

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
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9. Self-directed Community Benefits (SDCB)

9.1. Purpose

The SDCB is intended to provide a community--based alternative to institutional care that facilitates greater Member choice, direction and control over covered services and supports. For this section of the Manual, the terms “Member”, “care plan”, “services” and “providers” refer to SDCB.

- Home and Community Based Services (HCBS) shall meet all requirements of the HCBS Final Rule for Settings including the following requirements: Are integrated and support full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment, and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS;
- Are selected by the individual from among setting options including non-disability specific settings. The setting options are identified and documented in the person-centered service plan and are based on the individual’s needs and preferences;
- Ensure an individual’s rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimize, but do not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact; and
- Facilitate individual choice regarding services and supports, and who provides them.

CMS will take the following factors into account when determining whether a setting may have the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving HCBS:

- Due to the design or model of service provision in the setting, individuals have limited, if any, opportunities for interaction in and with the broader community, including with individuals not receiving Medicaid funded HCBS. Opportunities as well as identified supports to provide access to and participation in the broader community, should be reflected in both the individuals’ person-centered service plans and policies and practices of the setting in accordance with 42 CFR 441.301(c)(1)(3) and (4)(vi)(F), 42 CFR 441.530(a)(1)(vi)(F) and 441.540, and 42 CFR 441.710(a)(1)(vi)(F) and 441.725;

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	---	--

- The setting restricts beneficiary choice to receive services or to engage in activities outside of the setting; or
- The setting is physically located separate and apart from the broader community and does not facilitate beneficiary opportunity to access the broader community and participate in community services, consistent with the beneficiary’s person-centered service plan.

9.2. Guiding Principles

All members:

- Have value and potential;
- Will be viewed in terms of their abilities;
- Have the right to participate and be fully included in their communities; and
- Have the right to live, work, learn, and receive services and supports to meet their individual needs, in the most integrated settings possible within their community.

9.3. Philosophy of Self Direction

Self-direction is a tool that leads to self-determination, through which members can have greater control over their lives and have more freedom to lead a meaningful life in the community. Within the context of SDCB, self-direction means members choose which covered services they need, as identified in the most recent CNA. Members also decide when, where and how those SDCB covered services will be provided and who they want to provide them. Members decide who they want to assist them with planning and managing their SDCB covered services within a managed care environment. Self-direction means members have more choice, control, flexibility, freedom and responsibility in directing their CBs.

9.4. Definitions

- 1. Authorized Representative (AR):** The AR is an individual designated to represent and act on the Member’s behalf. The Member or AR must provide formal documentation authorizing the named individual or individuals to access the identified case information for a specified purpose and time frame. An AR may be an attorney representing a person or household, a person acting under the

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	---	--

authority of a valid power of attorney, a guardian, or any other individual or individuals designated in writing by the eligible recipient or Member.

2. **Centers for Medicare and Medicaid Services (CMS):** Federal agency within the United States Department of Health and Human Services that works in partnership with the states to administer Medicaid. CMS must approve all Medicaid programs.
3. **Electronic Visit Verification (EVV):** EVV is a computer-based system that electronically verifies the occurrence of authorized personal care service visits by electronically documenting the precise time and location where a service delivery visit begins and ends. For SDCB, EVV will be implemented according to federal requirements and timelines.
4. **Employer of Record (EOR):** Individual responsible for directing the work of SDCB employees by recruiting, hiring, training, supervising and terminating employees, and ensuring payment to employees and vendors.
5. **Financial Management Agency (FMA):** Contracted with each MCO and helps the Member implement the approved SDCB Care Plan by receiving and processing payment requests for the Member's employees and vendors, tracking the SDCB expenditures and credentialing the SDCB employees and vendors.
6. **FOCoSonline:** The web-based system used by the SDCB FMA for receiving and processing SDCB payment requests. The FOCOsonline system is also used by members, Care Coordinators, and Support Brokers to develop and submit SDCB care plan/budget requests for MCO/UR review, and to monitor utilization and spending throughout the SDCB care plan year.
7. **Health Care Authority (HCA):** Designated by CMS as the Medicaid administering agency in New Mexico. HCA is also responsible for operating the SDCB HCBS for populations that meet the NF LOC (disabled & elderly, brain injury, and AIDS).
8. **Legally Responsible Individual (LRI):** A person who has a duty under State law to care for another person. This category typically includes: the parent (biological or adoptive) of a minor child; the guardian of a minor child who must provide care to the child; or the spouse of a Member. Payment may not be made to a LRI for the provision of personal care or similar services that the LRI would ordinarily perform or be responsible to perform on behalf of a Member. Exceptions to this prohibition may be made under extraordinary circumstances specified by the State, utilizing documentation specified by the State and only after approval by the appropriate MCO.

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	---	--

9. **MCO/UR:** Provides services related to medical eligibility determination and re-determination, and NF LOC for members. The MCO also performs UM duties, review and approval or denial of each individual services or related goods requested in the SDCB care plan/budget.
10. **Quality Assurance and Quality Improvement (QA/QI):** Processes utilized by state and Federal governments, programs and providers whereby appropriate oversight and monitoring of CB assurances and other measures provide information about the health and welfare of members and the delivery of appropriate services. This information is then collected, analyzed and used to improve services and outcomes and to meet requirements by state and Federal agencies. Quality plans, systems and processes are designed and implemented to maintain continuous QI.
11. **Reconsideration:** Members who disagree with an adverse decision made by the MCO/UR may submit a written request through a Care Coordinator/Support Broker to the MCO/UR for a reconsideration of the adverse decision. These requests must include new, additional information that is different from, or expands on, the information submitted with the initial request.
12. **SDCB:** Is a component of the State's 1115 Medicaid Managed Care waiver which allows eligible members meeting NF LOC the option to access SDCB Medicaid funds, using the essential elements of person-centered planning, individualized budgeting, Member protections, and QA/QI. Members have choices (among the state-determined SDCB services and related goods) in identifying, accessing and managing the services and related goods needed to meet their personal goals.
13. **SDCB Budget:** The maximum budget allotment available to an eligible Member, determined by their established NF LOC, CNA, and the amount and type of services the Member was receiving in the ABCB. Based on this maximum amount, the eligible Member will develop a SDCB care plan to meet their assessed functional, medical and habilitative needs to enable that Member to remain in the community.
14. **SDCB Care Plan:** A plan that includes approved SDCB services of the SDCB Member's choice; the projected cost, frequency and duration of services and related goods; the type of provider who will furnish each service or related good; other services and related goods to be used by the Member. Each SDCB care plan shall include a backup plan which lists who the Member will contact if regularly scheduled employees or service providers are unable to report to work. The SDCB care plan is mandatory for all SDCB members and must be processed through the FOCOnline or other state approved system.

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	---	--

15. SDCB Member: An individual who meets the medical and financial eligibility and is approved to receive services through the SDCB after receiving services in the ABCB for a minimum of 120 calendar days.

16. Signature: Signature of Member or Member’s legal representative. If a Member is unable to sign and does not have a legal representative, a thumbprint or personal mark (i.e., an “X”) will suffice. Wherever signature is required, verified electronic signature may be used.

17. Support Broker (SB): An individual who provides support to members and assists the Member (or the Member’s family or representative, as appropriate) in arranging for, directing and managing services and supports as well as developing, implementing and monitoring the SDCB care plan and budget. Individual Support Brokers work for MCO contracted Support Broker agencies or may be directly employed by an MCO.

18. Verified Electronic Signature: A verified electronic signature is an electronic signature that has been confirmed to be authentic and has not been tampered with. There are multiple ways to verify an electronic signature, including, but not limited to, Digital Certificates, Passwords, and Two-Factor Authentication.

9.5. SDCB Member Rights

SDCB Member has the right to:

- Decide where and with whom to live;
- Choose their own work or productive activity;
- Choose how to establish community and personal relationships;
- Make decisions regarding their own support, based upon informed choice;
- Be respected and supported during the decision-making process and in the decisions made;
- Recruit, hire, train, schedule, supervise and terminate SDCB service providers, as necessary;
- Receive training, resources and information related to SDCB in a format that meets the ADA requirements;
- Have the right to appeal denial decisions through the MCO appeals and State fair hearing processes;
- Transfer to programs that are not self-directed; and
- Receive culturally competent services.

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	---	--

9.6. SDCB Member Responsibilities

SDCB members have certain responsibilities in order to participate in the program. Failure to comply with these responsibilities or other program rules and policies can result in an involuntary termination from the SDCB.

The most basic responsibility of each Member is to maintain their financial and medical eligibility to remain in the SDCB. This includes completing the required documentation to determine initial and annual financial eligibility and participating in the initial and annual CNA conducted by the MCO. The Care Coordinator and Support Broker may assist with the application and recertification process as needed.

Ongoing SDCB Member responsibilities include:

- Comply with the rules and policies that govern the SDCB;
- Maintain an open and collaborative relationship with the Care Coordinator and Support Broker, and work together to determine support needs related to the activities of self-direction, develop an appropriate SDCB care plan/budget request, receive necessary assistance with carrying out the approved SDCB care plan/budget, and with documenting service delivery;
- Communicate with the Support Broker at least once a month, either in person or by phone, and meet with the Support Broker in-person at least once every three months. Report concerns or problems with any part of SDCB to the Support Broker or Care Coordinator;
- Use SDCB funds appropriately by only requesting services and related goods covered by the SDCB and only purchasing services and related goods after they have been approved by the MCO;
- Comply with the approved SDCB care plan and not spend more than the authorized budget;
- Work with the Care Coordinator by attending scheduled meetings and assessments, in the Member's home as required, and providing documentation as requested;
- Respond to requests for additional documentation and information from the Care Coordinator, Support Broker, FMA, and the MCO within the required deadlines;
- Report to the local ISD office, within 10 business days, any change in circumstances, including, but not limited to, a change in address or hospitalization, which may affect eligibility for the program. Changes in address or other contact information must also be reported to the Care Coordinator, Support Broker and the FMA within 10 calendar days;

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	---	--

- Report to the Care Coordinator and Support Broker if hospitalized for more than three consecutive nights so that a new appropriate LOC or CNA can be conducted; and
- Communicate with SDCB service providers, State contractors and State personnel in a respectful, non-abusive and nonthreatening manner.

Member/employer of record (EOR) Responsibilities: Every Member must have an EOR who is responsible for directing the work of SDCB employees and ensuring accurate and timely employee and vendor payment requests are sent to the FMA for processing. The EOR must authorize by signing, either electronically or on paper, all invoices and timesheets for their employees and vendors. A Member may be their own EOR unless the Member is a minor or has a guardianship or conservatorship in place that precludes the individual from exercising control over financial matters. A designated EOR may not be an employee of the Member. Members may also designate an individual of their choice to serve as their EOR, subject to the EOR meeting the qualifications specified in the SDCB rules and policies. The Care Coordinator completes an EOR self-assessment at least annually with the Member to determine if the Member requires assistance in fulfilling the EOR responsibilities. If the EOR self-assessment demonstrates the Member is not able to be their own EOR, and the Member does not designate a qualified individual to serve as the EOR, the Member shall not be allowed to transfer to SDCB until the Member designates a suitable EOR. If the Member was already their own EOR, and based on the results of the self-assessment, the Care Coordinator determines that the Member requires assistance to direct their services, the Care Coordinator shall inform the Member that they will need to designate an EOR to assume the self-direction functions on their behalf. A Member's failure to follow this direction may be cause for involuntary termination from the SDCB program.

An EOR is responsible for recruiting, hiring, training, supervising and terminating employees, as necessary. The EOR will establish work schedules and tasks and provide relevant training. The EOR will keep track of SDCB budget amounts spent on paying employees and for approved services and related goods. EORs authorize the payment of timesheets and invoices by the FMA. EORs must use the FMA electronic timesheet system, unless granted an exception by the MCO. EORs must also ensure that their self-directed personal care and respite providers use the State approved EVV system as required. An EOR cannot be paid for any services utilized- by the Member for whom they are the EOR and the EOR cannot be paid for performing the EOR functions. An individual may serve as an EOR for more than one SDCB Member.

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

The SDCB Member/EOR responsibilities include:

- Arranging for the delivery of SDCB services, supports and related goods as approved in the SDCB care plan;
- Verifying and attesting that employees meet the minimum qualifications for employment as required by the SDCB;
- Orienting, training, and directing SDCB employees in providing the services that are described and authorized in the Member's SDCB care plan;
- Establishing a mutually agreeable schedule for employees' services in writing and providing fair notice of changes in the employee's work schedule in the event of unforeseen circumstances or emergencies;
- Submitting all necessary and required documents to the FMA. Documents must be completed and provided to the FMA according to the timelines and rules established by the State. Documents include, but are not limited to, vendor and employee agreements, vendor information forms, CBC forms, time-sheets, payment request forms (PRFs) and invoices, updated employee information, and other documentation needed by the FMA to process timely and accurate payment to SDCB providers;
- Agreeing that SDCB employees may not begin work until all materials necessary for a CBC have been received by the FMA and the employee has successfully passed the COR background check and the National Sex Offender Registry;
- Agreeing to select or employ the employee on an interim (temporary) basis until a final CBC has been successfully completed, for those crimes determined to be disqualifying convictions as stated in NMSA 1978, Section 29-17-3. The EOR discusses this with the employee and reserves the right to dismiss the employee based on the results of the CBC;
- Providing fair notice of changes in the employee's work schedule in the event of unforeseen circumstances or emergencies;
- Reviewing and approving/denying completed employee timesheets in order to pay employees according to the FMA predetermined payroll schedule. Net wages are gross earnings calculated according to the employee's pay rate, minus payroll deductions for the employee's share of applicable State, Federal, and local payroll withholdings;
- Ensuring employees are not signing or sending in their own timesheets;

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	---	--

- Reporting any incidents of abuse, neglect or exploitation by any employee or other service provider to the Support Broker and/or Care Coordinator;
- Maintaining SDCB employee and service records and documentation in accordance with SDCB rules and policies, and Federal and state employment rules;
- As the common-law employer, fully cooperating with the New Mexico Department of Workforce Solutions (DWS) in any investigations or other matters related to their SDCB employees;
- Working with the FMA and Care Coordinator on payment issues;
- Fully cooperating with the State’s worker’s compensation carrier. Responsibilities include reporting claims and providing information to New Mexico Mutual;
- Meeting Federal employer requirements, such as completing and maintaining a Federal I-9 form for each employee as required by law;
- Meeting Federal requirements by using the state EVV system to document PCS and Respite services; and
- When necessary, requesting assistance from the Support Broker and/or Care Coordinator with any of these SDCB responsibilities.

9.7. SDCB Supports

Important resources of support and direction for members are the MCO, the Support Broker and the FMA. The MCO determines initial and ongoing medical eligibility, reviews and authorizes the SDCB care plan/budget, and provides care coordination and support to the Member to ensure successful implementation of the care plan. The Support Broker provides support to the SDCB Member (or the Member’s family/representative, as appropriate) in arranging for, directing, and managing SDCB services and supports as well as developing, implementing, and monitoring the care plan and budget. The FMA acts as the intermediary between the Member and the Medicaid payment system and assists the Member or the EOR with employer--related responsibilities.

MCO

The MCO provides services related to medical eligibility determination and re-determination and determines the NF LOC for SDCB members. The MCO also performs Utilization Management (UM) duties, including review and approval or denial of each individual care plan. All SDCB members have an

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	---	--

MCO Care Coordinator and a Support Broker. The Care Coordinator and Support Broker assist the Member with virtually every aspect of the SDCB. The Support Broker is instrumental in developing the SDCB care plan and provides an additional layer of assistance to ensure successful implementation of the SDCB care plan.

Care Coordinator

The Care Coordinator is responsible for managing the Member’s acute care, BH care, LTC, and HCBS. In SDCB, the Care Coordinator is primarily responsible for coordinating all aspects of the Member’s care, determining the SDCB budget, and submitting the care plan to the MCO for review and approval/denial. Care Coordinator related assistance includes, but is not limited to:

- Understanding SDCB Member and EOR roles and responsibilities;
- Identifying resources outside the SDCB, including natural and informal supports, that may assist in meeting the Member’s needs;
- Understanding the array of SDCB covered services, supports, and related goods;
- Determining and assigning the annual budget for the SDCB Member, based on the CNA, to address the home and community-based needs of the SDCB Member in accordance with the requirements stated in the Agreement and the Member’s CB;
- Providing the Support Broker with the current and all historical CNAs including the assessor’s individual specific health and safety recommendations, and the calculations used to determine the SDCB budget;
- Monitoring utilization of SDCB services and related goods on a regular basis;
- Assisting the EOR, and working with the FMA; on payment issues;
- Conducting employer related activities such as completing the EOR self-assessment with the Member and informing the FMA of the designated EOR;
- Identifying and resolving issues related to the implementation of the SDCB care plan/budget;
- Assisting the SDCB Member with QA activities to ensure implementation of the Member’s SDCB care plan/budget, and utilization of the authorized budget;
- Recognizing and reporting critical incidents, including abuse, neglect, exploitation, emergency services, law enforcement involvement, and environmental hazards, elopement/missing and death;
- Monitoring the quality of services provided by Support Brokers;

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	---	--

- Assisting the Member with Support Broker changes; and
- Working with the Member to provide the necessary assistance for successful SDCB implementation.

Support Broker

Support Broker services are direct services intended to educate, guide, and assist the SDCB Member to make informed planning decisions about SDCB services and supports and to assist the Member with QA related to the SDCB care plan. This leads to the development of a Care Plan that is based on the Member's assessed needs and is in accordance with 8.308.12 NMAC, and the Manual.

Support Broker services help the SDCB Member to identify supports, services and related goods that meet their needs as identified in the most recent CNA and are specific to the Member's disability or qualifying condition and help prevent institutionalization. Support Broker services provide a level of support to SDCB members that are unique to their individual needs in order to maximize their ability to self--direct.

