State Funded Follow Along

April 1, 2016

Program Description

The South Carolina Department of Disabilities and Special Needs (DDSN) is the state agency established by state law that plans, develops, coordinates and funds services for South Carolinians with the following severe lifelong disabilities:

- Intellectual Disabilities/Related Disabilities
- Autism
- Traumatic Brain Injury /Spinal Cord Injury /Similar Disability

When possible, those who are eligible for DDSN services are assisted to maximize the programs, resources, and benefits available to them in order to secure needed services. However, when other programs, resources or benefits are not available to provide needed services, DDSN offers some services and programs exclusively.

State Funded Follow Along (SFFA) is a set of employment focused services offered by DDSN to those who are eligible for DDSN services, who have secured individual integrated employment***** in the community in collaboration with the South Carolina Vocational Rehabilitation Department (SCVRD), at or above minimum wage, for at least ten (10) hours per week or 20 hours per two (2) week pay period, who have been closed by SCVRD (Status 26 closure******), who require on-going supports to maintain their employment, and who are not currently enrolled in a DDSN operated Home and Community Based Waiver.

> *******Per DDSN Directive 700-07 DD: Employment First, individual integrated employment is defined as: working for at least minimum wage and paid directly by the employer in a typical workplace where the majority of individuals employed do not have disabilities and where the employee with a disability has opportunities to interact with coworkers, vendors, sub-contractors, customers and/or the public.*
>
> ********SCVRD Status 26 closure is the SCVRD status that is designated to an individual who has successfully attained their vocational goal and reached an employment outcome. Prior to SCVRD Status 26 closure, an individual should have received additional services such as job coaching, assistive technology, a uniform or safety shoes. Additionally, DDSN recommends that the individual meet with a Community Work Incentive Coordinator (CWIC) to discuss how Social Security benefits may be impacted and how to report Impaired Related Work Expense (IRWE) prior to transitioning to DDSN for services.*

When assessed by a DDSN contracted Case Manager, the following SFFA services are available when needed:

- Employment Services – Individual
- Assistive Technology and Appliances (as necessary for employment)
- Behavior Support Services (as necessary for employment)

Participants may receive service(s) that cost no more than the annual cost limit per state fiscal year (July 1- June 30). The annual cost cap will be prorated for those who begin participating during any month other than July. Funding not used during the state fiscal year cannot be carried forward to the next year. The annual cost limit for State Fiscal Year 2016 is $5,000.00. The annual cost limit is subject to change each State Fiscal Year.

Those participating in this program may also receive Individual and Family Support as described in DDSN Directive 734-01-DD: Individual and Family Support and Respite – State Funding, if the needed service or product is not available through State Funded Follow Along.

Program Entrance

DDSN will offer SFFA to:

- Those who are eligible for DDSN services; and
- Who have secured individual integrated employment in the community in collaboration with SCVRD, at or above minimum wage, for at least ten (10) hours per week or 20 hours per two (2) week pay period); and
- Who have been closed by SCVRD (Status 26 closure); and
- Who require ongoing supports to maintain their employment; and
- Who are not currently enrolled in a DDSN operated Home and Community Based Waiver.

DDSN reserves the right to restrict enrollment, adjust or impose additional limits to this program or its services as DDSN determines necessary.

Those receiving SFFA will also be eligible for and will receive Case Management. If the individual is being served by a DDSN contracted Case Management provider, the current Case Management provider will be notified of the individual's eligibility for the program. If the individual is Medicaid eligible, he/she may be eligible for and/or may be receiving Medicaid Targeted Case Management (MTCM); if so, State Funded Case Management would not also be provided unless the MTCM provider is not a DDSN contracted provider of Case Management.

The Case Manager will notify the individual of their eligibility for SFFA and will be expected to discuss the program with the individual, his/her representative or legal guardian, including a discussion of the:

- DDSN Directive 700-07 DD: Employment First;
- Services potentially available through the program;
- Requirement that services only be provided when the need for the service is established by assessment;
- Annual cost limit, and
- Their right to choice of service provider.

