September 18, 2014

Dear Provider,


Health and Recovery Plan (HARP) eligible enrollees will have the ability to access an enhanced benefit that includes an array of HCBS services. All programs wishing to provide HCBS must apply to be designated for each service they propose to offer and attest to meeting the staffing and service delivery criteria as outlined in the manual. Applications must be submitted via an online portal on the OMH website that will be available beginning in October. Additional guidance will be available shortly. All New York City provider applications must be filed on or before December 5, 2014, but applicants are encouraged to submit prior to that date. Applications for the rest of the state may be submitted at this time, however official provider designation for areas outside of the New York City service area will not be made at this time. Additional guidance will follow concerning the application deadlines for the rest of the state.

HARPs will utilize the HCBS to provide opportunities for Medicaid beneficiaries with mental illness and/or substance use disorders to receive person-centered recovery services in their own community. HARPs will have specialized staffing qualifications and network adequacy requirements, along with focused behavioral health performance metrics. In order to participate in a HARP’s network, programs must be designated as eligible to provide HCBS.

New York seeks stakeholder comments/questions on this HCBS Manual. Please be advised that the service definitions described in the manual are subject to change based on The Centers for Medicare and Medicaid Services (CMS) approval of the 1115 waiver. A separate billing manual outlining the reimbursement rates and billing codes will be available in October. Please submit any comments/questions on the HCBS manual electronically to BHO@OMH.ny.gov.

Thank you for your efforts to assist NYS in transitioning behavioral Health services to a person-centered, community-based system that supports recovery.

Sincerely,

Robert Myers, Senior Deputy Commissioner, NYS Office of Mental Health
Robert Kent, General Counsel, NYS Office of Alcoholism and Substance Abuse Services
Greg Allen, Director, Division of Program Development and Management

cc: G. Weiskopf
    D. Zalucki
    E. DeLorenzo
New York State is pleased to release the initial version of the Home and Community Based Services (HCBS) Manual that will be used as a basis to begin the HCBS designation process. The Office of Mental Health (OMH), Office of Alcoholism and Substance Abuse (OASAS) and the Department of Health (DOH) are open to stakeholder input on the established service standards as the 1115 waiver amendment is being negotiated with the Centers for Medicaid and Medicare Services (CMS). This manual is subject to change based upon the final terms and conditions approved by CMS. All comments should be submitted electronically to BHO@omh.ny.gov.

The HCBS manual describes the basic requirements for any entity that is interested in providing HCBS behavioral health services within New York’s public behavioral health system. These entities may include:

- Behavioral health contracted and non-contracted providers, including those that provide rehabilitation, employment, community-based treatment, peer support, and crisis services;
- State entities providing behavioral health services, including mental health and/or substance use disorder services; or other organizations or clinicians that meet criteria;
- Hospitals providing specialized behavioral health services;
- Licensed/Certified residential, inpatient and organizations providing mental health and/or substance use disorder clinical services; and
- Programs that are currently providing outreach, peer, vocational, or rehabilitative services to people with substance use disorders (SUD) that are funded through Alternatives to Incarceration, Ryan White Federal funding, or funding from Department of Health and Mental Hygiene, NYC Department of Health or the AIDS Institute.

The HCBS Services Manual includes information regarding services that are allowable and reimbursable as approved by CMS. This information, includes service definitions and service requirements reflective of documents that were developed in accordance with Medicaid policies and protocols and submitted for approval. A separate billing manual outlining the reimbursement rates and billing codes will be available in October. Specifically, the HCBS Services Manual outlines the following:

1. Services Definitions & Descriptions
2. Provider Qualifications
3. Eligibility Criteria
4. Limitations/Exclusions
5. Allowed Modes of Delivery
6. Additional Service Criteria
7. Practitioner credentials for service provision
8. HCBS Services that may be provided together (HCBS clusters)
9. Sample attestation forms
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I. Introduction

The Centers for Medicare and Medicaid Services (CMS) has authorized various home and community-based services (HCBS) under their Medicaid waiver authority. HCBS services were initially established in an effort to keep individuals out of hospitals, nursing homes or other institutions. Recipients had to be evaluated and assessed to meet an institutional level of care, i.e., they could be admitted to an institution if not for the availability of an HCBS waiver program. A person served in a HCBS waiver must be assessed using a validated comprehensive assessment tool to determine their treatment, rehabilitation and support needs. A comprehensive, person-centered plan of care is then developed and the person is then connected to appropriate services. The care plan must be developed in a “conflict free” manner, meaning the person conducting the assessment and developing the plan of care cannot direct referrals for service only to their agency or network. The person must have choice among available providers. New York State is working with CMS to determine how appropriate checks and balances will be established to meet this conflict free requirement for the 1915i HCBS HARP benefit.

The CMS also requires state oversight to determine: that the assessment is comprehensive, the planning process is person-centered and addresses services and support needs in a manner that reflects individual preferences and goals, the services were actually provided, and the person is assessed at least annually or when there is a change in condition (e.g., loss of housing, inpatient admission, etc.) to appropriately reflect service needs. CMS also requires assurances which the state, managed care plans and providers must monitor and report on to assure people enrolled in HCBS waivers are receiving appropriate services.

On March 17, 2014 CMS issued the Final HCBS Rule that established, upon other provisions, conformity across HCBS authorities for person-centered planning and allowable settings. The rule states that HCBS services can only be provided in settings which are considered integrated community settings. New York State is reviewing these rules to determine how this will be addressed in certain housing, residential and day programs.

Section 1915i of the Social Security Act was established as part of the Deficit Reduction Act of 2005. 1915i afforded States the opportunity to provide HCBS under the Medicaid State Plan without the requirement that Medicaid members need to meet the institutional level of care as they do in a 1915(c) HCBS Waiver. The intent is to allow and encourage states to use the flexibility of HCBS services to develop a range of community based supports, rehabilitation and treatment services with effective oversight to assure quality. These services are designed to allow individuals to gain the motivation, functional skills and personal improvement to be fully integrated into communities. The 1915i option acknowledges that even though people with disabilities may not require an institutional level of care (e.g. hospital, nursing home) they may still be isolated and not fully integrated into society. This isolation and lack of integration may have been perpetuated by approaches to service delivery which cluster people with disabilities, and don’t allow for flexible, individualized services or services which promote skill development and community supports to overcome the effects of certain disabilities or functional deficits, motivation and empowerment.

The CMS allows states to include the flexibility of 1915i state plan services in Medicaid Managed care 1115 waivers. New York State has chosen to include 1915i like HCBS services in its 1115 waiver amendment for behavioral health. The inclusion of these HCBS services will give NYS managed care provider networks and most importantly, enrollees in managed care, a new range of
HCBS services in their benefit package. These services are designed to help overcome the cognitive and functional effects of behavioral health disorders and help individuals with behavioral health conditions to live their lives fully integrated into all aspects of their community. The addition of these services to the benefit package will also assist NYS to meet the requirements of the Americans with Disabilities Act and the Olmstead Law. The primary goal is to create a supportive and empowering environment for people with behavioral health conditions to live productive lives within our communities.

The provider manual describes these services in detail and the requirements for providers' participation. We look forward to working with managed care plans and provider networks to transform our system of care to one that supports rehabilitation and recovery from behavioral health conditions.

II. Values/Core Principles

The past 30 years have seen a transformation of the public mental health system. The State-operated adult psychiatric hospital census has declined from over 20,000 to under 2,900. Access to outpatient treatment, community supports, rehabilitation, and inpatient psychiatric services at general hospitals have expanded. More than 38,000 units of state supported community housing for people living with mental illness have been developed. These community based resources have created a safety net which has helped the mental health system to evolve from a primarily hospital focused system to one of community support. The emergence of the peer recovery and empowerment movement in the 1990s has stimulated the shift in focus from support to recovery. The legal system’s expansion of civil rights to include people with mental illness, as part of Olmstead Legislation and Americans with Disabilities Act, has begun to move policy from the concept of least restrictive setting to full community inclusion.

In 2008, New York State initiated detox reform that reduced incentives for unnecessary hospital detox and began the process of building community and ambulatory access to withdrawal symptom management for SUD patients who do not require a hospital level of care for safely discontinuing the use of substances. OASAS initiated ancillary withdrawal services to allow for the management of mild to moderate withdrawal symptoms in outpatient and inpatient settings. The goal will include access to medically supervised withdrawal management in all levels of care for symptom management where there is very low risk of medical complications of withdrawal. SUD individuals will be able to access treatment in the lowest level of care necessary to support long-term recovery.

The development of Health and Recovery Plans (HARPs) is intended to promote significant improvements in the Behavioral Health System as we move into a recovery-based Managed Care delivery model. A recovery model of care emphasizes and supports a person's potential for recovery by optimizing quality of life and reducing symptoms of mental illness and substance disorders through empowerment, choice, treatment, educational, vocational, housing, and health and well-being goals. Recovery is generally seen in this approach as a personal journey rather than a set outcome, and one that may involve developing hope, a secure base and sense of self, supportive relationships, self-direction, social inclusion, and coping skills.

The 1915(i) HCBS provide opportunities for Medicaid beneficiaries with mental illness and/or substance use disorders to receive services in their own home or community. Implementation of the Home and Community Based Services will help to create an environment where managed care
plans, service providers, plan members, families, and government partner to help members prevent and manage chronic health conditions and recover from serious mental illness and substance use disorders. The partnership will be based on these core principles:

**Person-Centered Care:** Services should reflect an individual’s goals and emphasize shared decision-making approaches that empower members, provide choice, and minimize stigma. Services should be designed to optimally treat illness and emphasize wellness and attention to the persons overall well-being and full community inclusion.

**Recovery-Oriented:** Services should be provided based on the principle that all individuals have the capacity to recover from mental illness and/or substance use disorders. Specifically, services should support the acquisition of living, vocational, and social skills and be offered in home and community-based settings that promote hope and encourage each person to establish an individual path towards recovery.

**Integrated:** Services should address both physical and behavioral health needs of individuals. Care coordination activities should be the foundation for care plans, along with efforts to foster individual responsibility for health awareness.

**Data-Driven:** Providers should use data to define outcomes, monitor performance, and promote health and well-being. Performance metrics should reflect a broad range of health and recovery indicators beyond those related to acute care.

**Evidence-Based:** Services should utilize evidence-based practices where appropriate and provide or enable continuing education activities to promote uptake of these practices.

**Trauma-Informed:** Trauma-informed services are based on an understanding of the vulnerabilities or triggers experienced by trauma survivors that may be exacerbated through traditional service delivery approaches so that these services and programs can be more supportive and avoid re-traumatization. All programs should engage all individuals with the assumption that trauma has occurred within their lives. (SAMHSA, 2014)

**Peer-supported:** Peers will play an integral role in the delivery of services and the promotion of recovery principles.

**Culturally Competent:** Culturally competent services that contain a wide range of expertise in treating and assisting people with Serious Mental Illness (SMI) and Substance Use Disorder (SUD) in a manner responsive to cultural diversity.

**Flexible and mobile:** Services should adapt to the specific and changing needs of each individual, using mobile service delivery approaches along with therapeutic methods and recovery approaches which best suit each person.

**Inclusive of Social Network:** The person, and when appropriate, family members and other key members of the person’s social network are always invited to initial meetings, or any necessary meetings thereafter to mobilize support.