- The extent of assistance is based upon the individual Member's needs, and includes, but is not limited to, providing help and guidance to:
 - Educate members on how to use self-directed supports and services and provide information on program changes or updates;
 - Review, monitor and document progress of the Member's care plan;
 - Assist in managing budget expenditures and complete and submit care plan revisions;
 - Urgent care plan revisions must be made within three (3) business days of the EOR/Member's request. Updates are required to be made in the FMA system and the Member's Managed Care Organization must be notified of the update. Assist with EOR functions including, but not limited to recruiting, hiring and supervising SDCB providers;
 - Assist with developing job descriptions for the SDCB direct support caregivers;
 - Assist with completing forms related to SDCB employees;
 - Assist with approving timesheets and purchase orders or invoices for related goods, obtaining quotes for services and related goods as well as identifying and negotiating with vendors;
 - Assist with problem solving employee and vendor payment issues with the FMA and other relevant parties;
 - Facilitate resolution of any disputes regarding payment to providers for services rendered;

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	---	--

- Develop the care plan based on the SDCB budget amount determined by the annual CNA;
- Assist in completing all documentation required by the FMA; and
- Assist with EVV functions including device registration and entering location information.
- Support Broker services begin with the enrollment of the Member in SDCB and continue throughout the Member's participation in SDCB. The Support Broker shall:
 - Conduct a transition meeting, including the transfer of program information prior to the SDCB enrollment meeting, for those members transitioning from the ABCB;
 - Assist members to transition from/to ABCB/SDCB.
 - Provide the SDCB Member with information, support and assistance during the annual Medicaid eligibility processes, including the annual CNA and the annual medical/financial eligibility processes;
 - Assist existing members with annual LOC requirements within 120 calendar days prior to the expiration of the LOC; and
 - Schedule Member enrollment meetings within five business days of notification and Support Broker agency selection. The actual enrollment meeting should be conducted within 30 calendar days. Enrollment activities include but are not limited to:
 - Ensure the Member has received and reviewed the SDCB Rules and the Manual and provide responses to their questions and/or concerns;
 - General overview of the SDCB including key agencies, their responsibilities and contact information;
 - Discuss the annual Medicaid eligibility requirements and offer assistance in completing these requirements as needed;
 - Discuss and review SDCB Member roles and responsibilities;
 - Discuss and review the EOR roles and responsibilities;
 - Discuss and review the processes for hiring SDCB employees and contractors and required paperwork;
 - Discuss and review the requirements, process and paperwork for hiring LRIs as employees;
 - Discuss and review the background check and other credentialing requirements for SDCB employees and vendors;

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

- Referral for accessing training for the FOCOnline system; and to obtain information on the FMA;
- Discuss and review the EVV system that personal care and respite provider(s) will be required to use;
- Schedule the date for SDCB care plan meeting within 10 business days of the SDCB enrollment meeting;
- Provide information on the SDCB care plan including covered services and related goods, and community resources available;
- Assist the members in utilizing all program assessments including the CNA, to develop each SDCB care plan;
- Educate members regarding SDCB covered services, supports and related goods;
- Assist Member to identify resources outside SDCB that may assist in meeting their needs as identified in the CNA;
- Assist the Member with the application for LRI as employee process; submit the application to the MCO/UR;
- Assist members with the environmental modification process;
- Serve as an advocate for the SDCB Member, as needed, to enhance their opportunity to be successful in the SDCB;
- Assist the Member with reconsiderations of services or related goods denied by the MCO/UR, submit documentations as required, and participate in MCO appeals process and State Fair Hearings as requested by the MCO, SDCB Member or state;
- Assist the Member with QA activities to ensure implementation of the Member's SDCB care plan, and utilization of the SDCB annual budget;
- Assist members to transition to another Support Broker agency when requested. Support Broker transitions should occur within 30 calendar days of SDCB Member's written request, but may occur sooner based on the needs of the SDCB Member. Transition from one Support Broker agency to another can only occur at the first of the month. Support Broker agency transitions may not occur if there are less than 120 days remaining in the current LOC;
- Assist members to identify and resolve issues related to the implementation of the SDCB care plan; and

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	---	--

- Assist the Member, employee(s) and EOR in utilizing the EVV system, including but not limited to:
 - Registering the device (tablet, computer or mobile device) to be utilized for EVV;
 - Collaborating with MCO Care Coordination and the Member/EOR to resolve any time entry, timecard, or payment issues;
 - Understanding and agreeing to all roles and responsibilities of the EVV system;
 - Training and assisting Member/EOR and employee(s) on the EVV system to include:
 - Employee and EOR device enrollment
 - Employee initial log in
 - Employer Web log in
 - Alternate Interactive Voice Response (IVR) phone numbers
 - Updating alternate care locations
- Support Brokers must ensure the SDCB care plan for each Member is submitted in the appropriate format as prescribed by the state and MCOs, utilizing the *FOCoSonline* system. The care plan in *FOCoSonline* shall include the following:
 - The requested services and supports that are covered by the SDCB, and necessary to address the needs of the Member as determined through the CNA and person-centered planning process;
 - The purpose for the requested services, expected outcomes, and methods for monitoring progress must be clearly and specifically identified and addressed;
 - Clear, specific and accurate calculation of the employee/vendor reimbursement rate including all local and/or Federal taxes using the calculator in *FOCoSonline*; and
 - The quality indicators, identified by the Member, for the services and supports provided through the SDCB. SDCB care plan revisions shall be completed and submitted as needed, in the format as prescribed by the state. No more than one revision is allowed to be submitted at any given time. The annual SDCB care plan must be submitted to the Care Coordinator and MCO/UR at least 30 calendar days prior to the expiration of the current SDCB plan so that sufficient time is afforded for MCO/UR review. A copy of the final approved SDCB care plan and budget documents must be provided to each SDCB Member.

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	---	--

- Support Brokers will contact the SDCB Member in person or by telephone at least monthly for a routine follow-up. Support Brokers will meet in person with the Member at least once per quarter. It is mandatory that a minimum of one visit per SDCB care plan year is to be conducted in the Member's home. Support Brokers will, at a minimum:
 - Review spending patterns;
 - Review and document progress of care plan/budget implementation;
 - Document the usage and effectiveness of the SDCB backup plan; and
 - Document the purchase of related goods.

The quarterly visits are for the following purposes:

- Review and document progress on implementation of the SDCB care plan;
- Review and document any usage and the effectiveness of the 24-hour backup plan and update the backup plan as necessary;
- Review SDCB care plan and budget spending patterns (over and underutilization);
- Review and document the SDCB Member's access to SDCB related goods requested and approved in the SDCB care plan;
- Review any incidents or events that have impacted the SDCB Member's health and welfare or ability to fully access and utilize service(s) as identified and approved in the SDCB care plan; and
- Identify other concerns or challenges as noted by the Member/representative/EOR.

Administrative Requirements

Support Broker services may be provided by direct MCO personnel or by Support Broker agencies subcontracted by the MCO. SDCB members may choose to work with one of their MCO's contracted Support Broker agencies that is providing Support Broker services in their region. If an MCO employs MCO personnel to provide Support Broker services, the same qualifications and criteria that are used for Support Broker agencies also apply to the MCO personnel.

The Support Broker agency shall comply with all applicable Federal and State rules, all policies and procedures governing Support Broker services, all terms of their provider agreement and shall meet all of the following requirements, as applicable:

- Have a current business license issued by the state, county, or city government as required;
- Maintain financial solvency;

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
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- Ensure all employees providing Support Broker services under this standard attend all State-required orientation and trainings and demonstrate knowledge of and competence with the SDCB rules, policies and procedures, philosophy of self-direction, financial management processes and responsibilities, CNA, person-centered planning and SDCB care plan development, and adhere to all other training requirements as specified by the State;
- Ensure all employees are trained and competent in the use of the FMA and FOCOonline system;
- Ensure all employees providing services under this scope of service and all other staff are trained on how to identify and where to report critical incidents, abuse, neglect and exploitation; and
- Ensure compliance with the Caregivers Criminal History Screening Requirements (7.1.9 NMAC) for all employees.

The Support Broker agency shall develop a quality management plan to ensure compliance with regulatory and program requirements and to identify opportunities for continuous QI.

The Support Broker agency shall ensure that SDCB members have access to their Support Broker. This requirement includes, but is not limited to the following:

- The Support Broker agency must maintain a presence in each region for which they are providing services;
- The Support Broker agency must maintain a consistent way (for example, phone, pager, email, and fax) for the SDCB Member to contact the Support Broker provider during typical business hours which are 8:00 a.m. to 5:00 p.m. Monday through Friday;
- The Support Broker agency must maintain a consistent way (for example phone, pager, email, and fax) for the SDCB Member to contact the Support Broker provider during nonbusiness hours: prior to 8:00 a.m. and after 5:00 p.m. MST on weekdays and on weekends and for emergency purposes;
- The Support Broker agency must provide a location to conduct confidential meetings with SDCB members when it is not possible to do so in the SDCB Member's home. This location must be convenient for the SDCB Member and compliant with the ADA;
- The Support Broker agency must maintain an operational fax machine at all times;
- The Support Broker agency must maintain an operational email; address, internet access, and the necessary technology to access SDCB related systems;
- The Support Broker agency shall maintain a current local/state community resource manual;
- The Support Broker agency shall adhere to Medicaid General Provider policies 8.302.1.;

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

- The Support Broker agency shall ensure the development and implementation of a written grievance procedure in compliance with 8.349.2.11 NMAC;
- The Support Broker agency shall meet all of the qualifications set forth in 8.304.12 NMAC; and/or
- The Support Broker agency shall maintain HIPAA compliant primary records for each Member including, but not limited to:
 - Current and historical SDCB care plan and budget;
 - Contact log that documents all communication with the SDCB Member;
 - Completed/signed quarterly visit form(s);
 - MCO/UR documentation of approvals/denials, including SDCB care plan and revision requests;
 - MCO/UR correspondence; (requests for additional information, etc.);
 - Copy of current and all historical CNAs including the assessor's individual specific health and safety recommendations;
 - Notifications of medical and financial eligibility;
 - SDCB budget utilization reports from the FMA;
 - Environmental modification approvals/denials;
 - LRI approvals/denials;
 - Documentation of SDCB Member and employee incident management training;
 - Copy of legal guardianship or representative papers and other pertinent legal designations;
 - Copy of the approval form for the AR and/or AA; and
 - Copies of completed EOR self-assessments.

Support Broker Qualifications

Support Broker agencies shall ensure that all individuals providing Support Broker services meet the criteria specified in this section. Support Broker providers shall:

- Be at least 18 years of age; and
- Possess a minimum of a Bachelor's degree in social work, psychology, human services, counseling, nursing, special education or a closely related field; or
- Have one year of supervised experience working with seniors and/or people living with disabilities; or

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

- Have a minimum of six years of direct experience related to the delivery of social services to seniors and/or people living with disabilities;
- Complete all required SDCB orientation and training courses; and
- Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29172 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 277a1 et seq. and 8.11.6 NMAC; and the National Sex Offender Registry.

Conflict of Interest

The Support Broker agency may not provide any other direct services for SDCB members that have an approved SDCB care plan and are actively receiving services in the SDCB. The Support Broker agency may not employ, as a Support Broker, any immediate family Member or guardian of a Member in the SDCB that is served by the Support Broker agency.

Critical Incident Management Responsibilities and Reporting Requirements

All incident reports for the HCBS and BH services population involving abuse, neglect, self-neglect, exploitation, environmental hazard, law enforcement involvement, and emergency services, must be reported to the Member's MCO, Support Broker and/or APS.

The Support Broker agency shall provide training to SDCB members related to recognizing and reporting critical incidents. Critical incidents include: abuse, neglect, exploitation, emergency services, law enforcement involvement, environmental hazards, elopement/missing and Member deaths. This SDCB Member training shall also include reporting procedures for SDCB employees, members/Member representatives, and other designated individuals. Please refer to the Critical Incident Management Responsibilities for requirements.

The Support Broker agency will also maintain documentation that each SDCB Member has been trained on the critical incident reporting process. This Member training shall include reporting procedures for SDCB members, employees, Member representative, and/or other designated individuals. The Support Broker agency shall report incidents of abuse, neglect and/or exploitation as directed by the State.

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	---	--

The Support Broker agency will maintain a critical incident management system to identify, report, and address critical incidents. The Support Broker is responsible for follow-up and assisting the individual to help ensure health and safety when a critical incident has occurred.

Financial Management Agent

The FMA is under contract with the MCOs to provide payment for services and related goods which are approved on the SDCB care plan. The FMA is responsible for providing the following services in the SDCB:

- Assure SDCB compliance with state and Federal employment and IRS requirements;
- Assist each Member/EOR to set up a unique EIN if they intend to hire employees;
- Answer Member inquiries, solve related problems, and offer periodic trainings for members and their representatives on how to handle the SDCB billing and invoicing processes;
- Provide all members with necessary documents, instructions and guidelines;
- Collect all documentation necessary to verify that SDCB providers and vendors have the qualifications and credentials required by the SDCB rules;
- Collect all documentation necessary to support the Member's specific arrangements with each employee and vendor, including employment agreement forms and vendor agreement forms;
- Successfully complete criminal history and/or background investigations for prospective SDCB service providers, pursuant to 7.1.9 NMAC and in accordance with 1978 Section 29171 NMAC of the Caregivers Criminal History Screening Act and the National Sex Offender Registry;
- Check the Department of Health Employee Abuse Registry, pursuant to 7.1.12 NMAC COR, to determine whether prospective SDCB service providers or employees of members are included in the registry. If a prospective SDCB provider or employee is listed in the Abuse Registry, that person or vendor may not be employed by a SDCB Member/EOR;
- Process and pay invoices for services and related goods that are approved in the Member's care plan, when supported by required documentation;
- Handle all payroll functions on behalf of members who hire direct service employees and other support personnel, including collecting and processing timesheets of support workers, processing payroll, withholding, filing and payment of applicable Federal, State and local employment related taxes and insurances;

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	---	--

- Track and report on SDCB employee payment disbursements and balances of Member funds, including providing the Member and their Care Coordinator/Support Broker with a monthly report of expenditures and budget status; and
- Report any concerns related to the health and safety of a Member or that the Member is not following the approved SDCB care plan/budget to the Care Coordinator and/or Support Broker, and HCA/MAD, as appropriate.
- Participate in an annual audit conducted by the MCOs.

FOCoSonline

In addition to the above functions, the FMA operates *FOCoSonline*. *FOCoSonline* is a web-based system that is used for FMA functions such as housing the SDCB care plan, noting the annual SDCB budget, tracking the credentialing status of employees and vendors, timesheet submission, payment processing for employees and vendors, and tracking the SDCB care plan/budget expenditures.

FOCoSonline is also used by SDCB members/EORs, Support Brokers and Care Coordinators to develop and submit a SDCB care plan for MCO/UR review and approval/denial.

The MCO/UR also uses *FOCoSonline* to receive SDCB care plan/budget requests and request additional information from the SDCB Member and Care Coordinator/Support Broker, and to indicate what SDCB services, supports and related goods have been approved or denied.

The FMA will provide SDCB members/EORs, Care Coordinators and Support Brokers with training and access for *FOCoSonline*, as well as on-going technical assistance and help with problem solving.

9.8. Planning and Budgeting for SDCB Covered Services

SDCB Care Plan Development Processes

The SDCB care plan development process starts with person--centered planning. In person--centered planning, the SDCB care plan must revolve around the individual SDCB Member and reflect their chosen lifestyle, cultural, functional, and social needs for successful community living. The goal of the SDCB care plan development process is for the SDCB Member to achieve a meaningful life in the community, as defined by the SDCB Member. Upon enrollment in SDCB and choosing their Support Broker agency, each SDCB Member shall receive a SDCB budget amount, which is determined by the Care Coordinator, based on the results of the NF LOC and the CNA. The SDCB budget amount is entered into *FOCoSonline* by the

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

Care Coordinator. The SDCB Member will receive information and training from the Care Coordinator and/or Support Broker about covered SDCB services and the requirements for the content of the SDCB care plan.

The SDCB Member is the leader in the development of the SDCB care plan. The Member will take the lead or be encouraged and supported to take the lead to the best of their abilities, to direct the development of the SDCB care plan. If the Member desires, they may include family members or other individuals, including service workers or providers, in the SDCB care plan development process. The SDCB care plan is entered into *FOCoSonline* by the Support Broker. The SDCB care plan is developed one goal at a time. Each goal shall include a clear and complete explanation of the requested service(s) or good(s) as defined in the service description, how they are related to the Member's condition and why they are appropriate for the Member.

In addition, each goal includes full details about each of the requested service(s) or good(s), including, but not limited to amount, frequency, cost or estimated cost, and rate of pay.

The SDCB care plan is developed by the Member and the Support Broker. Once the SDCB care plan request is complete and approved by the SDCB Member, the Support Broker notifies the Care Coordinator, via *FOCoSonline*, the Member's SDCB care plan is ready for review and submission into *FOCoSonline*. After reviewing the SDCB care plan, the Care Coordinator will submit it in *FOCoSonline* to the MCO/UR for review and approval or denial using *FOCoSonline*. Annual SDCB care plans shall be submitted by the Care Coordinator to the MCO/UR no later than 30 calendar days prior to the end of the current SDCB care plan/budget year. MCOs must provide the Member with a written Notice of Action for all MCO/UR decisions made in response to SDCB service-related requests made by the SDCB Member via *FOCoSonline*.

SDCB Member's Employer Authority

The SDCB EOR is the common-law employer of all SDCB service providers. The FMA serves as the Member's agent in conducting payroll and other employer-related responsibilities that are required by Federal and State law.

SDCB Member Decision-Making Authority

Members shall have authority to do the following:

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

- Complete the employer paperwork to be submitted to the FMA;
- Determine the amount paid for SDCB services within the State’s approved limits (Range of Rates, 9.22.1);
- Schedule the provision of SDCB services;
- Specify service provider qualifications of the SDCB Member’s choice, consistent with the qualifications specified in the SDCB rules and the Manual;
- Specify how SDCB services are provided, consistent with the SDCB rules and the Manual;
- Identify potential SDCB service providers and vendors and refer them to the FMA for enrollment;
- Arrange to have potential SDCB service providers paid for the approved SDCB services by ensuring that all proposed SDCB employees and service providers complete all FMA required paperwork, including a CBC when necessary. Payment for approved SDCB services and related goods cannot be made until all necessary and required paperwork is successfully completed and approved by the FMA;
- Review, approve and submit SDCB provider timesheets to the FMA within established timeframes. Timesheets must be submitted to the FMA electronically through *FOCoSonline*. The Member’s MCO shall approve an exception to the online timesheet requirement if the Member is unable to submit timesheets electronically. Failure to submit SDCB provider timesheets within the required timeframes will result in SDCB providers not being paid in accordance with the employee payroll schedule;
- Review, approve and submit payment requests, according to the SDCB care plan, for approved SDCB services and related goods identified in the approved SDCB care plan. The SDCB Member/EOR must submit a PRF to the FMA and an invoice or receipt from a SDCB vendor for any item the member has an approved SDCB goal and budget to purchase; and
- Additionally, the SDCB members:
 - Cannot/will not be reimbursed directly for any SDCB services, supports and/or related goods;
 - Must follow the SDCB care plan as approved by the MCO/UR;
 - Shall work with the FMA to have all potential SDCB employees, providers and vendors approved and enrolled prior to delivery or provision of any SDCB service or good; and
 - Shall be accountable for the use of all SDCB funds.

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

9.9. SDCB Qualifications for all SDCB Employees, Independent Providers, Provider Agencies and Vendors

In order to be approved as a SDCB employee, an independent provider, a provider agency (excluding Support Broker agencies, which are covered later in this document) or a vendor, each entity must meet the general and service specific qualifications found in the SDCB rules and the Manual and submit an employee agreement packet or vendor agreement packet, specific to the SDCB provider or vendor type, for approval to the FMA.

