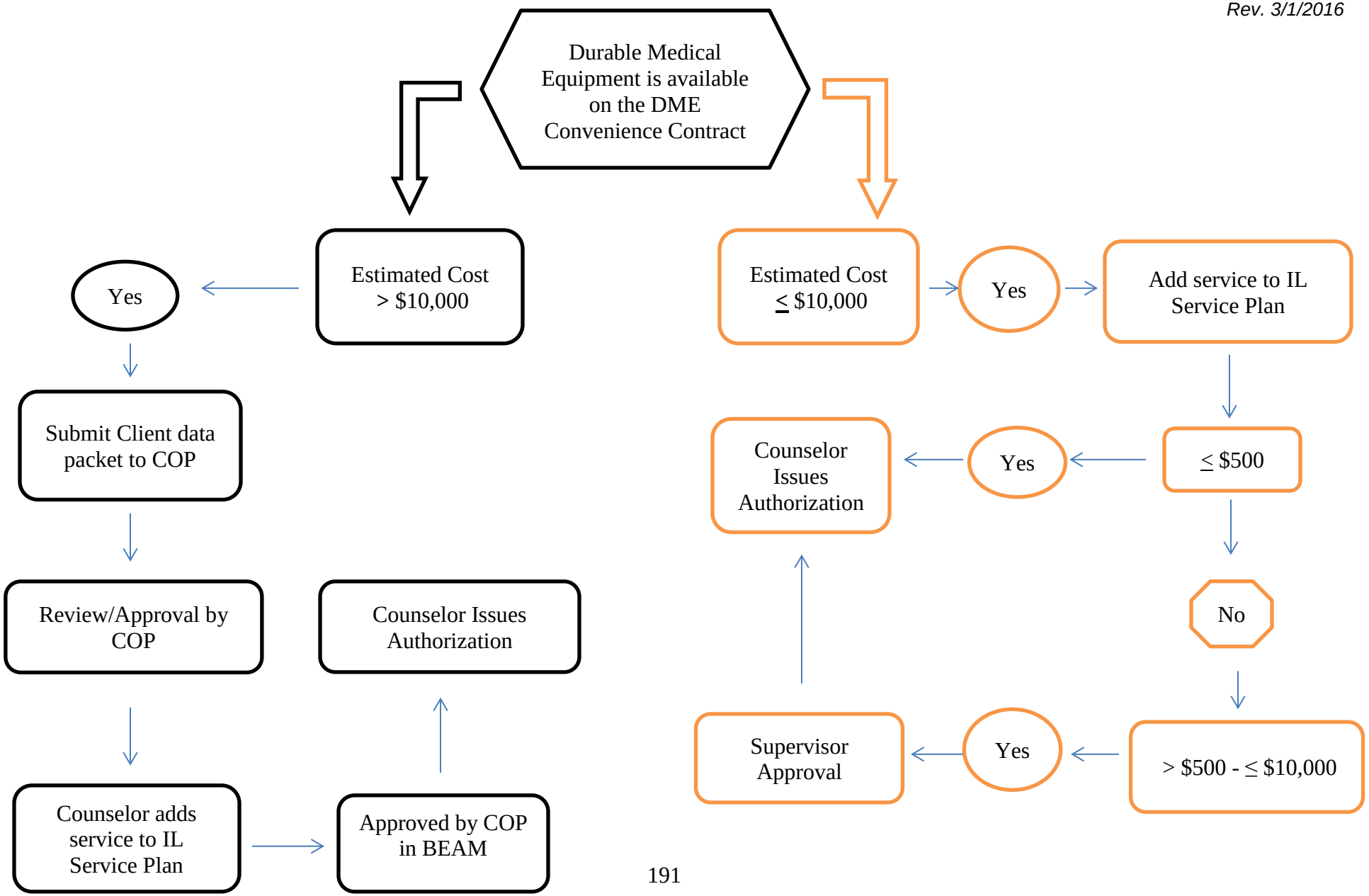
etiologies elevate previous subtypes in the DSM-IV to separate, independent disorders (e.g., NCD due to Alzheimer's disease; NCD due to traumatic brain injury; NCD due to Parkinson's disease; NCD due to a substance use disorder).

The following link provides additional information regarding changes from DSM-IV to DSM-5:

http://www.dsm5.org/Documents/changes%20from%20dsm-iv-tr%20to%20dsm-5.pdf

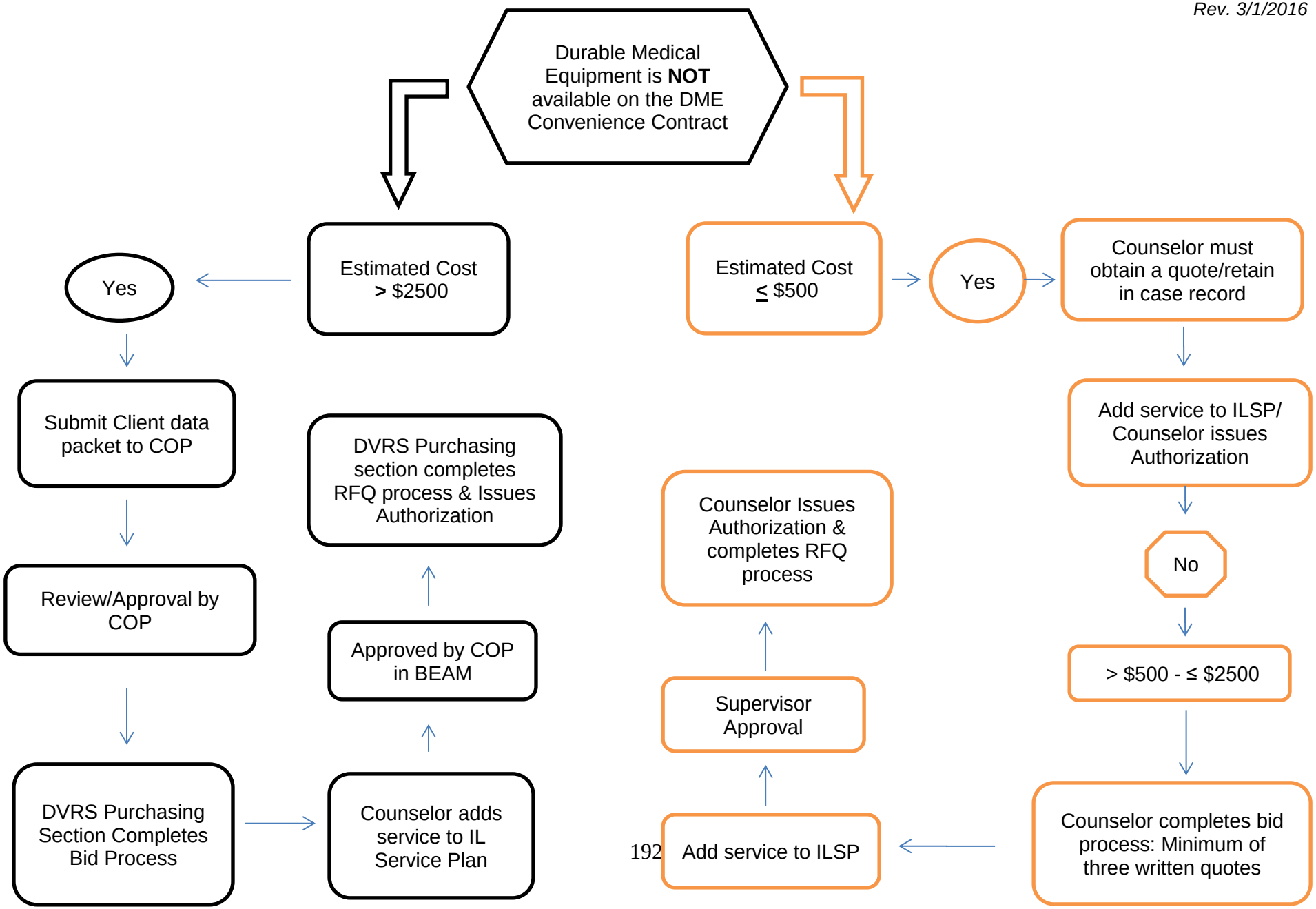
Durable Medical Equipment: Purchase Procedures - Chart A

Rev. 3/1/2016



Durable Medical Equipment: Purchase Procedures - Chart B

Rev. 3/1/2016



Hearing Disabilities

revised: 8/1/2018

Since hearing impairments present in varying degrees, the Division has developed specific criteria for the determination of an impairment based on a hearing loss. These criteria are designed to assist the service delivery staff in working with those individuals whose impairment is to such a degree that substantial impediments to employment may exist.

All IL clients with hearing disabilities, regardless of type and degree of hearing loss, must be served by the Rehabilitation Counselor for the Deaf unless it delays services. If clients with hearing disabilities are served by other counselors, the case must be staffed with the Rehabilitation Counselor for the Deaf or the Program Specialist on Deafness and Communicative Disorders using the Hearing Loss Consultation Form (DVR-0902). The Rehabilitation Counselor for the Deaf must always be consulted in the eligibility decision, the assessment of comparable benefits, and in the development of the IPE to ensure proper services are provided. The Hearing Loss Consultation Form must be kept in the case record as verification that the hearing loss criteria is met/not met but the decision regarding eligibility for IL services resides with the counselor of record. If the Rehabilitation Counselor for the Deaf has not obtained Rehabilitation Counselor proficiency status, the form must have supervisor approval. Regular staffings should be documented in the case record. Bone Anchored Hearing Aids must be staffed with the Program Specialist on Deafness and Communicative Disorders.