**Coordination and collaboration:** These characteristics should guide all aspects of treatment and rehabilitation to support effective partnerships among the individual, family and other key natural supports and service providers.
III. Eligibility and Enrollment

HARP enrollment will be open to Medicaid beneficiaries with serious mental illness and/or substance use disorders. Individuals identified as HARP eligible must be offered care management through State-designated Health Homes. An initial cohort of individuals have been identified as HARP eligible based on their utilization of behavioral health services. This cohort has been shared with mainstream managed care plans for their members and with Health Homes to begin the process of engaging HARP eligible members in care management. Going forward, HARP eligible members will be identified by the State on an ongoing basis and shared with the HARP Plans, which will make assignments to Health Homes. Individuals can also be referred to HARP plans. HARP members will be required to be assessed for HCBS eligibility using an HCBS eligibility tool that contains items from the NYS Community Mental Health Suite of the InterRAI Functional Assessment. The eligibility assessment tool will determine if an individual is eligible for Tier 1 or Tier 2 services. Tier I services include employment, education and peer supports services. Tier 2 includes the full array of 1915i-like services. If HCBS eligibility is determined based on the initial assessment, then the full NYS Community Mental Health Suite of the InterRAI will be completed and a Plan of Care developed. Once completed, a Health Home Care Manager will work in collaboration with the individual and identify the HCBS services that will be included in the plan of care. At least one HCBS service must be included on the plan of care for eligible individuals. If the individual does not meet the functional need for 1915i-like services through the HARP/HCBS eligibility tool, the Plan of Care cannot include 1915i-like services. Re-assessment for HCBS eligibility will be conducted on an annual basis, or after a significant change in the member’s condition such as an inpatient admission or a loss of housing. Health Homes will provide care management and will have a role in the assessment of individuals for HCBS services. Provider agencies will deliver the HCBS services as described in this manual.

Adjustment Authority:
The state will notify CMS and the Public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i).

IV. Person-Centered Planning and Service Delivery

Based on an independent assessment of functioning and informed by the individual, the written service plan must meet the following requirements:

1. The service plan must include services chosen by the individual to support independent community living in the setting of his or her own choice and must support integration in the community, including opportunities to seek employment, engage in community life, control personal resources, and to receive services within the community;
2. Include the individual’s strengths and weaknesses;
3. Be developed to include clinical and support needs that are indicated by the independent functional assessment;
4. Be comprised of goals and desired outcomes that are chosen by the individual;
5. Include services and supports (paid by Medicaid, natural supports and other community supports) that will enable the individual to meet the goals and outcomes identified in the service plan;
6. Identification of risk factors and barriers with strategies to overcome them;
7. Be written in a way that is clearly understandable by the individual;
8. Include the individual and the entity that is responsible for the oversight of the plan of care implementation, review of progress and need for modifications if desired outcomes are not being met or the individual’s needs change;
9. Include an informed consent of the individual in writing along with signatures of all individuals responsible for the plan implementation;
10. Be sent to all of the individuals and others involved in implementing and monitoring the plan of care; and
11. The plan should not include services that are duplicative, unnecessary or inappropriate.

V. HCBS Service Definitions

<table>
<thead>
<tr>
<th>Psychosocial Rehabilitation (PSR)</th>
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<tbody>
<tr>
<td><strong>Definition</strong></td>
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<tr>
<td>PSR services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their behavioral health condition (i.e., SUD and/or mental health). Activities included must be intended to achieve the identified goals or objectives as set forth in the individual’s Recovery Plan. The intent of PSR is to restore the individual’s functional level to the fullest possible (i.e., enhancing SUD resilience factors) and as necessary for integration of the individual as an active and productive member of his or her family, community, and/or culture with the least amount of ongoing professional intervention.</td>
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<tr>
<th>Service Components</th>
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<tr>
<td>This service may include the following components:</td>
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<tr>
<td>• Rehabilitation counseling including recovery activities and interventions that support and restore social and interpersonal skills necessary to increase or maintain community tenure, enhance interpersonal skills, establish support networks, increase community awareness, develop coping strategies and effective functioning in the individual’s social environment such as home, work, and school including:</td>
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<tr>
<td>o Independent Living: A close working relationship between staff and participant to develop and strengthen the individual’s independent community living skills and support community integration</td>
</tr>
<tr>
<td>o Social: Establishing and maintaining friendships and a supportive recovery social network, developing conversation skills and a positive sense of self; coaching on interpersonal skills and communication; training on social etiquette; relapse prevention skills; identify trauma triggers; develop anger management skills; engender civic duty and volunteerism</td>
</tr>
<tr>
<td>o Community: Support the identification and pursuit of personal interests (e.g. creative arts, reading, exercise, faith-based pursuits, cultural exploration); identify resources where these interests can be enhanced and shared with others in the community; identify and connect with natural supports and recovery resources, including family, community networks, and faith-based communities</td>
</tr>
<tr>
<td>• Rehabilitation, counseling, recovery activities, interventions and support with skills necessary for the individual to improve self-management of and reduce relapse to substance use, the negative effects of psychiatric, or emotional symptoms, that interfere with a person’s daily living, and daily living skills that are critical to remaining in home, school, work, and community. Rehabilitation counseling and support necessary for the individual to implement learned skills so the person can remain in a natural community location including:</td>
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<tr>
<td>o Personal autonomy: Learning to manage stress, unexpected daily events and disruptions, mental health symptoms, relapse triggers and cravings with confidence; develop and pursue leisure and recreational interests, manage free time</td>
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comfortably; transportation navigation

- Health: Developing constructive and comfortable interactions with health-care professionals, Relapse Prevention Planning (Individual Recovery Plan); managing chronic medical conditions, mental health symptoms and medications; establishing good health routines and practices
- Social Skills: Engaging with people respectfully, appropriate eye contact, conversation skills, listening skills and advocacy skills
- Wellness: meal planning, healthy shopping and meal preparation, nutrition awareness, exercise options
- Personal care: grooming, maintaining living environment, managing finances and other independent living skills

- Rehabilitation counseling including recovery activities, interventions and support necessary for the individual to implement learned skills so the person can remain in a natural community location
- Assisting the individual with effectively learning adaptive behaviors responding to or avoiding identified precursors such as cravings or triggers that result in relapse or functional impairments

Ongoing assessment of the individual’s progress toward recovery, functional skill and impairment levels that is used to select PSR interventions and periodically assess their effectiveness in achieving goals.

**Modality**

PSR is a face-to-face intervention with the individual who has a behavioral health (i.e., SUD/Mental Health) diagnosis

**Setting**

- Services must be offered in the setting best suited for desired outcomes, including home, or other community-based setting in compliance with Medicaid regulations. The setting may include programs that are peer driven/operated or peer informed and that provide opportunities for drop-in.
- Services may be provided individually or in a group setting and should utilize (with documentation) evidence-based rehabilitation and recovery. The program should utilize all goal-directed individual and group task to meet the goals identified above.
- On or off site.

**Admissions/Eligibility Criteria**

An individual must have the desire and willingness to receive rehabilitation and recovery services as part of their individual recovery plan, with the goal of living their lives fully integrated in the community and, if applicable, to learn skills to support long-term recovery from substance use through independent living, social support, and improved social and emotional functioning.

**Limitations/Exclusions**

These services may complement, not duplicate, services aimed at supporting an individual to achieve an employment-related goal in their plan of care. The total combined hours for Psychosocial Rehabilitation and Community Psychiatric Support and Treatment are limited to no more than a total of 500 hours in a calendar year.

**Certification/Provider Qualifications**

Providers of service may include non-licensed behavioral health staff (see appendix). Workers who provide PSR services should periodically report to a supervising licensed practitioner on participants’ progress toward the recovery and re-acquisition of skills.
Staffing Ratio/Case Limits

Staff to Member Ratio: 1:20.
Community Psychiatric Support and Treatment (CPST)

**Definition**
CPST includes time-limited goal-directed supports and solution-focused interventions intended to achieve identified person-centered goals or objectives as set forth in the individual's Plan of Care and CPST Individual Recovery Plan.

The following activities under CPST are designed to help persons with serious mental illness to achieve stability and functional improvement in the following areas: daily living, finances, housing, education, employment, personal recovery and/or resilience, family and interpersonal relationships and community integration. CPST is designed to provide mobile treatment and rehabilitation services to individuals who have difficulty engaging in site-based programs who can benefit from off-site rehabilitation or who have not been previously engaged in services, including those who had only partially benefited from traditional treatment or might benefit from more active involvement of their family of choice in their treatment.

**Service Components**
The service may include the following components to meet the needs of the individuals with mental health and/or a substance use diagnosis:

- Assist the individual and family members or other collaterals to identify strategies or treatment options associated with the individual's mental illness, with the goal of minimizing the negative effects of mental illness symptoms or emotional disturbances or associated environmental stressors which interfere with the individual's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration

- Provide individual and their family supportive counseling, solution-focused interventions, emotional and behavioral management, and problem behavior analysis with the individual, with the goal of assisting the individual with social, interpersonal, self-care, daily living, and independent living skills to restore stability, to support functional gains and to adapt to community living

- Facilitate participation in and utilization of strengths based planning and treatments which include assisting the individual and family members or other collaterals with identifying strengths and needs, resources, natural supports, and developing goals and objectives to utilize personal strengths, resources, and natural supports to address functional deficits associated with their mental illness

- Assist the individual with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location, including assisting the individual and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan and/or as appropriate, seeking other supports to restore stability and functioning

- Provide ongoing rehabilitation support for individuals pursuing employment, housing, or education goals. Assist the individual with independent living skills to promote recovery and growth specific to managing their own home including managing their money, medications, and using community resources and other self-care requirements

- Implement interventions using evidence-based and best practice techniques, drawn from cognitive-behavioral therapy and other evidence-based psychotherapeutic interventions that ameliorate targeted symptoms and/or recover the person's capacity to cope with or prevent symptom interference with daily activities.
CPST is a face-to-face intervention with the individual, family or other collaterals.

Setting
- Services must be offered in the setting best suited for desired outcomes, including home or other community-based setting.
- Off site

Admissions/Eligibility Criteria
CPST services are intended to help engage individuals with mental health and/or a substance use diagnosis who are unable to receive site-based care or who may benefit from community based services including those who had only partially benefited from traditional treatment or might benefit from more active involvement of their family in their treatment. In addition, this service is intended for individuals who are being discharged from inpatient units, jail or prisons, and with a history of non-engagement in services, transitioning from crisis services, and for people who have disengaged from care.

Limitations/Exclusions
Community treatment for eligible individuals can continue as long as needed, within the limits, based on the individual’s needs. The intent of this service is to eventually transfer the care to a place based clinical setting.

The total combined hours for CPST and Psychosocial Rehabilitation (PSR) and are limited to no more than a total of 500 hours in a calendar year.

Certification/Provider Qualifications
- Agencies who have experience providing similar services should already have a license to provide treatment services (i.e., Clinics, PROS, Intensive Psychiatric Rehabilitation Treatment (IPRT), Partial Hospitalization, Comprehensive Psychiatric Emergency Programs (CPEP), or currently utilize an evidence based or best practice off-site treatment model using licensed professionals.
- Licensed staff (see appendix) must provide this service.

Staffing Ratio/Case Limits
Decisions about how to balance caseloads will be left to the provider agencies as they see appropriate to ensuring quality of care and maintaining acceptable performance outcomes.
### Habilitation/Residential Support Services

#### Definition

Habilitation services are typically provided on a 1:1 basis and are designed to assist participants with a behavioral health diagnosis (i.e. SUD or mental health) in acquiring, retaining and improving skills such as communication, self-help, domestic, self-care, socialization, fine and gross motor skills, mobility, personal adjustment, relationship development, use of community resources and adaptive skills necessary to reside successfully in home and community-based settings.

