PROVIDER REQUIREMENTS

Provider participation in the Louisiana Medicaid program is voluntary. In order to participate in the Medicaid program, a provider must:

- Meet all of the requirements for licensure as established by state laws and rules promulgated by the Louisiana Department of Health (LDH);
- Agree to abide by all rules and regulations established by the Centers for Medicare and Medicaid Services (CMS), LDH and other state agencies if applicable; and
- Comply with all of the terms and conditions for Medicaid enrollment.

Providers must attend all mandated meetings and training sessions as directed by the Office for Citizens with Developmental Disabilities (OCDD) or the Human Services Authority or District as a condition of enrollment and continued participation as a waiver provider. A Provider Enrollment Packet must be completed for each LDH administrative region in which the agency will provide services. Providers will not be added to the Freedom of Choice (FOC) list of available providers until they have been issued a Medicaid provider number.

Providers must participate in the initial training for prior authorization and data collection and any training provided on changes in the system. Initial training is provided at no cost to the agency. Any repeat training must be paid for by the requesting agency.

Providers must have available computer equipment, software, and internet connectivity necessary to participate in prior authorization (PA), data collection, and Electronic Visit Verification.

It is the provider's responsibility to ensure that use of contractors, including independent contractors, complies with all state and federal laws, rules and/or regulations, including those enforced by the United States Department of Labor.

All providers must maintain a toll-free telephone line with 24-hour accessibility manned by a staff person or an answering service. This toll-free number must be given to recipients at intake or at the first meeting.

Brochures providing information on the agency's experience must include the agency's toll-free number along with the OCDD's toll-free information number. OCDD must approve all brochures prior to use.

Providers must develop a Quality Improvement and Self-Assessment Plan. This is a document completed by the provider describing the procedures that are used, and the evidence that is

presented, to demonstrate compliance with program requirements. The first Self-Assessment is due six months after approval of the Quality Improvement Plan and yearly thereafter.
The Quality Improvement Plan must be submitted for approval within 60 days after the training is provided by LDH.

Providers must be certified for a period of one year. Re-certification must be completed no less than 60 days prior to the expiration of the certification period.

The agency must be excluded for participation as an entity as evidenced by an open exclusion on the Louisiana State Adverse Actions database, the Office of Inspector General's (OIG) national exclusions database, or the federal System for Award Management (SAM) database. The agency must not have an outstanding Medicaid Program audit exception or other unresolved financial liability owed to the state.

Changes in the following areas are to be reported to the Office of the Secretary's Health Standards Section, OCDD and the fiscal intermediary's Provider Enrollment Section in writing at least 10 days prior to any change:

- Ownership;
- Physical location;
- Mailing address;
- Telephone number; and
- Account information affecting electronic funds transfer (EFT).

The provider must complete a new provider enrollment packet when a change in ownership of 5 percent to 50 percent of the controlling interest occurs, but may continue serving recipients. When 51 percent or more of the controlling interest is transferred, a complete re-certification process must occur and the agency shall not continue serving recipients until the re-certification process is complete.

Waiver services are to be provided only to persons who are waiver recipients, and strictly in accordance with the provisions of the approved plan of care (POC).

Providers may not refuse to serve any waiver recipient that chooses their agency unless there is documentation to support an inability to meet the individual's health, safety and welfare needs, or all previous efforts to provide services and supports have failed and there is no option but to refuse services. Such refusal to serve an individual must be put in writing by the provider, and include a detailed explanation as to why the provider is unable to serve the individual. Written notification

must be submitted to the Human Services Authority or District. Providers who contract with other entities to provide waiver services must maintain copies of such contracts signed by both agencies. Such contracts must state that the subcontractor may not refuse to serve any waiver recipient referred to them by the enrolled direct service provider agency.

The recipient's provider and support coordination agency must have a written working agreement that includes the following:

- Written notification of the time frames for POC planning meetings;
- Timely notification of meeting dates and times to allow for provider participation;
- Information on how the agency is notified when there is a POC or service delivery change; and
- Assurance that the appropriate provider representative is present at planning meetings as invited by the recipient.