The Case Manger will be expected to provide the individual, his/her representative or legal guardian with the document entitled "**Statement of Understandings, Rights, and Responsibilities**" complete with legible Case Management provider contact information. The signature of the individual, his/her representative or legal guardian acknowledging receipt the "Statement of Understandings, Rights, and Responsibilities" must be secured on the form entitled "**Acknowledgement of Understandings, Rights, and Responsibilities**" (SFFA Form 1).

The individual will be considered "ENROLLED" in the SFFA program when the "Acknowledgement of Understandings, Rights, and Responsibilities" (SFFA Form 1) is signed. This form must be submitted to DDSN and can be submitted to DDSN by:

Scanning the signed SFFA Form 1, attaching to an email message with "SFFA Enrollment" noted in the subject line and sending the email message to llugo@ddsn.sc.gov. An email acknowledging receipt will be sent.

Or

Faxing the completed SFFA Form 1 to the attention of Lynn Lugo at (803) 898-9660. The fax cover sheet should indicate the means by which an acknowledgement of receipt should be sent (e.g., "please confirm receipt via email to c.manager@CMP.org;" or "please confirm receipt via fax to (803) 555-1212," etc.).

Program Exit/Disenrollment

Participation in this program will end if/when the participant:

- Enrolls in a DDSN operated Medicaid Home and Community Based Waiver;
- Is admitted to an ICF/IID or Nursing Facility;
- Voluntarily withdraws or no longer wishes to receive State Funded Follow Along;
- Moves out of state, into a Psychiatric Residential Treatment Facility (PRTF) or a Correctional Facility;
- Is admitted to a DDSN-sponsored Residential setting (e.g., CTH, CRCF, SLP);
- Refuses to cooperate with the terms listed in the Statement of Understandings, Rights, and Responsibilities, or
- Loses or has a reduction of employment such that the minimum requirements [integrated, community based job earning at or above minimum wage, for at least ten (10) hours per week or 20 hours per two (2) week pay period] are no longer met and within 90 calendar days following the loss or reduction a new position (that meets the minimum requirements) has not been secured or restored.

When the individual's participation in the program cannot continue, the **State Funded Follow Along - Notice of Disenrollment** form must be completed and the effective date of the disenrollment noted. The completed form must be sent to the participant/representative, the Financial Management board/provider and to DDSN. Completed forms sent to DDSN may be sent by:

Scanning the completed **Notice of Disenrollment** form, attaching to an email message with "SFFA Disenrollment" noted in the subject line, sending the email message to llugo@ddsn.sc.gov. An email acknowledging receipt will be sent.

Or

Faxing completed **Notice of Disenrollment** form to the attention of Lynn Lugo at (803) 898-9660. The fax cover sheet, should indicate the means by which an acknowledgement of receipt should be sent (e.g., "please confirm receipt via email to c.manager@CMP.org;" or "please confirm receipt via fax to (803) 555-1212," etc.).

Case Management

Once enrolled, the Case Manager will be expected to complete a new or update an existing **Case Management Assessment and Plan (CMAP)**. The completed or updated assessment portion of the CMAP must reflect all of the participant's need(s) including those need(s) that can be met through the provision of SFFA services. The plan portion of the CMAP must include the actions to be taken (e.g., services to which the individual will be referred, products to be received, etc.) to address the need(s). The plan must include the name of each SFFA service to be provided and the amount and frequency of the service to be delivered.