These services assist participants with developing skills necessary for community living and, if applicable, to continue the process of recovery from an SUD disorder. Services include things such as: instruction in accessing transportation, shopping and performing other necessary activities of community and civic life including self-advocacy, locating housing, working with landlords and roommates and budgeting. Services are designed to enable the participant to integrate full into the community and endure recovery, health, welfare, safety and maximum independence of the participant.

#### Service Components

- Habilitation/Residential Support services may help participants develop skills necessary for community living and recovery with ongoing assessment of participants’ functional status and development of rehabilitative goals, such as:
  - Instruction in accessing and using community resources such as transportation, translation, and communication assistance as identified as a need in the plan of care and services to assist the participant in shopping and performing other necessary activities of community and civic life, including self-advocacy; for example, coordinating and helping to secure TTY services, language bank services, or other adaptive equipment needs
  - Instruction in developing or maintaining financial stability and security (e.g., understanding budgets, managing money, and the right to manage their own money). Assistance in developing financial skills through instruction of budget development, money management skills, and self-direction with regards to managing own funds and relapse triggers. (Specifically, if a resident has a representative payee, one goal must be to develop skills to manage more independently)
  - Skill training and hands-on assistance of instrumental activities of daily living, including assistance with shopping, cooking, cleaning, and other necessary activities of community and civic living (voting, civic engagement via community activities, volunteerism)
  - Habilitation/Residential Supports provide onsite modeling, training, and/or supervision to assist the participant in developing maximum independent functioning in community living activities. The on-site modeling, cueing, and/or instruction and support may assist participant in developing maximum independent problem-solving, interpersonal, communication, and coping skills, including relapse prevention planning, integration/adaptation to home/community, on-site symptom monitoring, and self-management of symptoms
  - Facilitation of family reunification through coordination of family services as applicable and self-advocacy instruction. The goal would be to facilitate communication with family members/natural supports to encourage the development of recovery support plans, i.e., medication compliance, ADL skills, and functional changes
  - Housing preservation and advocacy training, including assistance with developing positive landlord-tenant relationships, and accessing appropriate legal aid services if needed including skills to successfully live with roommates
- Assistance with developing strategies and supportive interventions for avoiding the need for more intensive services such as inpatient detoxification, coordinating crisis services, and consulting with current service providers (including SUD providers, mental health providers, health care providers, family-friends-natural supports, parole-probation-drug courts, state vocational rehabilitation services and other stakeholders) to develop a plan for intervention.
- Assistance with increasing social opportunities and developing social support skills that ameliorate life stressors resulting from the participant’s disability and promote health, wellness and recovery. For example, helping a participant to connect to community-based organizations based on participants' identified interests that are available to the public and promote recovery and social integration.
- Instruction in self-advocacy skills including activities designed to facilitate participants' ability to access social service systems (health care, substance abuse, employment, vocational rehabilitation, entitlements/benefits, self-help groups) and other recovery-oriented systems of care are included.
- Instruction in developing strategies to manage trauma induced behaviors and/or PTSD as per a Trauma Informed Assessment.

The cost of transportation provided by residential service providers to and from activities is included as a component within the rate of the residential service. Providers of residential services are responsible for the full range of transportation services needed by the participants they serve to participate in services and activities specified in their recovery-oriented service plan. This includes transportation to and from recovery-oriented services and employment services, as applicable.

**Modality**
Habilitation/Residential Support Services are face-to-face services and may be delivered individually or in a group.

**Setting**
Habilitation/Residential Support Services may be delivered in a home (on-site), or in the community (off-site) and may be provided by the provider of housing services of the individual.

**Admissions/Eligibility Criteria**
An Individual requires residential support, rehabilitation, and onsite services that may include, but are not limited to: cognition (cognitive skills), functional status (ADL), and recovery-oriented community support.

**Limitations/Exclusions**
The total combined hours for Habilitation and Residential Supports/Supported Housing are limited to no more than a total of 250 hours in a calendar year. Time limited exceptions to this limit for individuals transitioning from institutions are permitted if prior authorized and found to be part of the cost-effective package of services provided to the individual compared to institutional care.

**Certification/Provider Qualifications**
Non-licensed Staff (see appendix) may provide this service.

**Staffing Ratio/Case Limits**
- Staff ratio of 1:15 or less (1 Direct Care staff to 15 participants to provide individual, and group residential supports services).
- Supervisory ratio: 1:5 (1 supervisor to 5 Direct Care Staff).
# Family Support and Training

## Definition

Training and support necessary to facilitate engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. This service is provided only at the request of the individual. A person-centered or person-directed, recovery oriented, trauma-informed approach to partnering with families and other supporters to provide emotional and information support, and to enhance their skills so that they can support the recovery of a family member with a substance use disorder/mental illness. The individual, his or her treatment team and family are all primary members of the recovery team.

For purposes of this service, “family” is defined as the persons who live with or provide care to a person served on the waiver and may include a parent, spouse, significant other, children, relatives, foster family, or in-laws. “Family” does not include individuals who are employed to care for the participant.

Training includes instruction about treatment regimens, elements, recovery support options, recovery concepts, and medication education specified in the Individual Recovery Plan and shall include updates, as necessary, to safely maintain the participant at home and in the community. All family support and training must be included in the individual’s recovery plan and for the benefit of the Medicaid covered participant.

## Service Components

Allowable activities include:

- Training on treatment regimens including elements such as: recovery support options, recovery concepts and medication education and use of equipment
- Assisting the family to provide a safe and supportive environment in the home and community for the individual (e.g., coping with various behavior challenges, understanding Substance use disorder, psychotherapy, and behavioral interventions)
- Provide one-on-one and group counseling
- Facilitate family and friends support groups under the direction of a certified peer
- Provide family mediation and conflict resolution services
- Development and enhancement of the family’s specific problem-solving skills, coping mechanisms, and strategies for the individual’s symptom/behavior management and prevention of relapse. This includes providing tools on problem solving and coping skills and strategies
- Collaboration with the family and caregivers in order to develop positive interventions to address specific presenting issues and to develop and maintain healthy, stable relationships among all caregivers, including family members, in order to support the participant’s recovery. Emphasis is placed on the acquisition of coping skills by building upon family strengths
- Assisting the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the Medicaid eligible individual in relation to their substance use disorder/mental illness and treatment
- Provide family with training/workshops on topics including recovery orientation and advocacy, psycho-education, person-centeredness, recovery orientation, trauma, psychosocial rehabilitation, crisis intervention and related tools and skills such as Individual recovery plans, WRAP, self-care, emotional validation, communication skills, boundaries, emotional regulation, relapse prevention, violence prevention and suicide
- Assisting the family in understanding various requirements of the waiver process, such as the individual recovery plan, crisis/safety plan and plan of care process; training on
understanding the individual’s diagnoses; understanding service options offered by service providers; and assisting with understanding policies, procedures and regulations that impact the individual with substance use disorder/mental illness concerns while living in the community (e.g., training on system navigation and Medicaid interaction with other individual-serving systems)

- Training on community integration and self-advocacy
- Training on behavioral intervention strategies (e.g., communication skills, relapse prevention, violence and suicide prevention, etc.)
- Training on mental health conditions, services and supports including providing benefits and entitlements counseling and providing skills and knowledge to parents with mental illness and SUD on issues such as problems with Criminal Justice stakeholders, Child Protective Services, Housing entities, etc. Training and technical assistance on caring for medically fragile individuals including those with severe substance use disorder/mental illness and chronic medical conditions.

### Modality
Face-to-face individual and groups.

### Setting
Home, Community, office.

### Admissions/Eligibility Criteria
- Participant assessed to need, and has a preference for family support and consultation services. All families and those in the individual’s support network are eligible for this service at the discretion of the individual
- A release of information from the individual is always required to allow staff to contact significant people, except in cases of threat of injury or death

### Limitations/Exclusions
The total combined hours for Family Support and Training are limited to no more than a total of 40 hours in a calendar year.

### Certification/Provider Qualifications
Para-professional staff (see appendix) may provide this service.

### Staffing Ratio/Case Limits
- 1:15 for staff to individual ratio, and 1:16 for groups with family members.
- Para-professional staff (see appendix) may provide this service.
Mobile Crisis Intervention

Definition
Mobile Crisis Intervention services are provided as part of a comprehensive specialized psychiatric services program available to all Medicaid eligible adults with significant functional impairments meeting the need levels in the 1915(i)-like authority resulting from an identified mental health or co-occurring diagnosis. Mobile Crisis Intervention services are provided to a person who is experiencing or is at imminent risk of having a psychiatric crisis and are designed to interrupt and/or ameliorate a crisis including a preliminary assessment, immediate crisis resolution and de-escalation. Services will be geared towards preventing the occurrence of similar events in the future and keeping the person as connected as possible with environment/activities. The goals of Mobile Crisis Intervention services are engagement, symptom reduction, and stabilization. All activities must occur within the context of a potential or actual psychiatric crisis.

Service Components
Mobile Crisis Intervention services include the following components:

- A preliminary assessment of risk, mental status, medical stability and community tenure and the need for further evaluation or other mental health services. Includes contact with the consumer, family members, and/or other collateral sources (e.g. caregiver, school personnel) with pertinent information for the purpose of a preliminary assessment, treatment and/or referral to other alternative mental health services at an appropriate level
- Crisis resolution and consultation with the identified Medicaid eligible individual and the treatment provider
- Referral and linkage to appropriate Medicaid behavioral health community services to avoid more restrictive levels of treatment
- Linkage to Short Term Crisis Respite or Intensive Crisis Respite when clinically appropriate
- Includes contact with the client, family members, or other collateral sources Short-term CIs include crisis resolution and de-briefing with the identified Medicaid eligible individual and the treatment provider
- Follow-up with the individual, and when appropriate, with the individuals’ caretaker and/or family members
- Follow-up with the individual and the individuals’ family/supportive network which could be provided by a Peer Specialist in order to confirm linkage to Care Coordination, outpatient treatment or other services as appropriate
- Consultation with a physician or other qualified providers to assist with the individual’s specific crisis and plans for the individual’s future.

Modality
Mobile Crisis is a face-to-face intervention.

Setting
Mobile Crisis may occur in various settings, including emergency rooms and community locations where a person lives, works, attends school and/or socializes.

Admissions/Eligibility Criteria
All Medicaid eligible adults with significant functional impairments meeting the need levels in the 1915(i)-like authority resulting from an identified mental health or co-occurring diagnosis receiving this service are experiencing or at imminent risk of experiencing a psychiatric crisis.

Limitations/Exclusions
No Limits.
Certification/Provider Qualifications

- Agency must possess a current license to provide crisis and/or treatment services (i.e. clinic, Comprehensive Psychiatric Emergency Programs (CPEP), Partial Hospital, PROS or have licensed professionals who have a minimum of 1 year of experience in delivering off-site crisis services including conducting psychiatric evaluations and providing treatment.
- Agency must demonstrate capacity for mobile crisis visits to be conducted by a minimum of 2 staff persons – one of whom must be a licensed clinician.
- Services must be staffed by a multidisciplinary team including licensed, para-professional and certified peer staff (see appendix).