Establishing a Hearing Related Impairment

A hearing evaluation (audiogram) must be used to determine if a person has a hearing related impairment regardless of shelf life. For individuals who are deaf or are long-term users of hearing aids, an audiogram is sufficient for the establishment of an impairment and eligibility. However, depending on the discretion of the counselor, a new hearing evaluation can be authorized if a person has a progressive hearing loss or the counselor feels that a new hearing evaluation is needed.

Audiological Data and Purchases for VR and IL:

The Counselor **MUST NOT** purchase a hearing aid without updated audiological data that is less than one year old. (See 2-16-2: Hearing Aids for VR or 2-12-2: Hearing Aids for IL) To be considered as valid audiological data, the medical information must include the type of hearing loss - sensorineural, conductive, mixed, or central; and the prognosis as to future development of the condition. Audiological data must include:

1. A statement from the otologist identifying the type of hearing loss or the identification of a progressive loss.
2. Medical clearance for fitting of an aid must be obtained from a physician skilled in diseases of the ear (ENT exam).

3. An audiogram with three-frequency pure tone average (PTA), speech discrimination (SD) scores, and the speech reception threshold (SRT) listed.
4. A narrative that provides a general description of the amplification device recommended and indicates the individual's preference regarding the device.

VR Policy for Hearing Related Impairment

A client is considered to have a hearing related impairment if **one** of the following criteria is met:

1. A **chronic** ear disease requiring medical treatment or surgery (not contingent upon decibel loss in either ear.); or
2. Average pure tone loss of 40 dB (ANSI) or more in the better ear in the speech range (500, 1,000, and 2,000 cycles per second) (UNAIDED); or
3. Average pure tone hearing loss of 20 dB (ANSI) or more in the better ear in the speech range when the pure tone average loss in the other ear exceeds 80 dB (ANSI)(UNAIDED); or
4. Regardless of the pure tone average loss, speech discrimination of less than 75% at 50-60 dB (average conversational intensity level) in the better ear in a quiet environment **(UNAIDED)**; or
5. A borderline chronic condition, which has been otologically and audiologically diagnosed as **rapidly progressive** and documented by a physician skilled in the diseases of the ear.

   "Rapidly progressive" is defined as having additional 10dB or more hearing loss in the better ear in the last year **EITHER** with the pure tone average in the speech range (500, 1000, and 2000Hz) (UNAIDED) **OR** the other three frequencies (2000, 4000, and 6000Hz) (UNAIDED).

6. A **Cochlear implant (CI)** has been implanted in one ear; the client must also have one of the above 5 criteria listed above occurring with the second ear.

   An individual with a CI does meet the criteria for VR services if they already have an implant **and they meet the above criteria for hearing loss in the opposite ear**. If they have a CI and they meet the criteria for a hearing disability, the counselor must show documentation of **substantial impediments** to employment due to adjustment, residual perceptual problems or other impediments/problems related to the cochlear implant in order for the individual to be eligible for services. If they have an implant in one ear and normal hearing in the 2nd ear, they are not eligible. Any questions regarding eligibility, contact the Statewide Coordinator for Deafness and Communicative Disorders.

Independent Living Policy for Hearing Related Impairment

A client is considered to have a significant hearing disability if **ONE** of the following three criteria is met:

1. Speech Reception Threshold (SRT) of 55dB loss or more in the better ear in the speech range (500 Hz, 1000 Hz, and 2,000 Hz) (UNAIDED). SRT is the softest level of sound at which a participant can correctly respond to at least 50% of a list of spondee (bi-syllabic) words.

2. Average pure tone loss of 55dB (ANSI) or more in the better ear in the speech range (500 Hz, 1000 Hz, and 2000 Hz) (UNAIDED).

   For example, if the thresholds are 60dB at 500 Hz, 80dB at 1000 Hz, and 90dB at 2000 Hz. The pure tone average would be:

   $$\frac{60 + 80 + 90}{3} = \frac{230}{3} = 77\text{dB (right ear)}$$

   $$\frac{50 + 40 + 30}{3} = \frac{120}{3} = 40\text{dB (left ear)}$$

   The most useful ear is the left and the person would not be eligible for IL services.

3. The Speech Reception Threshold (SRT) or the Pure Tone Average (PTA) is between 30-54 dB in the better ear plus one of the following:

   a. Speech discrimination (SD) of less than 50% at 50-60 dB (average conversational intensity level) in the better ear in a quiet environment (UNAIDED).

   OR

   b. A statement from a physician skilled in diseases of the ear indicating a **rapidly progressive loss**.

      "Rapidly progressive" is defined as having additional 10dB or more hearing loss in the better ear in the last year **EITHER** with the pure tone average in the speech range (500, 1000, and 2000Hz) (UNAIDED) **OR** the other three frequencies (2000, 4000, and 6000Hz) (UNAIDED).

The above criteria must be considered in terms of the individual's ability to understand speech and communication in everyday situations, understanding of and adjustment to the hearing disability at home and work, and job safety considerations.

HIV/AIDS

Individuals with HIV as a primary impairment or secondary restoration issue must be diagnosed by a physician specializing in the assessment and medical management of this disease (i.e., infectious disease doctor). Counselors must use existing medical information when such is available or refer the individual to a physician as described above when the individual is without proper medical care. For individuals presumed eligible as a result of HIV or AIDS, as always, the counselor should try to obtain impairment-related data from the infectious disease professional that is providing treatment. The counselor may elect to staff the case with the unit medical consultant if it is deemed that the consultant can offer medical opinion or interpretation not otherwise available through the treating physician, however consultation with the unit medical consultant is not required.

IMPAIRMENT

The primary modes of transmission of HIV or Human Immunodeficiency Virus are unprotected sexual contact, intravenous drug use, exposure before and during birth and through breastfeeding, and the transfusion of blood and blood products[1]. Once an individual is exposed, the individual will either be HIV-positive, asymptomatic or HIV-positive, symptomatic. A person is diagnosed as having AIDS (Autoimmune Deficiency Syndrome) when the individual either (1) demonstrates the presence of an AIDS-defining disease (one of 24 opportunistic infections) and/or (2) demonstrates a CD4 cell count of less than 200[2]. Counselors should obtain current medical information which describes the viral load and CD4 count as well as symptoms in order to determine whether impediments to employment exist for an individual with HIV or AIDS.

HIV-Positive, Asymptomatic

The individual may demonstrate few to no symptoms. Symptoms during this phase may be similar to those found in other common communicable diseases and may include fatigue, unexplained weight loss, skin problems, bacterial pneumonia, and oral/vaginal thrush. Despite few symptoms, the virus is actively destroying the individual's immune system and can be transmitted to others as described above[2]. Since symptoms are transient, it is unlikely that an individual with asymptomatic HIV will present substantial impediments to employment as a result of the condition itself.

HIV-Positive, Symptomatic

During this phase, the individual's viral load increases and CD4 count (the amount of virus-fighting white blood cells) decreases. Therefore, the individual is less able to fight off communicable disease and opportunistic infections. Physical symptoms which may

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[1] Department of Health and Human Services, Center for Disease Control and Prevention: HIV/AIDS Topics. (2008, September 3). *How HIV Is and Is Not Transmitted.* Retrieved April 7, 2009 from http://www.cdc.gov/hiv/topics/basic/index.htm#transmission

[2] Berry, J. D., & Hunt, B. (2005). HIV/AIDS 101: A primer for vocational rehabilitation counselors. Journal of Vocational Rehabilitation, 22, 75-83.

be present include: prolonged fever, night sweats, severe headache, persistent diarrhea, respiratory problems, problems with swallowing, vision problems, difficulty with sleeping and eating patterns, and pain[2]. In addition, the individual may experience cognitive and psychological symptoms including difficulty with concentration and short-term memory as well as comorbid depression[2]. Individuals may live as HIV-Positive, Symptomatic for decades before progressing to a diagnosis of AIDS. Individuals with symptomatic HIV can be considered for eligibility based on the individual's impediments to employment and ability to benefit from and need for a program of VR services.

AIDS

During this phase, an individual has very little resistance to communicable disease and is likely to have one or more serious opportunistic diseases including, but not limited to: cancer, tuberculosis, recurrent pneumonia, non-Hodgkin's lymphoma, Kaposi's sarcoma, AIDS dementia complex, and HIV wasting syndrome. It is often the complications of these opportunistic diseases which cause fatalities for individuals with AIDS. Individuals survive an average of two to four years following a diagnosis of AIDS; however some individuals have survived for more than 15 years following an AIDS diagnosis[2]. Individuals with AIDS may be considered for eligibility based on the individual's impediments to employment as well as their ability to benefit from and their need for a program of VR services.

IMPEDIMENT

HIV and AIDS are no longer considered terminal illnesses, but are viewed instead as chronic illnesses. Individuals with HIV or AIDS can experience periods of symptom exacerbations and remissions like other chronic illnesses. Therefore, careful consideration must be given to determine how an individual's illness presents impediments to employment. The following *may* represent impediments associated with HIV or AIDS:

- Difficulty with maintaining work schedule
- Difficulty with maintaining treatment regimen with required work demands
- Difficulty storing or administering medications in the workplace (need to have regular meals or snacks, need refrigeration, need private space to administer medications, etc.)
- Difficulty concentrating on the job
- Difficulty remembering job tasks or job functions
- Limited self-advocacy skills (related to disclosure issues and return-to-work fears)
- Difficulty maintaining motivation due to change in life values and inconsistencies with physical symptoms and response to treatment
- Comorbid disabling conditions and associated impediments to employment

Impediments to employment may vary widely from one individual to the next depending on the stage of the illness, the individual's assets, priorities, and concerns, and any comorbid conditions such as depression, substance abuse, or opportunistic diseases.