Once the CMAP is completed, the SFFA Budget must be calculated. Using the **State Funded Follow Along Budget Calculator**, which can be found on DDSN's Application Portal under *Business Tools>State Funded Follow Along,* enter participant's name, and the SFFA Enrollment Date *(which is date the SFFA Form 1 was signed)*. By entering the Enrollment Date, the calculator will adjust/prorate the total amount available for the State Fiscal Year to reflect the amount remaining in the fiscal year. This amount will be shown on the Calculator as "*Available Funding."*

Enter the number of units or price/cost of each service to be provided for the remainder of the state fiscal year in the "Budgeted Units" column. If explanatory notes are needed, enter notes in the "Note" column. The Calculator will calculate the cost of each service based on the units/price entered. The Calculator will add together the "total cost" of each service to determine the "*Total Budgeted Cost*" for all services entered and "*Total Budgeted Cost*" will appear on the line titled "*Amount Budgeted Below.*" The calculator will subtract "*Total Budgeted Cost*" from the "*Available Funding*" leaving any "*Balance Remaining.*". Any "*Balance Remaining*" can be used for additional State Funded Follow Along services to address assessed needs. The "*Total Budgeted Cost*" cannot exceed the "*Available Funding.*"

Once SFFA services are assessed, planned and budgeted, then services must be arranged and authorized. When a *service* (Employment Services - Individual or Behavior Support Services) is to be delivered, the Case Manger will be responsible for offering the participant or his/her

representative a choice among available service providers. The list of qualified service providers is available on the DDSN's web site at: http://www.ddsn.sc.gov/consumers/findaprovider/Pages/QualifiedServiceProvidersList.aspx. This choice should be documented in the service notes.

When a *product* (Assistive Technology & Appliances) is to be delivered, the participant or his/her representative will choose the method through which the product(s) will be secured (by Reimbursement or Financial Management Board/Provider Purchase).

The Reimbursement method can be used if the participant/representative is willing and able to purchase the needed item and follows the specific instructions from the Financial Management board/provider in order to be reimbursed.

Financial Management Board/Provider Purchase method can be used if the participant/representative is not willing or able to purchase the needed item. The needed item can be purchased by the Financial Management board/provider and delivered to the participant.

The Reimbursement method should be offered first. If Reimbursement is not the preferred option for the participant, then the Financial Management Board/Provider Purchase method should be used.

If the "Financial Management Board/Provider Purchase" method will be used, the specifications of the product (*e.g., brand and strength of magnifying glass, computer software, standing mat, etc.)* must be determined and shared with the Financial Management Board/Provider.

When a *service* is to be delivered and a service provider is chosen, the Case Manager will refer the individual to the chosen provider. This referral may be by phone or in writing, but must be sufficient for the provider to decide if they will serve the participant and if so, when the service will begin.

All SFFA services (*services and products*) will be secured by the Case Manager. All delivered services and products will be paid for by the participant's Financial Management Board/Provider. This may be a new or unique situation for some service providers and may require additional explanation by the Case Manager. For that reason, the Financial Management Board/Provider must make available the name of staff who will answer the provider's questions about billing, payment, etc. of SFFA services.

For DDSN Employment Services - Individual, the Service Tracking System (STS) "Services Menu" must be updated to reflect that the participant is receiving Employment Services - Individual. As appropriate, other SFFA services should also be reflected on the STS/CDSS.

The participant or his/her representative has the right to be notified of any decision/action that may adversely affect him/her. If adversely affected, the participant/representative may choose to appeal the decision/action. Therefore, when a service is reduced or ended (terminated), the participant/representative has the right to be notified prior to the action being taken.

Ten (10) calendar days waiting period (from the date the participant or responsible party is notified) should be given before proceeding with the adverse action unless the action is one noted below. For these actions, no waiting period is required:

- Participant requested reduction;
- Voluntary withdrawal;
- Death;
- Participant moves out of state or into a Nursing Facility, ICF/IID, Psychiatric Residential Treatment Facility (PRTF) or Correctional Facility;
- Participant enrolls in a HCB Waiver;
- Cost limit has been reached; or
- Participant loses or has a reduction of employment such that the minimum requirements [integrated, community based job earning at or above minimum wage, for at least ten (10) hours per week or 20 hours per two (2) week pay period] are no longer met and within 90 calendar days following the loss or reduction a new position (that meets the minimum requirements) has not been secured or restored.