SDCB providers must meet all Federal and State requirements for home and community--based providers. In order to- be an authorized provider for SDCB, and receive payment for delivered services, the potential provider must complete and sign an employee agreement or vendor agreement and provide all required credentialing documents. The potential provider's credentials must be verified by the Member/EOR and the FMA.

General qualifications for SDCB individual employees, independent providers, including non-licensed homemaker/companion workers and provider agencies who are employed by a SDCB Member/EOR to provide direct services:

- Be at least 18 years of age;
- Be qualified to perform the service and demonstrate capacity to perform required tasks;
- Be able to communicate successfully with the SDCB Member;
- Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29172 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 277a1 et seq. and 8.11.6 NMAC and the National Sex Offender Registry;
- Complete training on critical incident, abuse, neglect, and exploitation reporting;
- Complete Member specific training; the evaluation of training needs is determined by the Member or their legal representative; the Member is also responsible for providing and arranging for employee training and supervising employee performance; training expenses for paid employees cannot be paid for with the SDCB Member's annual budget;
- Meet any other service specific qualifications, as specified in the SDCB rules (8.308.12 NMAC); and
- Maintain documentation of services provided per the SDCB rules (8.308.12 NMAC).

General qualifications for SDCB vendors, including those providing professional services:

- Be qualified to provide the service;
- Possess a valid business license, if applicable;

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
--	--	---

- If a professional provider, be required to follow the applicable licensing regulations set forth by the profession; refer to the appropriate New Mexico Board of Licensure for information regarding applicable licenses;
- If a Support Broker provider, meet all of the qualifications set forth in 8.308.12 NMAC;
- If a currently approved SDCB provider, be in good standing with the appropriate state agency;
- Meet any other service specific qualifications, as specified in the SDCB rules (8.308.12 NMAC); and
- Maintain documentation of services provided per the SDCB rules (8.308.12 NMAC).

General qualifications for LRIs who provide services:

- LRIs (e.g., the parent/guardian biological, legal or adoptive) of a minor child (under age 18) or the guardian of a minor child, who must provide care to the child, or a spouse of a Member, may be hired and paid for the provision of SDCB-covered services (except Support Broker) under extraordinary circumstances in order to assure the health and welfare of the Member, to avoid institutionalization and provided that the state is eligible to receive Federal financial participation;
- Extraordinary circumstances include the inability of the parent/legal guardian to find and retain other qualified, suitable caregivers when the parent/guardian would otherwise be absent from the home and, thus, the parent/guardian must stay at home to ensure the Member's health and safety. The Member may request that the LRI (parent/guardian or spouse) be allowed to be employed by the Member/EOR and provide services as approved in the Member's current SDCB care plan. The request must include documentation showing all attempts to employ other available resources in the Member's community, the challenges the Member and/or providers encountered, and why the member chosen providers were unable to successfully provide the approved covered service as approved in the SDCB care plan;
- LRIs may not be paid for any services that they would ordinarily perform in the household for individuals of the same age who do not have a disability or chronic illness. This includes, but is not limited to, transportation of minors to and from school, activities and events; and
- Requests to employ an LRI must be submitted in writing to the MCO. The request must be approved or denied in writing by the appropriate MCO/UR staff Member. The approval of an LRI must be renewed annually, at the same time as the NF LOC and SDCB care plan.
- Services provided by LRIs must:

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
--	---	--

- Meet the definition of a SDCB covered service and be specified in the Member’s approved SDCB care plan;
- Be provided by a SDCB Member’s parent/guardian or spouse who meets the provider qualifications and training standards specified in the SDCB rules and these service descriptions and qualifications for that covered service; and
- Be paid at a rate that does not exceed the SDCB Range of Rates (9.22.1) for the specific service the LRI is approved to provide and be approved by the MCO/UR.

9.10. SDCB Covered Services

All services are subject to the approval of the MCO/UR. Below is a list of SDCB covered services and related goods for members in SDCB, followed by a detailed service description:

- Behavior Support Consultation Services;
- Customized Community Support;
- Emergency Response;
- Employment Supports;
- Environmental Modifications;
- HH Aide;
- Nutritional Counseling;
- Private Duty Nursing;
- Related Goods;
- Respite;
- Self-Directed Personal Care;
- Skilled Maintenance Therapy Services for Adults;
- Specialized Therapies; and
- Transportation (Non-Medical).

Descriptions for each of the above SDCB covered services are as follows.

Behavior support consultation services

- Definition of Service

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	---	--

Behavior Support Consultation services consist of functional support assessments, treatment plan development and training and support coordination for a SDCB Member related to behaviors that compromise a Member's quality of life. Behavior support consultation services are provided in an integrated/natural setting or in a clinical setting.

- Scope of Services:
 - Inform and guide the SDCB Member, family, employees and/or vendors on understanding the contributing factors to the SDCB Member's behavior;
 - Identify support strategies to enhance functional capacities, adding to the provider's competency to predict, prevent and respond to interfering behavior and potentially reducing interfering behaviors;
 - Support effective implementation based on a functional assessment and subsequent SDCB care plans;
 - Collaborate with medical and ancillary therapies to promote coherent psychotherapeutic medications; and
 - Monitor and adapt support strategies based on the response of the SDCB Member and their family, employees and/or vendors.
- Behavior Support Consultant Qualifications – Individual:
 - Provide a tax identification number;
 - Maintain a Member file within HIPAA guidelines to include:
 - Member's SDCB care plan;
 - Reports as requested in the SDCB care plan;
 - Contact notes; and
 - Training roster(s).
 - Have and maintain a current New Mexico license with the appropriate professional field licensing body; current licensure may be any of the following:
 - MD;
 - Licensed clinical psychologist;
 - Licensed psychologist associate (master's or PhD level);
 - LISW or LMSW;
 - LPCC;

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

- Licensed professional counselor (LPC);
- Licensed psychiatric nurse;
- LMFT; or
- Licensed practicing art therapist (LPAT).
- Behavior Support Consultant Qualifications Provider Agency
 - Provide a tax identification number; and current business license issued by State, county or city government, if required;
 - Maintain a Member file within HIPAA guidelines to include:
 - Member’s SDCB care plan;
 - Reports as requested in the SDCB care plan;
 - Contact notes; and
 - Training roster(s).
 - Ensure therapists have and maintain a current New Mexico license with the appropriate professional field licensing body; current licensure may be any of the following:
 - MD;
 - Licensed clinical psychologist;
 - Licensed psychologist associate (master’s or PhD level);
 - LISW or LMSW;
 - LPCC;
 - LPC;
 - MSN/RNSC;
 - LMFT; or
 - LPAT.

Customized Community Supports

- Definition of Service
 - Customized community support services are designed to offer the SDCB Member flexible supports that are related to the Member’s qualifying condition or disability. Customized community supports may include participation in congregate community day programs and centers that offer functional meaningful activities that assist with acquisition, retention, or

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	---	--

improvement in self-help, socialization and adaptive skills. Customized community supports may include adult day habilitation, adult day health and other day support models. Customized community supports are provided in community day program facilities and centers and can take place in noninstitutional and nonresidential settings.

- Customized community supports settings must be integrated and support full access of individuals receiving CB to the greater community, including opportunities to seek employment, and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, with the same degree of access as individuals not receiving Medicaid HCBS.
- These services are provided at least four or more hours per day one or more days per week as specified in the Member's SDCB care plan. Customized community supports cannot duplicate any other SDCB service.
- Scope of Services
 - Customized Community Support services include, but are not limited to the following:
 - Provide supports in congregate and community day programs that assist with the acquisition, retention or improvement in self-help, socialization and adaptive skills;
 - Adult day health services;
 - Adult day habilitation services; and
 - Other day support model services.
 - Customized Community Supports Qualifications - Provider Agency:
 - Possess a current business license, if applicable;
 - Meet financial solvency;
 - Adhere to training requirements;
 - Maintain Member records for each Member within HIPAA compliance;
 - Develop and adhere to a records management policy;
 - Develop and adhere to QA rules and requirements;
 - Adult day health provider agencies must be licensed by New Mexico DOH as an adult day care facility pursuant to 7.13.2 NMAC; and
 - Ensure all assigned staff meets the following qualifications:
 - Be at least 18 years of age;

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	---	--

- Have at least one year of experience working with people with disabilities;
- Be qualified to perform the service and demonstrate capacity to perform required tasks;
- Be able to communicate successfully with the Member/Member representative;
- Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;
- Complete training on critical incident, abuse, neglect, and exploitation reporting;
- Complete Member specific training: the evaluation of training needs is determined by the Member or their legal representative; Member is also responsible for providing and arranging for provider training and supervising provider performance; training expenses for paid providers cannot be paid for with the SDCB Member's budget; and
- Meet any other service qualifications, as specified in the SDCB rules.

Emergency Response

- Definition of Service:
 - Emergency Response Services provide an electronic device that enables a Member to secure help in an emergency at home and thereby avoid institutionalization. The Member may also wear a portable "help" button to allow for mobility. The system is connected to the Member's phone and programmed to signal a response center when a "help" button is activated. The response center is staffed by trained professionals.
- Scope of Services:
 - Testing and maintaining equipment;
 - Training SDCB members, caregivers and first responders on the use of the equipment;
 - 24-hour monitoring for alarms;
 - Checking systems monthly or more frequently if warranted (e.g., electrical outages, severe weather); and
 - Reporting Member's condition that may affect service delivery; and
 - Initial set-up and installation of Emergency Response Service devices is not a covered service; see the service description for environmental modification for allowance of the initial set-up and installation.

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

- Emergency Response Qualifications – Vendor/Agency
 - Comply with all laws, rules and regulations of the New Mexico State Corporation Commission for Telecommunications and Security Systems; and
 - Comply with all laws, rules and regulations from the Federal Communications Commission for telecommunications.

Employment Supports

- Definition of Service:
 - Employment support services provide support to the Member in achieving and maintaining employment in jobs of their choice in their community. The Member must exhaust all available vocational rehabilitation supports prior to requesting Employment Supports on their SDCB care plan. Employment Supports cannot duplicate any other SDCB service. Employment Supports include two types of services: job coaching and job-development. The specific employment support service to be provided must be clearly described in the Member’s care plan and must address specific employment-related activities;
 - Employment Supports will be provided by staff at current or potential work sites. If Member is self-employed, Employment Supports may be provided in a setting other than a formal work site. 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 members receiving SDCB 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. Employment Supports settings must be integrated in, and support full access for individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment, and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Turquoise Care CBs; and
 - Providers will maintain a confidential case file for each individual that documents activities, progress and scope of work outlined in the Member’s SDCB care plan. Documentation is maintained in the file of each Member receiving this service to demonstrate that the service is

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

not available under a program funded under section 110 of the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act (IDEA).

- Employment Supports include the following services:
 - Job coaching is a service provided to members when the services are not otherwise available for the Member under a program funded under the Rehabilitation Act of 1973, the Division of Vocational Rehabilitation (DVR) or through the New Mexico Department of Education. Job coaching services are available 365 days a year, 24 hours a day. Services are driven by the Member's SDCB care plan, budget and job. Medicaid funds are not used to pay the Member. Job coaches will adhere to the specific supports and expectations negotiated with the Member and employer prior to service delivery; and
 - Job development services are provided to members when the services are not otherwise available for the Member under a program funded under the Rehabilitation Act of 1973, the DVR or through the New Mexico Department of Education. Job development is a service provided to members by skilled staff. The service has five components: job identification and development activities; employer negotiations; job restructuring; job sampling; and job placement.
- Scope of job coach services:
Job coach services will include, but are not limited to the following:
 - Provide support to members as contained in the SDCB care plan as to achieve their outcomes;
 - Teach vocational skills in a workplace setting;
 - Employ job-coaching techniques and help members learn to accomplish job tasks to the employer's specifications;
 - Increase the Member's capacity to engage in meaningful and productive interpersonal interactions with co-workers, supervisors and customers;
 - Identify and strengthen natural supports that are available to the Member at the job site and decrease paid supports in response to increased natural supports;
 - Identify specific information about the Member's employment interests, preferences and abilities;

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

- Effectively communicate with the employer about how to support the Member to succeed including any special precautions and considerations of the Member’s disability, medications, or other special concerns;
- Monitor and evaluate the effectiveness of the service and provide reports or documentation to the Member as requested in the SDCB care plan;
- Address behavioral, medical or other significant needs identified in the SDCB care plan;
- Follow any individual specific therapeutic recommendations including speech, occupational and/or PT, behavioral support, special diets and other therapeutic routines that are noted in the SDCB care plan;
- Communicate effectively with the Member including communication through the use of adaptive equipment as well as the Member’s communication dictionary, if applicable, at the work site;
- Monitor the health and safety of the Member;
- Model behavior, instruct and monitor any workplace requirements to the Member;
- Adhere to professionally acceptable business attire and appearance, and communicate professionally and in a respectful manner; and
- Adherence to rules of the specific workplace, including dress, confidentiality, safety rules and other areas required by the employer.
- Scope of job development services:
 - Identify potential employers and jobs in the area that provide work opportunities consistent with the Member’s preferences, interests and choice;
 - Negotiate job functions, hours and supervision in the Member’s best interest;
 - Conduct satisfaction surveys as requested by the Member;
 - Broker relationships between the employer and the Member in order to develop and maintain job success;
 - Identify potential employers and jobs in the area that provide work opportunities consistent with the Member’s preferences, interests and choices;
 - Conduct job task analysis to ensure appropriate job match(es);
 - Assess barriers to Member skill development on the job and provide or obtain appropriate accommodations tailored to the SDCB Member’s ability to master task;

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	---	--

- Interact professionally in individual and group contacts, on the phone, in writing with various levels of the company, including human resources and management;
- Assist the employer with ADA issues, Work Opportunity Tax Credit eligibility, requests for reasonable accommodations, disability awareness training and workplace modification or make referrals to appropriate agencies;
- Utilize, refer, and communicate with the DVR concerning job placement and referral activities consistent with industry and SDCB standards;
- Utilize DWS Navigators and One-Stop Career Centers, Business Leadership Network (BLN), Chamber of Commerce, Job Accommodation Network (JAN), Small Business Development Centers, Retired Executive, Businesses, community agencies, and the New Mexico Employment Institute to achieve employment outcomes;
- Maintain on-going communication with various levels of the employer company to assure satisfaction to both the Member and the company;
- During the time of service delivery, ensure the Member's earnings and benefits are in accordance with Fair Labor Standards Act. Each Member's earnings and benefits will be reviewed at least semi-annually during the SDCB care plan year to ensure the appropriateness of pay rates and benefits;
- Conduct a vocational assessment or profile as deemed necessary upon request of the Member;
- Provide a career development plan as deemed necessary or upon the request of the Member;
- Develop specific supports and expectations at the work site that are appropriate to the setting and negotiated with the employer prior to and during employment;
- Verify and ensure that members receive job benefits and services such as paid time off, health insurance, retirement, awards, raises, performance reviews and training consistent with those in a similar job category; and
- Provide career and skill development for advancement and integration in work-related activities or events.
- Job Coach Qualifications – Individual Provider:
 - Be at least 18 years of age;
 - Be qualified to perform the service and demonstrate capacity to perform required tasks;
 - Be able to communicate successfully with the Member;

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

- Experience as a job coach for at least one year;
- Experience for at least one year using job and task analyses;
- Trained on ADA;
- Trained on the purpose, function and general practices of the DVR;
- Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;
- Complete training on critical incident, abuse, neglect, and exploitation reporting;
- Complete Member specific training; the evaluation of training needs is determined by the Member or their legal representative; Member is also responsible for providing and arranging for provider training and supervising provider performance; training expenses for paid providers cannot be paid for with the Member's annual budget; and
- Meet any other service qualifications, as specified in the SDCB rules.
- Job Developer Qualifications – Individual Provider:
 - Be at least 18 years of age;
 - Pass CBC and abuse registry screen;
 - Experience as a job developer for at least one year;
 - Experience for at least one year developing and using job task and analyses;
 - Experience for at least one year working with the DVR, an independent living center or organization that provides Employment Supports or services for people with disabilities;
 - Trained on the purposes, functions and general practices entities such as:
 - DWS Navigators;
 - One-Stop Career Centers;
 - BLN;
 - Chamber of Commerce;
 - JAN;
 - Small Business Development Centers;
 - Retired Executives; and
 - New Mexico Employment Institute.

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

- Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;
- Complete training on critical incident, abuse, neglect, and exploitation reporting;
- Complete Member specific training; the evaluation of training needs is determined by the Member or their legal representative; Member is also responsible for providing and arranging for provider training and supervising provider performance; training expenses for paid providers cannot be paid for with the SDCB Member's annual budget; and
- Meet any other service qualifications, as specified in the SDCB rules.
- Job Coach and/or Job Developer Qualifications – Provider Agency:
 - Possess a current business license, if applicable;
 - Meet financial solvency;
 - Adhere to training requirements;
 - Maintain individual records for each Member within HIPAA compliance. The agency will maintain a confidential case file for each Member that documents activities, progress and scope of work outlined in the Member's SDCB care plan;
 - Develop and adhere to a records management policy;
 - Develop and adhere to QA rules and requirements;
 - Ensure job coaches have the following qualifications:
 - Be at least 18 years of age;
 - Be qualified to perform the service and demonstrate capacity to perform required tasks;
 - Be able to communicate successfully with the Member;
 - Experience as a job coach for at least one year;
 - Experience for at least one year using job and task analyses;
 - Trained on ADA;
 - Trained on the purpose, function and general practices of the DVR;
 - Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;
 - Complete training on critical incident, abuse, neglect, and exploitation reporting;

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
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- Complete Member specific training; the evaluation of training needs is determined by the Member or their legal representative; Member is also responsible for providing and arranging for provider training and supervising provider performance; training expenses for paid providers cannot be paid for with the Member’s annual budget; and
- Meet any other service qualifications, as specified in the SDCB rules.
- Ensure job developers have the following qualifications:
 - Be at least 18 years of age;
 - Experience as a job developer for at least one year;
 - Experience for at least one year developing and using job task and analyses;
 - Experience for at least one year working with the DVR, an independent living center or organization that provides Employment Supports or services for people with disabilities; and
 - Trained on the purposes, functions and general practices entities such as:
 - DWS Navigators;
 - One-Stop Career Centers;
 - BLN;
 - Chamber of Commerce;
 - JAN;
 - Small Business Development Centers;
 - Retired Executives;
 - New Mexico employment institute;
 - Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7;
 - a-1 et seq. and 8.11.6 NMAC;
 - Complete training on critical incident, abuse, neglect, and exploitation reporting;
 - Complete SDCB Member specific training; the evaluation of training needs is determined by the SDCB Member or their legal representative; SDCB Member is also responsible for providing and arranging for provider training and supervising provider performance; training expenses for paid SDCB providers cannot be paid for with the SDCB Member’s annual budget; and

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

- Meet any other service qualifications, as specified in the SDCB rules.