OTHER CONSIDERATIONS

Treatment

Currently, most individuals with HIV/AIDS are treated using HAART (highly active antiretroviral therapy). This is also called "combination therapy." Treatment results in various side effects including: nausea, headaches, dizziness, cognitive effects, rash, redistribution of body fat (increase in abdomen and decrease in face, buttocks, and extremities), diarrhea, peripheral neuropathy, and abdominal discomfort[2]. Individuals' responses to treatment vary. HAART involves a very strict treatment regimen where an individual takes many pills/injections a day with very specific indications. HAART requires extreme treatment adherence or the individual may develop a resistance to a class of medications, or, in the least, the effectiveness is minimized. Counselors should consider the vocational impacts of side effects from treatment as well as treatment adherence issues in determining eligibility and developing rehabilitation plans.

Disclosure

Whether to disclose an individual's diagnosis of HIV-positive or AIDS is a significant issue for individuals with these conditions because of the stigma which can be associated. Issues of disclosure should be taken into consideration with individuals with HIV/AIDS in terms of completing job applications and interviewing, requesting reasonable accommodation under ADA, requesting leave under FMLA, completing drug screenings, completing employer health questionnaires, and making decisions about health benefits. Only a few occupations require full disclosure, such as surgeons who perform invasive procedures, due to the risk for transmission. Otherwise, Counselors should assist clients with HIV/AIDS in identifying their functional limitations as well as training individuals to carefully consider job goals and to limit disclosure, including the request for workplace accommodations, to functional terms (i.e., Mr. Smith has a chronic illness which requires that he have access to a private place to administer his treatment regimen and that he have a modified schedule which begins no earlier than 10:00 AM.). For individuals whose employers require them to complete health questionnaires due to the nature of the work performed, one strategy is to request that the treating physician write a summary of the individual's functional needs and/or limitations or a statement summarizing the lack of impact of the illness on the items addressed in the health questionnaire as a substitute for completing a health questionnaire which has items that may subject the individual to disclosing his/her HIV/AIDS diagnosis[3].

Further, some forms of combination therapy will result in a positive drug screen for marijuana. The likelihood for testing a false-positive does not require that a person with

[3] Breuer, N. L. (2005). Teaching the HIV-positive client how to manage the workplace. Journal of Vocational Rehabilitation, 22, 163-169.

HIV/AIDS disclose his/her condition to an employer. Typically, a Medical Review Officer with the drug testing company will request legal proof of prescription. This information is not shared with the employer. If the Medical Review Officer verifies that the medication is the cause of the positive test result, the result is reported to the employer as negative [3,4].

Resources

For more information on HIV/AIDS, resources, and treatment locations, visit the websites below:

The NC Department of Health and Human Services Epidemiology Section link to HIV/STD Prevention and Care:
http://www.epi.state.nc.us/epi/hiv/index.html

Project Inform link to NC HIV/AIDS resource list:
http://www.projectinform.org/info/state/NC.shtml

The Body: The Complete HIV/AIDS Resource:
http://www.thebody.com/index.html

US Department of Health and Human Services AIDSinfo:
http://aidsinfo.nih.gov/

US Department of Health and Human Services AIDS.gov:
http://www.aids.gov/

Centers' for Disease Control National Prevention Information Network Organization Search Engine:
http://www.cdcnpin.org/scripts/search/orgSearch.aspx

[4] Pietrandoni, G. (2000, September/October). Back to Work Drug Screenings. *Positively Aware.* Retrieved April 7, 2009, from http://www.tpan.com/publications/positively_aware/sept_oct_00/back_to_work_drug_screen.html

IL Closure Process Guide			
Status			
From	To	Form	Procedure
00	08	Case Note: IL – Status Change	1. Add case note to ECF 2. Filter for status change 3. Open status pick list and select 08 4. In "Note" field type an explanation for the closure 5. Close case note; case moves to 08
02	08	IL Eligibility for reasons of not eligible and too severe	1. Add IL Eligibility to the ECF 2. If the consumer has a significant impairment complete the impairment section. Continue to complete the form as relevant. (Example) If the client has functional limitations complete that section, and so forth. Discontinue completing the form at the point that the consumer's information no longer applies to the form. If the consumer does not have a significant impairment do not enter any data into the form, enter a date. This will populate an ineligibility decision. 3. Manually add the Ineligibility Decision Letter 4. Case moves to status 08
02	08	IL Eligibility for all reasons other than ineligibility	1. Add IL Eligibility to the ECF 2. Do not complete the Eligibility Form 3. Date the form 4. Manually add the IL Other Outcome Decision Letter to the ECF 5. Complete the form and document the reason for closure 6. Case moves to status 08
10	30	Case Information Form	1. Select the Case Information Form that is already on file 2. Complete the closure information section 3. Complete the closure date and approval date sections 4. An Outcome Statement Letter will populate. Document within the letter the appropriate closure reason 5. Case moves to status 30
12 18	28 28	IL Progress and Closure Report	1. Manually add the IL Progress and Closure Report and complete 2. Select if services were provided or not 3. Complete the IL Other Outcome Letter

18	26	IL Progress and Closure Report (an authorization has been keyed for payment)	1. Manually add the IL Progress and Closure Report 2. For services that were not provided the service should be deleted from the IL service plan resulting in an amended plan in accordance with policy. 3. Complete the form 4. An IL Successful Outcome Letter will launch 5. After supervisory approval the case will move to status 26
26	32	Case note: status change	1. Manually add the case note 2. Filter for status change 3. Status change to 32 4. All previous goals will open 5. Add appropriate services to the plan
32	34	Case note: status change	1. Manually add the case note 2. Filter for status change 3. Status change to 34 4. Manually add an Outcome Statement Letter

IL Federal Service Definitions

The definitions below are provided by federal regulations established for the Independent Living Programs. The IL Program is required to report services provided to IL clients in one of the following service categories. These definitions are not intended to supplant those specific policies outlined in Chapter 2 of this manual. However, in order to provide consistency in Federal reporting, the categories below are the only options available when selecting service labels in the Division's electronic case management system. Therefore, all services provided under policies in Chapter 2 must be selected on the IL Service Plan and reported within one of the categories below:

Assistive Devices/Equipment
Provision of specialized devices and equipment such as wheelchairs, tub transfer benches, personal lifts, TDDs, or the provision of assistance to obtain these devices and equipment from other sources.

Communication Services
Services to enable consumers to better communication such as interpreter services, training in communication equipment use, Braille instruction, and reading services.

Counseling Services
Services including psychological, psychotherapeutic, and related services.

Family Services
Services provided to the family members of an individual with a significant disability when necessary for improving the individual's ability to live and function more independently, or ability to engage or continue in employment. Such services may include respite care.

Housing, Home Modification and Shelter
Services related to securing housing or shelter or modifying existing housing.

Information and Referral
Services provided to a consumer to assist with identifying and locating additional resources. This would include transition to Vocational Rehabilitation.

Mobility Training
Services involving assisting consumer to get around their homes and communities such as gait training or training in how to utilize public transportation.

Other
Any IL service not included in a specific service category.

Personal Assistance Services
Services including personal assistance and personal assistance management training.

Physical Rehabilitation
Restoration services including physical therapy; occupational therapy; speech, language or hearing therapy; and/or eye glasses and visual services.

Prosthetics/Orthotics
Services including prosthetic, orthotic, and other assistive appliances and devices.

Recreational Services
Services to provide opportunities for the involvement of consumers in meaningful leisure-time activities. May include such things as participation in community affairs or other activities of a competitive, active or quiet nature.

Rehabilitation Technology
Services provided through the systematic application of technologies, engineer methodologies, or scientific principles to address barriers confronted by consumers with significant disabilities. Engineer services, vehicle modifications, and seating clinics are included in this service.

Transportation
Provision of or arrangement of transportation for completion of other goals/services.

Vocational Services
Any services provided to obtain, maintain, or advance in employment.

[CFR 364.4]

Intellectual Disability

Revised 5/1/2017

Diagnostic criteria for Intellectual Disability (Intellectual Developmental Disorder) emphasizes the need for an assessment of both cognitive capacity (IQ) and adaptive functioning, with severity (mild, moderate, severe, profound) being determined by adaptive functioning rather than IQ test scores alone. Adaptive behavioral functioning refers to how well a person meets community standards of personal independence and social responsibility in comparison to others of similar age and sociocultural background.

Regardless of IQ scores, adaptive behavior deficits are critical elements in determining eligibility on the basis of intellectual disability. For VR eligibility purposes, documentation of an intellectual impairment must include both the IQ test scores and the significant deficits in adaptive behavior functioning in at least the three core domains: conceptual, social, and practical. The clinician's interpretive report will include all subdomain scores within the core domains and relate the adaptive functioning scores directly to the intellectual impairment.

Learning Disability

Learning Disabilities (defined as “learning disorder” in the DSM-IV) are diagnosed when the individual's achievement on individually administered, standardized tests in reading, mathematics, or written expression is substantially below that expected for age, schooling, and the level of intelligence. The learning problems must significantly interfere with academic achievement or activities of daily living that require reading, mathematical, or writing skills.