A **Notice of Reduction or Termination** form should be used to notify the participant/representative and/or the service provider and the Financial Management Board/Provider of the action.

A reduction means that fewer units of the same service will be authorized to the provider who currently provides the services. When services are to be reduced, the **Notice of Reduction or Termination** is issued to the participant/representative and the Financial Management Board/Provider and a new Authorization/Referral with the reduced number of units or price is issued.

A termination means that the service will no longer be provided. Either the provider can no longer be paid for rendering the service or the noted price will no longer be paid for the service. When a service is to be terminated, the **Notice of Reduction or Termination (Form 1, 2 or 3)** is issued to the participant/representative and/or the provider and the Financial Management Board/Provider.

SFFA services should be monitored in accordance with DDSN Case Management Standards.

SC DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
STATE FUNDED FOLLOW ALONG (SFFA)
STATEMENT OF UNDERSTANDINGS, RIGHTS, AND RESPONSIBILITIES

Participant's Name:_____

DOB:_____

I acknowledge that this information is to help me understand the SFFA program and the rights and responsibilities of program participants. I understand I will work with a Case Manager from the Case Management Board/Provider. The Case Manager will determine the services needed, will assist in arranging for them, and will monitor them. He/she will be available to answer questions about the program.

Case Management Board/Provider:_____

Case Manager:_____

Phone Number(s): _____ email address:_____

I. Understandings:

As a SFFA participant or his/her representative, I understand that:

- The SFFA program will not provide for all of my service needs.
- If non-responsive to requests from DDSN, the Case Manager or the Financial Management Board/Provider, services could be delayed, suspended, or terminated.
- Not abiding by the rights and responsibilities indicated in this document may lead to the termination of certain SFFA funded services or from the SFFA program.

II. Rights

As a SFFA participant or his/her representative, I have the right to:

- Be treated with dignity and respect by the Case Manager and the providers of SFFA services;
- Receive a full explanation of all the forms I am asked to sign;
- Be told about all services available from DDSN;
- Participate in the development of a plan for my services, have the plan explained to me and have a copy provided to me;

- Choose the board or provider that will deliver services directly from the available qualified providers (a list for most SFFA services is available online at http://www.ddsn.sc.gov/consumers/findaprovider/Pages/QualifiedServiceProvidersList.aspx);
- Contact potential direct service providers to evaluate service quality and gather information to assist in making an informed choice;
- Change my direct service provider and can do so by notifying the Case Manager;
- Appeal to DDSN if I disagree with any decision or action concerning services or participation in the SFFA program (http://ddsn.sc.gov/about/directives-standards/Documents/currentdirectives/535-11-DD%20-%20Revised%20(051712).pdf);
- Complain about services/providers by contacting the Case Manager;
- Discontinue participation in the SFFA program by contacting the Case Manager;
- Refuse to participate in/receive a service or the SFFA program.

III. Responsibilities

As a SFFA participant or his/her representative, I will:

- Treat the Case Manager and service providers/caregivers in a considerate, respectful and courteous manner and will expect the same treatment in return.
- Be present at the time of the provider's scheduled visits or inform them in advance when I will not be available on dates of scheduled services/visits.
- Allow the Case Manager and chosen service providers to enter my home.
- Not ask the service provider to perform tasks that are against the law or that are not a part of my Plan.
- Follow the agreed upon Plan for service provision.
- Provide accurate and complete information about:
    - Family members or others who can provide supports;
    - Other services being received;
    - Changes in my condition or situation, (i.e. hospitalization, additional caregiver(s)), and other events impacting my care;
    - Changes of important addresses, phone number(s)

SC DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
STATE FUNDED FOLLOW ALONG (SFFA)
ACKNOWLEDGMENT OF UNDERSTANDINGS, RIGHTS, AND RESPONSIBILITIES

Participant's Name:_____

DOB:_____

DDSN's SFFA, "Statement of Understandings, Rights and Responsibilities" document has been provided to me as the SFFA program participant or his/her representative. This document included legible contact information about the Case Management Board/Provider. I have been offered the opportunity to ask questions about the understandings, rights and responsibilities included within the document and know that I may contact the Case Management Board/Provider should I have any additional questions.