The NOW services outlined below may be provided by the provider or by an agreement with other contracted agents. The actual provider of the service, whether it is the provider or a subcontracted agent, must meet the following licensure or other qualifications:

Waiver Service	Requirements	Service Provided by
Individualized and Family Support	Home and Community-Based Services Provider License (Personal Care Attendant Module)	Enrolled agency
Center Based Respite	Home and Community-Based Services Provider License (Respite Care Module)	Enrolled agency
Community Integration Development	Home and Community-Based Services Provider License (Personal Care Attendant or Supervised Independent Living Module)	Enrolled agency
Residential Habilitation – Supported Independent Living	Home and Community-Based Services Provider License (Supervised Independent Living Module)	Enrolled agency
Substitute Family Care	Home and Community-Based Services Provider License (Substitute Family Care Module and approved by OCDD)	Enrolled agency
Day Habilitation	Home and Community-Based Services Provider License (Adult Day Care Module)	Enrolled agency
Supported Employment	Valid Certificate of Compliance as a Community Rehabilitation Provider from Louisiana Rehabilitation Services or 15 hours of documented initial and annual	Enrolled agency

Waiver Service	Requirements	Service Provided by
	vocational-based training plus a Home and Community-Based Services Provider License (Supported Employment Module)	
Prevocational Services	Home and Community-Based Services Provider License (Adult Day Care Module with notification to Health Standards that Prevocational Services will be provided)	Enrolled agency
Environmental Accessibility Adaptations	Registered through the Louisiana State Licensing Board for Contractors as a Home Improvement Contractor.	Enrolled agency
	Vehicle Lifts: Licensed by the Louisiana Motor Vehicle Commission as a specialty vehicle dealer and accredited by the National Mobility Equipment Dealers Association under the Structural Vehicle Modifier category.	
Specialized Medical Equipment and Supplies	Must meet all applicable vendor standards and requirements for manufacturing, design and installation of technological equipment and supplies.	Enrolled agency
Personal Emergency Response Systems	Must meet all applicable vendor requirements, federal, state, parish and local laws for installation.	Enrolled agency
Professional Services	Current valid Louisiana license to practice in the field of expertise	Employed or contracted by Home and Community-Based Service Provider (Personal Care Attendant Module, Supervised Independent Living Module or Home Health agency
Skilled Nursing	Home Health license	Enrolled agency
Adult Companion Care	Home and Community-Based Services Provider License (PCA Module) or Monitored In Home Caregiving License	Enrolled agency
One Time Transitional Expenses		OCDD

When required by state law, the person performing the service, such as building contractors, plumbers, electricians or engineers, must meet applicable requirements for professional licensure and modifications to the home and must meet all applicable building code standards.

Other Provider Responsibilities

Providers of NOW services are responsible for the following:

- Ensuring an appropriate representative from the agency attends the POC planning meeting and is an active participant in the team meeting;

  NOTE: An appropriate representative is considered to be someone who has knowledge and authority to make decisions about the recipient's service delivery. This person may be a program manager, case supervisor, or the executive director or designee. An unlicensed direct service worker is not considered an appropriate representative for the POC planning meeting.

- Communicating and working with support coordinators and other support team members to achieve the recipient's personal outcomes;

- Ensuring the provider plan of care documents are updated as changes occur, including the recipient's emergency contact information and list of medications;

- Informing the support coordinator by telephone or e-mail as soon as the agency recognizes that any goals, objectives or timelines in the POC will not meet the recipient's needs, but not later than 10 days prior to the expiration of any timelines in the service plan that cannot be met;

  - An update to the provider documents should only occur as a result of a **documented** meeting with the recipient or authorized representative where the reason for change is indicated and all parties sign the meeting attendance record;

- Ensuring the provider agency support team member(s) sign and date any revisions to the service plan indicating agreement with the changes to the goals, objectives or time lines;

- Providing the support coordination agency or LDH representatives with requested written documentation including, but not limited to:

  - Completed, signed and dated service plan;,
  - Service logs, progress notes, and progress summaries;
  - Direct service worker attendance and payroll records;
  - Written grievance or complaint filed by recipient/family;
  - Critical or other incident reports involving the recipient; and
  - Entrance and exit interview documentation.

- Explaining to the recipient/family in his/her native language the recipient rights and responsibilities within the agency; and

- Assuring that recipients are free to make a choice of providers without undue influence.

Support Coordination Providers

Support Coordination

Support Coordination is a service that will assist recipients in gaining access to all of their needed support services, including medical, social, educational and other services, regardless of the funding source for the services. Providers of support coordination for the NOW program must have a signed performance agreement with OCDD to provide services to waiver recipients. Support coordination agencies must meet all of the performance agreement requirements in addition to any additional criteria outlined by the program office..