Learning Disabilities vary in severity, as do all disabilities. In both categories I and II below, it is the counselor’s responsibility to review all available information regarding the individual’s work history, extra-curricular activities, overall skills, aptitudes, interests, and achievement in secondary school. This information should be considered to determine if the individual’s learning disability represents an impediment to employment and to assist the individual in planning for a job choice that is appropriate to his or her capabilities. Under no circumstances will the Division sponsor remedial services while the individual is enrolled in secondary school.

CATEGORY 1: The following criteria will apply to:

- Students enrolled in the public school system or public charter school with an Individualized Education Program (IEP) for the current year developed to address the individual’s learning disability.
- Individuals who have been out of public school less than two years and were identified as disabled with an IEP during the last year of enrollment developed to address a learning disability.

Impairment

The learning disability as an impairment must be documented by obtaining a copy of the Learning Disabilities Eligibility Report, which includes the psychological and educational evaluation and a copy of the IEP Team Report recommending the individual’s identification as having a learning disability and in need of special education services.

If a learning disability (LD) has been previously diagnosed in a secondary education setting and the individual has been served under an IEP within the past two years, a school psychological evaluation with the IEP team report may be regarded as current for up to five years from the date of application for services. For psychological reports providing the DSM diagnosis of learning disability, the five year shelf life also applies. When the Woodcock-Johnson Tests for Achievement is used as a part of the eligibility decision, counselors should use the Broad Reading, Broad Math and Broad Written Language Scores, rather than the individual subtests.

Determination of Substantial Impediment(s)
Emphasis should be on the identification of the impediments to employment caused or created by the impairment. The following criteria apply and must be documented:

Scores on an individually administered achievement test in reading, mathematics, or written expression indicate that the applicant's achievement score is below grade level. Achievement scores must be at least three grade levels below current grade placement with a maximum achievement level of 8.0 grade level in the 11th grade, the 12th grade and the two years after exiting school. The following criteria apply and must be documented:

- Ninth grade level (9.0-9.9) students must score 6.0-6.9 respectively or below on achievement tests.
- Tenth grade level (10.0-10.9) students must score 7.0-7.9 respectively or below on achievement tests.
- Eleventh grade level students must score below 8.0 on achievement tests.
- Twelfth grade level students must score below 8.0 on the achievement tests.
- Students who are referred within two years of exiting school must score below 8.0 on achievement tests.

Utilization of achievement data is a required component of all referrals for Vocational Rehabilitation Services. In order to avoid unnecessary testing, existing data from previously administered achievement tests may be used if the most recent achievement score(s) were obtained within two years of the application for services. Otherwise, current achievement data must be secured from a vocational evaluator or other sources. Achievement scores from the Wide Range Achievement Test (WRAT) will <u>not</u> be accepted for purposes of eligibility.

AND

The student is currently receiving at least three supplemental aides during this academic year (or received them during the last year of school) as stated on the IEP and/or through verification from the individual, parent or school system personnel. A copy of the IEP should be included in the case record. The following list is not intended to be an exhaustive list of possible <u>supplemental aides or services:</u>

- Note taker services
- Oral testing
- Additional support from a teacher assistant
- Job coach
- Enrollment in exceptional children curriculum support class
- Tutorial services
- Enrollment in exceptional children resource room
- Extended test time

- Abbreviated assignments
- Assistive devices
- Requires the use of audiotapes for instruction

CATEGORY 2:

For those individuals who do not meet Category I criteria, a psychologist using the current Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria, must document the learning disability, which establishes the existence of impairment. Also, the psychologist must provide scores on an individually administered achievement test in reading, mathematics, or written expression. When the Woodcock-Johnson Tests for Achievement is used as a part of the eligibility decision, counselors should use the Broad Reading, Broad Math and Broad Written Language Scores, rather than the individual subtests. Achievement test scores from the Wide Range Achievement Test (WRAT) will not be accepted for purposes of eligibility. The shelf life for psychological reports providing the DSM diagnosis of learning disability is five years.

Determination of Substantial Impediment(s)

As in all cases, emphasis should be on identification of the functional limitations which are imposed by the impairment and which establish the impediment to employment. Scores on an individually administered achievement test must be at or below the 8.0 grade level in reading, math, or written expression. The analysis by the counselor must demonstrate that the diagnosis of LD results in substantial impediments to employment, examples of which could include:

- The learning disability has resulted in the individual being impeded in obtaining job skills and experiences commensurate with his/her abilities.
- The individual has lost employment or experienced difficulty on jobs or in post-secondary training programs because of an inability to access written training materials or perform written or computational job requirements, etc.

In instances where the diagnosis is indicated as Learning Disabled, Not Otherwise Specified (LD-NOS), these cases must be reviewed on an individual case-by-case basis in determining the existence of substantial impediments to employment.

Morbid Obesity – Determination of Impairment and Functional Capacity Limitations for Eligibility

Rev. 7/1/2017

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. Being overweight or obese may cause little or no inconvenience to a person's independence. However, when this condition reaches the extreme it may be diagnosed as morbid obesity and may result in serious limitations in one or more functional capacity areas.

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 IL 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

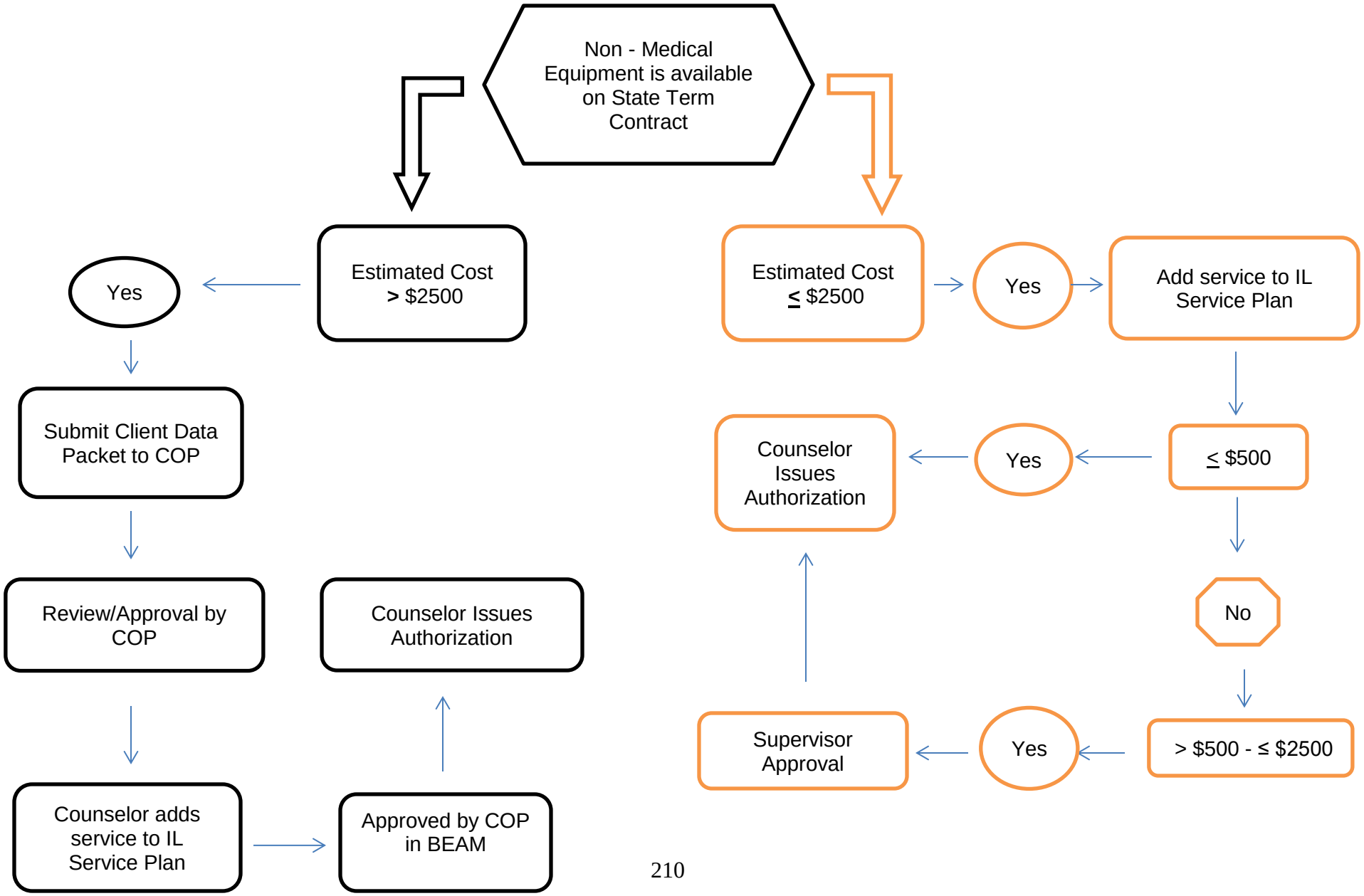
Determination of Functional Capacity Limitations

The counselor must document how the morbid obesity is resulting in serious functional capacity limitations in terms of an independent living outcome. This documentation is accomplished through an analysis of the medical records along with other case data 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 need for frequent breaks during the performance of activities of daily living, tendency to have shortness of breath.