_____ Date:_____
Signature of Participant or Representative

_____ _____
Printed name of signatory Relationship to Participant

_____ Date:_____
Signature of Witness

Original - Participant's file
Copy - DDSN Central Office

South Carolina Department of Disabilities and Special Needs
State Funded Follow Along (SFFA) Participant Information Sheet

DDSN is pleased to offer employment focused follow along services to those who are eligible for DDSN services and meet the following criteria:

- Have secured individual integrated employment in the community in collaboration with the South Carolina Vocational Rehabilitation Department (SCVRD), at or above minimum wage, for at least ten (10) hours per week 20 hours per two (2) week pay period);
- Have been closed by SCVRD (Status 26 closure);
- Require ongoing supports to maintain their employment; and
- Are not currently enrolled in a DDSN operated Home and Community Based Waiver

These services and/or products constitute a program called SFFA. As part of SFFA, each participant will work with a Case Manager to determine which services/products are needed, then plan for and arrange for those needed services/products to be provided/delivered.

Services and /or Products: The services/products available, when needed, are:

Employment Services - Individual: Intensive, on-going supports that enable participants for whom competitive employment at or above minimum wage is unlikely absent the provision of supports and who, because of their disabilities, need supports to perform in a regular work setting. This may include, but is not limited to: establishing long term supports, negotiating advancement, work schedule changes, employee/employer satisfaction, job loss and job development to secure new employment, reporting earned wages, intervention activities, employer visits, additional skills acquisition (coaching), assistive technology assessment and acquisition , and transportation guidance.
Assistive Technology and Appliances: A device, item, or product that is used to increase or improve functional capabilities of the participant as necessary for employment.
Behavior Support Services: Services to assist those who provide services to a participant who exhibits problem behaviors that interfere with their employment to learn why the behavior occurs, strategies to prevent and respond to behaviors, and how to teach the participant appropriate behaviors to replace the problem behaviors.

Program Limitations:

Enrollment in State Funded Follow Along (SFFA) is limited to those who are eligible for DDSN services who meet the criteria listed above.

Through SFFA, services/products, costing up to an amount determined by DDSN can be provided each year. DDSN will determine the annual amount or cost limit per state fiscal year (July 1 – June 30). The amount available will be prorated or adjusted during the first year of participation based on the month in which participation begins. For example, if the participant begins receiving services in January, one-half of the total annual amount will be available for services/products delivered between January and June 30th. On July 1, the total annual amount will be available for services/products to be delivered between July 1st and June 30th. Amounts not used during the fiscal year will not roll over and cannot be used to increase the cost limit for the next year.

DDSN reserves the right to adjust or impose additional limits to this program or its services as needed.

Program Exit/Disenrollment:

Participation in this program will end if/when the participant:

- Enrolls in a DDSN –operated Medicaid Home and Community Based Waiver;
- Is admitted to an ICF/IID or Nursing Facility;
- Voluntarily withdraws or no longer wishes to receive SFFA;
- Moves out of state, into a Psychiatric Residential Treatment Facility (PRTF) or a Correctional Facility;
- Is admitted to a DDSN-sponsored Residential setting (e.g., CTH, CRCF, SLP);
- Refuses to cooperate with the terms listed in the Statement of Understandings, Rights, and Responsibilities; or
- Loses or has a reduction of employment such that the minimum requirements [integrated, community based job earning at or above minimum wage, for at least ten (10) hours per week or 20 hours per two (2) week pay period] are no longer met and within 90 calendar days following the loss or reduction a new position (that meets the minimum requirements) has not been secured or restored.

Rights:

Decisions that adversely affect SFFA participants may be appealed in accordance with DDSN Directive 535-11-DD: Appeal and Reconsideration Policy and Procedures, which can be found on our website at http://www.ddsn.sc.gov/about/directives-standards/Pages/CurrentDDSNDirectives.aspx.