Environmental modification

- Definition of Service:

Environmental modification services include the purchase and/or installation of equipment and/or making physical adaptations to a SDCB Member's residence that are necessary to ensure the health, welfare, and safety of the SDCB Member or enhance the SDCB Member's level of independence. All approved services shall be provided in accordance with applicable Federal, State, and local building codes.

The environmental modification provider must ensure proper design criteria is addressed in the planning and design of the adaptation, provide or secure licensed contractor(s) or approved vendor(s) to provide construction services, provide administrative and technical oversight of construction projects, provide consultation to family members, providers and contractors concerning environmental modification projects to the SDCB Member's residence, and inspect the final environmental modification project to ensure that the adaptations meet the approved plan submitted to the SDCB Member's Care Coordinator for environmental adaptation.

Environmental modifications are managed by professional staff available to provide technical assistance and oversight to environmental modification projects. All services shall be provided in accordance with applicable Federal, State, and local building codes.

- Scope of Services:

- Environmental adaptations include the following:
 - Installation of ramps and grab-bars;
 - Widening of doorways/hallways;
 - Installation of specialized electric and plumbing systems to accommodate medical equipment and supplies;
 - Installation of lifts/elevators;
 - Modification of bathroom facilities (roll-in showers, sink, bathtub, and toilet modifications, water faucet controls, floor urinals, and bidet adaptations and plumbing);
 - Turnaround space adaptations;
 - Installation of specialized accessibility/safety adaptations/additions;

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

- Installation of Trapeze and mobility tracks for home ceilings;
- Installation of Automatic door openers/doorbells;
- Installation of Voice-activated, light-activated, motion activated and electronic devices;
- Installation of Fire safety adaptations;
- Installation of Air filtering devices;
- Installation of heating/cooling adaptations;
- Installation of glass substitute for windows and doors;
- Installation of modified switches, outlets or environmental controls for home devices; and
- Installation of alarm and alert systems, emergency response systems, and/or signaling devices.
- Environmental modification Qualifications – Individual Contractor and Agency Contractor:
 - Current business license;
 - Appropriate plumbing, electrician, contractor license; and/or
 - Appropriate technical certification or other license to perform the modification.
- The environmental modification provider must:
 - Provide a one-year warranty from the completion date on all parts and labor;
 - Have a working knowledge of environmental modifications and be familiar with the needs of persons with functional limitations in relation to environmental modifications;
 - Provide consultation to family members, providers and MCOs concerning environmental modification projects to the SDCB Member’s individual’s residence, and inspect the final environmental modification project prior to the Member/EOR requesting the final payment to ensure that the adaptations meet the approved plan as submitted and approved for environmental adaptation; and
 - Provider must establish and maintain financial reporting and accounting for each Member.
- The environmental modification provider will submit the environmental modification Service Cost Quote Packet containing the following information and documentation to the MCO:
 - Environmental modification evaluation;
 - Service Cost Estimate;
 - Photographs of the proposed modifications;

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

- The estimated start date of the work on the proposed modification; (equipment, materials, supplies, labor, travel, per diem, report writing time, and completion date of modification);
- Letter of Acceptance of Service Cost Estimate signed by the SDCB Member/EOR;
- Letter of Permission from property owner. If the property owner is someone other than the Member, the letter must be signed by the property owner and the Member;
- The Construction Letter of Understanding. If the property owner is someone other than the Member, the letter must be signed by the property owner and the Member; and
- Documentation demonstrating compliance with the ADA.
- The environmental modification provider must submit the following to the MCO, after the completion of work:
 - Letter of Approval of Work completed signed by the SDCB Member/EOR; and
 - Photographs of the completed modifications.
- The MCO must submit a Care Coordinator Individual Assessment of Need to the provider.
- Reimbursement:

Environmental modification providers must maintain appropriate record keeping of services provided, and fiscal accountability as indicated in the Medicaid PPA. Billing is on a project basis, one unit per environmental modification project. Reimbursement for environmental modification services will be based on the negotiated rate with the SDCB Member/EOR; Environmental modification services are limited to \$6,000.00 every five years, beginning from the first date of service. Additional services may be requested if the Member’s health and safety needs exceed the specified limit. The \$6,000.00, five-year time limit applies across all CB packages where environmental modifications are a covered service. Example: an ABCB Member receives an environmental modification of \$3,300.00 leaving a \$2,700.00 available balance for future environmental modification. Six months later the ABCB Member transitions to the SDCB, the Member now has \$2,700.00 available for environmental modifications; and

Environmental modifications exclude those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the Member, such as carpeting, fences, roof repair, storage sheds or other outbuildings, furnace replacement, insulation, and other general household repairs. Adaptations that add to the total square

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

footage of the home are also excluded from this benefit except when necessary to complete an adaptation related to the Member's medical condition.

Home Health Aide

- Definition of Service:

HH Aide services provide total care or assist a Member in all activities of daily living. HH Aide services assist the Member in a manner that will promote and improve the Member's quality of life and provide a safe environment for the Member. HH aide services can be provided outside the Member's home;

State plan HH Aide services are intermittent and are provided primarily on a short-term basis; whereas, in SDCB, HH Aide services are hourly services for members who need this service on a long-term basis; and

HH Aides may provide basic noninvasive nursing assistant skills within the scope of their practice. HH Aides do not administer medication(s), adjust oxygen levels, perform any intravenous procedures or perform sterile procedures. HH Aide services are not duplicative of self-directed PCS.

- Scope of Services:

- Provide personal hygiene (e.g. sponge bathing, showering, bed shampooing, shaving, oral hygiene dressing);
- While under the supervision of a licensed physical therapist or licensed nurse (RN or LPN), assist with ambulation, transfer and range of motion exercises;
- Assist with menu planning, meal/snack preparation and assist Member with eating as necessary;
- As ordered by a physician and under supervision of a licensed nurse (RN or LPN), they will assist with bowel and bladder elimination with activities such as: catheter care, colostomy care, enemas, insertion of non-prescribed suppository, prosthesis care and vital signs;
- Provide homemaking services (e.g. laundry, linen change, cleaning);
- Pick up medication(s);
- Assist or prompt Member in self-administration of medication(s);
- Observe general condition of Member and report changes to supervisor;
- Document SDCB Member's status and services furnished, infection control procedures; and
- Recognize emergencies and adhere to emergency procedures.

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

- HH Aide Qualifications – Agency Provider:
 - Licensed in New Mexico as an HH agency, RHC or FQHC;
 - Possess current business license;
 - Meet financial solvency;
 - Adhere to training requirements;
 - Maintain individual records for each SDCB Member within HIPAA compliance;
 - Develop and adhere to records management policy;
 - Develop and adhere to QA policies and processes;
 - Supervision must be performed by an RN. Such supervision must occur at least once every 60 calendar days in the Member's home and shall be in accordance with the New Mexico Nurse Practice Act and be specific to the Member's SDCB care plan. Contact must be made with family members during supervision; and
 - Ensure all assigned staff meets the following qualifications:
 - Be at least 18 years of age;
 - Be qualified to perform the service and demonstrate capacity to perform required tasks;
 - Have successfully completed a HH aide training program, as described in 42 CFR 484.36(a)(1) and (2); or have successfully completed a HH aide training program pursuant to 7.28.2.30 NMAC. Copies of CNA certificates must be maintained in the personnel file of the HH aide;
 - Be able to communicate successfully with the Member;
 - Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;
 - Complete training on critical incident, abuse, neglect, and exploitation reporting; and
 - Meet any other service qualifications, as specified in the SDCB rules.

Nutritional Counseling

- Definition of Service:
 - Nutritional Counseling services are designed to meet the unique food and nutritional needs of SDCB members. This does not include oral-motor skill development services, such as those provided by a speech pathologist.

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

- **Scope of Services:**
 - Assessment of nutritional needs;
 - Development and/or revision of the SDCB Member’s nutritional plan; and
 - Counseling and nutritional intervention and observation and technical assistance related to implementation of the nutritional plan.
- **Nutritional Counseling Qualifications Individual Provider:**
 - Be licensed per the New Mexico Regulation and Licensing Department; Nutrition and Dietetics Practice Act, NMSA 1978, Section 61-7A et. seq.
- **Nutritional Counseling Qualifications Agency Provider:**
 - Current business license; and provide a tax identification number;
 - Rendering providers are Licensed per the New Mexico Regulation and Licensing Department; Nutrition and Dietetics Practice Act, NMSA 1978, Section 61-7A et. seq.

Private Duty Nursing for Adults

- **Definition of Service:**
 - Private duty nursing for adult services includes activities, procedures, and treatment for a Member’s physical condition, physical illness or chronic disability. Children (individuals under the age of 21) receive this service through the State plan EPSDT.
- **Scope of Services:**
 - Private duty nursing services for adults may include performance, assistance and education with the following tasks:
 - Medication management, administration and teaching;
 - Aspiration precautions;
 - Feeding tube management, gastrostomy and jejunostomy;
 - Skin care;
 - Weight management;
 - Urinary catheter management;
 - Bowel and bladder care; wound care; health education and screening;
 - Infection control;
 - Environmental management for safety;

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

- Nutrition management;
- Oxygen management;
- Seizure management and precautions;
- Anxiety reduction;
- Staff supervision; and
- Behavior and self-care assistance.
- Private Duty Nursing Qualifications – Agency:
 - Licensed in New Mexico as a HH Agency, RHC or FQHC agency;
 - Possess current business license;
 - Meet financial solvency;
 - Adhere to training requirements;
 - Maintain individual records for each Member within HIPAA compliance;
 - Develop and adhere to a records management policy;
 - Develop and adhere to QA policies and processes;
 - Ensure all assigned staff meet the following qualifications;
 - Licensed by the New Mexico State Board of Nursing as a RN or LPN;
 - Demonstrate capacity to perform required tasks;
 - Be able to communicate successfully with the Member;
 - Complete training on critical incident, abuse, neglect, and exploitation reporting;
 - Individual RN/LPN providers must be licensed by the New Mexico State board of nursing as an RN or LPN; and
 - Meet any other service qualifications, as specified in the SDCB rules.
- Private Duty Nursing Qualifications – Individual:
 - Provide a tax identification number;
 - Individual RN/LPN providers must be licensed by the New Mexico State Board of Nursing as an RN or LPN;
 - Demonstrate capacity to perform required tasks;
 - Be able to communicate successfully with the SDCB Member;
 - Complete training on critical incident, abuse, neglect, and exploitation reporting; and
 - Meet any other service qualifications, as specified in the SDCB rules.

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	---	--

Related Goods

- **Definition of Service:**

Related Goods are services, goods, and equipment, including supplies, fees or memberships (such as for conferences or classes), which support the SDCB Member to remain in the community, decrease the need for other Medicaid services and reduce the risk for institutionalization. Related goods must promote personal safety and health, accommodate the SDCB Member in managing their household and/or facilitate ADLs. The related goods must not be available through another source including the Medicaid State Plan and/or Medicare, and the SDCB Member must not have the personal funds needed to purchase the goods; and

Related goods must be documented in the SDCB care plan in a manner that clearly describes how the related good will advance the desired outcomes in the SDCB Member's care plan. Related goods must be linked to the SDCB Member's identified needs and are intended for the sole use of the SDCB Member, and one caregiver, if appropriate. All related goods must be approved by the MCO/UR. The cost and type of related good is subject to approval by the MCO/UR. SDCB members are not guaranteed the exact type and model of related good that is requested. The Support Broker and/or the Care Coordinator can work with the SDCB Member to find other (including less costly) alternatives. Items that are purchased with SDCB funds cannot be returned for store credit, cash or gift cards. Experimental or prohibited treatments and related goods are excluded. For members who enter the SDCB program after January 1, 2019, related goods are limited to a total maximum of \$2,000.00 annually.

- **Scope of Services:**

Related goods must address a specific, assessed need identified in the Member's CNA (including improving and maintaining the Member's opportunities for full membership in the community) and must directly relate to the Member's qualifying condition or disability. Related goods must explicitly address the Member's clinical, functional, medical or habilitative needs;

Related goods must meet all of the following requirements:

- Are related to a need or goal identified in the approved care plan;
- Are for the purpose of increasing independence or substituting for human assistance, to the extent the expenditures would otherwise be made for that human assistance;

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

- Promote opportunities for community living and inclusion;
- Are able to be accommodated within the Member's budget without compromising the Member's health or safety; and
- Are provided to, or directed exclusively toward, the benefit of the Member.

Medicaid does not pay for the purchase of related goods or services that a household not including a person with a disability would be expected to pay for as a routine household or personal expense.

Examples include, but are not limited to:

- Goods or services that are considered primarily recreational or diversional;
- Cell phones and cell phone service for members who are minors (these are items that LRI such as a parent/guardian, or spouse would ordinarily purchase for household members of the same age who do not have a disability or chronic illness);
- Cell phone services including fees for data and GPS in excess of \$100.00 per month or more than one cell phone per SDCB Member;
- Cell phone services that include more than one cell phone or cell phone line per Member; cell phone service, including data, is limited to the cost of \$100.00 per month;
- Room and board, meaning shelter expenses (including property-related costs such as home and property maintenance, insurance policies, utilities and all deposits; and all food items other than nutritional supplements as approved in the SDCB care plan);
- Purchase of usual and customary furniture/home furnishings,
- Regularly scheduled upkeep, maintenance and repairs of a home, addition of fences, insulation, construction of storage sheds or other outbuildings, except upkeep and maintenance of modifications or alterations to a home which are an accommodation directly related to the Member's qualifying condition or disability;
- Regularly scheduled upkeep, maintenance and repairs of a vehicle or van, or tire purchase or replacement, except upkeep and maintenance of modifications or alterations to a vehicle or van, which is an accommodation directly related to the Member's qualifying condition or disability.
- Purchase, lease, or rental of a vehicle, including recreational vehicles;
- Memberships/fees related to religious activities/events;

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

- Purchase of animals and the costs of maintaining animals, including the purchase of food, veterinary visits, grooming and boarding but with the exception of training and certification for service dogs;
- Purchase of insurance policies, such as automobile, health, life, burial, renter's, home-owner, service warranties or other such policies, including the purchase of cell phone insurance;
- Personal goods or items not related to the Member's qualifying condition or disability, including clothing and personal hygiene products and accessories;
- Moving expenses including but not limited to the cost of moving truck rental, gas/mileage, labor, storage, moving equipment and supplies;
- Vacation expenses, including means of transport, guided tours, meals, tips, lodging or similar recreational expenses including fuel, mileage or driver time reimbursement for vacation travel by an automobile;
- Costs associated with conferences or classes, including airfare, lodging, mileage/gas, or meals;
- Training expenses for employees;
- Professional housecleaning or yard maintenance;
- Formal academic degrees or certification seeking education, educational services covered by IDEA, or vocational training provided by the public education department, DVR
- For electronics such as cell phones, computers (including desktop, laptop, and tablets), monitors, printers and fax machines, copiers, and other electronic equipment, no more than one of each type of item may be purchased at one time, and Member electronics may not be replaced more frequently than once every three years.
- Related Goods Qualifications Vendor Agency Provider:
 - Valid tax identification for the state and Federal governments.

Respite

- Definition of Service:
 - Respite is to be used to give the primary caregiver a break on an episodic basis in the event of an emergency or to prevent burnout. Respite provides a temporary relief to the primary caregiver of a SDCB Member during times when the caregiver would normally provide unpaid care. Respite services can be provided in the SDCB Member's home, the provider's home, in

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

community setting of the family's choice (e.g., community center, swimming pool and park, or at a center in which other individuals are provided care); and

- Respite services may be provided by eligible individual respite providers; RN or LPN; or respite provider agencies.
- **Scope of Services:**
Respite services include, but are not limited to the following:
 - For members meeting NF LOC, respite services are limited to a maximum of 300 hours annually per care plan year provided there is a primary caregiver. The 300-hour respite service applies across all CB packages where respite is a covered service. Additional hours may be requested if an eligible beneficiary's health and safety needs exceed the specified limit;
 - Assist with routine ADLs;
 - Enhance self-help skills, leisure time skills and community and social awareness;
 - Provide opportunities for leisure, play and other recreational activities;
 - Provide opportunities for community and neighborhood integration and involvement;
 - Provide opportunities for the SDCB Member to make their own choices with regards to daily activities;
 - Respite services do not include the cost of room and board;
 - Cannot be used for purposes of day-care;
 - Cannot be provided to school age children during school hours; and
 - Respite must be documented through the EVV system.
- **Respite Qualifications – Individual Provider:**
 - Be at least 18 years of age;
 - Be qualified to perform the service and demonstrate capacity to perform required tasks;
 - Be able to communicate successfully with the SDCB Member;
 - Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;
 - Complete training on critical incident, abuse, neglect, and exploitation reporting;
 - Complete Member specific training; the evaluation of training needs is determined by the Member or their legal representative; Member is also responsible for providing and arranging

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	---	--

for provider training and supervising provider performance; training expenses for paid providers cannot be paid for with the SDCB Member's annual budget;

- Meet any other service qualifications, as specified in the SDCB rules and the Manual; and
 - Individual RN/LPN providers must be licensed by the New Mexico State Board of Nursing as an RN or LPN.
- **Respite Qualifications Provider Agency:**
 - Possess a current business license, if applicable;
 - Meet financial solvency;
 - Adhere to training requirements;
 - Maintain individual records for each SDCB Member within HIPAA compliance;
 - Develop and adhere to a records management policy;
 - Develop and adhere to QA rules and requirements; and
 - Ensure all assigned staff meet the following qualifications:
 - Be at least 18 years of age;
 - Be qualified to perform the service and demonstrate capacity to perform required tasks;
 - Be able to communicate successfully with the SDCB Member;
 - Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;
 - Complete training on critical incident, abuse, neglect, and exploitation reporting;
 - Complete SDCB Member specific training; the evaluation of training needs is determined by the SDCB Member or their legal representative; Member is also responsible for providing and arranging for provider training and supervising provider performance; training expenses for paid providers cannot be paid for with the SDCB Member's SDCB annual budget;
 - Individual RN/LPN providers must be licensed by the New Mexico State Board of Nursing as an RN or LPN; and
- Meet any other service qualifications, as specified in the SDCB rules and the Manual.

Nursing Respite Services

- Nursing respite services provide the Member's primary caregiver with a limited leave of absence to prevent burnout and provide temporary relief to meet a family crisis, emergency or

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

caregiver's illness as determined in the CCP. A primary caregiver is the individual who has been identified in the PCCP and who assists the Member on a frequent basis (i.e., daily or at a minimum weekly). It is not necessary for the primary caregiver to reside with the Member in order to receive nursing respite services. Nursing respite services may be provided in the Member's home, in the nursing respite provider's home, and in the community. Nursing respite services may be provided by an RN, or an LPN. Nursing respite services are limited to a total maximum of 300 hours per PCCP year. Nursing respite services must not be provided by a Member of the Member's household or by any relative approved as the employed, paid caregiver. Nursing respite provider agencies will use the state mandated EVV system as required by the 21st Century Cures Act.