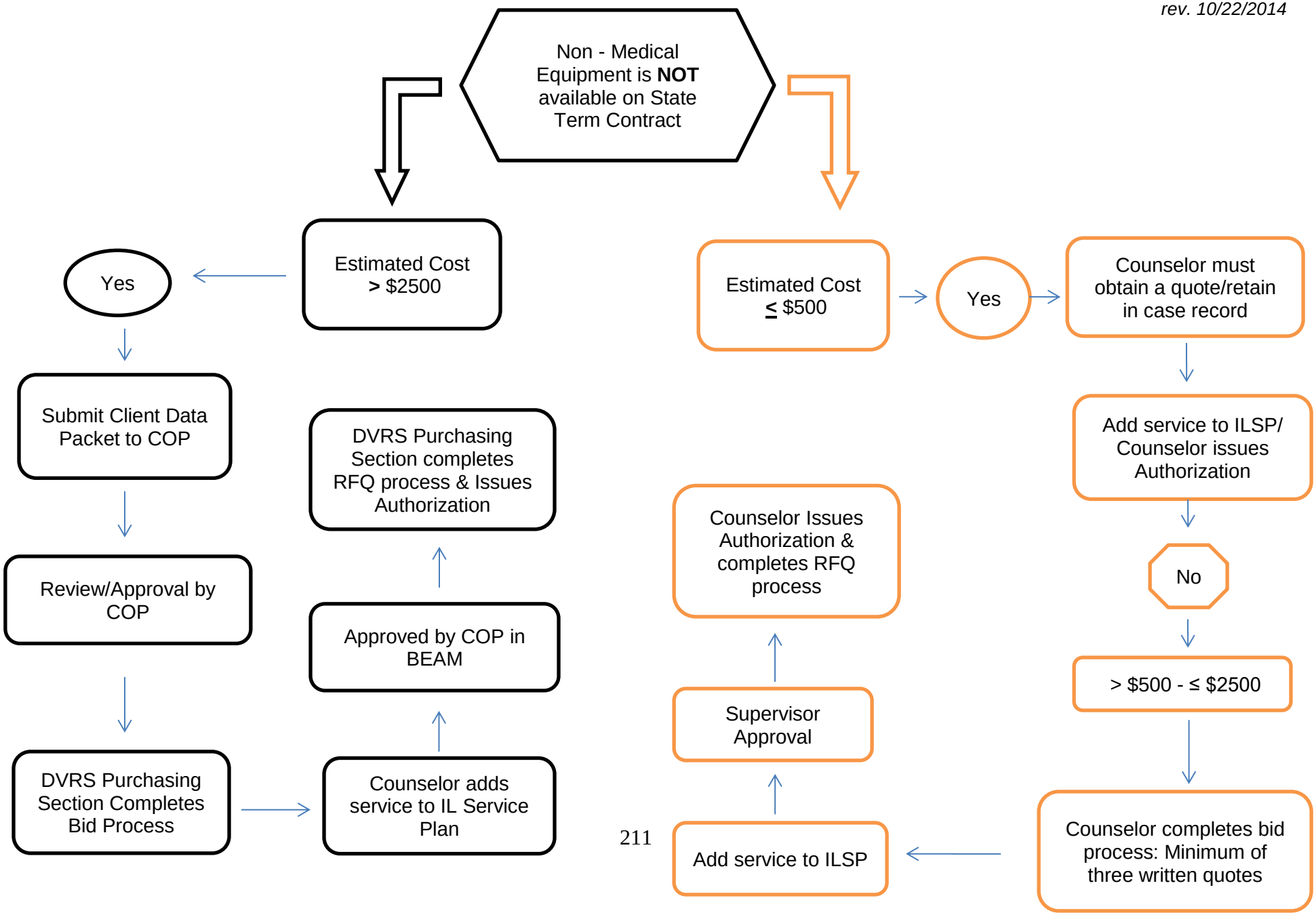
- The obesity causes substantial orthopedic or physical limitations as documented by the medical history records including x-ray findings and other diagnostic test results. The ability to ambulate or carry-out physical tasks may be substantially impaired. Other limitations could include inability to 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 limitations could include excessive daytime drowsiness and impaired alertness, fatigability, tendency to have shortness of breath upon exertion, inability to participate in sustained productivity in the home without extended restorative rest.
- 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.

Non-Medical Equipment: Purchase Procedures – Chart A



Non-Medical Equipment: Purchase Procedures – Chart B

rev. 10/22/2014



North Carolina Achieving a Better Life Experience (NC ABLE)

1/1/2019

The North Carolina Achieving a Better Life Experience (ABLE) Act, signed into law in 2015 allows individuals with disabilities the opportunity to save money in a tax-advantaged NC ABLE account. These accounts are designed to improve the quality of life for individuals with disabilities and pay for any expenses that are incurred as a result of the disabling condition. Individuals with disabilities (acquired prior to age 26) or their parent/guardian may open a NC ABLE account.

Savings up to $100,000 are not counted towards an individual's eligibility for SSI, and Medicaid eligibility is maintained with savings up to $450,000. Contributions to an individual's NC ABLE account generally may not exceed $15,000 per year. Qualified expenses for ABLE accounts funds include, but are not limited to:

- Education
- Health and wellness
- Housing
- Transportation
- Legal fees
- Financial management
- Employment training and support
- Assistive technology
- Personal support services
- Oversight and monitoring
- Funeral and burial expenses

Both the Federal and State ABLE statutes specify that ABLE accounts are excluded from financial needs testing for government programs. As such, ABLE account funds are excluded from the assessment of financial need for both VR and IL.

The Department of the State Treasurer administers NC ABLE for North Carolina citizens. Additional information is available at www.nctreasurer.com

Personal Assistance Definitions & Resources

The provision of personal assistance services requires that the IL client be established as a household employer of his/her own personal assistant(s). Therefore, the client is required to adhere to tax laws specific to household employers. DVRS is not responsible for any penalties which would result if the client is delinquent in paying employer related taxes. Any and all correspondence with the Federal Internal Revenue Service or NC Employment Security Commission is the client's sole responsibility. Clients may obtain assistance in understanding their employer-related obligations from the Internal Revenue Service or NC Employment Security Commission. DVRS, including the client's counselor, will not advise the client on employer-related obligations or in completing the required paperwork for reporting and payment of the federal/state household employer taxes.

Household Employer Terms

Federal Household Employer ID:	Unique nine-digit number that the client obtains from the Internal Revenue Service; also called the Employer Identification Number (EIN).
FICA Taxes:	Taxes established under the Federal Insurance Contributions Act. These are federal taxes required of employees, and matched by employers, to fund the Social Security and Medicare programs. FICA must be computed and paid for each employee and applies to each personal assistance client and the assistant(s) the client employs. FICA rates are subject to adjustment by the Internal Revenue Service (IRS), effective in January of any given year. The current FICA rate is found in Volume V. FICA tax is broken into two (2) separate but equal parts - employer (client) contribution and employee (assistant) contribution. The employer (client) is responsible for one-half of the overall FICA tax, and the employee (assistant) is responsible for the other half. The employee's portion is withheld by the employer from the assistant's gross pay each pay period. The formula for both the employer and employee share of FICA tax is: FICA TAX = FICA TAX RATE x GROSS PAY. FICA taxes are paid either quarterly or annually depending on the anticipated amount of tax owed during a calendar year. The client is responsible for reporting to the Division whether the client is required to pay FICA taxes annually or quarterly.
Form NCUI-101:	NC Employment Security Commission Form by which the client files his/her SUTA taxes each quarter.

Form NCUI-104:	NC Employment Security Commission Form entitled, "Unemployment Tax Rate Assignment," by which the client is notified of his/her SUTA Rate. A copy of the form must be provided to the Division by December 15 of each year.
Form SS-4	Form client receives from the IRS with federal employer ID number.
Form W-2, Wage and Tax Statement:	The IRS form completed by the client and given to the client's assistant(s) to file with the IRS to report the employer FICA taxes owed for each employee.
Form W-3, Transmittal of Income and Tax Statement:	The IRS form filed by the client with the Social Security Administration to report the employer FICA taxes owed for each employee when an employer has more than one employee.
FUTA Taxes:	Taxes imposed by the Federal Unemployment Tax Authority. This authority rests with the Internal Revenue Service (IRS). The FUTA rate may change at the beginning of the calendar year, but it is the same for all employers. The current FUTA rate may be found in Volume V. Wages over a certain annual threshold, per employee, are not taxed for FUTA purposes. FUTA taxes are paid annually.
Gross Pay:	Total remuneration owed to an employee prior to withholdings or deductions. The formula for gross pay for each assistant employed is: GROSS PAY = EMPLOYEE SHARE FICA + NET PAY to EMPLOYEE.
Household Employer:	An individual who employs a household worker to perform work at the direction of the individual (i.e., directs the worker in what the worker will do and how and when the worker will do it).
Net Pay:	The employee's "take home" pay once the employee's share of FICA taxes have been withheld. The formula for net pay is: NET PAY = GROSS PAY – *(minus)* EMPLOYEE SHARE FICA.
Qualifying Quarter:	A quarter, in the North Carolina tax year, in which the combined gross pay paid to all employees of the household employer is equal to or greater than $1000.
Reimbursement Rate:	Includes the total funds paid to the client, including assistant hourly wage and applicable employer taxes, in order to employ the assistant(s). The formula for reimbursement rate for the client is: REIMBURSEMENT RATE = GROSS PAY + EMPLOYER FICA + FUTA + SUTA (if applicable).
Schedule H:	IRS form which must be filed by the client to file FICA and FUTA taxes by March 15th of each year.
State Household Employer ID:	Unique nine-digit identification number that the client obtains from the NC Department of Revenue.