SC DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
STATE FUNDED FOLLOW ALONG (SFFA)
Notice of Disenrollment

Participant's Name:_____ Date of Birth:_____

Effective Date of Disenrollment:_____

Effective on the date noted above, this individual's participation in DDSN's SFFA program will end. His/her participation is ending because he/she:

☐Enrolled in a SCDDSN –operated Medicaid Home and Community Based Waiver;

☐Was admitted to an ICF/IID or Nursing Facility;

☐Voluntarily withdrew or no longer wishes to receive;

☐Moved out of state, into a Psychiatric Residential Treatment Facility (PRTF) or a Correctional Facility;

☐Was admitted to a DDSN-sponsored Residential setting (e.g., CTH, CRCF, SLP);

☐Did not comply with the terms listed in the Statement of Understandings, Rights, and Responsibilities; or

☐Lost or had a reduction of employment such that the minimum requirements [integrated, community based job earning at or above minimum wage, for at least ten (10) hours per week or 20 hours per two (2) week pay period] are no longer met and within 90 calendar days following the loss or reduction a new position (that meets the minimum requirements) was not secured or restored.

Because his /her participation is ending, the following service(s), which have been received through this program, will not continue:

(Check all services provided to the participant through SFFA.)

☐Employment Services-Individual
☐Assistive Technology and Appliances
☐Behavior Support Services

Please direct any questions regarding this notice to the Case Manager noted below.

Case Management Board/Provider:_____

Case Manger's Name:_____

Phone Number:_____ Email Address:_____

_____ Date:_____

Signature of Individual Completing Form

In accordance with DDSN Directive 535-11-DD: Appeal and Reconsideration Policy and Procedures, SFFA participants have the right to appeal any decisions with which he/she disagrees. Appeals should be in writing and mailed to the DDSN State Director, PO Box 4706, Columbia, SC 29240.

Employment Services - Individual

Definition: Employment Services – Individual, consists of intensive, on-going supports that enable those for whom competitive employment at or above minimum wage is unlikely absent the provision of supports, and who because of their disabilities, need supports to perform in regular work settings. This may include, but is not limited to: establishing long term supports, negotiating advancement, work schedule changes, employee/employer satisfaction, job loss and job development to secure new employment, reporting earned wages, intervention activities, employer visits, additional skills acquisition (coaching), assistive technology assessment and acquisition and transportation guidance.

In the event of a job termination or reduction such that employment no longer meets the minimum requirements [integrated community based job earing at or above minimum wage, for at least ten (10) hours per week or 20 hours per two (2) week pay period], SFFA can continue to fund services for the purpose of Job Development up to 90 calendar days, not to exceed the annual cost limit of SFFA for the fiscal year. If within 90 calendar days a new position (that meets the minimum requirements) has not been found or restored, a referral back to SCVRD may be appropriate.

Providers: A list of Employment Services providers can be found on the Qualified Provider Listing found on DDSN's website at: http://ddsn.sc.gov/consumers/findaprovider/Pages/QualifiedServiceProvidersList.aspx . In some locations across the state, only one provider is available.

Arranging for the Service: For those determined to need the kind of assistance described in the Employment Services - Individual definition, the plan must clearly reflect the need for the service. A choice of service providers should be offered and the offering of choice must be documented. If there is only one available choice then this must be explained to the participant/representative and documented.

For Employment Services - Individual, one unit equals one hour of service. This service can be authorized using the **Authorization/Request for Employment Services - Individual form**.

Guidance: Most SFFA participants will be employed. National best practice dictates that at least two (2) monthly contacts at the job site be conducted, unless the employer/employee requests otherwise. At a minimum, authorizations should reflect national best practice.

The "Services Menu" of Service Tracking System (STS) must be updated to indicate the participant is receiving Employment Services - Individual.

The cost of Employment Services - Individual must be added to the SFFA Budget Calculator. Under no circumstances may the annual cost limit of SFFA be exceeded.