Support Coordination activities include but are not limited to the following:

- Convening the person-centered planning team comprised of the recipient, recipient's family, direct service providers, medical and social work professionals, as necessary, and advocates, who assist in determining the appropriate supports and strategies needed in order to meet the recipient's needs and preferences;
- On-going coordination and monitoring of supports and services included in the recipient's approved POC.
- Building and implementing the supports and services as described in the POC.
- Assisting the recipient to use the findings of formal and informal assessments to develop and implement support strategies to achieve the personal outcomes defined and prioritized by the recipient in the POC.
- Providing information to the recipient on potential community resources, including formal resources and informal/natural resources, which may be useful in developing strategies to support the recipient in attaining his/her desired personal outcomes.
- Assisting with coordinating transportation to access medical services and community resources.
- Assisting with problem solving with the recipient, families, services providers, and/or local governing entities (LGEs).

- Assisting the recipient to initiate, develop and maintain informal and natural support networks and to obtain the services identified in the POC assuring that they meet their individual needs.
- Advocating on behalf of the recipient to assist them in obtaining benefits, supports or services, i.e. to help establish, expand, maintain and strengthen the recipient's information and natural support networks. This may involve calling and/or visiting recipients, community groups, organizations, or agencies with or on behalf of the recipient.
- Training and supporting the recipient in self-advocacy, i.e. the selection of providers and utilization of community resources to achieve and maintain his/her desired outcomes.
- Oversight of the service providers to ensure that their recipient receives appropriate services and outcomes as designated in the POC.
- Assisting the recipient to overcome obstacles, recognize potential opportunities and developing creative opportunities.
- Meeting with the recipient in a face-to-face meetings as well as telephone contact as specified. This includes meeting them where the services take place.
- Must report and document any incidents/complaints/abuse/neglect according to the OCDD policy and in accordance with licensure, state laws, rules, and regulations, as applicable.
- Must arrange any necessary professional/clinical evaluations needed and ensure recipient choice.
- Must identify, gather and review the array of formal assessments and other documents that are relevant to the recipient's needs, interests, strengths, preferences, and desired personal outcomes.
- Develop an action plan in conjunction with the recipient to monitor and evaluate strategies to ensure continued progress toward the recipient's personal outcomes.
- On-going discussions with the recipient (16 and older) about employment including identifying barriers to employment and working to overcome those barriers, connecting the recipient to certified work incentive coordinators (CWIC) to do benefits planning, referring the recipient to Louisiana Rehabilitation Services (LRS) and following the case through closure with LRS, and other activities of the employment process as identified. This includes the quarterly completion of and data input using the Path to Employment Form.

NOTE: Advocacy is defined as assuring that the recipient receives appropriate supports and services of high quality and locating additional services not readily available in the community.

Support Coordination Providers Qualifications

Support Coordination providers must meet the following requirements:

- Be licensed as a support coordination provider; and
- Meet all requirements as outlined in the *Support Coordination Performance Agreement*

NOTE: Please refer to the Guidelines for Support Planning, Operational Instruction for Critical Incident Review, and OCDD Support Coordination Reference Guide for additional information.

Direct Service Provider Responsibilities

Direct service provider agencies must have written policy and procedure manuals that include, but are not limited to, the following:

- Training policy that includes orientation and staff training requirements according to the Home and Community-Based Service Providers Licensing Standards and the Direct Service Worker Registry;
- Direct care abilities, skills and knowledge requirements that employees must possess to adequately perform care and assistance as required by waiver recipients;
- Employment and personnel job descriptions, hiring practices including a policy against discrimination, employee evaluation, promotion, disciplinary action, termination and hearing of employee grievances, staffing and staff coverage plan;
- Record maintenance, security, supervision, confidentiality, organization, transfer and disposal;
- Identification, notification and protection of recipient's rights, both verbally and in writing, in a language the recipient/family is able to understand;
- Written grievance procedures; and
- Information about abuse and neglect as defined by LDH regulations and state and federal laws.

- EVV: requirements/proper use of check in/out; acceptable editing of electronically captured services; reporting services when in "no service zones" or failure to clock in/out (Electronic Connectivity Form and manual entry); confidentiality of log in information; monitoring of EVV system for proper use.

- DSW Registry: requirement for accessing the department's Adverse Action database for findings placed against the direct service workers prohibiting employment.

- Criminal History Checks: requirement for compliance with state statutes for non-licensed direct care personnel.

POC Provider Documents

The direct service provider must complete the provider portion of the plan of care to include all waiver services that the agency provides to the recipient based on the identified POC goals and other supports required.