▪ **Scope of Services/Requirements:**

- Specific services may include the following:
 - Assistance with routine ADLs such as bathing, eating, meal preparation, dressing, and hygiene;
 - Assistance with routine IADLs such as general housekeeping;
 - Assistance with PCS or PDN services, based on the Member's needs;
 - Assistance with the enhancement of self-help skills;
 - Assistance with providing opportunities for leisure, play and other recreational activities-;
- Requirements include the following:
 - Nursing Respite services are available to any Member of any age;
 - Nursing Respite services are determined by the MCO Care Coordinator and documented on the CCP;
 - Scheduling of hours for use of nursing respite services is the responsibility of the nursing respite provider and the Care Coordinator; and
 - Nursing respite services provided by a PDN provider requires a physician's order that includes the scope and duration of service(s). A new physician's order will be

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	---	--

obtained annually with the CCP renewal or when there is a revision in the service. The order must be obtained by the agency providing PDN and shared with the MCO Care Coordinator. The provider agency may require advanced notice from the Member/family for provision of services and will notify members of their advanced notice requirement. The provider of nursing respite services must maintain a cumulative record of utilization of respite care, to include time used.

- **Provider Requirements/Qualifications:**

The provider agency of nursing respite services must meet all requirements, certifications, and training standards set forth by the HCASD/MAD to provide PDN services, as described in this section of the policy.

- Nursing respite services must be provided by an active, Medicaid approved provider type 363 Nursing Respite provider.
- Nursing respite providers must maintain (no gap in license) a full permanent license through the New Mexico Board of Nursing. Provisional licenses will not be accepted.
 - Nursing respite services may also be furnished through a licensed HH Agency, licensed RHC or certified FQHC who meet all requirements/qualifications in this section of the policy and are approved by the HCA/MAD/LTSSB as a provider type 363 nursing respite provider.
- Nursing respite providers must comply with provisions of the Nurse Practice Act and the state rules/regulations.
- In order to be approved and certified by the HCA/MAD/LTSSB, Nursing respite providers must be holding and operating with a full permanent license (no gaps in license). All incomplete applications submitted to the HCA/MAD/LTSSB shall be rejected and not considered for review until a complete application is submitted.
- Nursing respite providers must comply with all applicable State and Federal rules and regulations under the nurse practice Act and program standards determined by HCA/MAD including but not limited to CBCs, OSHA training requirements, incident management system reporting, labor laws, etc.;

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	---	--

- Nursing respite providers must have a functioning office located in New Mexico where staff and members can go to obtain information and/or assistance.
- The provider agency of nursing respite services must meet all requirements, certifications, and training standards set forth by the HCASD/MAD to provide PDN services, as described in this section of the policy.
- **Staffing Requirements:**
 - An RN or LPN is considered a qualified respite nurse when the following criteria are met:
 - Must be holding and maintaining a current (no gaps in licensure) permanent license as required by the state of New Mexico;
 - Nursing experience preferably with disabled and elderly individuals. This includes settings such as HH, hospital, NF facility, or other types of clinics and institutions;
 - RNs who supervise must have at least one year of supervisory experience. Supervision of RNs and LPNs must be provided by a qualified RN on a quarterly basis and shall be in accordance with the New Mexico Nursing Practice Act. The supervision of all personnel is the responsibility of the agency's Administrator and Director;
 - Be culturally sensitive to the needs and preferences of members and their households based upon language. Communicating in a language other than English may be required; and

Hepatitis B vaccine will be offered by the provider agency upon employment at no cost to the employee per the Federal OSHA requirements. Record of prior Hepatitis B immunization, acceptance or denial by the employee will be maintained in the employee's personnel record.

Supervision of nursing respite employees must be documented by the nursing respite supervisor. The supervisor must be a staff Member of the nursing respite provider agency and provide in-service training to the personnel providing the care.

Nursing respite providers must maintain a current roster that is updated quarterly of nurse respite providers to provide services as requested by the Member or family.

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

Nursing respite service providers must immediately notify the MCO Care Coordinator if there is a change in the Member's condition, if the Member refuses care or if the agency is unable to comply with the care delivery as agreed upon in the CCP.

- **Reimbursement**

Reimbursement is on an hourly basis and is accrued to the nearest quarter of an hour. Training on Member specific issues is reimbursable and included in the negotiated rate, general training requirements are an administrative cost and not billable.

Reimbursement for nursing respite services will be based on the negotiated rate with the MCO. Providers of service have the responsibility to review and ensure the information on the prior authorization for their services is correct. If the provider identifies an error, they must contact the MCO immediately to have the error corrected.

- **Limits or Exclusions**

The Member cannot schedule his or her own nursing respite with the nursing respite staff. The Member may receive a maximum of 300 total hours of nursing respite hours annually per CCP year provided there is a primary caregiver. Additional hours may be requested if an eligible Member's health and safety needs exceed the specified amount.

Self-directed Personal Care

- **Definition of Service:**

Self-directed PCS are provided on a continuing basis to assist the Member with accomplishing tasks they would normally do for themselves if they did not have a disability. Self-directed PCS are provided in the Member's home and in the community, depending on the Member's needs. The Member/EOR identifies the self-directed personal care worker's training needs. If the SDCB Member/EOR is unable to do the training him/herself, the SDCB Member/EOR arranges for the needed training;

Services are not intended to replace supports available from a primary caregiver or natural supports. Although a Member's assessment for the amount and types of services may vary, Self-directed PCS

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

are not provided 24 hours a day. Allocation of time and services must be directly related to an individual's functional level to perform ADLs and IADLs as indicated in the CNA; and this service is not available for members under age 21 because PCS are covered under the Medicaid State Plan as expanded EPSDT benefits for members under age 21.

- Scope of Services:
 - Self-directed PCS include but are not limited to the following:
 - Assist the Member with ADLs;
 - Perform general household tasks, not including services such as yard maintenance;
 - Provide companionship to acquire, maintain or improve social interaction skills in the community; and
 - Attend trainings as designated by the Member in the care plan.
 - Must be provided as a one-on-one service; multiple members cannot receive services at the same time by one employee.
 - Self-directed Personal Care Qualifications – Individual Provider:
 - Be at least 18 years of age;
 - Be qualified to perform the service and demonstrate capacity to perform required tasks;
 - Be able to communicate successfully with the Member;
 - Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC and the National Sex Offender Registry;
 - Complete training on critical incident, abuse, neglect, and exploitation reporting;
 - Complete Member specific training; the evaluation of training needs is determined by the Member or his/her legal representative; Member is also responsible for providing and arranging for provider training and supervising provider performance; training expenses for paid providers cannot be paid for with the Member's annual budget;
 - Use the State-approved EVV system to record location of services and time worked; and
 - Meet any other service qualifications, as specified in the SDCB rules.
 - Self-directed Personal Care Qualifications – Agency Provider:
 - HHAs must hold an HHA license;

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

- Possess a current business license, if applicable;
- Meet financial solvency;
- Adhere to training requirements;
- Maintain individual records for each SDCB Member within HIPAA compliance;
- Develop and adhere to a records management policy;
- Develop and adhere to QA rules and requirements; and
- Ensure all assigned staff meet the following qualifications. Documented proof of all requirements must be provided to Conduent upon request:
 - Be at least 18 years of age;
 - Be qualified to perform the service and demonstrate capacity to perform required tasks;
 - Be able to communicate successfully with the Member;
 - Each caregiver providing personal care services to a SDCB Member must pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screening pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC and the National Sex Offender Registry;
 - Complete training on critical incident, abuse, neglect, and exploitation reporting;
 - Complete Member specific training; the evaluation of training needs is determined by the Member or his/her legal representative; Member is also responsible for providing and arranging for employee training and supervising employee performance; training expenses for paid employees cannot be paid for with the Member's annual budget;
- Ensure employees use the State-approved EVV system to record location of services and time worked; and
- Meet any other service qualifications, as specified in the SDCB rules and the Manual. Self-Directed PCS are to be delivered only in the State of New Mexico. However, consumers who require PCS out of the state, for medically necessary reasons, may request an exception, and must obtain written approval from the MCO for out of state delivery of service prior to leaving the state. The following must be submitted for consideration when requesting medically necessary out-of-state services:
 - A letter from the consumer or the consumer's legal representative requesting an out of state exception and reasons for the request; the letter must include:
 - The consumer's name and SSN;

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	---	--

- How time sheets/logs/check-off list will be transmitted and payroll checks issued to the attendant;
- Date the consumer will be leaving the state, including the date of the medical procedure or other medical event, the anticipated date of return;
- Where the consumer will be housed after the medical procedure;
- A letter or documentation from the physician, surgeon, physician assistant, nurse practitioner, or clinical nurse specialist verifying the date of the medical procedure; and
- A revision of services within the SDCB Care Plan must be requested during the time the consumer is out-of-state; support services and household services will not be approved unless justified; if the consumer has been approved for services under self-administered medications, a statement from the physician, physician assistant, nurse practitioner, or clinical nurse specialist must be included indicating the consumer will continue to have the ability to self-administer for the duration of time they are out-of-state.
- Utilization Review (UR): All PCS require prior LOC approval by the MCO; therefore, retroactive services are not authorized. All PCS are subject to UR for medical necessity and program compliance. The MCO will perform UR for medical necessity.
- The MCO makes final authorization of PCS using:
 - The HCA-approved LOC criteria; and
 - The CNA

Skilled Maintenance Therapies Services

- **Definition of Service:**

Skilled maintenance therapies are provided when Medicaid State Plan skilled therapy services are exhausted. Adult members in SDCB access therapy services under the Medicaid State Plan for acute and temporary conditions that are expected to improve significantly in a reasonable and generally predictable period of time. A signed therapy referral for treatment must be obtained from the Member's PCP. The referral will include frequency, estimated duration of therapy, and treatment/procedures to be rendered. Therapy services provided to adults in SDCB are to focus on

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

health maintenance, improving functional independence, community integration, socialization, exercise or to enhance supports and normalization of family relationships.

- PT is the diagnosis and management of movement dysfunction and the enhancement of physical and functional abilities;
- OT is the diagnosis, assessment and management of functional limitations intended to assist adults to regain, maintain, develop and build skills that are important for independence, functioning and health; and
- SLT services preserve speech fluency, voice, verbal, written language, auditory comprehension, cognition, swallowing dysfunction, oral pharyngeal or laryngeal and sensor motor competencies. Speech language pathology is also used when a SDCB Member requires the use of an augmentative communication device. Based upon therapy goals, services may be delivered in an integrated natural setting, clinical setting or in a group.
- Scope of Services
 - PT:
 - Diagnostic activities to determine the dysfunction of physical and functional activities;
 - Activities to increase, maintain or reduce the loss of functional skills;
 - Treat specific condition(s) clinically related to a member's qualifying condition or disability;
 - Activities to support the Member's health and safety needs; and
 - Identify, implement and train on therapeutic strategies to support the Member, family and/or staff in the home setting or other environments as addressed in the SDCB care plan.
 - OT:
 - Diagnostic activities to determine skills assessment and treatment;
 - Write treatment program to improve one's ability to perform daily tasks;
 - Comprehensive home, employment and/or volunteer sites evaluations with adaptation recommendations;
 - Provide guidance to family members and caregivers;
 - Make assistive technology recommendations and provide usage training for members, family and staff; and

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	---	--

- Identify, implement and train on therapeutic strategies to support the SDCB Member, family and/or staff in the home setting or other environments as addressed in the SDCB care plan.
- Speech and Language Pathology:
 - Improve or maintain the Member’s capacity for successful communication or to lessen the effects of the Member’s loss of communication skills;
 - Consultation on usage and training on augmentative communication devices;
 - Activities to improve or maintain the Member’s ability to eat food, drink liquid and manage oral secretions with minimal risk of aspiration or other injuries or illness related to swallowing disorders; and
 - Activities to identify, implement, and train on therapeutic strategies to support the Member, his/her family and/or staff consistent with the Member’s Care Plan.
- Therapy Qualifications – Individual Therapist Provider:
 - Provide a tax identification number; and
 - Maintain a case file within HIPAA guidelines for the Member to include:
 - Member’s SDCB care plan;
 - Reports as requested in the care plan;
 - Contact notes;
 - Training roster(s); and
 - Assessments for environmental modification requests.
- Licensures:
 - Physical therapists will be licensed as per the New Mexico Regulation and Licensing Department; Physical Therapy Act NMSA 1978, Section 61-12-1.1 et. seq;
 - Occupational therapists will be licensed as per the New Mexico Regulation and Licensing Department; Occupational Therapy Act NMSA 1978, Section 61-12A- 1et.seq.; and
 - Speech and Language Pathologists will be licensed as per the New Mexico Regulation and Licensing Department; Occupational Therapy Act NMSA 1978, Section 61-14B- 1et.seq.
- Therapy Qualifications – Provider Agency:
 - Current business license;

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	---	--

- Provide tax identification number;
- Ensure physical therapists maintain a case file within HIPAA guidelines for the Member to include:
 - Member’s SDCB care plan;
 - Reports as requested in the SDCB care plan;
 - Contact notes;
 - Training roster(s); and
 - Environmental modification requests.
- Ensure therapists has appropriate license for service:
 - Physical therapists will be licensed as per the New Mexico Regulation and Licensing Department; Physical Therapy Act NMSA 1978, Section 61-12-1.1 et. seq.;
 - Occupational therapists will be licensed as per the New Mexico Regulation and Licensing Department; Occupational Therapy Act NMSA 1978, Section 61-12A- 1et.seq.; and
 - Speech and Language Pathologists will be licensed as per the New Mexico Regulation and Licensing Department; Occupational Therapy Act NMSA 1978, Section 61-14B- 1et.seq.

Specialized Therapies Services

- Definition of Service:

Specialized therapies are non-experimental therapies or techniques that have been proven effective for certain conditions. Services must be related to the Member’s disability or condition and ensure the Member’s health and welfare in the community. The service will supplement to (not replace) the Member’s natural supports and other community services for which the Member may be eligible. Experimental or investigational procedures, technologies or therapies and those services covered in Medicaid State Plans are excluded. For members who enter the SDCB program on or after January 1, 2019, specialized therapies are limited to a total maximum of \$2,000.00 annually.

Only the specific specialized therapy services outlined below are covered through the SDCB.
- Scope of Services:
 - Acupuncture is a distinct system of primary health care;

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

The goal of acupuncture is to prevent, cure or correct any disease, illness, injury, pain or other physical or mental condition by controlling and regulating the flow and balance of energy, form and function to restore and maintain PH and increased mental clarity. Acupuncture may provide effective pain control, decreased symptoms of stress, improved circulation and a stronger immune system, as well as other benefits. See Acupuncture and Oriental Medicine Practitioners 16.2.1 NMAC.

- Biofeedback uses visual, auditory or other monitors to provide SDCB members physiological information of which they are normally unaware. This technique enables a Member to learn how to change physiological, psychological and behavioral responses for the purposes of improving emotional, behavioral and cognitive health performance. Biofeedback may assist in strengthening or gaining conscious control over the above processes in order to self-regulate. Biofeedback is also useful for muscle re- education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm or weakness;
- Chiropractic care is designed to locate and remove interference with the transmissions or expression of nerve forces in the human body by the correction of misalignments or subluxations of the vertebral column and pelvis. Chiropractic care restores and maintains health for treatment of human disease primarily by, but not limited to, adjustment and manipulation of the human structure. Chiropractic therapy may positively affect neurological function, improve certain reflexes and sensations, and increase range of motion and lead to improved general health. See Chiropractic Practitioners 16.4.1 NMAC;
- Cognitive rehabilitation therapy is designed to improve cognitive functioning with the following activities: reinforcing, strengthening, or reestablishing previously learned patterns of behavior; establishing new patterns of cognitive activity; or compensatory mechanisms of impaired neurological systems. Treatments may be focused on improving a particular cognitive domain such as attention, memory, language, or executive functions. Alternatively, treatments may be skill-based, aimed at improving performance of activities of daily living. The overall goal is to restore function in a cognitive domain or set of domains or to teach compensatory strategies to overcome specific cognitive problems;
- Hippotherapy is a physical, occupational and SLT treatment strategy that utilizes equine movement as part of an integrated intervention program to achieve functional outcomes.

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

Hippotherapy applies multidimensional movement of a horse for members with movement dysfunction and may increase mobility and range of motion, decrease contractures and aid in normalizing muscle tone. Hippotherapy requires that the Member use cognitive functioning especially for sequencing and memory. Members with attention deficits and behavior problems are redirecting attention and behaviors by focusing on the activity. Hippotherapy involves therapeutic exercise, neuromuscular education, kinetic activities, therapeutic activities, sensory integration activities and individual speech therapy. The activities may also help improve respiratory function and assist with improved breathing and speech production. Hippotherapy must be performed by a physical therapist, occupational therapist, or speech therapist licensed by the New Mexico Regulation and Licensing Department;

- Massage therapy is the assessment and treatment of soft tissues and their dysfunction for therapeutic purposes primarily for comfort and relief of pain. It includes gliding, kneading, percussion, compression, vibration, friction, nerve strokes, stretching the tissue and exercising range of motion and may include the use of oils, salt glows, hot or cold packs or hydrotherapy. Massage increases the circulation, helps loosen contracted, shortened muscles and can stimulate weak muscles to improve posture and movement, improves range of motion and reduces spasticity. Massage therapy may increase, or help sustain, a Member's ability to be more independent in the performance of activities of daily living; thereby, decreasing dependency upon others to perform or assist with basic daily activities. See Massage Therapists 16.7.1 NMAC;
- Naprapathy focuses on the evaluation and treatment of neuro-musculoskeletal conditions and is a system for restoring functionality and reducing pain in muscles and joints. The therapy uses manipulation and mobilization of the spine and joints and muscle treatments such as stretching and massage. Based on the concept that constricted connective tissue (ligaments, muscles and tendons) interfere with nerve, blood and lymph flow, Naprapathy uses manipulation of connective tissue to open these channels of body function. See Naprapathic Practitioners 16.6.1 NMAC; and
- Specialized Therapy Qualifications – Individual Provider:
 - Current New Mexico state license as applicable:
 - Acupuncture and Oriental medicine license;

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

- Biofeedback – license in a healthcare profession whose scope of practice includes biofeedback, and appropriate specialized training and clinical experience and supervision;
- Chiropractic Physician license;
- Cognitive rehabilitation therapy – license in a health care profession whose scope of practice includes cognitive rehabilitation therapy, and appropriate specialized training and clinical experience and supervision;
- Hippotherapy – licensed occupational therapist, physical therapist, or speech therapist;
- Massage therapy license; and
- Naprapathic physician license.
- Specialized Therapy Qualifications Provider Agency:
 - Current business license;
 - Tax identification number; and
 - Group practice/vendor staff must hold current New Mexico licensure and training in their respective discipline as follows:
 - Acupuncture and Oriental Medicine license;
 - Biofeedback – license in a healthcare profession whose scope of practice includes biofeedback, and appropriate specialized training and clinical experience and supervision;
 - Chiropractic Physician license;
 - Cognitive rehabilitation therapy – license in a health care profession whose scope of practice includes cognitive rehabilitation therapy, and appropriate specialized training and clinical experience and supervision;
 - Hippotherapy – license in a health care profession whose scope of practice includes Hippotherapy and appropriate specialized training and experience;
 - Massage therapy license; and
 - Naprapathic physician license.