SUTA Taxes:	Taxes imposed by the State Unemployment Tax Authority. In North Carolina, this authority is the Employment Security Commission (ESC). The SUTA rate varies for each individual employer (client) based on the given calendar year and is subject to change effective January 1 of each year. The NC ESC will provide the client with a copy of their SUTA Tax Rate upon request. SUTA taxes are paid quarterly if the employer exceeds a certain quarterly threshold for gross wages paid to all employees. The current threshold is found in Volume V.

Household Employer Resources

Because the client is responsible for carrying out all responsibilities of a household employer, the Division shall direct the client to resources specific to this role. These include:

Internal Revenue Service (IRS)
www.irs.gov
1-800-829-1040

NC Employment Security Commission (visit website for local office contact information)
www.ncesc.com

NC Department of Revenue
www.dornc.com
1-877-252-3052

IRS Publication 926, Household Employer's Tax Guide: This guide defines the federal roles and responsibilities of a household employer including a description of the tax forms which need to be filed by the employer.

IRS Publication 525, Taxable and Non-Taxable Income: This publication indicates that reimbursements received by the client in order to employ a household worker to provide personal assistance is not considered taxable income.

20 CFR §416.1103: This is the citation of the Federal Code pertaining to the Social Security Administration which also defines personal assistance reimbursements as non-taxable income.

Referral - Script

The following script shall be used when introducing any potential applicants to the VR/IL process. Office staff responsible for providing phone coverage should become familiar with and use the script when potential applicants call or present in person. This language needs to be used in any written materials that are made available to the public in explaining our referral process, including letters to parents of students.

In order to become an applicant for services with the NC Division of Vocational Rehabilitation, you must be available to participate in assessments for purposes of determining your eligibility, rehabilitation needs and services. Individuals in the following circumstances are <u>not</u> considered available for participation in services:

1. *Have outstanding warrants for arrest and/or pending charges that would prevent the individual from participating in a program of vocational rehabilitation services.*
2. *Cannot/or are unwilling to attend appointments and evaluations.*
3. *Are unwilling to participate in essential disability related treatment that will enable an individual to benefit from Division services in terms of an employment outcome.*

As a division of North Carolina state government, Vocational Rehabilitation is required to comply with any orders on file from the NC Department of Justice for reporting individuals having outstanding warrants to the appropriate authorities. A criminal check is done on all referrals before they come to a VR office. Please take this into account when you make a decision to come to our office.

In order to maintain a safe and supportive environment for our staff and consumers, we ask that you comply with the Division's Code of Conduct which is posted in all unit offices and printed in your application materials.

Rehabilitation Counselor II (RCII) Process

Revised 05/15/2011

POLICY:

In recognition and support of Rehabilitation Counseling as a profession and the Counselor as a professional, the Division encourages and expects Rehabilitation Counselors to develop the capacity to function with considerable independence in the areas of casework, service delivery and decision making. The role of the Counselor is of utmost importance in assuring that individuals with disabilities receive the services necessary to achieve independence and/or vocational outcomes. Other staff provides consultation and support for the Counselor in achieving these goals. The Division delegates the responsibility for caseload management and service delivery from the Director to the Regional Director and from the Regional Director to the Unit Manager/Facility Director. Further delegation is based on performance-based criteria. The Agency has adopted a Rehabilitation Counselor II classification for qualified personnel who successfully complete the processes described in this policy. Reallocation to Rehabilitation Counselor II is based upon the outcome of a comprehensive casework review.

PREREQUISITES

Individuals being considered for reallocation to Rehabilitation Counselor II will have demonstrated proficiency in the areas of service delivery; productivity; caseload management; timely decision making; client advocacy; community, vendor, and staff relations; time and budget management. The Unit Manager/Facility Director and Quality Development Specialist are responsible for assuring the Agency that the individual meets these expectations through regularly conducted case record reviews and performance evaluations.

1. Counselors must have completed the following external education requirements and be classified as a Rehabilitation Counselor I.

   (a) Master's Degree in Rehabilitation Counseling or Counseling; or
   (b) Master's Degree in a closely related Human Services Field; or
   (c) Current certification as a Certified Rehabilitation Counselor (CRC) by The Commission on Rehabilitation Counselor Certification

2. In addition to the external educational requirements counselors will have:

   (a) Successfully completed the agency's Casework Orientation and

Skills Training (COAST) with an average score of 80% as certified by the Quality Development Specialist; and

(b) Twelve months Rehabilitation Counseling experience with the agency. *(Note: Trainee experience is creditable as Rehabilitation Counseling, however; a promotion directly from Rehabilitation Counselor Trainee to Rehabilitation Counselor II is not permissible).*

(c) An overall performance rating of GOOD or better on his/her work plan under the agency's Performance Management Program**; and**

(d) A favorable recommendation of the Unit Manager/Facility Director.

3. When a Rehabilitation Counselor II leaves the agency for twelve months or longer and is reinstated, reinstatement will occur as a Rehabilitation Counselor I. After a minimum of 6 months, the Unit Manager will determine the Counselor's readiness for the Rehabilitation Counselor II process. The individual, at the discretion of the Regional Director, may have to complete COAST training before applying. Factors to be considered will be the length of time since COAST training was last completed and the length of time the individual has been out of the agency. Any exception must be approved by the Human Resources Director (example – an employee who has been on extended military leave).

PROCESS FOR REHABILITATION COUNSELOR II

Application for Rehabilitation Counselor II shall not be initiated until all prerequisites are met.

1. The Unit Manager will assess the overall readiness of the Rehabilitation Counselor I for the RC II Process and will recommend when the RC I should apply for the RC II Process. The Unit Manager will assure that the Counselor has participated in at least one developmental case review prior to requesting the RC II process to begin. The Quality Development Specialist will prepare a written report of his/her findings for the Unit Manager and Regional Director to consider in making their decision.

2. The Unit Manager/Facility Director will conduct an overall performance evaluation using a Special PMP. The narrative will include: The employee's understanding of the Rehabilitation Counselor role and the Division's mission, the disability served, and work responsibilities (use of policy and procedures, communication, relationships with consumers

and community resources, use of comparable benefits, job development/placement, budget management, and others).

3. The Unit Manager/Facility Director will provide a copy of the Special PMP to the Regional Director.

4. The Regional Director will approve or deny the application within 30 days of receipt.

If approved, the Counselor will be granted temporary independent status. Temporary independent status allows the Counselor to function independently during the Rehabilitation Counselor II process. (If the Counselor fails the Rehabilitation Counselor II Process, the Regional Director will withdraw independent status, and the Unit Manager will change the Counselor's role in the Division's case management database.

Upon granting temporary independent status, the Regional Director will then appoint a minimum of two Quality Development Specialists to conduct the Rehabilitation Counselor II review.

REHABILITATION COUNSELOR II PROCESS

The Rehabilitation Counselor II Process consists of a casework review that evaluates the Counselor's application of casework policy and procedure, service delivery, and decision making. The entire process, which begins with the Regional Director's letter granting temporary independent status, must be completed within eighteen (18) months. Should the Counselor fail the casework review, the Unit Manager/Facility Director, with input from the Quality Development Specialist, will prepare a written plan outlining objectives, timeframes, and evaluation criteria designed to improve the Counselor's proficiency. The Unit Manager will also complete a special PMP review to document deficit areas from the casework review and will incorporate the deficit areas into an improvement plan.

CASEWORK REVIEW

This is a review of a minimum of 20 records of service from the Rehabilitation Counselor's caseload. The purpose of this review is to evaluate the Counselor's application of agency policy and procedure, the Counselor's decision-making

ability, caseload management skills, service delivery, and service delivery documentation. The casework review may occur any time after 90 days of temporary independent status, provided that the Unit Manager has determined that sufficient casework activity for the Quality Development Specialist to evaluate has been carried out by the Counselor during the temporary independent status.

The Quality Development Specialists conduct the casework review utilizing the standard case review form. This form assesses cases in terms of compliance to key casework policy and procedural items, and quality of service delivery as reflected in the client record. The only errors that will count are those made during the temporary independent status period. In scoring the casework review, the review items are structured in a weighted scoring system so that the most critical items, such as eligibility, carry the greatest weight. This system contains three levels of errors which are defined in the attached document to this policy. The Counselor will be deemed to have failed the casework review if any of the following is found:

- **LEVEL ONE**: **Two or more errors on eligibility result in failure**.
- **LEVEL TWO:** Three or more errors in the same item or a total of nine or more errors in different items results in failure.
- **LEVEL THREE:** Six or more errors in the same item results in failure. ***NOTE: IN THE OVERALL SCORING OF THE CASEWORK REVIEW, TWO (2) LEVEL THREE ERRORS EQUATE TO ONE (1) LEVEL TWO ERROR.***
- A combination of errors from level two and level three constituting a total of nine or more errors in different items

If the Counselor fails the casework review, the process stops.

A second casework review may be conducted (see below).

SECOND CASEWORK REVIEW

After assuring the deficiencies have been corrected, the Unit Manager will assess the readiness of the RC I to return to the RC II Process. The Regional Director grants temporary independent status via a letter to the Counselor with copies to the Unit Manager and Quality Development Specialist. Any time after 60 days of reinstatement, the Quality Development Specialist conducts a second casework review of a minimum 20 cases. The Quality Development Specialist examines the Counselor's Master List to ensure that the casework selected for the RC II review is generated during the period of temporary independent status. Any errors reported are those made during the period of temporary independent status. The system of scoring for the second review remains the same as that of the initial case review.