The provider documents in the POC must be person-centered, focus on the recipient's desired outcomes and include the following elements:

- Specific activities to achieve the goals outlined in the recipient's approved POC;

- Strategies or supports needed to meet the individual's needs;

The POC provider documents must be reviewed and updated as necessary to comply with the specified goals, objectives and timelines stated in the recipient's approved POC or when changes are necessary based on recipient needs.

Back-up Planning

Direct service providers are responsible for providing all of the necessary staff to fulfill the health and welfare needs of the recipient when paid supports are scheduled to be provided. This includes times when the scheduled direct service worker is absent or unavailable or unable to work for any reason.

All direct service providers are required to develop an individualized back-up plan for each recipient t. Direct service providers are required to have policies in place which outline the protocols the agency has established to assure that back-up direct service workers are readily available, lines of communication and chain of command procedures have been established, and

procedures for dissemination of the back-up plan information to recipients, their authorized representatives and support coordinators. Protocols must also describe how and when the direct support staff will be trained in the care needed by the recipient. This training must occur prior to any direct support staff being solely responsible for a recipient.

Back-up plans must be updated as changes occur to assure that the information is kept current and applicable to the recipient's needs. The back-up plan must be submitted to the recipient's support coordinator in a timely manner to be included as a component of the recipient's initial and annual POC.

Direct service providers may not use the recipient's informal support system as a means of meeting the agency's individualized back-up plan and/or emergency evacuation response plan requirements without documented consent of the informal support system. The recipient's family members and others identified in the recipient's circle of support may elect to provide backup, but this does not exempt the provider from the requirement of providing the necessary staff for backup purposes when paid supports are scheduled.

Emergency Evacuation Planning

Emergency evacuation plans must be developed in addition to the recipient's individualized back-up plan. Providers must have an emergency evacuation plan that specifies in detail how the direct service provider will respond to potential emergency situations such as fires, hurricanes, tropical storms, hazardous material release, flash flooding, ice storms and terrorist attacks.

The emergency evacuation plan must be person-specific and include at a minimum the following components:

- Individualized risk assessment of potential health emergencies;
- A detailed plan to address the recipient's individualized evacuation needs, including a review of the recipient's individualized back-up plan, during geographical and natural disaster emergencies and all other potential emergency conditions;
- Policies and procedures outlining the agency's implementation of emergency evacuation plans and the coordination of these plans with the local Office of Emergency Preparedness and Homeland Security;
- Establishment of effective lines of communication and chain of command procedures;

- Establishment of procedures for the dissemination of the emergency evacuation plan to recipients and support coordinators; and

- Protocols outlining how and when direct service workers and recipients will be trained in the implementation of the emergency evacuation plan and post-emergency procedures.

Training for direct service workers and competency ensured must occur prior to the worker being solely responsible for the support of the recipient.

The recipient must be provided with regular, planned opportunities to practice the emergency evacuation response plan.

OCDD, support coordination agencies and direct service provider agencies are responsible for following the established emergency protocol before, during and after hurricanes or other natural disasters or events as outlined in the "Emergency Protocol for Tracking Location Before, During and After Hurricanes" document found in the OCDD *Guidelines for Support Planning* manual. (See Appendix D for *Guidelines for Support Planning* information.)

Residential Habilitation – Supported Independent-Living Provider Responsibilities

In addition to the approved direct support hours provided to the recipient, the Supported Independent Living (SIL) provider is responsible for maintaining weekly contact with the recipient for supervision purposes, and making a minimum of one monthly face-to-face contact in the home to ensure the living situation complies with licensing requirements. The minimum requirements for SIL contacts are:

- Two contacts every week (Sunday through Saturday) with the recipient, either face-to-face, by phone, or adaptive communication technology. These two weekly contacts are for supervision purposes and are intended to provide the recipient an opportunity to express concern and provide assurance that all needs are being met.

- One monthly contact (each calendar month) face-to-face with the recipient in the recipient's home. This contact is intended to ensure the living situation is safe, it complies with licensing requirements, and all necessary support is provided to the recipient (medications are refilled, no repairs are necessary, adequate food is in home, bills are paid, staff is working the hours required, no abuse/neglect, etc.). The frequency of the face-to-face contacts shall be based on the recipient's needs.