Start-Up Goods

- Definition of Service:

Startup goods are available to a Member who is transitioning from the ABCB to the SDCB for the first time. Startup goods are limited to one time. Startup goods help the Member in self-directing his or

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

her services. Examples of startup goods include, but are not limited to a computer, fax machine, and printer. All startup goods must be approved by the MCO. The cost and type of related good is subject to approval by the MCO. Startup goods must be purchased during the Member’s first budget period. Startup goods are limited to \$2,000.00.

Transportation (Non-Medical)

- **Definition of Service:**

Transportation services are offered in order to enable SDCB members to gain access to and from community services, activities and resources, as specified by the SDCB care plan. Transportation services are intended for access to the Member’s local area, within a 75-mile radius of the SDCB Member’s home. Transportation services under SDCB are non-medical in nature, whereas transportation services provided under the Medicaid State Plan are to transport members to medically necessary physical and BH services. Transportation for the purpose of picking up pharmacy prescriptions is allowed. Transportation for the purpose of vacation is not covered through the SDCB;

Non-medical transportation services for minors is not a covered service;

Non-medical transportation may be reimbursed:

- To the driver by the mile; and/or
- Through the purchase of a bus pass or local taxi.

Payments are made to the Member’s individual transportation employee or vendor or to a public or private transportation service vendor. Payments cannot be made to the SDCB Member. Whenever possible, natural supports should provide this service without charge. For members who enter the SDCB program on or after January 1, 2019, SDCB non-medical transportation is limited to a total maximum of \$1,000.00 annually.

- **Scope of Services:**

The service will be provided as specified in the Member’s SDCB care plan. SDCB non-medical transportation services cannot be used instead of, or to replace, medical transportation services available under the Medicaid State Plan; and

Payment is allowable for transportation to and from specific locations/sites that provide specific services that are approved in the Member’s care plan goals.

- **Transportation Qualifications Individual Provider:**

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

- Be at least 18 years of age;
- Possess a valid New Mexico driver's license;
- Be free of physical or mental impairment that would adversely affect driving performance;
- No driving while intoxicated convictions within the previous two years;
- No chargeable (at fault) accidents within the previous two years;
- Complete training on critical incident, abuse, neglect, and exploitation reporting; and
- Possess and maintain current insurance policy and registration.
- Transportation Qualifications – Provider Agency:
 - Current business license;
 - Valid tax identification number;
 - Have a current basic First Aid kit in the vehicle;
 - Each vehicle will contain a current insurance policy and registration; and
 - Ensure drivers meet individual qualifications:
 - Be at least 18 years of age;
 - Possess a valid New Mexico driver's license;
 - Be free of physical or mental impairment that would adversely affect driving performance
 - No driving while intoxicated convictions within the previous two years;
 - No chargeable (at fault) accidents within the previous two years;
 - Complete training on critical incident, abuse, neglect, and exploitation reporting;
 - Trained on New Mexico Department of Health Improvement (DHI) Critical Incident Reporting and Procedures; and
 - Possess current insurance policy and registration.

9.11. Self-directed Non-Covered Services

When a Member requests a non-covered service or good, the Support Broker and/or Care Coordinator shall work with the Member to find other (including less costly) alternatives. Services and goods that are not covered by the SDCB program include, but are not limited to:

- The SDCB Program is the payer of last resort; and
- Any service or good, the provision of which would violate Federal or State statutes, rules or guidance. This includes services that are recreational or diversional, which are not deemed eligible

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	---	--

SDCB services by CMS. Recreational and diversional in nature is defined as inherently and characteristically related to activities done for enjoyment. This includes, but is not limited to tickets for movies, theatrical and musical performances, sporting events, zoos or museums.

9.12. SDCB Budget and Care Plan Approval Process

The Care Coordinator adds the Member to *FOCoOnline* when the Member has expressed a desire to transfer to SDCB by signing the SDCB statement. Once the Member selects the Support Broker agency they wish to work with, the Care Coordinator informs the Support Broker agency of the selection. After the Support Broker meets with the Member and an anticipated transfer date is agreed upon, the Support Broker creates a Working Plan shell with the anticipated SDCB care plan dates. Once the Working Plan shell is created, the Care Coordinator shall enter the SDCB budget amount in *FOCoOnline*.

9.13. Initial SDCB Budget Determination Process

The SDCB budget is determined by the Care Coordinator and is based on two factors: the needs identified in the CNA, and the amount and type of services the Member has been receiving in the ABCB. Both of these evaluations are used to assign the SDCB budget amount for development of the SDCB care plan. The Care Coordinator shall provide the Support Broker with the SDCB budget amount.

The Member must receive his/her HCBS in the ABCB for a minimum of 120 calendar days before transferring to the SDCB. The initial 12-month SDCB budget shall be pro-rated based on the number of months already completed in the ABCB. The SDCB Member may request a new CNA if the SDCB Member thinks his/her needs were not adequately addressed in the initial CNA.

9.14. Initial SDCB Care Plan Approval Process

Once the Care Plan is developed, the Support Broker, in cooperation with the Member, shall inform the Care Coordinator that the Care Plan is ready for review. Once the Care Coordinator reviews the Care Plan, the Care Coordinator shall formally submit the care plan in *FOCoOnline* to the MCO for review and approval/denial decisions. The Member's Care Plan must be reviewed, and each individual requested goal approved or denied by the MCO. Written notification must be sent to the Member before any services may be utilized and related goods may be purchased. If, during the process of reviewing the Care Plan and all subsequent Care Plan revisions, the MCO is unable to make a decision on a goal, due to

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	---	--

insufficient information, the MCO shall initiate an RFI via *FOCoSonline*. The MCO shall provide written notification to the Member and the Support Broker, specifying what is needed by the MCO to satisfy the RFI. It is the Member’s responsibility to provide a timely and complete response to the RFI. The Support Broker/Care Coordinator may assist the Member in obtaining the requested documents to fulfill the RFI. The Member/Support Broker must provide the RFI response to the Care Coordinator within 15 calendar days from the date of the RFI letter. After review of the RFI response the Care Coordinator shall submit the RFI response to the MCO for approval/denial decision. If the requested information is not received by the Care Coordinator within 15 calendar days from the date of the RFI letter, the service or good shall be denied by the MCO.

If the Care Coordinator or MCO identify an administrative error on the submitted SDCB care plan a “Request for Administrative Action” (RFA) shall be sent to the Support Broker. The RFA shall specify what is needed to correct the administrative error. The Support Broker must respond to the RFA within five calendar days from the date of the RFA notification. If the RFA is not addressed by the Support Broker or Care Coordinator within five calendar days from the date of the RFA letter, the service or good shall be denied by the MCO/UR

The MCO will notify the Member, Care Coordinator, and Support Broker in writing when a determination has been made on the Care Plan. The determination may be a full approval, a partial approval, or a full denial. The MCO shall indicate which goal(s) of the Care Plan have been approved or denied in *FOCoSonline*. Written notifications will include steps for the SDCB Member/legal representative to follow if the Member disagrees with a denial decision.

The FMA will utilize the approved care plan/budget to process payment for the approved amount of SDCB services and related goods.

The Member’s Care Plan must be approved before SDCB services can begin. The MCO will not issue payment for any services, supports and/or related goods which are provided or purchased prior to the approval of the Care Plan, or before the provider is linked to the Care Plan.

At the earliest opportunity, the Care Plan and the NF LOC shall be aligned to start/end on the same day. This may entail truncating the existing SDCB care plan to align with the annual NF LOC or truncating the existing NF LOC to align with the annual SDCB care plan.

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	---	--

9.15. Annual SDCB Budget Determination and Approval Process

Approximately 90 calendar days prior to the expiration of the existing SDCB care plan/budget, the Care Coordinator shall conduct the annual CNA. The Care Coordinator shall assign the budget based on the assessed needs identified in the CNA. The budget is determined annually, and the budget amount may differ from year to year. The budget shall not be higher than the cost of care for persons served in a private NF, unless the Member transitioned into SDCB with their prior approved -self-directed budget. Unused budget amounts from a previous year cannot be carried over to the new SDCB care plan year. Approximately 90 days prior to the expiration of the existing care plan/budget, the Support Broker shall open the new Working Plan shell in *FOCoSonline*, with the begin and end dates for the upcoming SDCB Care Plan. Upon the annual SDCB budget determination, the Care Coordinator shall enter the SDCB budget amount in *FOCoSonline*, allowing the Member and Support Broker to begin developing the upcoming year's Care Plan.

9.16. Annual SDCB Care Plan Development and Approval Process

At a minimum, the Care Plan must be developed and submitted to the MCO for review annually, and no less than 30 calendar days prior to the expiration of the existing care plan/budget. This 30 calendar day timeframe allows enough time for the Care Coordinator and MCO to make an informed and accurate determination of all requested services before the existing care plan/budget expires. The MCO will notify the Member, Care Coordinator, and Support Broker in writing when a determination has been made on the Care Plan request. The determination may be a full approval, a partial approval, or a full denial. The MCO shall indicate which goal(s) of the Care Plan have been approved or denied in *FOCoSonline* and a letter shall be sent to the Member including written instructions for the Member/legal representative to follow if the Member disagrees with the denial decision(s).

9.17. SDCB Budget and Care Plan Approval Process for Individuals Who Transitioned from the MI VIA Waiver Program

Prior to 1/1/2014, the Mi Via TPA approved many Mi Via employees/vendors at a reimbursement rate which was above the maximum Mi Via rate for a particular Mi Via service. The higher reimbursement rates are to continue to be approved in SDCB so long as the specific EOR and SDCB provider relationship does not encounter a break in service. If, for any reason, the relationship ends and a new

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	---	--

employee/vendor is hired, the SDCB reimbursement rate for the new provider shall not exceed the current approved SDCB range of rates (9.22.1) for any SDCB covered service. When the aforementioned situation occurs, the budget may be reduced by the corresponding amount, if the SDCB Member has no other legitimate SDCB need(s).

Although Related Goods are not a covered service in ABCB, the need for “continuity of care” exists for Related Goods. When redetermining the annual SDCB budget for SDCB members who transitioned from the Mi Via waiver program, the MCO CC/UM shall allow the currently approved related good(s) and previously approved reimbursement rate to be requested and approved, as deemed appropriate, for each ongoing year of the SDCB care plan/budget.

At each annual assessment and budget determination, the Care Coordinator shall determine if the Member has underutilized his/her current SDCB care plan/budget. Underutilization is defined as using less than 75% of the total budget by the end of quarter three of the Member’s current Care Plan year. If underutilization has occurred, the Care Coordinator shall consider reducing the budget by an amount which is no more than the approved total for the underutilized service for the upcoming care plan year/budget. However, if underutilization is due to, for example, a temporary hospital admission, and if the hospital admission had not occurred, the Member would have utilized SDCB services as requested and approved, the Care Coordinator may not adjust the budget for the upcoming care plan year/budget. If overutilization of the Care Plan/budget is identified at any time during the care plan/budget year, the MCO shall not increase the current budget and level of services without identifying the need for a new CNA and determining whether all other available resources have been exhausted. Overutilization is defined as using more than: 1) 50% of the budget by the end of quarter two of the Member’s current care plan year; 2) 75% of the budget by the end of quarter three of the Member’s current care plan year; or 3) 100% of the budget by the end of quarter four of the Member’s current Care Plan year.

Underutilization and overutilization of the budget may result in an involuntary termination from the SDCB to ABCB depending on the situation; please refer to the SDCB involuntary termination policy.

9.18. Denials, Revisions and Reconsiderations of the SDCB Care Plan

- **Denials:**

The MCO shall send final decisions to the Member in writing, including steps for the Member/legal representative to follow if they disagree with the denial decision and wants to pursue a

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	---	--

reconsideration and/or the MCO appeal process. The MCO appeal process must be exhausted prior to the Member requesting a State Fair Hearing.

- **Revisions:**

The Care Plan may be revised based upon a change in the Member’s needs or circumstances identified in the CNA, such as a change in the Member’s health status or condition, or a change in the Member’s natural support system such as the death or disabling condition of a family Member or other individual who was providing services.

If the revision is to provide new or additional services other than those originally included in the Care Plan, these services must not be able to be acquired through other programs or sources. The Member may be required to document the fact that the services are not available through another source. The Care Coordinator and/or Support Broker shall assist the Member with exploring other available resources.

The Member must provide written documentation of the change in needs or circumstances as specified in the Manual. The Member submits the documentation to the Care Coordinator/Support Broker. In *FOCoSonline*, the Member or the Member’s legal representative and the Support Broker initiate the process to modify the Care Plan by developing a revision in *FOCoSonline* and forwarding the completed request for a care plan revision to the Care Coordinator who will submit the revision to the MCO/UR for review, via *FOCoSonline*. At the MCO’s discretion, another CNA may be performed. Per the SDCB rule, if the revision includes a request for additional services, another CNA must be performed to determine whether the change in needs or circumstances necessitate an increase to the budget.

The Care Plan may be revised once the original care plan has been submitted and approved. Only one Care Plan revision may be submitted at a time, for example, a Care Plan revision may not be submitted if an initial Care Plan or prior Care Plan revision request is under initial review by the MCO/UR.

Other than for critical health and safety reasons, Care Plan revision requests may not be submitted to the MCO within the last 60 calendar days prior to the expiration date of the current Care Plan /budget. This constraint does not apply to environmental modifications requests, as environmental modification work is not tied to a specific care plan year and the funding is not part of the overall SDCB budget amount.

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

Anytime a Member exits SDCB and transfers to ABCB, another Medicaid waiver such as the DD Waiver, or is permanently institutionalized, the Support Broker must develop a close-out budget to coincide with the last day the Member will receive SDCB services. The only time a close-out budget is not needed is when a Member’s Care Plan will expire in the same month as the Member’s final month in SDCB. The close-out budget must be reviewed/approved by the MCO.

- **Reconsiderations:**

If the Care Plan, or a part of the Care Plan, is not approved, the Care Coordinator and/or Support Broker assists the Member to explore his/her options, including the right to request a reconsideration of the denial decision. Reconsideration requests must be submitted to the MCO within 30 calendar days of the date on the denial notice. Reconsideration requests must be made by the Support Broker through *FOCoSonline*, and additional documentation or additional clarifying information must be submitted in writing regarding the Member’s request for reconsideration of the denied services or related goods.

9.19. SDCB Care Plan Review Criteria

Services and related goods identified in the Member’s requested Care Plan may be considered for approval if all the following requirements are met:

- The services or related goods must be responsive and directly related to the Member’s qualifying condition or disability;
- The services or related goods must address the Member’s clinical, functional, medical or habilitative needs;
- The services or related goods must accommodate the Member in managing his/her household;
- The services or related goods must facilitate ADLs;
- The services or related goods must promote the Member’s personal health and safety;
- The services or related goods must afford the Member an accommodation for greater independence;
- The services or related goods must support the Member to remain in the community and reduce his/her risk for institutionalization;
- The services or related goods must be documented in the Member’s Care Plan and facilitate the desired outcomes stated in the Member’s Care Plan;
- The service or related good is not prohibited by Federal and State statutes, rules and guidance;

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	---	--

- Each service or good must be listed as an individual line item; when services or related goods must be “bundled” the Care Plan must document why bundling is necessary and appropriate;
- The proposed Care Plan is within the Member’s approved budget;
- The proposed rate for each service is within the SDCB range of rates (9.22.1) for that chosen service;
- The proposed cost for each good is reasonable, appropriate and reflects the lowest available cost for that chosen good; and
- The estimated cost of the service or good is specifically documented in the Member’s Care Plan.

9.20. Implementation of the SDCB Care Plan

- Enrolling SDCB Employees and Vendors:
 - Pre-Hire Packet:
 - Before providing services to a Member, most employees and vendors are required to submit the appropriate State-approved pre-hire packet to the FMA and pass the COR screening. The exception to this requirement is when the vendor has a professional license, such as an RN or Speech Language Pathologist (SLP) that qualifies them to provide the approved service. The FMA is responsible for maintaining, distributing and processing the pre-hire packets. For answers to questions about hiring employees or vendors and to obtain the pre-hire packet, an EOR shall contact the Consolidated Customer Service Center at 1-800-283-4465.
 - Potential SDCB employees are required by New Mexico law through the caregivers’ criminal history screening act (7.1.9 NMAC) to pass a CBC which begins by screening against the COR. This COR screening is completed by the FMA, usually within 48 hours, once the complete and correct pre-hire packet is received by the FMA. Once the COR check is completed, and the potential SDCB provider has passed the COR check, the EOR will receive an email notification from the FMA that the potential SDCB employee has passed his/her COR and CBC and may begin providing SDCB services. If the EOR does not have an email address listed in FOCO*online*, the FMA Help Desk will contact the EOR, via telephone to let the EOR know that the potential SDCB employee has passed the COR check. Although an employee may begin providing services as soon as they have passed the COR Background Check, payment will not be issued until all required paperwork as indicated below is successfully completed and has been approved by the FMA. If a potential SDCB employee or vendor

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

- does not pass the CBC, as required by New Mexico law, they may not continue to provide services to the SDCB Member. The potential SDCB employee or vendor and FMA will be notified by the Department of Health if they do not pass the CBC. The FMA will notify the SDCB Member/EOR when a potential SDCB employee has or has not successfully completed the COR check and/or CBC; and
- No SDCB provider shall exceed 40 hours paid work in one work week per EOR. If an employee works for more than one EOR, the employee shall not exceed 40 hours paid work in one work week, per EOR.
 - Credentialing Requirements:
 - The State has set credentialing requirements for credentialing providers of SDCB services, and these requirements have been approved by CMS. The FMA shall ensure these requirements are met. These requirements include certain licenses which must be submitted by the potential SDCB provider to the FMA and are described in 9.B & 9.C (Vendor and Employee Credentialing Requirements). Services cannot be provided to a Member until the SDCB care plan is approved, and there is a credentialed and approved provider linked to the approved SDCB goal.
 - Other Required Documents:
 - There are other documents that must be correctly completed by the potential SDCB employee or vendor and submitted to the FMA for review and approval before payment can be made. Potential SDCB employees and vendors may obtain these documents by contacting the FMA. It is the Member/EOR's responsibility to ensure all employment documents are submitted to the FMA.

For potential SDCB employees, the required documents are included in the Employee Packet:

- Employment Agreement;
- Employee Information Form;
- Declaration of Relationship Form;
- Federal W-4; and
- State W-4.

For potential SDCB vendors who are providing services the required documents are included as part of the Vendor Packet:

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

- Vendor Agreement;
- Vendor Information Form; and
- Federal W-9.