Staffing Ratio/Case Limits

N/A
**Short-term Crisis Respite**

**Definition**

Short-term Crisis Respite is a short-term care and intervention strategy for individuals who have a mental health or co-occurring diagnosis and are experiencing challenges in daily life that create risk for an escalation of symptoms that cannot be managed in the person’s home and community environment without onsite supports including:

- A mental health or co-occurring diagnosis and are experiencing challenges in daily life that create imminent risk for an escalation of symptoms and/or a loss of adult role functioning but who do not pose an imminent risk to the safety of themselves or others
- A challenging emotional crisis occurs which the individual is unable to manage without intensive assistance and support
- When there is an indication that a person’s symptoms are beginning to escalate

Referrals to Crisis Respite may come from the emergency room, the community, self-referrals, a treatment team, or as part of a step-down plan from an inpatient setting. Crisis respite is provided in site-based residential settings. Crisis Respite is not intended as a substitute for permanent housing arrangements.

**Service Components**

Components offered may include: peer support, either on site or as a wrap-around service during the respite stay, health and wellness coaching, WRAP planning, wellness activities, family support, conflict resolution, and other services as needed:

- Onsite peer support during the respite stay
- Working with existing treatment providers
- Health and wellness coaching
- Relaxation techniques to help reduce stress, anxiety, emerging panic or feelings of losing control
- Coordinating with primary care, Health Home or other BH providers (on-site or through referrals)
- WRAP (Wellness Recovery Action Plan) planning
- Wellness activities
- Family support
- Conflict resolution
- Ongoing communication between the consumer, crisis respite staff, natural supports, and the individuals’ established mental health providers to assure collaboration and continuity in managing the crisis situation and identifying subsequent support and service systems
- Collaboration with the individual, BH providers, and natural supports to make recommendations for modifications to the recipients’ plan of care and treatment.

At the conclusion of a Crisis Respite period, crisis respite staff, together with the individual and his or her established mental health providers, will make a determination as to the continuation of necessary care and make recommendations for modifications to the recipients’ plan of care.

**Modality**

Short-term Crisis Respite is a face-to-face service.
Setting

- Site-based residential settings will offer a supportive home-like environment with a maximum preferred capacity of 8-10 guests (fewer in rural areas), preferably in single rooms.
- The setting must be code compliant.
- Staffed and open 24 hours a day, seven days a week when a resident is present.
- Residents should be allowed to leave and return as needed, maintaining employment and other daily activities to the extent possible.

To the greatest extent possible, guests will be encouraged to maintain contact with significant others, including family members, friends, and spouses. To facilitate this contact, guests may have visitors at any time that is convenient and practical for the guest as well as the operations of the CRC.

Admissions/Eligibility Criteria

All individuals receiving this service must be experiencing a crisis, and be:

- Willing to voluntarily stay at a Crisis Respite
- Willing to be assessed by a treating professional including undergo a HARP and 1915(i) assessment
- Willing to authorize release of medical records by relevant treating providers
- Have a mental health or co-occurring diagnosis and are experiencing challenges in daily life that create imminent risk for an escalation of symptoms and/or a loss of adult role functioning but who do not pose an imminent risk to the safety of themselves or others

EXCLUSIONS:

- Diagnosis of dementia, organic brain disorder or TBI
- Those with an acute medical condition requiring higher level of care
- At imminent risk to self or others that requires higher level of care
- Displays symptoms indicative of active engagement in substance use manifested in a physical dependence or results in aggressive or destructive behavior
- Does not have permanent housing or is homeless
- Is not willing or able to respect and follow the guest agreement during his/her stay
- Is not willing to sign necessary registration documentation
- Is not willing to participate in the wellness process during his/her stay

Limitations/Exclusions

No longer than 1 week per episode, not to exceed a maximum of 21 days per year. Individual stays of greater than 72 hours require prior authorization. Individuals requiring crisis respite for longer periods may be evaluated on an individual basis and approved for greater length of stay based on medical necessity.

Certification/Provider Qualifications

Crisis Respite services may be delivered by peers or non-licensed staff (see appendix):

- The CR should have a Program Director (1 FTE) who will have 3-5 years of management experience working in a social service or related setting and will supervise CR staff and coordinate the day-to-day activities associated with managing the CR
- Peer Respite staff will have experience as a recipient of mental health services with a willingness to share personal, practical experience, knowledge, and first-hand insight to benefit program enrollees
- Peer Respite staff will possess the competency to meet requirements outlined in the job description, and will complete any relevant trainings within 90 days of employment

All Peer staff must be OMH or OASAS certified.
Staffing Ratio/Case Limits

- There shall be a minimum of one staff person on-site for every four guests from 7 am to 8 pm.
- Between the hours of 8 pm and 7 am, there shall be a minimum of two staff on-site.
- The director or a designee shall be available at all times by cell phone.
Intensive Crisis Respite

**Definition**
Intensive Crisis Respite (ICR) is a short-term, residential care and clinical intervention strategy for individuals who are facing a behavioral health crisis, including individuals who are suicidal, express homicidal ideation, or have a mental health or co-occurring diagnosis and are experiencing acute escalation of mental health symptoms. In addition, the person must be able to contract for safety.

Individuals in need of ICR are at imminent risk for loss of functional abilities, and may raise safety concerns for themselves and others without this level of care. The immediate goal of ICR is to provide supports to help the individual stabilize and return to previous level of functioning or as a step-down from inpatient hospitalization.

**Service Components**
Services offered include:
- Comprehensive assessment including screening for physical health conditions
- Comprehensive risk assessment medication management
- Individual and group counseling
- Training in de-escalation strategies
- Relaxation techniques to help reduce stress, anxiety, panic or feelings of losing control
- Monitoring for high risk behavior
- Psychiatric evaluation for competency
- Linkage to resources and referrals to community-based mental health and substance abuse treatment
- Peer support
- WRAP (Wellness Recovery Action Plan) planning
- Wellness activities
- Family support
- Engagement of Natural Supports
- Conflict resolution
- Hotline

Ongoing communication between individuals receiving ICR, crisis respite staff, and the individuals’ established mental health providers is necessary to assure collaboration and continuity in managing the crisis, as well as to identify effective subsequent support and service resources. At the conclusion of an Intensive Crisis Respite period, clinical staff, together with the individual, will make recommendations for modifications to the recipients’ plan of care.

**Modality**
Intensive Crisis Respite is a face-to-face intervention.

**Setting**
Participants are encouraged to receive respite in the most integrated and cost-effective settings appropriate to meet their respite needs, preferably in a residential, community-based setting.

**Admissions/Eligibility Criteria**
- Individuals who may be a danger to self or others and are experiencing acute escalation of mental health symptoms and/or at imminent risk for loss of functional abilities, and raise safety concerns for themselves and others but can contract for safety.
- Experiencing symptoms beyond what can be managed in a short term crisis respite.
- Individual does not require inpatient admission or can be used as an alternative to inpatient admission if clinically indicated and person can contract for safety.
Limitations/Exclusions

- 7 days maximum
- Intensive Crisis Respite services include a limit of 21 days per year. Individuals requiring Intensive Crisis Respite for longer periods than those specified may be evaluated on an individual basis and approved for greater length of stay based on medical necessity.
- Have an acute medical condition requiring higher level of care.

Certification/Provider Qualifications

- Agency must possess a current license to provide crisis and/or treatment services (i.e. clinic, Comprehensive Psychiatric Emergency Programs (CPEP), Partial Hospital, PROS, Psychiatric Inpatient or have licensed professionals who have a minimum of 1 year of experience in delivering off-site crisis services including conducting psychiatric evaluations and providing treatment.
- Agency must demonstrate capacity for mobile crisis visits to be conducted by a minimum of 2 staff persons – one of whom must be a licensed clinician.
- This service will be provided by a multidisciplinary team of licensed, para-professional and certified peer staff.

Staffing Ratio/Case Limits

- Adequate number of staff and an appropriate staff composition to carry out its goals and objectives as well as to ensure the continuous provision of sufficient ongoing and emergency supervision and treatment.
- Every ICR shall have at least one psychiatrist as primary medical coverage. Back-up coverage may be a physician who will consult with the psychiatrist. The psychiatrist or physician shall be on call 24-hours-a-day and will make daily rounds. Counties of less than 50,000 population may utilize a licensed physician for on-call activities and daily rounds as long as the physician has postgraduate training and experience in diagnosis and treatment of SMI and SUD
- At least one registered nurse shall be on duty 24-hours-a-day, 7-days-a-week when there is a consumer in care.

- Staffing ratio:

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<tr>
<th>Beds:</th>
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<th>11-20</th>
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<tbody>
<tr>
<td>RNs</td>
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<td>1</td>
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<tr>
<td>Mental Health Treatment Staff</td>
<td>1</td>
<td>2</td>
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Education Support Services

Definition

Education Support Services are provided to assist individuals with mental health or substance use disorders who want to start or return to school or formal training with a goal of achieving skills necessary to obtain employment. Education Support Services consist of special education and related services as defined in Sections (22) and (25) of the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) (20 U.S.C. 1401 et seq.), to the extent to which they are not available under a program funded by IDEA or available for funding by the NYS Adult Career & Continuing Education Services Office of Vocational Rehabilitation (ACCES-VR) (The Vocational Rehabilitation component (ACCES-VR) encompasses many of the services that were previously part of Vocational and Educational Services for Individuals with Disabilities, or VESID).

Education Support Services may consist of general adult educational services such as applying for and attending community college, university or other college-level courses. Services may also include classes, vocational training, and tutoring to receive a Test Assessing Secondary Completion (TASC) diploma, as well as support to the participant to participate in an apprenticeship program.

Participants authorized for Education Support Services must relate to an employment goal or skill development documented in the service plan. Education Support Services must be specified in the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. Examples of these goals would include, but not be limited to: tutoring or formal classes to obtain a Test Assessing Secondary Completion (TASC) diploma, vocational training, apprenticeship program or formal classes to improve skills or knowledge in a chosen career, community college, university or any college-level courses or classes.

Ongoing Supported Education: is conducted after a participant is successfully admitted to an educational program. Ongoing follow-along is support available for an indefinite period as needed by the participant to maintain their status as a registered student.

Service Components

Service components include:

- Providing support in a variety of educational settings, such as classroom and test-taking environments
- Serve as a resource clearinghouse for educational opportunities, tutoring, financial aid and other relevant educational supports and resources
- Provide linkages to education-related community resources including supports for learning and cognitive disabilities
- Assist with admission applications and registration
- Identify financial aid resources and assist with applications
- Assist with transitions and/or withdrawals from programs such as those resulting from mental health or substance abuse challenges, issues and medical conditions and other co-occurring disorders
- Orient individual to school settings, navigating the school system and student services particularly disability services
- Providing cognitive remediation services to improve executive functioning abilities such as attention, organizing, planning and working memory
- Conducting a needs assessment, based on employment goal to identify education/training requirements, personal strengths and necessary support services
- Evaluate educational/career plan on an ongoing basis and revise as needed in response to
individuals' needs and recovery process
- Assist with skill development including study skills, note taking, time and stress management and social skills in relation to mental health and SUD history and other related issues
- Providing advocacy support to obtain accommodations such as requesting extensions for assignments and different test-taking setting if needed for documented cognitive or learning disability
- Providing instruction on self-advocacy skills in relation to independent functioning in the educational environment

**Modality**
Face to face service.

**Setting**
Ideal setting is in the educational setting site, but can also be provided at program site and other community-based locations as well as the individual's home.