Monitoring: The CMAP, which will include the Employment Services - Individual must be monitored in accordance with DDSN Case Management Standards.

Reduction or Termination of Services: When Employment Services - Individual is being reduced or terminated the **Notice of Reduction or Termination** (Form 3) must be used to notify the participant/representative, the provider and the Financial Management Board/Provider. See the Case Management section for more information.

SC DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
STATE FUNDED FOLLOW ALONG (SFFA)
Authorization/Request for Employment Services - Individual

TO:_____
(Employment Services - Individual, Service Provider)

Re: Name:_____

Address:_____

Date of Birth:_____

Beginning on the date noted below, you are hereby authorized to provide the following service to the individual named above. Only the number of units rendered may be billed. *Please note: This nullifies any previous authorization to this provider for this service(s).*

Number of Units yearly:_____ [one unit=1 hour]

The individual noted above participates in DDSN's SFFA program. Through this program, when authorized services are provided, payment for services, up to the amount authorized above, will be made by the Financial Management Board/Provider serving the participant. For the individual noted above, please request payment from and direct questions regarding payment to:

Financial Management Board/Provider:_____

Address:_____

Representative:_____
(Name of Individual to Contact)

Phone Number:_____ Email Address:_____

Case Management Board/Provider:_____

Case Manager's Name:_____

Phone Number:_____ Email Address:_____

_____ Date:_____
Signature of Case Manager Authorizing Services

SC DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
STATE FUNDED FOLLOW ALONG (SFFA)
Notice of Reduction or Termination

Effective:_____
(Date the authorization will end)

The authorization(s) for service (s) issued to:

_____
(Name of provider authorized to provide the service)

For service (s) to be provided to:

_____
(Name of the individual receiving the service and his/her date of birth)

Is/Are being *(check one)*: ☐Reduced ☐Terminated

Payment will not be made for units of service (s) rendered after the effective date of this Notice for the following service(s):

☐Employment Services-Individual

Comments:_____

Direct any questions regarding this notice to:

Case Manager:_____

Phone Number:_____ Email Address:_____

_____ Date:_____
Case Manager's signature

In accordance with DDSN's policy 535-11-DD, State Funded Follow Along participants have the right to appeal any decisions with which he/she disagrees. Appeals should be in writing and mailed to the DDSN State Director, PO Box 4706, Columbia, SC 29240.

Assistive Technology and Appliances

Definition: Assistive Technology and/or Appliances means a device, an item, piece of equipment, or product system, that is used to increase or improve functional capacities of participants when necessary for employment. This service may include the evaluation of the assistive technology/appliance needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the work environment of the participant; and training or technical assistance for the participant, or when appropriate, the family members, guardians, advocates, authorized representatives, or employer of the participant. This service is not intended to replace traditional household appliances for the convenience of family/household members or caregivers. Additionally, devices, items, equipment and/or product systems not proven effective, or those considered experimental or trial are not covered. Repairs not covered by warranty are covered, and replacement of parts/equipment is covered, if these repairs or parts/equipment are not related to abuse, mistreatment or carelessness. For SFFA, this service is limited to only those items necessary for employment.

Arranging for the Service:

The need for employment - related Assistive Technology and Appliances must be identified and the specific item, piece of equipment, device, or appliance (the item) must be documented on the Plan. Once the need is determined and the item to meet the need documented, the method to be used to secure the item must be determined.

Reimbursement Method: If the participant/representative is willing and able to purchase the needed item and follows the specific instructions from the Financial Management Board/Provider in order to be reimbursed. When this method is used, the Authorization/Request for Assistive Technology and Appliances [SFFA (ATA1)] will be used. The participant/representative must be given the specific instructions for requesting reimbursement from the Financial Management Board/Provider. These instructions will be provided by the Financial Management Board/Provider. The Authorization/Request for Assistive Technology and Appliances [SFFA (ATA 1)] should reflect the needed item and the maximum amount allowed for the purchase of the item including any taxes or shipping that will be charged. The participant/representative will not be reimbursed for more than the "maximum amount" noted on the form. When the Authorization/Request is completed, copies of the form should be shared with the participant/representative and with the Financial Management Board/Provider. The SFFA (ATA) will remain in effect until a new authorization is issued or a Notice of Reduction or Termination is issued.