Vendors who are providing SDCB related goods only (such as a large retailer) do not need to provide the Vendor Agreement and Federal W-9, however the SDCB Member/EOR or vendor must submit the Vendor Information Form to the FMA before payment is issued.

Direct deposit is provided and strongly recommended for all employees and vendors when possible. The FMA also offers the service of providing payment through a ComData Card. Please contact the FMA if interested in using this service. Direct deposit forms can be completed as part of the initial hire documentation or may be completed and submitted to the FMA at a later date.

- Purchasing Services and Related Goods:
 - Timesheets:
 - SDCB employee (or EOR) must enter and approve the employee(s)'s timesheet(s) in *FOCoSonline* unless they are approved for an exception to fax timesheets to the FMA. Upon completing the *FOCoSonline* training, a new user will receive a *FOCoSonline* Account Authorization form (via email). Once the new user completes the *FOCoSonline* Account Authorization form and faxes it to the FMA Technical Department, the user will receive an email with his/her password and login instructions;
 - Timesheets are submitted and processed on a two-week pay schedule according to the SDCB Payroll Payment Schedule. The payroll workweek starts on Saturday and ends the following Friday. The payment schedule is available through the FMA and on the MCOs' websites. Timesheets are due at the end of the two week pay period and must be received at the FMA no later than Saturday at 11:59 pm for a SDCB employee to be paid on time and according to the payment schedule; and
 - An AR may also complete the training and gain access to *FOCoSonline*. If an AR has access, they will be able to view payments and monitor SDCB budget spending, however, the AR will not have authorization to perform the functions of the EOR and approve timesheets. To designate an AR, members must complete the AR form, which may be requested through the FMA or the Support Broker.

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

- Self-Directed Personal Care and Respite providers must utilize the EVV system to clock-in and out in order to generate a timesheet in FOCoSonline or other state approved system.
- Invoices:
 - Vendor PRF and invoices may be submitted to the FMA on any day of the week (unlike timesheets which must be submitted according to the payroll schedule). The processing time for a PRF/invoice is approximately two weeks. The vendor payment schedule is available through the FMA. Vendor checks are generated by TeleCheck and are mailed directly to the EOR (payments are not mailed to the vendor). After the EOR receives the vendor check, it is recommended that the EOR mail/deliver the check to the vendor as soon as possible to ensure prompt payment. For phone/internet payments, the EOR must send the payment to the phone/internet company's main billing address (with the payment coupon). It is not recommended that phone/internet payments be attempted through kiosks or at local phone/internet stores (e.g., T-Mobile or Cricket) since these payments are frequently rejected by TeleCheck. Uncashed checks may be voided by the FMA after six months; and
 - Although an EOR must submit timesheets online (after completing necessary FOCoSonline training and paperwork), it is not possible to submit invoices online. PRFs and invoices must be faxed or sent electronically to the FMA for processing. If a SDCB Member/EOR has access to FOCoSonline, they should review the payments and monitor them as they are being processed. In addition, the SDCB Member, EOR, or AR may run reports through FOCoSonline to monitor spending activity.
- Return to Member (RTM) Process:
 - RTM letters are an effective means used by the FMA to assist in communicating with the EOR when there are problems in processing SDCB payment. For example, if a timesheet or invoice is submitted to the FMA and it does not contain the appropriate signature
 - s, the FMA uses the RTM process to inform the EOR that payment cannot be made. In addition to the RTM letter, which is mailed, the FMA attempts contact with the EOR by phone. If three unsuccessful phone call attempts to the EOR have been made and the corrected document still has not been received, the FMA will send an email to the EOR (provided the EOR has an email address in FOCoSonline) with a copy to the Care Coordinator

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

- and Support Broker. If the EOR does not have an email address in *FOCoSonline*, the FMA will send an email to the Care Coordinator and Support Broker and attach a copy of the RTM letter. Since frequent contact is attempted by the FMA to the EOR, it is extremely important that *FOCoSonline* contain the EOR's correct contact information. If the EOR contact information needs to be updated, please contact the FMA Help Desk for assistance.
- Employee and Vendor Pay Rates:
 - Employee and vendor pay rates must be approved in the Member's care plan. Once the SDCB rate is approved, completed employee agreements and vendor agreements must be submitted to the FMA in order to indicate the rate of pay. If a potential SDCB employee or vendor does not submit an employee or vendor agreement, as appropriate, the FMA will not know the correct rate of pay for the service that the employee or vendor is providing. In order for the FMA to pay a SDCB employee or vendor, a completed employee agreement or vendor agreement needs to be submitted to, and approved by, the FMA and the employee/vendor must be linked to the SDCB goal inside *FOCoSonline*. If the pay rate for an approved SDCB employee or vendor needs to be changed, the new rate must be approved by the MCO via a SDCB care plan revision in *FOCoSonline* and in the Member's SDCB care plan and a new employee agreement or vendor agreement, signed by the EOR, must be submitted to the FMA at least 15 calendar days before the effective date of the rate change. If a change to a SDCB employee's rate of pay is made after the SDCB care plan has started, the change will not be effective until the beginning of the next pay period.
 - Timely Filing Requirements:
 - New Mexico has a 90 calendar day time limit for filing all Medicaid claims and since the SDCB is a Medicaid benefit, the same requirements apply. If timesheets or invoices are submitted more than 90 calendar days after the service has been provided, payment will not be processed and the timesheet or invoice and PRF will be returned to the EOR/Member through the RTM process.
 - SDCB Care Plan Expenditure Safeguards:
 - The SDCB Member holds the primary responsibility for monitoring and ensuring their approved SDCB care plan is spent appropriately; however, the Care Coordinator and Support Broker must support the SDCB Member in this activity. The FMA also assists in ensuring that

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

- funds are spent appropriately through payment of approved services and related goods according to the approved SDCB care plan and Employee/Vendor Agreements;
- The Member/EOR is responsible for reviewing their monthly spending report which is available to each Member/EOR by the FMA on a monthly basis. The SDCB Member/EOR may also obtain “real-time” information on service usage and spending by directly accessing *FOCoSonline*. It is highly recommended that members/EORs obtain access to *FOCoSonline* so that they can effectively monitor their care plan/budget and track spending. Monthly training for *FOCoSonline* is offered for SDCB members, employees, and EORs. If interested in training, the SDCB Member, employee, or EOR should contact the FMA Help Desk for assistance;
 - The Support Broker is required to review the Member’s SDCB care plan expenditures during each quarterly face-to-face contact with the Member. The Care Coordinator and/or Support Broker will provide the Member with expenditure information and discuss any concerns. If the Member needs to revise their SDCB care plan, the Support Broker shall assist with drafting the revision and the Care Coordinator will submit it to the MCO/UR for consideration per established procedures. The Care Coordinator may also initiate a new CNA as needed; and
 - The FMA is responsible for processing payments for approved SDCB services and related goods. When an invoice or timesheet is received by the FMA, they verify that the particular service or good is approved in the Member’s SDCB Care Plan/budget and payment is processed according to the approved SDCB Care Plan/budget and employee/vendor agreement. In regard to internet and phone services (landline or cell), the FMA will pay up to the approved monthly amount. This helps to ensure that this category of service is not overspent which could put the Member at-risk of losing these services due to possible nonpayment later in the SDCB Care Plan year. If the FMA is unable to make payment as requested due to lack of funds remaining in the Care Plan, the FMA will send an RTM letter to the Member and make three attempts to contact the Member by telephone to inform the EOR/Member of the insufficient funds issue.

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

9.21. Transitions, Terminations, and Reinstatement Processes

Upon initial eligibility for the CB, the Member will be eligible for the ABCB. An ABCB Member may choose to move to SDCB at any time but may not move to SDCB until the first day of the month after 120 calendar days are completed in the ABCB. The Member must utilize CB services in the ABCB prior to transitioning to SDCB. If the Member has a short-term admission to an NF, the 120 calendar days does not start over. The Member must always end the current CB model on the last day of the month and start the new CB model on the first day of the following month. The Care Coordinator must ensure there is no break in CB services during model switches. Examples of transition for members who enter an NF include, but are not limited to, the following:

- The Member only has a waiver COE (090, 091, 092, 093 or 094) and is institutionalized more than 60 days, the Member must apply for IC and submit their name back on the Central Registry. They then must receive a Community Reintegration allocation. If, when they are discharged, they still have living arrangements in place, they are not required to complete the 120 days in ABCB again;
- If the Member does not have living arrangements in place, the Member must go back to ABCB during the transition and is not mandated to complete another 120 days in ABCB. Meaning, the Member can begin self-directing after all living arrangements have been set up and the Member is successfully in that living arrangement and the SDCB budget, Care Plan and employees are approved to provide SDCB-covered services; and
- If the Member has a full Medicaid COE (001, 003, 004, etc.) and is institutionalized for more than 60 days and the Member does not have living arrangements still in place, the Member must go back to ABCB during the transition and is not mandated to complete another 120 days. Meaning, the Member can begin self-directing after all living arrangement have been set up and the Member is successfully in that living arrangement and the SDCB budget, Care Plan and employees are approved to provide SDCB-covered services.

Voluntary Termination

- SDCB members may transfer from the SDCB to the ABCB at any time. To the extent possible, the SDCB Member shall provide their SDCB provider(s) with 10 business days advance notice regarding their intent to withdraw from the SDCB. All transfers will become effective on the 1st day of the following month.

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

Involuntary Termination

- Reasons SDCB members may be involuntarily terminated from the SDCB and offered services through the ABCB include, but are not limited to, the following circumstances:
 - The SDCB Member refuses to follow SDCB rules after receiving focused technical assistance on multiple occasions; and support from the program staff, Care Coordinator/Support Broker, or FMA that is supported with documentation of the efforts to assist the SDCB Member. Focused technical assistance is defined as a minimum of three separate occasions where the Member /EOR have received training, education or technical assistance, or a combination of both;
 - The SDCB Member has immediate risk to their health or safety by continued self-direction of services, e.g., the SDCB Member is in imminent risk of death or serious bodily injury related to participation in the SDCB. Examples include, but are not limited to, the following:
 - The SDCB Member refuses to include and maintain services in their SDCB Care Plan that would address health and safety issues identified in the Member's CNA or challenges the assessment after repeated and focused technical assistance and support from program staff, Care Coordinator/Support Broker, or FMA;
 - The SDCB Member is experiencing significant health or safety needs, and, after having been referred to the State contractor team (that includes the appropriate State program manager and additional parties as deemed necessary by the State) for technical assistance, refuses to incorporate the team's recommendations into their SDCB Care Plan, or the SDCB Member exhibits behaviors which endanger him/her or others;
 - The SDCB Member misuses SDCB funds following repeated and focused technical assistance and support from the Care Coordinator/Support Broker or FMA, which is supported by documentation;
 - The SDCB Member expends their entire SDCB budget prior to the end of the SDCB Care Plan year;
 - The SDCB Member commits Medicaid fraud. The examples below are not all encompassing and only provide a few scenarios:
 - Altering SDCB employee/vendor payment checks
 - Cancelling gym membership and receiving cash back for the purchase

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	--	---

- Purchasing miscellaneous/unapproved items with funds received for approved goods
- The final decision to terminate a SDCB Member and move him/her to ABCB is made by the State. The MCO shall submit sufficient documentation to the State for approval of the involuntary termination request. Upon State approval, the MCO shall notify the Member of the involuntary termination, in writing, and shall include appeal rights per HCA rules. The MCO must transition the Member to the ABCB with no break in services. The transition must be completed within 90 calendar days of the date of HCA approval. SDCB involuntary terminations may become effective any time during the month;
- Requests to be reinstated back to SDCB may be made one time during a 12-month period. The Member must make the request to their MCO in writing. All members shall be required to participate in SDCB training prior to their reinstatement;
- A SDCB Member who voluntarily terminated their participation in SDCB may request to move back from ABCB to SDCB any time during a 12-month period. The final decision to allow the reinstatement to SDCB is at the discretion of the MCO. The Care Coordinator must ensure the transition does not cause a break in services; and/or
- A SDCB Member who was involuntarily terminated from SDCB may request to be reinstated to SDCB once per 12month period. The final decision to allow the reinstatement to SDCB is at the discretion of the State. The MCO shall submit sufficient documentation to the State for approval of reinstatement to the SDCB. If approved, the Care Coordinator shall work with the FMA to ensure the issues previously identified as reasons for termination have been adequately addressed prior to the reinstatement.

9.22 Method of Payment for Goods and Services

- **Desired Method of Payment**

There are 3 options on the Vendor Payment Request form for the Desired Method of Payment that can be selected for members to purchase goods and pay vendors.

- Direct Deposit selection is for the funds to be deposited to the selected and approved Vendor
- Money Network selection is for the funds to be deposited into the EOR's Money Network Card and there after the EOR makes the payment to the vendor

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
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- o Paper Check selection is for the funds to be sent via a check made out to the Vendor through the mail and sent to the EOR to pay the vendor
- **Money Network Card**

The Money Network Card is an alternative option to pre-printed paper checks to pay for approved goods and services in stores and online that accepts credit or debit cards for payments.

- o EORs may choose to continue to receive printed paper checks.
- o The first time the Money Network Card is requested as the method of payment on the VPR the EOR will be mailed one Money Network Card.
- o Money Network offers both card and check payments. An EOR will receive 3 checks when the card arrives. Additional checks can be ordered at any time free of charge.
- o Any funds not used before the end of the budget year must be removed from the Money Network Card and be put back into the closing budget. NO Money Network Card funds can be transferred from one budget year to the next.

Proof of Purchase for Money Network Card

Conduent will conduct audits on purchases and may request receipts to verify approved items were purchased.

- o EORs are required to keep proof of purchase (receipt, invoice, etc.) when using the Money Network Card or Check.
- o EORs are required to respond to requests for documentation and information from Conduent, Support Broker, or their Care Coordinator.
- o If there is no contact from the EOR/Member a sanction process will begin. Technical Assistance may be provided by the MCO to support the EOR/Member to be successful in providing the required proof of purchase when requested.

Money Network Card prohibited activity:

- o Cash withdrawals
- o ATM withdrawals
- o Cash back from purchases
- o Transferring Money Network Card funds to another bank

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
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- o Payment to self
- o Payment to friends or family

SDCB EORs have certain responsibilities in order to utilize the Money Network Card. Failure to comply with these responsibilities can result in the EOR being disallowed from further use of the Money Network Card to purchase goods and services.

Approved SDCB Service Codes allowed for the Money Network Card

- o T1999 – All Codes
- o T028 – Start Up Goods and Services

The Money Network Card is also available to pay SDCB Employees-

Please visit the [New Mexico - PALCO \(palcofirst.com\)](http://palcofirst.com) website to download and complete the Pay Selection and Direct Deposit form found in the Self-Directed Community Benefit Documents section under Worker Forms.

-Under extraordinary circumstances a Member may qualify for an Electronic Timesheet Exception and complete a paper timesheet. The EOR must contact their Support Broker to discuss their Member options.

Link to Palco-paper invoice VPR

Please visit the [New Mexico - PALCO \(palcofirst.com\)](http://palcofirst.com) website to download the Vendor Payment Request form found in the Self-Directed Community Benefit Documents section under Vendor Forms.

9.23 Demand Notices

Employee Guidance for Demand Notices received from the New Mexico Department of Workforce Solutions:

- The New Mexico Department of Workforce Solutions (WFS) sends Demand Notices to Employees who do not send a quarterly wage report. The Demand Letter means the Employer of Record's, employee's Wage Detail Report for the quarter is due.
- Palco files these reports and makes any appropriate payments.

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
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If a Demand Notice is received from WFS, have the employee send the letter to Conduent for Palco to review and follow up to ensure resolution via email, fax, or drop off.

9.24. Appendices

9.24.1 SDCB Range of Rates Chart

9.24.2 SDCB Vendor Credentialing Requirements

9.24.3 Employee Credentialing Requirements Grid

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
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9.22.1. SDCB Range of Rates Chart

SDCB Service	Billing Code	Internal Focus Code	Unit	SDCB Payment Rate
Self-Directed Personal Care	99509	99509	Hour	Minimum wage-\$17.20
HH Aide	S9122	S9122	Hour	\$35.52
Employment Supports (includes Job Coach)	T2019	T2019	15 min.	\$5.10
Job Developer (Per job that is developed for Member)	T2019	T2019JD	Each	\$104.68-\$732.76
Customized Community Supports (adult day hab.)	S5100	S5100	15 min.	\$2.96-\$9.35
PT	G0151	G0151	15 min.	\$25.34-\$49.66
OT	G0152	G0152	15 min.	\$24.82-\$40.83
Speech/Language Pathology	G0153	G0153	15 min.	\$25.35-\$48.93
Behavior Support Consultation	H2019	H2019	15 min.	\$31.08
Private Duty Nursing – Adults- RN	T1002	T1002	15 min.	\$29.76
Private Duty Nursing – Adults- LPN	T1003	T1003	15 min	\$19.92
Nutritional Counseling	S9470	S9470	Hour	\$88.88
Acupuncture	97810	97810	15 min.	\$13.09-\$26.17
Biofeedback	90901	90901	Visit	\$52.34-\$104.68
Chiropractic	98940	98940	Visit	\$52.34-\$104.68
Cognitive Rehabilitation Therapy	97532	97532	15 min.	\$13.09-\$26.17
Hippotherapy	S8940	S8940	Visit	\$52.34-\$104.68
Massage Therapy	97124	97124	15 min.	\$15.66-\$31.31
Naprapathy	S8990	S8990	Visit	\$52.34-\$104.68
Respite Standard (not provided by RN, LPN or HHA)	T1005	T1005SD	15 min.	Minimum Wage (per hour) - \$4.30
Respite RN	T1005	T1005RN	15 min.	\$29.76
Respite LPN	T1005	T1005LPN	15 min.	\$19.92
Respite HH Aide	T1005	T1005HHA	15 min.	\$8.88
Emergency Response (monthly fee)	S5161	S5161	Each	\$38.43-\$42.70

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
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SDCB Service	Billing Code	Internal Focos Code	Unit	SDCB Payment Rate
Emergency Response (testing and maintenance)	S5160	S5160	Each	As approved by MCO
Environmental Modifications	S5165	S5165	Each	As approved by MCO (maximum of \$6,000 every 5 years)
Transportation Mile	T2049	T2049	Per Mile	\$0.36-\$0.42
Transportation Commercial Carrier Pass	T2004	T2004	Each	As approved by MCO
Start Up Goods- Computer	T2028	T2028CR	Each	As approved by MCO
Start Up -Goods Fax Machine	T2028	T2028FX	Each	As approved by MCO
Start Up -Goods Internet Activation	T2028	T2028IA	Each	As approved by MCO
Start Up -Goods Landline Activation	T2028	T2028LA	Each	As approved by MCO
Start Up -Goods Office Supplies	T2028	T2028OS	Each	As approved by MCO
Start Up Goods Printer	T2028	T2028PR	Each	As approved by MCO
Fees and Memberships	T1999	T1999CP-I	Each	As approved by MCO
Coaching/education for parents, spouse or others (not available for paid caregivers)	T1999	T1999CE-I	Each	As approved by MCO
Coaching/education for parents, spouse or others <u>Classes only</u> (not available for paid caregivers)	T1999	T1999CL-I	Each	As approved by MCO
Coaching/education for parents, spouse or others <u>Conferences and seminars</u> (not available for paid caregivers)	T1999	T1999CS-I	Each	As approved by MCO
Technology for Safety and Independence	T1999	T1999TS	Each	As approved by MCO
Cell phone service (including data/GPS)	T1999	T1999CELL	Each	\$0.00-\$100.00
Cell phone and related equipment	T1999	T1999CPEP	Each	As approved by MCO
Cell phone/landline	T1999	T1999CPL	Each	As approved by MCO

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
---	---	--

SDCB Service	Billing Code	Internal Focos Code	Unit	SDCB Payment Rate
Internet service	T1999	T1999IS	Each	As approved by MCO
Landline service	T1999	T1999LS	Each	As approved by MCO
Internet/cell phone	T1999	T1999IC	Each	As approved by MCO
Internet/cell phone/landline	T1999	T1999ICL	Each	As approved by MCO
Internet/landline	T1999	T1999IL	Each	As approved by MCO
Fax machine	T1999	T1999FX	Each	As approved by MCO
Computer	T1999	T1999CR	Each	As approved by MCO
Office supplies	T1999	T1999OS	Each	As approved by MCO
Printer	T1999	T1999PR	Each	As approved by MCO
Health-related equipment and supplies	T1999	T1999HR-I	Each	As approved by MCO
Adaptive equipment and supplies	T1999	T1999AE-I	Each	As approved by MCO
Exercise equipment and related items	T1999	T1999EE-I	Each	As approved by MCO
Nutritional supplements	T1999	T1999NS-I	Each	As approved by MCO
OTC medications	T1999	T1999OM-I	Each	As approved by MCO
Household related goods	T1999	T1999HG-I	Each	As approved by MCO
Appliances for independence	T1999	T1999AI-I	Each	As approved by MCO
Adaptive furniture	T1999	T1999AF-I	Each	As approved by MCO

 HEALTH CARE AUTHORITY	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
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9.22.2. SDCB Vendor Credentialing Requirements

Requirements for enrolling SDCB Vendors

Before using any Vendor, please call the Consolidated Customer Service Center (CCSC) at (1-800-283-4465) to ensure all required vendor paperwork has been processed and the vendor has been set up on your SDCB Care Plan. If you use a vendor before their paperwork has been processed, they will not be paid for those DOS.