**Admissions/Eligibility Criteria**
Individual who have been assessed to need Education Support Services and clearly stated interest in obtaining employment with the skills obtained.

**Limitations/Exclusions**
- The hours for supported education are limited to no more than a total of 250 hours per year. Documentation is maintained in the file of each individual receiving this service that the service is not otherwise available under section 110 of the Rehabilitation Act of 1973 or the IDEA.
- Can only access this service if other appropriate state plan services are not available or appropriate.

**Certification/Provider Qualifications**
- Education Specialists should possess a BA, and two years of experience supporting individuals in pursuing education goals.
- A supervisor may be non-licensed (see appendix) and requires a minimum of a BA (preferably a Masters in Rehabilitation or a relevant field), a minimum of three years of relevant work experience preferably as an education specialist. All staff should have minimum of two years working in the behavioral health.
- Staff should have knowledge in the following areas: disability accommodations and assistive technology, financial aid, student loan default, SUD recovery resources on campus, etc.

**Staffing Ratio/Case Limits**
- Maximum caseload for a full-time education specialist is 20 individuals and proportional number for part-time staff.
## Empowerment Services - Peer Supports

### Definition

Peer Support services are peer-delivered services with a rehabilitation and recovery focus. They are designed to promote skills for coping with and managing behavioral health symptoms while facilitating the utilization of natural resources and the enhancement of recovery-oriented principles (e.g. hope and self-efficacy, and community living skills). Peer support uses trauma-informed, non-clinical assistance to achieve long-term recovery from SUD and Mental health issues.

Activities included must be intended to achieve the identified goals or objectives as set forth in the participants individualized recovery plan, which delineates specific goals that are flexibly tailored to the participant and attempt to utilize community and natural supports. The intent of these activities is to assist recipients in initiating recovery, maintaining recovery, sustaining recovery and enhancing the quality of personal and family life in long-term recovery.

The structured, scheduled activities provided by this service emphasize the opportunity for peers to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery. Persons providing these services will do so through the paradigm of the shared personal experience of recovery.

### Service Components

There are 6 categories of peer-support components. They include:

1. **Advocacy**:
   - Assistance seeking and obtaining benefits and entitlements, food, shelter, permanent housing
   - Assisting recipients in participating in shared decision making (e.g. MyPSYCKES)
   - Linkage to and systems navigation within behavioral health and allied human services systems to access appropriate care (e.g. Peer Bridgers)
   - Benefits advisement and planning
   - Development of psychiatric advance directives (PAD)
   - Assistance advocating for self-directed services

2. **Outreach and Engagement**:
   - Companionship and modeling of recovery lifestyle, including participation in recovery activities that might be beyond the scope of treatment providers (e.g., eating together at a restaurant, attending or participating in a sporting event, attending a social event such as a concert or recovery celebration event)
   - Raising the awareness of existing services, pathways to recovery and helping a person to remove barriers that exist for access to them
   - Interim visits with individuals after discharge from Hospital Emergency Rooms, Detox Units or Inpatient Psychiatric Units to facilitate community tenure and increased readiness while waiting for the first post-discharge visit with a community-based mental health provider, treatment provider or appropriate system of care

3. **Self-help tools**:
   - Assist selecting and utilizing self-directed recovery tools such as Wellness Recovery Action Plan (WRAP) or Individualized Recovery Plan
   - Assist selecting and utilizing the things that bring a sense of passion, purpose and meaning into his/her life and coaching the person as they identify barriers to engaging in these activities
   - Assist individuals to help connect to natural supports that enhance the quality and security of life
• Connecting individuals to “warm lines”
• Connections to self-help groups in the community

4. Recovery Supports:
• Recovery education and coaching for individuals and their family members.
• One to one peer support
• Person centered goal planning that incorporates life areas such as community connectedness, physical wellness, spirituality, employment, self-help
• Assisting with skills development that guides people towards a more independent life

5. Transitional Supports:
• Bridging from Jail or prison to a person’s home (note: that peer supports while in Jail are not Medicaid reimbursable)
• Bridging from institutions to a person’s home (note: that peer supports while in an institution are not Medicaid reimbursable)
• Bridging from general hospitals to a person’s home
• Bridging from a person’s home to the community

6. Pre-crisis and Crisis Supports:
• Providing companionship when a person is in an emergency room or crisis unit or preparing to be admitted to detox, residential or other service to deal with crisis
• Providing peer support in the person’s home or in the community to support them before (or in) a crisis or relapse
• Developing crisis diversion plans or relapse prevention plans

Modality
This is a face to face service.

Setting
Peer supports may be provided in a variety of setting including: inpatient, outpatient, community, and respite programs. With the exception of services provided in inpatient settings the majority of the contacts with the recipient should be offsite in the community. Meeting at community locations such as may include: a person’s home, homeless shelters and soup kitchens for the purpose of opening up a dialogue. Note: Peer Support must be the individual’s recovery plan.

Admissions/Eligibility Criteria
Peer support is voluntary, subject to periodic review of goals and based on medical necessity.

Limitations/Exclusions
Peer support services are limited to no more than a total of 500 hours in a calendar year. Individuals receiving SUD outpatient treatment may not receive Peer Supports, if they are receiving an OASAS state plan peer service.

Note: peer services while an individual is incarcerated or institutionalized are not Medicaid reimbursable. Time spent on the phone with individuals is not Medicaid reimbursable. The cost of admission to an event (i.e., sports event or concert) is not Medicaid reimbursable. Advocacy for community improvement (not specific to the Medicaid eligible individual) is not Medicaid reimbursable.

Certification/Provider Qualifications
Peer support providers must have a certification as of the following:
- OMH established Certified Peer Specialist
- OASAS established Peer Specialist

Certified Peer Specialists are appropriately supervised treatment team members who will play an integral role in care planning including the Wellness Recovery Action Plan (WRAP), treatment planning and the development of psychiatric advance directives (PAD). Training for Peer Specialists will be provided/contracted by OMH and OASAS and will focus on the principles and concepts of recovery, coping skills, and advocacy, the unique competencies needed to assist another individual based on the shared personal experience paradigm.

Supervision of peer support must be provided by a licensed behavioral health practitioner.

**Staffing Ratio/Case Limits**

Maximum 1 FTE to 20 consumers.
**Non-Medical Transportation**

**Definition**
Non-medical Transportation services are offered, in addition to any medical transportation furnished under the 42 CFR 440.17(a) in the State Plan. Non-medical Transportation services are necessary, as specified by the service plan, to enable participants to gain access to authorized home and community based services that enable them to integrate more fully into the community and ensure the health, welfare, and safety of the participant.

This service will be provided to meet the participant’s needs as determined by an assessment performed in accordance with Department requirements and as outlined in the participant’s service plan.

**Service Components**
Transportation services consist of:

Transportation (per/mile) - This Transportation service is delivered by providers, family members, and other qualified, licensed drivers. Mileage is used to reimburse the owner of the vehicle or other qualified, licensed driver who transports the participant to and from services and resources related to outcomes specified in the participant’s service plan. The unit of service is one mile. Mileage can be paid round trip. A round trip is defined as from the point of first pickup to the service destination and the return distance to the point of origin.

When Transportation is provided to more than one participant at a time, the provider will divide the shared miles equitably among the participants to whom Transportation is provided. The provider is required (or it is the legal employer’s responsibility under the Vendor Fiscal/Employer Agent (FMS) model) to track mileage, allocate a portion to each participant, and provide that information to the Case Manager for inclusion in the participant’s service plan.

Services must be delivered in a manner that supports the participant’s communication needs including, but not limited to, age appropriate communication, translation services for participants that are of limited-English proficiency or who have other communication needs requiring translation, assistance with the provider’s understanding and use of communication devices used by the participant.

Public Transportation - The utilization of Public Transportation promotes self-determination and is made available to participants as a cost-effective means of accessing services and activities. This service provides payment for the individual’s use of public transportation.

The Care Manager will monitor this service quarterly and will provide ongoing assistance to the participant to identify alternative community-based sources of transportation.

Replacement cards for lost or stolen cards or passes are to be approved by Case Manager. Participants must report lost or stolen card/pass and have written documentation to present.

**Modality**
In person

**Setting**
Community
**Admissions/Eligibility Criteria**
The type and amount of waiver transportation must be included in the approved Service Plan.

**Limitations/Exclusions**
No more than $2,000 per calendar year for both public and mile reimbursement combined.

Non-Medical Transportation will only be available for non-routine, time-limited services, not for ongoing treatment or services.

All other options for transportation, such as informal supports, community services, and public transportation must be explored and utilized prior to requesting waiver transportation. This service is not intended to replace services provided by ACCES-VR, or any other existing provider, but compliment them.

Individuals enrolled in residential services who receive transportation as part of the benefit will not be eligible for this 1915(i)-like service.

**Certification/Provider Qualifications**
A provider of transportation may be an agency or provider contracted by the managed care company for the provision of non-medical transportation, a public/mass transportation service, or a family member or individual designated in the Service Plan. All providers must have a current New York State driver's license in good standing; drive a New York State-registered, inspected and insured vehicle; and be identified in the Service Plan. For contracting provider agencies, drivers must have a clean driving record with no history of DWI/DUI in the preceding 5 years.

**Staffing Ratio/Case Limits**
The unit of service is one mile. Mileage can be paid round trip. A round trip is defined as from the point of first pickup to the service destination and the return distance to the point of origin. When Transportation is provided to more than one participant at a time, the provider will divide the shared miles equitably among the participants to whom Transportation is provided. The provider is required to track mileage, allocate a portion to each participant, and provide that information to the Case Manager for inclusion in the participant’s service plan.
Pre-vocational Services

Definition
Pre-vocational services are time-limited services that prepare a participant for paid or unpaid employment. This service specifically provides learning and work experiences where the individual with mental health and/or disabling substance use disorders can develop general, non-job-task-specific strengths and soft skills that contribute to employability in competitive work environment as well as in the integrated community settings. Pre-vocational services occur over a defined period of time and with specific person centered goals to be developed and achieved, as determined by the individual and his/her employment specialist and support team and ongoing person-centered planning process as identified in the individual’s person-centered plan of care. Pre-vocational services provide supports to individuals who need ongoing support to learn a new job and/or maintain a job in a competitive work environment or a self-employment arrangement. The outcome of this pre-vocational activity is documentation of the participant’s stated career objective and a career plan used to guide individual employment support.

Service Components
Service components include:

- Teaching concepts such as: work compliance, attendance, task completion, problem solving, and safety, and, if applicable, teach individuals how to identify obstacles to employment, obtain paperwork necessary for employment applications, and how to interact without the use of drugs with people who have not used drugs especially in the workplace
- Providing scheduled activities outside of an individual’s home that support acquisition, retention, or improvement in job-related skills related to self-care, sensory-motor development, socialization, daily living skills, communication community living, social and cognitive skills. This could include opening and maintaining a bank account for work-related direct deposit
- Gaining work-related experience considered crucial for job placement (e.g., volunteer work, time-limited unpaid internship) and career development

Services do not include development of job specific skills.

Modality
Pre-vocational services are face-to-face services.

Setting
This service is generally provided at the program site, but also includes support at a work location where the individual may acquire work-related experience such as volunteering and internships in the community.

Admissions/Eligibility Criteria
Individual must have a clear desire to work in competitive employment.

Limitations/Exclusions
The total combined hours (for pre-vocational services and transitional supported employment) are limited to no more than a total of 250 hours and a duration of 9 months of service in a calendar year.
For all employment supports services, documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses, such as the following:
• Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program
• Payments that are passed through to users of supported employment programs
• Payments for training that is not directly related to an individual's supported employment program

When Pre-vocational services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision, and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting or work environment.