The weekly supervision contacts are separate from the monthly in-home contact; therefore, the monthly in home contact will not count as one of the two weekly contacts required. Providers may make as many contacts in a day as are necessary to meet the needs of the recipient. However, only one contact per day (either weekly or monthly contacts) will count towards meeting the minimum contacts required. Attempted contacts) are unacceptable and will not count towards meeting any of the minimum contact requirements. Any identified payment made to a provider agency for an incomplete contact will be subject to recoupment of funds paid. All contacts used for billing purposes must be documented. The contact must identify the name of the recipient contacted, date of the contact, beginning and ending time of the contact, topics discussed during the contact, and the printed name and signature of the person making the contact.

Recipient contacts must be completed by a supervisor of the provider agency so designated due to the supervisor's experience and expertise relating to client needs or an employee of the provider agency who is a licensed/certified professional (Qualified Intellectual Disability Professional) qualified in the State of Louisiana and who meets the requirements as defined by the Title 42, Section 483.430 of the Code of Federal Regulations. Providers are required to maintain appropriate documentation indicating these requirements for all required contacts.

NOTE: The billing week begins at midnight Sunday (12:00 a.m.) and ends at midnight the following Sunday (12:00 a.m.).

The provider must provide back-up staff that is available on a 24-hours basis. SIL services must be coordinated with any services listed in the approved POC.

SIL providers are responsible for assisting recipients with obtaining the completed Form 90-L from their primary care physician on an annual basis.

Day Habilitation Provider Responsibilities

The service provider must possess a current valid Home and Community-Based Service Providers License to provide adult day care services and adhere to the following requirements in order to provide transportation to recipients:

- The provider's vehicles used in transporting recipients must adhere to the requirements of the HCBS licensing rule;
- Providers must maintain liability insurance in the amount specified in the HCBS licensing requirements.
- Drivers must have a current Louisiana driver's license applicable to the vehicle being used; and

- The provider must document this service in the provider's transportation log, which can be either electronic with GPS tracking or a paper log. The log is not required to be filed in the recipient's record file, but must contain information that identifies the participant, the time of pick up and the time of drop off. It shall also be available upon request for review by any Louisiana state agency, including Human Services Authorities and Districts and Support Coordination.

Supported Employment Provider Responsibilities

Supported Employment providers must maintain documentation in the file of each individual recipient that the services are not available to the recipient in programs funded under Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the Individuals with Disabilities Education Act (IDEA), 20 U.S.C. 1401 (16) and (71).

The service provider must possess a current valid Home and Community-Based Service Providers License provide adult day care services to provide adult day care services and adhere to the following requirements in order to provide transportation to recipients:

- The provider's vehicles used in transporting recipients must adhere to the requirements of the HCBS licensing rule;

- Drivers must have a current Louisiana driver's license applicable to the vehicle being used; and

- The provider must document this service in the provider's transportation log, which can be either electronic with GPS tracking or a paper log. The log is not required to be filed in the recipient's record file, but must contain information that identifies the participant, the time of pick up and the time of drop off. It shall also be available upon request for review by any Louisiana state agency, including Human Services Authorities and Districts and Support Coordination.

Prevocational Services Provider Responsibilities

The provider must maintain documentation in the file of each individual recipient receiving Prevocational Services that the services are not available to eligible recipients in programs funded under Section 110 of the Rehabilitation Act of 1973 or Section 602 (16) and (17) of the Individuals with Disabilities Education Act (IDEA) 20 U.S.C. 1401 (16) and (71).

Professional Services – Psychological Provider Responsibilities

Providers of psychological services must:

- Perform an initial evaluation to assess the recipient's need for services;
- Develop an Individualized Service Plan for the provision of psychological services, which must document the supports that will be provided to the recipient to meet his/her goals based on the recipient's approved POC;
- Implement the recipient's therapy service plan in accordance with appropriate licensing and certification standards;
- Complete progress notes for each session, within 10 days of the session, and provide notes to the recipient's support coordinator every three months or as specified in the POC;
- Maintain both current and past records and make them available upon request to OCDD, service providers, support coordinators, the Centers for Medicare and Medicaid Services (CMS), and/or legislative auditors; and
- Bill only for services rendered, based on the recipient's approved POC and prior authorization.

Skilled Nursing Services Provider Responsibilities

Provider agencies of Skilled Nursing services must:

- Ensure that all nurses employed to provide Skilled Nursing services are either registered nurses or licensed practical nurses who have a current Louisiana Board of Nursing license with a minimum of one year of supervised nursing experience in providing Skilled Nursing services in a community setting to recipients.
- Provide an orientation on waiver services to licensed nurses and assure that licensed nurses adhere to the OCDD Critical Incident Reporting policy. (See Appendix D for information regarding this policy.)
- Collect and submit the following documents to the recipient's support coordination agency:
    - Primary care physician's order for Skilled Nursing services.