DECISION AND NOTIFICATION OF PASS/FAIL

The Quality Development Specialist reports the results of the casework review to the Unit Manager who submits the final recommendation of pass/fail, along with supporting documentation, to the Regional Director. Upon receipt of this information, the Regional Director has 30 days to review the recommendation, make a final decision of pass/fail and provide the counselor written notification of the decision. In the event of any question or discrepancy in the decision or supporting documentation, the Regional Director will make a final decision in consultation with the Chief of Policy and Casework Operations.

Revised 05/15/2011

Residence Modification General Guidelines

Revised 6/1/2018

The intended purpose of these guidelines is to provide clear direction for staff to help them uniformly apply these standards in the planning and provision of residence modification services, thereby allowing funds to be most appropriately used to benefit the greatest number of clients. An engineer's evaluation and specifications are required before proceeding with any residence modification. Residence modifications shall be directed only at the issues of accessibility and must directly address those disability-related needs. They shall be the most technically appropriate and safe modifications that are within the Agency's spending limits that will meet a client's independent living needs and, as applicable, support their vocational goals. Any requests for exceptions to these guidelines and/or exceptions to the applicable spending limitations must be approved be the Chief of Policy before proceeding.

1. RAMPS & EXTERIOR ACCESS

a) Only one accessible entrance shall be addressed per residence. If there is an existing accessible entrance, an additional one shall not be provided.
b) Ramps, platform lifts, or low-rise steps shall all be considered dependent upon mobility equipment use and site limitations that are present.
c) Aluminum/steel (modular ramps) can be considered based on site limitations or permitting restrictions.
d) Entrance access structures shall not be roofed nor have protective coatings (stains or paints) applied.
e) If a new entry landing is being provided to replace an existing roofed landing, then a similar roofed section that matches the existing in style/type/size may be provided as part of the modification.
f) If an existing deck or landing area is removed as part of providing an access ramp, the new doorway entry landing shall be sized appropriately for wheelchair accessibility only. The new landing may not necessarily replace the original deck's entire area.
g) Railings shall normally be the horizontal type. Exceptions shall be based on local design codes or restrictions.
h) Synthetic or composite material decking shall not be used.
i) Paved vehicle parking pads and/or paved paths may be provided, but driveways shall not be paved. New or existing parking pads shall not be roofed, and carports shall not be provided.

2. BATHROOMS & INTERIOR ACCESS

a) Only doorways that provide access to those residential areas integral to daily life shall be considered for widening. Hallways shall not be widened and load bearing walls shall not be moved.
b) Only one bathroom per residence shall be addressed for accessibility.
c) For maximum clear bathroom access, vanity/cabinet sinks are not recommended – Pedestal, wall hung, or roll-under type sinks often provide better accessibility.
d) ADA height compliant taller toilets may not be the best solution, depending on the individual's environment, stature, or abilities. Market available DME may be considered the most appropriate recommendation.
e) Roll-in showers may not be required for individuals whose disability is stable and who have the ability to transfer to DME or can negotiate over low-threshold shower pans.

f) Walk-in/spa tubs with doors are typically not provided. Exceptions may be granted only if medically necessary, disability-related, and structurally/technically feasible.

3. GENERAL CONSTRUCTION & REPAIRS

a) Appropriate local permits must be provided for all Agency-funded work.
b) If technically and structurally feasible, the Division may support converting part of an existing room or space within the home into a bathroom. No additional square footage shall be added to a residence, but if the utilities are present/on location, it may be possible to help complete an added bathroom by installing the necessary accessible fixtures within the space provided.
c) Only repairs integral with a modification shall be done, and the scope of work shall be limited to that area. This includes any unforeseen repair issues discovered upon demolition that may require the customer and/or the homeowner to contribute to the repair cost(s). Utility repairs are the responsibility of the property owner.
d) Every attempt shall be made to match existing finish materials (i.e. colors of paint and vinyl) within the appropriate budget. If not possible, the customer shall be consulted concerning an acceptable cost-equivalent alternative.

4. MOBILE HOMES

a) Ceramic tile shall not be used in showers due to potential for leaks and water damage.
b) Shear walls may be modified, but should not be moved or removed.

Substance Abuse

When obtaining an evaluation for alcohol or drug abuse in the determination of eligibility for services and rehab needs, Counselors should utilize Psychologists, Licensed Psychological Associates, Psychiatrists, or Physicians who are certified in the area of substance abuse or affiliated with a licensed alcohol and/or drug treatment program, or Licensed Clinical Addictions Specialists (LCAS).* Evaluations from public or private treatment programs may be utilized if the evaluations are carried out or supervised by one or more of these specialties. Counselors should assure the evaluative data is current enough to establish the existence of an impairment that results in impediments to employment. The evaluation should include:

- A history of the disorder including a detailed description of the nature and severity of the addiction; response to previous treatment efforts if attempted or completed: evidence that the individual has accepted the reality of the addiction and is willing to take responsibility for ongoing treatment and/or support programs as recommended.
- Recommendations as to treatment (inpatient or outpatient) and/or community support systems necessary to ensure continued recovery.

***Note:** Staff of the Division having any of the above credentials are prohibited from diagnosing and providing treatment to individuals served by the Division of Vocational Rehabilitation Services. For questions about secondary employment contact the Human Resources Section of NC DVR.

INDEX

Activities of Daily Living (ADL) 86
Acupuncturists 51
Acute 55, 141
Administrative Review 12, 26, 99, *See* Client Appeals
Advocacy 12
Age 37
Age Validity 113
AIDS 177–80
Amending the Case Record 21
Americans with Disabilities Act (ADA) 36–37
Annual Review 133
of Closed Records 17–19
Annual Verification of Records of Service 19
Anxiety Disorder 113
Appeals *See* Client Appeals
Appeals Hearing *See* Client Appeals
Appliances 62, 119
Applicant Status 109
Application 109
Assistive Devices 61, 181
Assistive Listening Devices 64
Assistive Listening Devicies 64
Assistive Technology 62, 63, 61–72, 72, 81, 135
Assistive Technology Services 72
Attention Deficit Disorder 110, 111
Attention Deficit/Hyperactivity Disorder 113, 114
Audiogram 174
Audiologist 100
Audiologists 54
Audit 13, 24
Augmentative Communication 62
Autism 111, 112, 113
Auxiliary Aids and Services 147
Availability for Services 107
Bid 79
Bid Process 70, 71
Borderline Intellectual Functioning (BIF) 113, 149, 169
By History 112
Case Service Authorization (CSI) 39
Case Status Codes
52 19, 107, 118, 131, 132
58 18, 19, 38, 107, 138
60 107, 118
61 107
64 36, 107
65 107
66 137, *See*
76 38, 57, 107, 137, 141
78 18, 19, 38, 107, 139
80 18, 19, 38, 107, 138
82 107, 118, 141, 142
84 37, 107, 142
Center for Independent Living (CIL) 143
Child Care 124
Chiropractic Services 99
Chiropractors 51
Chore Worker 86, 87

Chronic 55, 110, 112
Chronic Fatigue 114
Chronic Fatigue (CFS) 150
Chronic Pain 114, 151
Civil Action 36
Client Appeals 27–36
Administrative Review 27–32, 35, 74
Appeals Hearing 26
Appeals Hearings 27–36
Impartial Hearing Officer (IHO) 31
Mediation 27–35, 74
Request for Appeal 28
Client Assistance Program (CAP) 11, 26–27, 27, 28, 29, 30, 110
Client Data Package 78
Client Master List 17, 19
Closure Codes
85 18
Cochlear Implant 175
Cochlear Implants 114, 154
Cognitive Disorder 113
Coils 154
Communication 115, 134, 181
Communication Services 72
Community Living 60, 117
Community Services 134
Comparable Benefits 127
Comprehensive Assessment 131
Computer 62, 147
Concurrent Records of Service 45–48, 87, 88
Confidentiality of Records 26
Charge for Photocopies 21
Client Failure to Provide Records 20
Court Order 24, 25
Disability Determination Section 22–23
Re-disclosure of Client Information 21, 23
Release of Information Without Consent of Client 24
Release with Consent of Client 23
Request for Client Information 23
Subpoenas 26
Consumer Satisfaction Survey 13
Contract Package 78
Contributions 125
CORE 143
Correction Enterprises 67
Counseling 181
Counseling and Guidance 75, 89, 118
Counselor Advisory Committee (CAC) 12
Criminal Background 107, 108
Current Procedural Terminology (CPT) 43
Day Care 52, 119
Deaf-Blindness 166
Deductions 122
Deinstitutionalization 60, 62, 63, 77, 107, 117, 134
Dental Impairments 156
Dentists 52
Department of Health and Human Services (DHHS) 10, 16, 25, 33, 52, 74
Disability Determination Section 22
Division of Services for the Blind (DSB) 148
DMV Review 79
Driver Evaluation 76, 103, 118, 170
Driver Rehabilitation Specialist 52–53, 53, 76