**Certification/Provider Qualifications**

- Employment Specialists may be non-licensed (see appendix) and should possess education and experience equivalent to an undergraduate degree in vocational services, disabilities services, business, personnel management, mental health or social services counseling.
- A program manager requires a minimum of a BA (preferably a Masters in Rehabilitation or a behavioral health field) and a minimum of three years' relevant work experience preferably as an employment specialist and minimum 18 months of management experience is a SUD rehab/treatment setting.
- OASAS Certified Clinics and in community based programs.

**Staffing Ratio/Case Limits**

- Maximum caseload for a full-time employment specialist is 20 clients and respective proportions for part-time staff.
- The recommended program manager to staff ratio is 1:10.
**Transitional Employment**

**Definition**

This service is designed to strengthen the participant’s work record and work skills toward the goal of achieving assisted or unassisted competitive employment at or above the minimum wage paid by the competitive sector employer. This service is provided, instead of individual supported employment, only when the person specifically chooses this service and may only be provided by clubhouse, psychosocial club program certified provider or recovery center.

This service specifically provides learning and work experiences where the individual with behavioral health and/or substance use disorders can develop general, non-job-task-specific strengths and soft skills that contribute to employability in the competitive work environment in integrated community settings paying at or above minimum wage.

The outcome of this activity is documentation of the participant’s stated career objective and a career plan used to guide individual employment support.

**Service Components**

Service components include:

- Provide time-limited employment and on-the-job training in one or more integrated employment settings as an integral part of the individual's vocational rehabilitation growth.
- Provide support to participants to gain skills to enable transition to integrated, competitive employment.
- Training activities provided in regular business, industry, and community settings.
- Promoting integration into the workplace and interaction between people without disabilities in those workplaces and other program participants if the TE placement is made for a group as well as individuals in recovery as well as those without disabling addiction or substance use disorders.
- Provide Transitional Employment supports during placement. This support includes: initial and ongoing employment planning and advancement, employment assessment not otherwise covered in the annual career planning, job placement, job development, negotiation with prospective employers, job analysis, training and systematic instruction, job coaching, benefits supports, training, and planning transportation.
- Training or referral to a training program.
- Planning transportation.
- Encourage and instill self-confidence to work in competitive employment.
- ADL skills specific to the TE placement.
- Teach Activities of Daily Living (ADL) skills specific to the Transitional Employment placement and may include appropriate dress, hygiene, walk, talk, and eye contact, money management, dealing with outstanding warrants, and legal history, time management, collection of work related documentation and credentials.
- Offer Services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting.

- Providing on the job supports, including:
  - On-site job training
  - Assisting the participant to develop natural supports in the workplace without the use of substances.
Adopt an identity as a worker
Accept responsibility for decision
Examine past work experiences for failure and successes.
Consider potential for transferability of skills
Coordinate with employers and coworkers, as necessary, to accommodate the individual in meeting employment expectations, and addressing work related and personal issues as they arise

**Modality**
Transitional Employment is a face-to-face intervention.

**Setting**
Clubhouses for OMH populations only, OASAS Certified Clinics and in community based programs.

**Admissions/Eligibility Criteria**
- An individual must have made a clear decision to work in competitive employment in the community regardless of limited or unsuccessful work history, or present status of sobriety and/or abstinence.
- The basic tenet of Transitional Employment is that all individuals are capable of working in competitive employment in the community even without prior training and all individuals interested in employment should be given the opportunity.

**Limitations/Exclusions**
The total combined hours for pre-vocational and transitional supported employment) are limited to no more than a total of 250 hours and a duration of 9 months of service in a calendar year.

Additionally, Transitional Employment placements should be part-time and time-limited, usually 15-20 hrs/week from 6-9 months in duration.

For all employment supports services, documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses, such as the following: incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program, payments that are passed through to users of the state VR supported employment programs, and payments for training that is not directly related to an individual's supported employment program. When employment support services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision, and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.

**Certification/Provider Qualifications**
- Employment Specialists may be non-licensed (see appendix) and should possess education and experience equivalent to an undergraduate degree in vocational services, business, personnel management, disability, mental health or social services.
- A program manager requires a minimum of a BA (preferably a Masters in Rehabilitation or a behavioral health field) and a minimum of three years’ relevant work experience working in a rehab or SUD treatment setting and minimum 18 months of management experience.
- Additionally, Clubhouses/Psychosocial clubs and Recovery Centers may be certified by
Clubhouse International, certified/licensed as Recovery Centers, or at a minimum provide services similar to those of clubhouses.

**Staffing Ratio/Case Limits**
- Maximum caseload for a full-time employment specialist is 20 clients and respective proportions for part-time staff.
- The recommended program manager to staff ratio is 1:10.
**Intensive Supported Employment (ISE)**

**Definition**
ISE services that assist individuals with MH/SUD to obtain and keep competitive employment. These services consist of intensive supports that enable individuals to obtain and keep competitive employment at or above the minimum wage. This service will follow the evidence based principles of the Individual Placement and Support (IPS) model.

This service is based on Individual Placement Support (IPS) model which is an evidence based practice of supported employment. It consists of intensive supports that enable individuals for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their clinical and functional needs, require supports to perform in a regular work setting. Individual employment support services are individualized, person-centered services providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Participants in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this activity is documentation of the participant’s stated career objective and a career plan used to guide individual employment support. Services that consist of intensive supports that enable participants for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their disabilities, need supports to perform in a regular work setting.

**Service Components**
Components include:
- Assist the participant to locate a job or develop a job on behalf of the individual via the use of individualized placement and support services that include rapid job search including acquisition of hard and soft skills to retain employment, training and systematic instruction, as well as providing support for the job application process such as resume writing, interviewing and application submission
- Support the individual to establish or maintain self-employment, including home-based self-employment
- Provide ongoing job related discovery and assessment

Provide job placement, systematic job development, job coaching, negotiation with prospective employers, job analysis, job carving (creating, modifying, or customizing a community-based job such that it can be successfully performed by an individual on supported employment,) customize employment training and systematic instruction, benefits counseling support, training and planning, transportation, asset development and career advancement services, customized employment, and other workforce support services. Workforce support services include benefits counseling support (e.g., personalized benefits counseling that assists individuals in obtaining personalized information about their government entitlements), training and planning, transportation navigation, asset development and career advancement services.

**Modality**
Intensive Supported Employment is a face-to-face intervention.

**Setting**
This service is generally provided at an employment program but can be provided at a location of the participant’s choosing including the workplace based on individual need.
Admissions/Eligibility Criteria
- In order to achieve a successful outcome in ISE, an individual must have made a clear decision to work in competitive employment in the community.
- The basic tenet of ISE is that all individuals are capable of working in competitive employment in the community even without prior training and all individuals interested in employment should be given the opportunity.
- The ongoing level of care criteria including service duration, intensity and effectiveness should be reviewed by the HCBS care manager and/or the MCO at least quarterly.

Limitations/Exclusions
250 hours per calendar year.

For all employment supports services, documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses, such as the following: incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program, payments that are passed through to users of supported employment programs, and payments for training that is not directly related to an individual's supported employment program. When employment support services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision, and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.

Certification/Provider Qualifications
- Employment Specialists may be non-licensed (see appendix) and should possess education and experience equivalent to an undergraduate degree in vocational services, business, personnel management, disability, mental health or social services.
- A program manager requires a minimum of a BA (preferably a Masters in a behavioral health field or vocational rehabilitation) and a minimum of three years’ relevant work experience preferably as an employment specialist or in a SUD treatment setting; and minimum 18 months of management experience.

Staffing Ratio/Case Limits
- Maximum caseload for a full-time employment specialist is 20 clients and respective proportions for part-time staff.
- The recommended program manager to staff ratio is 1:10.
Ongoing Supported Employment

Definition
This service is provided after a participant successfully obtains and becomes oriented to competitive and integrated employment. Ongoing follow-along is support available for an indefinite period as needed by the participant to maintain their paid employment position. Individual employment support services are individualized, person centered services providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Participants in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this activity is documentation of the participant’s stated career objective and a career plan used to guide individual employment support.

Service Components
Service components include:

- Providing support in a variety of settings, particularly work sites where persons without disabilities are employed:
  o Assists individuals to identify reasonable accommodations necessary to manage mental health symptoms that may emerge at work
  o Provides activities needed to retain paid work including job coaching and non-work task related training
  o Ongoing Supported Employment services may include assessment of issues and linkage/referral to other community resources as appropriate
- Providing activities needed to sustain paid work by participants, including supervision and training:
  o Provides supports to individuals who are currently employed in settings that are competitive and integrated
  o Assists individuals to establish positive workplace relationships, including interactions with supervisors, and co-workers
  o Helps individuals to build and sustain skills in the workplace, including time management, co-worker relationships, understanding supervisory roles and expectations, and accessing workplace supports, including EAP and job training
- Providing reminders of effective workplace practices and reinforcement of skills gained during the period of intensive supported employment services:
  o Assist individuals to manage mental health issues that may impact their ability to sustain employment

The basic tenet of ISE is that all individuals are capable of working in competitive employment in the community even without prior training and all individuals interested in employment should be given the opportunity.

Modality
Ongoing Supported Employment is a face-to-face intervention.

Setting
Ongoing Supported Employment services may be provided in any community location as well as at the workplace. Its primary focus is to support individuals to manage MH/SUD issues in a manner that will not jeopardize their employment.

Focus and delivery on Ongoing Supported Employment may not duplicate vocational services for
which the person is eligible through Rehabilitation Services Act (RSA/ACCES-VR).

**Admissions/Eligibility Criteria**
Must have made a clear goal to work in competitive employment in the community.

**Limitations/Exclusions**
250 hours per calendar year.

For all employment supports services, documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses, such as the following: incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program, payments that are passed through to users of supported employment programs, and payments for training that is not directly related to an individual's supported employment program. When employment support services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision, and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.

**Certification/Provider Qualifications**
- Employment Specialists may be non-licensed (see appendix) and should possess education and experience equivalent to an undergraduate degree in vocational services, business, personnel management, disability, mental health or social services.
- A program manager requires a minimum of a BA (preferably a Masters in a behavioral health field or vocational rehabilitation) and a minimum of three years’ relevant work experience preferably as an employment specialist or in a SUD treatment setting; and minimum 18 months of management experience.

**Staffing Ratio/Case Limits**
- Maximum caseload for a full-time employment specialist is 20 clients and respective proportions for part-time staff.
- The recommended program manager to staff ratio is 1:10.
VI. Appendix

HCBS Service Clusters:

Many of the 1915i-like services are designed to be provided in clusters that promote recovery along a spectrum. The clusters include:

- Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR)
- Crisis Services- Mobile Crisis Intervention, Intensive Crisis Respite and Short-term Crisis Respite
- Employment Services- Pre-vocational, Transitional, Intensive Supported Employment, Ongoing Supported Employment
- Peer Supports may be used in conjunction with other HCBS services.