The physician's order must be signed, dated and contain the number of hours per day and duration of Skilled Nursing services required to meet the recipient's needs. This order must be updated at least every 60 days. The physician's order must be submitted to the Human Services Authority or District with the recipient's annual POC and upon request. Prior authorization will not be released if the physician's order is not submitted as required.

- Primary care physician's letter of necessity for Skilled Nursing services.

  The physician's letter of medical necessity must be on the physician's letterhead,

- Current Form 90-L signed by the recipient's primary care physician.

- Summary of the recipient's medical history.

  The summary must indicate the recipient's service needs, based on a documented record review and specify any recent (within one year) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) extended home health approvals.

- CMS Form 485 completed by the home health agency to identify the Skilled Nursing service needs.

- Develop and implement an Individual Nursing Service Plan in conjunction with the recipient's physician, support team and the support coordinator to identify and fulfill the recipient's specific needs in a cost-effective manner.

- Render services to the recipient as ordered by the recipient's primary care physician and as reflected in the recipient's POC within the requirements of the Louisiana Nurse Practice Act. For the purpose of this policy, nursing assessments, nursing care planning and revisions of care planning must be consistent with the Outcome and Assessment Information Set (OASIS) requirements used by home health agencies that provide Skilled Nursing services.

- Complete progress notes for each treatment, assessment, intervention, and critical incident.

- Provide the support coordination agency with physician-ordered changes every 60 days regarding the recipient's health status and health needs.

- Inform the support coordinator immediately of the providers' inability to provide staff according to the recipient's nursing service plan.

- Report any recipient's non-compliance with or refusal of the established Individual Nursing Service Plan and provide these notes to the designated support coordinator every three months, or as specified in the POC.

- Maintain both current and past records and make them available upon request to the OCDD, service providers, support coordinators, the Centers for Medicare and Medicaid Services (CMS) and/or legislative auditors.

- Bill for prior authorized services rendered based on the recipient's approved Plan of Care.

- Ensure the home health nurse and the recipient's support coordinator communicate at least monthly to determine if any further planning is required.

- Report any changes in the recipient's nursing service needs to the support coordinator. If necessary, the support coordinator will call an Interdisciplinary Team meeting to review the POC and to discuss any needed revisions. Changes to Skilled Nursing services in accordance with regulations, must be reflected in the Individual Nursing Services Plan and submitted to the support coordinator every 60 days.

  NOTE: It is not necessary to revise the POC every 60 days unless there is a change in the recipient's medical condition requiring the need for additional Skilled Nursing services or the recipient requests a change.

- Changes in the Individual Nursing Service Plan must be approved by the primary care physician and reflect the physician's orders for the Skilled Nursing service.

- Ensure the Individual Nursing Service Plan is current and available in the recipient's home at all times.

- Follow all NOW requirements, minimum standards for home health agencies and state and federal rules and regulations for licensed home health agencies and nursing care.

- Comply with OCDD standards for payment, Medical Assistance Program Integrity Law (MAPIL), HIPAA, ADA and licensing requirements.

Adult Companion Care Services Provider Responsibilities

The provider organization shall develop a written agreement as part of the participant's POC which defines all of the shared responsibilities between the companion and the participant. The written agreement shall include, but is not limited to:

- Types of support provided by the companion;
- Activities provided by the companion; and
- A typical weekly schedule.

Revisions to this agreement must be facilitated by the provider organization and approved by the support team. Revisions may occur at the request of the participant, the companion, the provider or other support team members.

The provider organization is responsible for performing the following functions which are included in the daily rate:

- Arranging the delivery of services and providing emergency services;
- Making an initial home visit to the participant's home, as well as periodic home visits as required by the department;
- Contacting the companion a minimum of once per week or as specified in the participant's comprehensive plan of care; and
- Providing 24-hour oversight and supervision of the adult companion care services, including back-up for the scheduled and unscheduled absences of the companion.
- Facilitating a signed written agreement between the companion and the participant which assures that:
    - The companion's portion of expenses must be at least $200 per month, but shall not exceed 50 percent of the combined monthly costs which includes rent, utilities and primary telephone expenses; and
    - Inclusion of any other expenses must be negotiated between the participant and the companion. These negotiations must be facilitated by the provider and the resulting agreement must be included in the written agreement and in the participant's POC.