All enrollment requirements (with the exception of the final CBC) must be processed before services can be provided. Services that are provided prior to enrollment will not be paid by Medicaid or Conduent.

If a vendor provides only related goods (not services), you will only need to complete the Vendor Information Form (you do not need to complete the entire Vendor Packet). We use the Vendor Information Form to show that you will be using this vendor on your Plan. Since vendors that provide related goods are usually large companies (for example: CenturyLink, Comcast, Walmart, Kmart, Best Buy), it is not necessary to get their signature on the form. If you are not sure whether you are purchasing a “good” or a “service,” please call the CCSC for assistance.

Vendors (Independent Contractors and Agencies) that provide Services Ag = Agency, IC = Independent Contractor				
Service Code	Service Code Description	Billing Method	Vendor Packet	License and/or Additional Requirements
97810	Acupuncture <u>Allowed Providers:</u> Group Practice or Individual Specialized Therapist	Per 15 min	Agency: Yes IC: Yes	Agency: Business License IC: Acupuncture and/or oriental medicine license
H2019	Behavior Support Consultation <u>Allowed Providers:</u> Individual BSC or BSC Group Practice	Per 15 min	Agency: Yes IC: Yes	Agency: Business License IC: Licensed (MD, Clinical Psychologist, Psychologist Associate, SW, LPCC, LPC, Psychiatric Nurse, New Mexico LMFT, New Mexico LPAT)
90901	Biofeedback <u>Allowed Providers:</u> Group Practice or Individual Specialized Therapist	Visit	Agency: Yes IC: Yes	Agency: Business License IC: License in Health Care Profession whose scope of practice includes Biofeedback



Section 9: Self-directed Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025

Effective dates: July 1, 2024; December 22, 2025

Vendors (Independent Contractors and Agencies) that provide Services
Ag = Agency, IC = Independent Contractor

Service Code	Service Code Description	Billing Method	Vendor Packet	License and/or Additional Requirements
98940	Chiropractic <u>Allowed Providers:</u> Group Practice or Individual Chiropractor	Visit	Agency: Yes IC: Yes	Agency: Business License IC: Chiropractic Physician License
T1999CE-I	Coaching Education for Parents, Spouse or Other <u>Allowed Providers:</u> Vendor	Each	Agency: Yes IC: Yes	Agency: Business License IC: Pre-Hire Packet
T1999CS-I	Coaching Education for Parents/Spouse: Conferences & Seminars ONLY <u>Allowed Providers:</u> Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T1999CL-I	Coaching Education for Parents/Spouse: Classes ONLY <u>Allowed Providers:</u> Vendor	Each	Agency: No IC: No	VIF is required (goods only)
97532	Cognitive Rehabilitation Therapy <u>Allowed Providers:</u> Group practice or Individual Specialized Therapist	Per 15 min	Agency: Yes IC: Yes	Agency: Business License IC: License in Health Care Profession whose scope of practice includes Cognitive Rehabilitation Therapy
S5100	Customized Community Support <u>Allowed Providers:</u> Adult Day Health Agency or Adult Day Habilitation Agency	Per 15 min	Agency: Yes	Agency: Business License
S5160	Emergency Response Testing and Maintenance <u>Allowed Providers:</u> Emergency Response Provider (Agency)	Each	Agency: No	Agency: Business License
S5161	Emergency Response Monthly Service Fee <u>Allowed Providers:</u> Emergency Response Provider (Agency)	Monthly	Agency: No	Agency: Business License
T2019	Employment Supports (includes Job Coach) <u>Allowed Providers:</u> Supported Employment Provider Agency or Individual	Each	Agency: Yes IC: Yes	Agency: Business License IC: Pre-Hire Packet
S5165	Environmental Modifications <u>Allowed Providers:</u> Individual or Company (Agency)	Each	Agency: Yes IC: Yes	Agency: Appropriate License IC: Appropriate License
T1999CP-I	Fees and Memberships <u>Allowed Providers:</u> Vendor	Each	Agency: No IC: No	VIF is required (goods only)



Section 9: Self-directed Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025

Effective dates: July 1, 2024; December 22, 2025

Vendors (Independent Contractors and Agencies) that provide Services
Ag = Agency, IC = Independent Contractor

Service Code	Service Code Description	Billing Method	Vendor Packet	License and/or Additional Requirements
T1999HR-I	Health-Related Equipment and Supplies <u>Allowed Providers:</u> Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T1999AE-I	Adaptive Equipment and Supplies <u>Allowed Providers:</u> Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T1999EE-I	Exercise Equipment and Related Items <u>Allowed Providers:</u> Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T1999NS-I	Nutritional Supplements <u>Allowed Providers:</u> Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T1999OM-I	OTC Medications <u>Allowed Providers:</u> Vendor	Each	Agency: No Yes IC: No	VIF is required (goods only)
S8940	Hippotherapy <u>Allowed Providers:</u> Group Practice or Individual Specialized Therapist	Visit	Agency: Yes IC: Yes	Agency: Business License IC: License in Healthcare profession whose scope of practice includes Hippotherapy.
S9122	Home Health Aide <u>Allowed Providers:</u> HHA/PCS Agency	Hour	Agency: Yes	Agency: Business License
99509	Self-directed Personal Care <u>Allowed Providers:</u> Individual Self-directed Personal Care Provider or HHA/PCS Agency	Hourly	Agency: Yes IC: Yes	Agency: Business License IC: Pre-Hire Packet
T1999HG-I	Household Related Goods and Services Item/Invoice <u>Allowed Providers:</u> Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T1999AI-I	Appliances for Independence Item/Invoice <u>Allowed Providers:</u> Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T1999AF-I	Adaptive Furniture Item/Invoice <u>Allowed Providers:</u> Vendor	Each	Agency: No IC: No	VIF is required (goods only)



Section 9: Self-directed Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025

Effective dates: July 1, 2024; December 22, 2025

Vendors (Independent Contractors and Agencies) that provide Services
Ag = Agency, IC = Independent Contractor

Service Code	Service Code Description	Billing Method	Vendor Packet	License and/or Additional Requirements
T2019JD	Job Developer <u>Allowed Providers:</u> Supported Employment Provider Agency or Individual	Each	Agency: Yes IC: Yes	Agency: Business License IC: Pre-Hire Packet
97124	Massage Therapy <u>Allowed Providers:</u> Group Practice or Individual Specialized Therapist	Per 15 min	Agency: Yes IC: Yes	Agency: Business License IC: Massage Therapist License
S8990	Naprapathy <u>Allowed Providers:</u> Group Practice or Individual Specialized Therapist	Visit	Agency: Yes IC: Yes	Agency: Business License IC: Naprapathic Physician License
S9470	Nutritional Counseling <u>Allowed Providers:</u> Group Practice or Individual	Hourly	Agency: Yes IC: Yes	Agency: Business License IC: Registered Dietician License
G0152	Occupational Therapy <u>Allowed Providers:</u> Individual Occupational Therapist or Group Practice	Per 15 min	Agency: Yes IC: Yes	Agency: Business License IC: OT License
G0151	Physical Therapy <u>Allowed Providers:</u> Group Practice or Individual Physical Therapist	Per 15 min	Agency: Yes IC: Yes	Agency: Business License IC: PT License
T1003	Private Duty Nursing LPN <u>Allowed Providers:</u> HHA, RHC, FQHC or Individual	Per 15 min	Agency: Yes IC: Yes	Agency: Business License IC: LPN License
T1002	Private Duty Nursing RN <u>Allowed Providers:</u> HHA, RHC, FQHC or Individual	Per 15 min	Agency: Yes IC: Yes	Agency: Business License IC: RN License
T1005HHA	Respite Home Health Aide <u>Allowed Providers:</u> Respite Agency	Per 15 min	Agency: Yes	Agency: Business License



Section 9: Self-directed Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025

Effective dates: July 1, 2024; December 22, 2025

Vendors (Independent Contractors and Agencies) that provide Services
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Service Code	Service Code Description	Billing Method	Vendor Packet	License and/or Additional Requirements
T1005SD	Respite Standard <u>Allowed Providers:</u> Individual Provider (not RN, LPN or HHA) or Respite Provider Agency	Per 15 min	Agency: Yes IC: Yes	Agency: Business License IC: Pre-Hire Packet
T1005LPN	Respite LPN <u>Allowed Providers:</u> Respite Provider Agency or Individual LPN	Per 15 min	Agency: Yes IC: Yes	Agency: Business License IC: LPN License
T1005RN	Respite RN <u>Allowed Providers:</u> Respite Provider Agency or Individual RN	Per 15 min	Agency: Yes IC: Yes	Agency: Business License IC: RN License
G0153	Speech/Language Pathology <u>Allowed Providers:</u> Individual SLP or Group Practice	Per 15 min	Agency: Yes IC: Yes	Agency: Business License IC: RN License
T2028CR	Start-Up Goods- Computer Purchase <u>Allowed Providers:</u> Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T2028FX	Start-Up Goods - Fax Machine Purchase	Each	Agency: No IC: No	VIF is required (goods only)
T2028IA	Start-Up Goods - Internet Activation	Each	Agency: No IC: No	VIF is required (goods only)
T2028LA	Start-Up Goods - Landline Activation	Each	Agency: No IC: No	VIF is required (goods only)
T2028OS	Start-Up Goods – Office Supplies (purchased as items)	Each	Agency: No IC: No	VIF is required (goods only)
T2028PR	Start-Up Goods – Printer Purchase	Each	Agency: No IC: No	VIF is required (goods only)
T1999TS	Technology for Safety and Independence <u>Allowed Providers:</u> Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T1999CR	Computer Purchase (item) <u>Allowed Providers:</u> Vendor	Each	Agency: No IC: No	VIF is required (goods only)



Section 9: Self-directed Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025

Effective dates: July 1, 2024; December 22, 2025

Vendors (Independent Contractors and Agencies) that provide Services
Ag = Agency, IC = Independent Contractor

Service Code	Service Code Description	Billing Method	Vendor Packet	License and/or Additional Requirements
T1999PR	Printer Purchase (item) <u>Allowed Providers:</u> Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T1999FX	Fax Machine Purchase (item) <u>Allowed Providers:</u> Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T1999CPEP	Cell Phone and Related Equipment Purchase (item) <u>Allowed Providers:</u> Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T1999IS	Internet Service <u>Allowed Providers:</u> Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T1999CELL	Cell Phone Service <u>Allowed Providers:</u> Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T1999LS	Landline Service <u>Allowed Providers:</u> Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T1999ICL	Internet/Cell Phone/Landline Service (bundled) <u>Allowed Providers:</u> Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T1999IC	Internet/Cell Phone Service (bundled) <u>Allowed Providers:</u> Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T1999IL	Internet/Landline Service (bundled) <u>Allowed Providers:</u> Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T1999CPL	Cell Phone/Landline Service (bundled) <u>Allowed Providers:</u> Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T1999OS	Office Supplies (purchased as items) <u>Allowed Providers:</u> Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T2004	Transportation Commercial Carrier Pass <u>Allowed Providers:</u> Transportation Commercial Carrier	Each	Agency: No IC: No	VIF is required (goods only)
T2049	Transportation Mile <u>Allowed Providers:</u> Transportation Agency or Individual Driver	Per Mile	Agency: Yes IC: Yes	Agency: Business License IC: Transportation Appendix, Pre-Hire Packet

 HEALTH CARE AUTHORITY	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024; January 31, 2025 Effective dates: July 1, 2024; December 22, 2025
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If the vendor has a professional license (such as an RN or therapist), their licensing board has already completed a background check. Provider agencies are responsible for completing CBC on all their staff. Confirmation of the CBC must be available to the State and Conduent for review as requested.

Please remember that at the beginning of each SDCB Care Plan year (annual renewal), new Vendor Agreements are required for any vendor providing services. If Conduent does not receive a Vendor Agreement before your new Plan starts, your vendor will not be set up on your new Plan and they may be paid late. Please call the Consolidated Customer Service Center (CCSC) at (1-800-283-4465) before your new SDCB Care Plan starts to ensure all your SDCB providers are set up for payment.

The above grid provides an overview of general vendor credentialing requirements. In certain specific cases, additional licensing or other documentation may be required.

Please contact the Consolidated Customer Service Center (CCSC) at 1-800-283-4465 or your Support Broker if you have any questions.

	Section 9: Self-directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020 Effective dates: January 1, 2014
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9.22.3 Employee Credentialing Requirements Grid

SELF-DIRECTED COMMUNITY BENEFIT SERVICE	Service Code	*Pre-Hire Packet	**Employee Packet	Transportation Appendix
Employment Supports (includes Job Coach)	T2019	Yes	Yes	No
Self-directed Personal Care	99509	Yes	Yes	No
Respite – Standard	T1005SD	Yes	Yes	No
Transportation Mile	T2049	Yes	Yes	Yes

***Pre-Hire Packet:** Division of Health Improvement (DHI) form, copy of identification card, and three fingerprint cards.

****Employee Packet:** Employee Information Form, Employee Agreement, Transportation Appendix (if performing driving services), Declaration of Relationship, W-4 (Federal and State), I-9 Form, Direct Deposit Authorization Form (optional).

Helpful Reminders

- Employer of Record (EOR) documentation must be completed and approved before an employee's enrollment can be approved and before an employee can begin work.
- Employees may not begin working until they have passed their initial COR Background Check (this is included in the Pre-Hire- Packet).
- Employees cannot be paid until their entire Employee Packet has been successfully processed.
- In order to drive, an employee must have current vehicle registration and insurance in the employee's name.
- Please remember that Employees must complete a new Employee Agreement **for each Plan year**. If Conduent does not receive an Employee Agreement before the beginning of the new Plan, the employee may not get paid on time.



Section 9: Self-directed Community Benefit

Revision dates: August 15, 2014; March 3, 2015;
January 1, 2019; October 1, 2020

Effective dates: January 1, 2014

2-Week Self-Direction Timesheet for Payment FAX 1-866-302-6787

Have you faxed this timesheet before (is it a duplicate)? ☐ Yes ☐ No If Yes, when?

Employee Name: Ellie Employee				Employee ID# (last 4 digits of employee's social security #) 1234	
Member/Participant: Pauline Participant				Is this a correction to a PRIOR Timesheet? ☐ Yes ☒ No	
Member/Participant's Date of Birth: 1/4/57				Begin Date: 05/07/2011 End Date: 05/20/2011	

Date	Time In Circle AM or PM	Time Out Circle AM or PM	Hours	Service Code	Services Provided (Please enter)	
Week 1 05/07/2011	AM 8:00	PM 11:00	3	99509	Prepared meals, shopped for groceries.	
	AM	PM				
	05/08/2011	AM 8:00	PM 11:00	3	99509	Picked up Pauline's prescriptions at pharmacy, helped her with laundry.
	AM	PM				
	05/09/2011	AM 8:00	PM 11:00	3	99509	Helped Pauline pack for trip to visit brother.
	AM 2:00	PM 8:00	6	H2021	Took Pauline to event at library.	
Week 1 05/10/2011	AM 10:00	PM 12:00	2	99509	Cleaned apartment.	
	AM	PM				
	05/11/2011	AM 12:00	PM 1:00	1	99509	Prepared meals for next week.
	AM	PM				
	AM	PM				
	AM	PM				
Total Hours for Week 1 →			18	Must not be over 40		
Week 2 05/14/2011	AM 12:00	PM 12:00	2	99509	Laundry, cleaned apartment.	
	AM	PM				
	05/15/2011	AM 12:00	PM 3:00	3	99509	Teach Pauline how to use computer.
	AM	PM				
	05/16/2011	AM 2:00	PM 8:00	6	99509	Worked with Pauline on practicing better safety skills at home.
	AM	PM				
Week 2 05/17/2011	AM 8:00	PM 4:00	8	99509	Worked with Pauline on washing dishes and cleaning the apartment.	
	AM	PM				
	05/18/2011	AM 8:00	PM 1:00	5	99509	Prepared frozen meals for next week.
	AM	PM				
	AM	PM				
	AM	PM				
Total Hours for Week 2 →			34	Must not be over 40		
Total Hours for Timesheet (2 weeks) →			42	Must not be over 80		

Ellie Employee 5/21/2011

Employee Signature Date

Ellie Employee

Employee Printed Name

Pauline Participant 5/21/11

Employer Signature Date

Pauline Participant

Employer Printed Name

Signed & dated on or after last service date