HCBS Provider Competencies in Evidence Based Practices:

Licensed, non-licensed and certified peers who provide HCB services are encouraged to become trained on the various evidence based practices (EBPs). Free modules on various EBPs are available on the Website of Columbia University’s Center for Practice Innovation’s website (CPI; http://practiceinnovations.org/). The New York State Office of Mental Health (OMH) and the Department of Psychiatry, Columbia University, established the Center for Practice Innovations at Columbia Psychiatry and New York State Psychiatric Institute in November, 2007, to promote the widespread use of evidence-based practices throughout New York State. CPI uses innovative approaches to build stakeholder collaborations, develop and maintain practitioners’ expertise, build agency infrastructures that support implementing and sustaining evidence-based practices and direct staff competence. CPI is available to collaborate with agencies to increase the use of EBPs and improve staff clinical competencies.

CPI offers the following web-based training modules:

- Treating co-occurring mental health and substance use disorders (called “Focus on Integrated Treatment” or FIT)
- Assertive community treatment (ACT)
- Supported employment/education via individual placement and support (IPS)
- Wellness self-management (WSM)
- First episode psychosis (called OnTrackNY)
- Increasing the use of clozapine
- Suicide prevention
- Tobacco dependence treatment

CPI also offers programs training and other supports to help programs build capacity to implement evidence-based practices. These include:

- Online training modules using personal recovery stories, clinical vignettes, interactive exercises, frequent knowledge checks, and expert panel presentations to engage the learner (over 40 to date. As of January 31, 2014, 14,072 participants have completed 157,164 modules)
- Face-to-face training
- Interactive webinars
- Online resource library with practical tools
- Consultations (both in person and by telephone)

The Northeast Addiction Technology Center has many resources for SUD HCBS providers and can be found at http://www.nattc.org/home/.

**Staffing Guidelines:**

1. **Professional staff** means practitioners possessing a license or a permit from the New York State Education Department who are qualified by credentials, training, and experience to provide direct services related to the treatment of mental illness and shall include the following:

   a. **Certified Rehabilitation Counselor (CRC)** is certified with a national Certified Rehabilitation Counselor (CRC) designation by The Commission on Rehabilitation Counselor Certification (CRCC) that sets the standard for quality rehabilitation counseling services in the United States and Canada. All VR staff within the OASAS treatment provider system must adhere to the Code of Ethics set forth by the NYS Ethics Commission (http://www.nyintegrity.org/) and/or the Commission on Rehabilitation Counselor Certification (CRCC) (www.crccertification.com)

   b. **Creative arts therapist** is an individual who is currently licensed as a creative arts therapist by the New York State Education Department or possesses a creative arts therapist permit from the New York State Education Department.

   c. **Licensed practical nurse** is an individual who is currently licensed as a licensed practical nurse by the New York State Education Department or possesses a licensed practical nurse permit from the New York State Education Department.

   d. **Licensed psychoanalyst** is an individual who is currently licensed as a psychoanalyst by the New York State Education Department or possesses a permit from the New York State Education Department.

   e. **Licensed psychologist** is an individual who is currently licensed as a psychologist by the New York State Education Department or possesses a permit from the New York State Education Department and who possesses a doctoral degree in psychology, or an individual who has obtained at least a master's degree in psychology who works in a federal, state, county or municipally operated clinic. Such master’s degree level psychologists may use the title “psychologist,” may be considered professional staff, but may not be assigned supervisory responsibility.

   f. **Marriage and family therapist** is an individual who is currently licensed as a marriage and family therapist by the New York State Education Department or possesses a permit from the New York State Education Department.

   g. **Mental health counselor** is an individual who is currently licensed as a mental health counselor by the New York State Education Department or possesses a permit from the New York State Education Department.
h. **Nurse practitioner** is an individual who is currently certified as a nurse practitioner by the New York State Education Department or possesses a permit from the New York State Education Department.

i. **Nurse practitioner in psychiatry** is an individual who is currently certified as a nurse practitioner with an approved specialty area of psychiatry (NPP) by the New York State Education Department or possesses a permit from the New York State Education Department.

j. **Physician** is an individual who is currently licensed as a physician by the New York State Education Department or possesses a permit from the New York State Education Department.

k. **Physician assistant** is an individual who is currently registered as a physician assistant by the New York State Education Department or possesses a permit from the New York State Education Department.

l. **Psychiatrist** is an individual who is currently licensed to practice medicine in New York State, who (i) is a diplomate of the American Board of Psychiatry and Neurology or is eligible to be certified by that Board, or (ii) is certified by the American Osteopathic Board of Neurology and Psychiatry or is eligible to be certified by that Board.

m. **Registered professional nurse** is an individual who is currently licensed as a registered professional nurse by the New York State Education Department or possesses a permit from the New York State Education Department.

n. **Social worker** is an individual who is either currently licensed as a licensed master social worker or as a licensed clinical social worker (LCSW) by the New York State Education Department, or possesses a permit from the New York State Education Department to practice and use the title of either licensed master social worker or licensed clinical social worker.

II. **Paraprofessional/Non-licensed staff:**

   a. **Para-professional:** Individuals 18 years of age or older with a High School diploma or equivalent and 1-3 years of relevant experience or a BA degree.

   b. **Non-licensed staff:** Staff must have a high school diploma or equivalent, and must be 18 years of age and have experience working with individuals with SUD disorders and/or SMI. A Certified Peer Specialist, or equivalently qualified by education in the human services field or a combination of work experience and education, with one year of education substituting for one year of experience. A LMHP or QHP shall be available at all times to provide supervision, back up, support and/or consultation.

Direct service staff should be appropriately licensed or credentialed, trained and experienced practitioners with appropriate skills for engaging family members; providing education about substance use disorder/mental illness and its treatment; possessing information on community resources; guidance on how to manage or cope with substance use disorder relapse, maladaptive behaviors; emotional support and counseling; crisis planning; and problem solving skills training.
III. **Certified Peer:**
   a. *OMH-certified Peer Specialist*
   b. *OASAS-certified Peer Advocate*

IV. **State Credentialed Staff**
   a. **CASAC:** Staff person who holds a credential by the Office of Alcohol and Substance Abuse as a Credentialed Alcohol and Substance Abuse Counselor
   b. **CASAC-T:** Staff person who holds a credential by the Office of Alcohol and Substance Abuse as a Credentialed Alcohol and Substance Abuse Counselor

V. **Other Credentialed Staff**

   **Certified Psychiatric Rehabilitation Practitioner (CPRP):** Staff person who holds a credential from the Psychiatric Rehabilitation Association as a practitioner working within the adult mental health system.

**HCBS Documentation & Quality Assurance Reviews**

HCBS Documentation requirements for encounters:
- Name of consumer
- Type of service provided
- Date of service provided
- Location of service
- Duration of service, including start and end times
- Description of interventions to meet Plan of Care goals
- Outcome (s) or Progress made toward goal achievement
- Follow up/ next steps
- Your name, qualifications, signature and date

Quality Assurance Reviews:
- Quality Assurance reviews and claims audits will be conducted by NYS or its designee, including Local Government Units, to ensure providers comply with the rules, regulations, and standards of the program, and may be conducted without prior notice.
- The Quality Assurance reviews will focus on program aspects, but may include technical requirements such as billing, claims, and other Medicaid program requirements.
- Managed care plans may also be developing protocols to oversee the provision of these services in their provider networks.
ATTESTATION FORM

AGENCY NAME:

AGENCY ADDRESS:

CFR AGENCY CODE:

FEDERAL EMPLOYER ID NUMBER:

Person to Contact with Regard to Questions Concerning this Attestation:

____________________________________

(Provider Name)______________________________ IS SEEKING TO BE DESIGNATED TO PROVIDE THE FOLLOWING HOME AND COMMUNITY BASED SERVICES:

☐ Community Psychiatric Support and Treatment (CPST)
☐ Psychosocial Rehabilitation (PSR)
☐ Residential Support Services
☐ Family Support and Training
☐ Mobile Crisis Intervention
☐ Short-term Crisis Respite
☐ Intensive Crisis Respite
☐ Pre-vocational Employment
☐ Transitional Employment
☐ Intensive Supported Employment (ISE)
☐ Ongoing Supported Education
☐ Education Support Services
☐ Peer Supports
☐ Non-Medical Transportation
ATTESTATION STATEMENT

I HEREBY ATTEST THAT I AM THE DIRECTOR OF (Name of Provider ____________________________), THAT I AM AUTHORIZED BY (Provider________________________) TO EXECUTE THIS ATTESTATION AND THAT I HAVE READ AND UNDERSTAND THE REQUIREMENTS FOR THE ABOVE HOME AND COMMUNITY BASED SERVICES. I FURTHER ATTEST THAT ANY SUCH SERVICES PROVIDED BY THE AGENCY WHICH I DIRECT WILL ADHERE TO SUCH REQUIREMENTS, AND WILL MAINTAIN DOCUMENTATION SUFFICIENT TO DEMONSTRATE SUCH ADHERENCE. I ACKNOWLEDGE THAT THE NYS OFFICE OF MENTAL HEALTH, THE NYS OFFICE OF ALCOHOL AND SUBSTANCE ABUSE SERVICES, OR THE NYS DEPARTMENT OF HEALTH, OR LOCAL GOVERNMENT UNITS MAY CONDUCT AN AUDIT OR INSPECTION OF (Provider-__________________________), INCLUDING THE RIGHT TO INSPECT ANY BOOKS OR RECORDS, INCLUDING PATIENT RECORDS, AND INTERVIEW ANY STAFF OR CLIENTS, AND THAT ANY BOOKS OR RECORDS REQUESTED BY SUCH OFFICES SHALL BE MADE AVAILABLE UPON SUCH REQUEST.

Signature of Chief Executive Officer

___________________________________

Telephone Number

___________________________________

Address

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Date
PSYCHOSOCIAL REHABILITATION (PSR)

AGENCY NAME:

SITE LOCATION(S):

ANTICIPATED SERVICE HOURS PER MONTH AFTER 6 MONTHS:

Outline your expected staffing levels allotted to implement the above service:

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Briefly state how your agency meets the criteria for providing the above service:

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Provide a brief history of provider experience with the above service and how your agency mission is consistent with the HCBS values/core principles as articulated in section 2 of this manual.

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COMMUNITY PSYCHIATRIC SUPPORT AND TREATMENT (CPST)

AGENCY NAME:

SITE LOCATION(S):

ANTICIPATED SERVICE HOURS PER MONTH AFTER 6 MONTHS:

Outline your expected staffing levels allotted to implement the above service:

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Provide a brief history of provider experience with the above service and how your agency mission is consistent with the HCBS values/core principles as articulated in section 2 of this manual.

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HABILITATION/ RESIDENTIAL SUPPORT SERVICES

AGENCY NAME:

SITE LOCATION(S):

ANTICIPATED SERVICE HOURS PER MONTH AFTER 6 MONTHS:

Outline your expected staffing levels allotted to implement the above service:

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Provide a brief history of provider experience with the above service and how your agency mission is consistent with the HCBS values/core principles as articulated in section 2 of this manual.
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FAMILY SUPPORT AND TRAINING

AGENCY NAME:

SITE LOCATION(S):

ANTICIPATED SERVICE HOURS PER MONTH AFTER 6 MONTHS:

Outline your expected staffing levels allotted to implement the above service:

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Provide a brief history of provider experience with the above service and how your agency mission is consistent with the HCBS values/core principles as articulated in section 2 of this manual.

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MOBILE CRISIS INTERVENTION

AGENCY NAME:

SITE LOCATION(S):

ANTICIPATED SERVICE HOURS PER MONTH AFTER 6 MONTHS:

Outline your expected staffing levels allotted to implement the above service:

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Briefly state how your agency meets the criteria for providing the above service:

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Provide a brief history of provider experience with the above service and how your agency mission is consistent with the HCBS values/core principles as articulated in section 2 of this manual.