Driver Training 52, 119, 170
Driver's License 76
Durable Medical Equipment 61, 63, 65, 66, 67, 172, 173
Educational 134
Eligibility
of Employee's Family Member 14
Eligibility Criteria 114
Eligibility Determination 106
Employee
Services to Employees or Family Members 14
Employment Priority 117
Employment Transition 60, 117
Environmental Controls 62
Equipment 61–72, 181
Equipment Distribution Service 65
Equipment Lists 17
Equipment Repairs 71
Escorts 104
Excess Resources 125, 126
Existing Information 106, 109
Failure to Cooperate 36
Family Member
of Employee 14
Family Services 181
Family Unit 121, 117–29
FICA 190, 193, 194, 195, 196
Financial Need 117–29
Financial Need Category 119
fiscal agent 91, 92, 93, 94, 96, 97
Foreign Language 72, 73, 118
Forms
Agreement of Understanding 26
CAP Brochure 26
Case Notes 22, 23, 60, 138, 139, 142
DVR-0101, Pharmacy Invoice 41
DVR-0104, Subrogation Rights
Assignment of Reimbursement 56
DVR-0107, Medical Invoice 41
DVR-0108, Certificate of Signature on File 40
DVR-0116, Financial Needs Survey 118
DVR-0126, Dental Invoice 41
DVR-0191, Request for Worksite Modification 85
DVR-0196, Request for Vehicle Modification 79
DVR-0197, Request for Residence Modification 79
DVR-0199, Eyeglass Invoice 41, 42
DVR-0229-D, Standardized Driving Evaluation /Training Report 170
DVR-0304, Miscellaneous Vendor Review
On-Site 50
DVR-0304, Miscellaneous Vendor Review-On-Site 50, 51, 53, 54
DVR-0306, Certificate of Nondiscrimination Compliance 50, 52
DVR-0308, Application for Vendorship of Professionals-On-Site 50
DVR-0309, Application for Corporate Group of Professionals-On-Site 50, 53
DVR-0505, Agreement to Extend Eligibility Decision 106
DVR-1013, Case Service Invoice 40, 41, 45, 57
DVR-1015, Acknowledgement/Equipment Security Agreement 61, 64, 67
DVR-1021, Personal Assistance Services and Reimbursement Agreement 94, 95, 98
DVR-2048, Imprest Cash Receipt 42
DVR-7001, Vehicle Inspection Sheet 80
ILRP-1004, Eligibility Decision 116
ILRP-1005, IL Ineligibility Decision 139
ILRP-1005, IL Ineligibility Decision 138

ILRP-1005, Ineligibility Decision 140
ILRP-1008, Rehabilitation Analysis Page (WRAP) 132
ILRP-1010C, IL Successful Outcome 137
ILRP-1010D, IL Statement of Closure 139
Functional Capacity Areas 115
Functional Improvement 116
Furniture 63, 119
FUTA 191
Hard Of Hearing 165
Hearing Aid 53, 65, 100, 101
Hearing Disabilities 174
Hearing Officer *See* Client Appeals
HIV 20, 55, 114, 177–80
Home Health Agency 94, 96
Home Modification 181
Household Employer 87, 94, 190, 191, 192
Housekeeping 86, 87
Impairment Related Work Expense plans (IRWE) 129
Impairments, Determination of 110–14
Imprest Cash 48–49
In Full Sustained Remission" 112
Individualized Education Plan (IEP) 111, 112, 113, 114
Ineligibility
Due to Disability Too Severe 17
Informal Bids 70
Information Access/Technology 134
Information and Referral 77, 181
Informed Choice 58, 136
In-home Maintenance 57, *See* Maintenance
inpatient 102
Inpatient 42
Institutionalization 60, 98, 99, 117, 134
Insurance 22, 41, 84, 119, 129
Insurance Settlement 56
Intellectual Disability 110
Interns 24
Interpreters 54, *See* sign language interpreting
Interpreting Services 73
Invoice Processing 39–45
Comparable Benefits 44
Dental Invoices 42
Duplicate Invoices 45
Equipment Invoices 42
Eyeglass Invoices 42
Hospital Invoices 42
Housing Placement and Assistance Invoices 41
Imprest Cash Fund Invoices 42
Maintenance Invoices 41
Medical Invoice 41
Medical Invoices 43
Modification Invoices 41
Orthotic Invoices 44
Personal Assistance Service Invoices 41
Pharmacy Invoices 43
Prosthetic Invoices 44
Psychological Services Invoices 44
Recreational Service Invoices 41
Speech Therapy Invoices 44
Technological Aids and Device Invoices 41
Transportation Invoices 41
Invoicing *See* Invoice Processing

Learning Disability 110, 111, 112, 114
Lifts 61, 181
Limited English Proficient (LEP) 73
Litigation 17, 56
Lost Records of Service 19
Low-Vision Interpreting 74
Maintenance 77
Massage Therapists 53
Massage Therapy 152
Mediation *See* Client Appeals
Medicaid 42, 43, 44, 55, 77, 87, 95, 96, 98, 128
Medical Consultant 55
Medical Specialist 53, 101, 102, 110
Medicare 44, 128
Mental Health Disorders 111
Mental Retardation 111, 112, 113, 114
Mobile Home 81
Mobility 115, 135, 181
Money Follows the Person (MFP) 128
Mood Disorder 113
Moving 105
National Drug Code (NDC) 43
NC Department of Corrections 67
NC Housing Finance Agency 128
Neuropsychological 44
North Carolina Assistive Technology Program (NCATP) 64
North Carolina Association of Rehabilitation Facilities (NCARF) 12
Note takers 147
Occupational Therapists 53
Ophthalmologist 42
Opticians 53
Optometrist 42
Optometrists 54
Oral Interpreting 74
Orthotics 101, 182
Orthotists 54
Otologist 100, 174
Out-of-State 57
Outpatient 42
Pensions 122
Personal Assistance 86–99, 115, 123, 124, 182, 190, 193
Assessment 90
Bi-Annual Evaluation" 93
Calendar 189
Client Selection 90
Home Health Agency 96
Management Training 93
Selection Criteria 93
Suspension 97
Termination 98
Transition of Personal Assistance 88
Personal Care Assistants 104
Personal Resource Management 135
Personality Disorder 113
Pervasive Developmental Disorder 111, 112, 113
Physical Impairments 110
Physical Rehabilitation 182
Physical Restoration 99
Plans to Achieve Self-Support (PASS) 129
Podiatrists 54
Policy Development 10–13

Policy Exceptions 61
Post-Closure Follow-Up Study 13
Post-Secondary Training 124
Power Wheelchairs 57
Preliminary Assessment 106, 138
Preparatory Prosthesis 102
Prescription 63
Prescription Pain Medications 57
Presumption of Eligibility 116
Primary Impairment 110, 157
Priority of Services 117
Private Conveyance 104
Prosthetics 54, 101, 182
Prosthetists 54
Psychological Associates 54
Psychologist 44, 111
Psychologists 54
Psychotic Disorder 113
Public Conveyance 104
Public Rule Making Hearings 11
Purchase Orders 40
Purchasing Packet 67, 69
Reader Services 72, 75
Record Disposal 16–17
Record Retention 16–17
Records Management 19
Records of Appeals Hearings 35
Recreation Equipment 64
Recreational Services 182
Recreational Therapy 102, 118, 134
Referral 108, 197
Rehabilitation Counselor I 58
Rehabilitation Counselor II 58
Rehabilitation Engineering 103
Rehabilitation Services Administration (RSA) 10
Rehabilitation Technology 115, 182
Relocation 57, 62, 63, 105
Research 24
Residence 37
Residence Modification 57, 80, 81
Resurvey 120, 121
Scope of Services 60
Secondary Impairment 110, 157
Secretary of the Department of Health and Human Services 33
Section 504 36–37
Self-Care 115, 116, 135
Shelf Life 113, 114
Sign Language Interpreting 74
Signatures 127, 133
Client 48
Signatures on File 40
Significant Disability 106, 115
Social Security Disability Insurance (SSDI) 127
Social Security Number (SSN) 38–39, 109
Social Security Work Incentives 36, 129
Speech and Language Pathologists 54
Speech Processor 154
Spinal Subluxation 99
State Contract 57, 68
State Owned Vehicle 14
State Plan 10, 11, 12, 29

State Purchase and Contract 69
State Rehabilitation Council (SRC) 10, 31, 35
State Term Contract 62, 65, 67, 68, 69, 70
Statewide Independent Living Council (SILC) 10, 11
Subpoenas *See* Confidentiality of Records: Subpoenas
Subrogation Rights 56–57
Substance Abuse 23, 111, 114, 205
Supplemental Security Income (SSI) 127
Supported Employment 10
Survey *See* Consumer Satisfaction Survey
Sustained Activity 115, 116
SUTA 192, 193, 194, 195
Tactile Interpreting 74
Target Population 112
T-coil Switch 100
Telecommunicative Devices 64
Trainees 24
Transcript
of Client Appeals Hearing 36
Transfer of Client Record 15
Transportation 104, 135, 182
Transportation of Clients 14
TTY 65
Unemployment 122
Unit Manager Approval 57–58
Utilization of Resources 117
Vehicle 79, 123
Vehicle Modification 50, 57, 83, 84
Vehicle Repairs 57, 105
Vehicles 105
Vendor Review 49–54
Vendor Selection 78
Vendor Signatures 40–41
Veterans Affairs 129
Vocational 135
Vocational Services 182
Volunteers 24
VR Post-Employment Plan 88
Weekly Check-Write 45
Wheelchair 61, 70, 135, 181
Work Site Modification 86
Worker's Compensation 122, 129
Worksite Modification 85