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SHORT-TERM CRISIS RESPITE

AGENCY NAME:

SITE LOCATION(S):

ANTICIPATED SERVICE HOURS PER MONTH AFTER 6 MONTHS:

Outline your expected staffing levels allotted to implement the above service:

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Briefly state how your agency meets the criteria for providing the above service:

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Provide a brief history of provider experience with the above service and how your agency mission is consistent with the HCBS values/core principles as articulated in section 2 of this manual.

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INTENSIVE CRISIS RESPITE

AGENCY NAME:

SITE LOCATION(S):

ANTICIPATED SERVICE HOURS PER MONTH AFTER 6 MONTHS:

Outline your expected staffing levels allotted to implement the above service:

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<th>Staff Title</th>
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EDUCATION SUPPORT SERVICES

AGENCY NAME:

SITE LOCATION(S):

ANTICIPATED SERVICE HOURS PER MONTH AFTER 6 MONTHS:

Outline your expected staffing levels allotted to implement the above service:

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EMPOWERMENT SERVICES- PEER SUPPORTS

AGENCY NAME:

SITE LOCATION(S):

ANTICIPATED SERVICE HOURS PER MONTH AFTER 6 MONTHS:

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NON-MEDICAL TRANSPORTATION

AGENCY NAME:

SITE LOCATION(S):

ANTICIPATED SERVICE HOURS PER MONTH AFTER 6 MONTHS:

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### PRE-VOCATIONAL SERVICES

**AGENCY NAME:**

**SITE LOCATION(S):**

**ANTICIPATED SERVICE HOURS PER MONTH AFTER 6 MONTHS:**

Outline your expected staffing levels allotted to implement the above service:

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TRANSITIONAL EMPLOYMENT

AGENCY NAME:

SITE LOCATION(S):

ANTICIPATED SERVICE HOURS PER MONTH AFTER 6 MONTHS:

Outline your expected staffing levels allotted to implement the above service:

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INTENSIVE SUPPORTED EMPLOYMENT (ISE)

AGENCY NAME:

SITE LOCATION(S):

ANTICIPATED SERVICE HOURS PER MONTH AFTER 6 MONTHS:

Outline your expected staffing levels allotted to implement the above service:

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**ONGOING SUPPORTED EDUCATION**

**AGENCY NAME:**

**SITE LOCATION(S):**

**ANTICIPATED SERVICE HOURS PER MONTH AFTER 6 MONTHS:**

Outline your expected staffing levels allotted to implement the above service:

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Example 1:

**RESIDENTIAL SUPPORT SERVICES**

**AGENCY NAME:** Residential BH Services

**SITE LOCATION:** 100 Central Avenue, New York, NY 10012

**ANTICIPATED SERVICE HOURS PER MONTH AFTER 6 MONTHS:** 200

Outline your expected staffing levels allotted to implement the above service:

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<thead>
<tr>
<th>Staff Title</th>
<th>Anticipated FTE/ Hours Per Week</th>
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<tr>
<td>Residential Supervisor</td>
<td>.25 / 10 hours</td>
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<tr>
<td>Residential Counselor</td>
<td>.50 / 20 hours</td>
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<td>Residential Counselor</td>
<td>.50 / 20 hours</td>
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<tr>
<td>Residential Counselor</td>
<td>.25 / 10 hours</td>
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Briefly state how your agency meets the criteria for providing the above service:

Residential BH Services is licensed by the New York State Office of Mental Health and currently provides a wide range of behavioral health services for individuals of all backgrounds. Our comprehensive programs include: residential services, case management, activities of daily living, psychiatric rehabilitation, cognitive behavioral therapy, and family and community support. These existing services will be integrated into the implementation of Residential Support Services under HCBS.

Provide a brief history of provider experience with the above service and how your agency mission is consistent with the HCBS values/core principles as articulated in section 2 of this manual.

Residential BH Services has met the needs of communities in New York State for over 55 years. We provide programs in health, employment, education, housing, home care, and family and community support to over 850 individuals in 25 locations annually. Example Health and Social Services maintains a strong network of outside health and social service providers to enhance our service delivery and organizational accountability. Our mission is to promote independence and recovery, by providing a wide range of person-centered and integrated services, in effort to help each individual thrive within their home and community.
Example 2:

Psychosocial Rehabilitation

AGENCY NAME: Recovery PROS

SITE LOCATION(S): 54 Main Street, West NY, NY

ANTICIPATED SERVICE HOURS PER MONTH AFTER 6 MONTHS: 260

Outline your expected staffing levels allotted to implement the above service:

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<tr>
<th>Staff Title</th>
<th>Anticipated FTE/ Hours Per Week</th>
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<tr>
<td>Certified Rehab Counselor</td>
<td>.50 / 20 hrs / week</td>
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<tr>
<td>PROS/Rehab practitioner</td>
<td>.75 / 30 hrs / week</td>
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<tr>
<td>PROS/Rehab practitioner</td>
<td>.75 / 30 hrs / week</td>
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Briefly state how your agency meets the criteria for providing the above service:

Recovery PROS has a demonstrated record of providing effective, individualized, rehabilitation services. Currently these services are provided within the structured, site-based setting of the PROS. Many individuals in our community are unable to participate in this structured setting, however, and would benefit from receiving rehabilitation services through the more flexible format offered by the 1915i service, Psychosocial Rehabilitation. Psychosocial Rehabilitation would be made available to individuals whose mental health barriers preclude their abilities to access and attend a site-based program such as PROS successfully and comfortably or for people who have graduated from a PROS service and could benefit from some limited home based rehabilitation training. Practitioners will be required to have successfully completed stringent rehabilitation training and must have demonstrated expertise in delivering rehabilitation services. All staff providing 1915i Psychosocial Rehabilitation will be supervised by a CRC.

Psychosocial Rehabilitation will be provided as a discrete 1915i service, separate and distinct from services provided as part of the site-based Recovery PROS. Interventions will be delivered face-to-face with individuals, or small groups of individuals, in community-based settings of choice, other than the PROS, and in accordance with the parameters defined in the 1915i Services Manual.
Provide a brief history of provider experience with the above service and how your agency mission is consistent with the HCBS values/core principles as articulated in section 2 of this manual.

Recovery PROS has provided individualized, recovery-focused rehabilitation services within a certified, structured, site-based PROS since 2010. Our PROS has a documented record of helping individuals to achieve outstanding recovery outcomes. Individuals usually participate in PROS Services for 12 – 18 months; our data indicates that 80% of participants who leave Recovery PROS do so because they have achieved their identified life role goals. Achieved life role goals include attaining and sustaining competitive employment (25%); returning to live independently in their communities (60%); and regaining adult roles as parents and partners (65%).
Example 3:

**EMPOWERMENT SERVICES- PEER SUPPORTS**

**AGENCY NAME:** Support Service Club

**SITE LOCATION(S):** 500 W 48th Street  
New York, NY 10036

**ANTICIPATED SERVICE HOURS PER MONTH AFTER 6 MONTHS:** 400 hours

Outline your expected staffing levels allotted to implement the above service:

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<tr>
<th>Staff Title</th>
<th>Anticipated FTE/ Hours Per Week</th>
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<tr>
<td>Peer Service Coordinator</td>
<td>.75 / 30 hours</td>
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<tr>
<td>Peer Specialist</td>
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<tr>
<td>Peer Specialist</td>
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<tr>
<td>Clinical Supervisor</td>
<td>.25 / 10 hours</td>
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Briefly state how your agency meets the criteria for providing the above service:

Support Service club is an independent and private 501(c)(3) nonprofit organization that has demonstrated service delivery to individuals faced with serious mental health and substance abuse challenges. Current services and activities provided by Support Service Club are designed to encourage rehabilitation, recovery, and wellness through the use of outreach, empowerment, advocacy; social interaction; peer bridger; transitional support and acceptance-focused groups. All peer specialists providing empowerment services are certified through the New York State Offices of Mental Health.

Provide a brief history of provider experience with the above service and how your agency mission is consistent with the HCBS values/core principles as articulated in section 2 of this manual.

We pride ourselves on providing collaborative, person-centered, culturally relevant, and peer delivered services for the past 15 years. Our consumer base consists of over 500 members, from all five boroughs of New York City. Our mission is to deliver innovative and effective rehabilitation, advocacy, and support to individuals living with mental and substance abuse-related illnesses by creating an atmosphere of hope, acceptance, support and recovery. The beliefs and values of the Support Service Club directly parallel the HCBS core principles, thus making our ability to effectively provide HCBS Empowerment Services a seamless part of service delivery.
Example 4:

EDUCATION SUPPORT SERVICES

AGENCY NAME: ABC Program

SITE LOCATION(S): 100 Main Street, Bronx, NY 10468

ANTICIPATED SERVICE HOURS PER MONTH AFTER 6 MONTHS: 200

Outline your expected staffing levels allotted to implement the above service:

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<th>Staff Title</th>
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<tr>
<td>Certified Teacher</td>
<td>.5 FTE, 20 hours</td>
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<tr>
<td>Teacher Assistant</td>
<td>.5 FTE, 20 hours</td>
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<tr>
<td>Certified Peer Advocate</td>
<td>.5 FTE, 20 hours</td>
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Briefly state how your agency meets the criteria for providing the above service:

ABC has a record of providing quality education support services to individuals enrolled in the Alternative to Incarceration program as evidenced by the data demonstrating reduced recidivism and educational achievements among our participants.

Our Education program empowers clients to achieve personal and professional goals that might include earning their High School Equivalency diplomas, attending college, or preparing to enter a tough job market. Clients have the opportunity to develop essential reading, writing, math, and computer skills with the support of ABC’s teachers.

The Education Department at ABC serves more than 120 students. In addition to reading, math and other traditional classes, special groups and training have evolved: computer classes and food services, and classes on how to increase employment possibilities.

Our professional educators work with each participant to develop individualized educational plans that is coordinated with the overall services plan. This includes an assessment of educational and /training needs based on employment goals that will determine the array of educational/training services that may include but is not limited to remedial education, high school equivalency education, testing, applications and financial aid.
Provide a brief history of provider experience with the above service and how your agency mission is consistent with the HCBS values/core principles as articulated in section 2 of this manual.

The ABC program has been providing educational and employment services since 2001 to individuals with serious substance use disorders through Alternatives to Incarceration funding. The ABC program has a mission to provide rehabilitative services to people who have a history of incarceration to support their long-term recovery and re-integration as fully functioning and contributing members of society.

The ABC program has successfully provided education to more than 1,000 adults and has a proven track record of program completion due to the individualized planning and attention given from our highly trained staff. In 2013 over 80% of participants completed a program that they initiated.

ABC is committed to the values and principles of Home and Community Based Services. The agency mission is aligned with the person-centered and recovery-oriented approaches envisioned in the HCBS manual. Our agency has experience working with participants who are homeless or at risk of homelessness with serious mental health and/or substance use disorders. We are committed to providing the social and community supports to increase success in community based living so that each participant thrives. The agency has been recognized as a community leader in rehabilitative services receiving and award for innovation in 2004.

The agency seeks the input of each participant through a perception of care survey and uses that information in a continuous quality improvement process. Participants frequently cite the individualized attention, support from peers and overall positive and encouraging staff attitudes as being helpful to them in attaining their goals. Many alumni return remain engaged in helping other students through our peer services project.