Financial Management Board/Provider Purchase Method: If the participant/representative is not willing or able to be reimbursed for a purchased item, the needed item can be purchased by the Financial Management Board/Provider and delivered to the participant.

When this option is used, the Authorization/Request for Assistive Technology and Appliances [SFFA (ATA 2)] will be used. A description including any specifications for the item must be determined along with the maximum allowable cost. The maximum allowable cost should be determined by estimating the cost of the item plus tax and any potential shipping and handling

charges. Very specific information must be provided to the Financial Management Board/Provider so that needed items can be purchased. If needed, attach additional pages (e.g., printed manufacturer's or supplier's website that includes the specifications of the product to be purchased).

The maximum amount for the item must be noted. The Financial Management Board/Provider will not purchase an item that costs in excess of the maximum amount noted on the Authorization/Request for Assistive Technology and Appliances [SFFA (ATA 2)].

Whether or not the participant/representative is willing to pick up the item from the Financial Management Board/Provider's offices or other board/provider location rather than having the item shipped/delivered to the home should be noted. If the participant/representative is not willing to pick up item, the maximum monthly amount must include costs for shipping/handling/delivery.

The form must also indicate a shipping address for the item if the address is different than the participant's address noted at the top of the Authorization/Request for Assistive Technology and Appliances [SFFA (ATA 2)].

The maximum amount of the item must be added to the SFFA Budget Calculator. Under no circumstances may the annual cost limit of SFFA be exceeded.

When the Financial Management Board/Provider determines the means by which items will be supplied, the Financial Management Board/Provider will notify the Case Manager of the method and the cost of the item. The actual amount of the item must be added to the SFFA Budget Calculator, to update the cost from the maximum to the actual.

The Authorization/Request for Assistive Technology and Appliances [SFFA (ATA 2)] will remain in effect until a new authorization is issued or a Notice of Reduction or Termination is issued.

Consultations: Consultations can be used to assess and determine the specific needs related to the participant's disability for which appliances and assistive technology will assist the participant to function more independently when necessary for employment. Consultations must occur **prior to** the issuance of the authorization for the item. A Consultation may be authorized by completing the Authorization/Request for Assistive Technology and Appliances [SFFA (ATA 3)]. The amount for a consultation for the initial placement of an item should not typically exceed $300.00.

Monitoring the Services: "Assistive Technology and/or Appliances" must be included on the Plan; the Plan must be monitored in accordance with DDSN Case Management Standards.

Reduction or Termination of Services: When Assistive Technology and or Appliances services are being reduced or terminated the Notice of Reduction or Termination (Form 2) must be used to notify the participant/representative, the provider and the Financial Management Board/Provider. See the Case Management section for more information.

SC DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
STATE FUNDED FOLLOW ALONG (SFFA)
Authorization/Request for Assistive Technology and Appliances Reimbursement

TO:_____
(Participant/Representative)

Re: Name:_____

*Address:_____

Date of Birth:_____

The individual noted above participates in DDSN's SFFA program. The individual referenced above has been determined to need the following employment related item(s) which is considered:

Assistive Technology and Appliances

Name of Item:_____

Description/Specifications:_____

Maximum Allowable Cost:_____

The participant or his/her representative has agreed to purchase this item and be reimbursed for the cost of the item purchased. He/she agrees to provide itemized, dated receipt to the Financial Management Board/Provider in order to be reimbursed. Receipts dated prior to the date of this Authorization/Request or not itemized will not be reimbursed. Written instructions for how request reimbursement from the Financial Management Board/Provider has been given to the individual noted below:

Name and relationship of individual willing to purchase:_____

Case Management Board/Provider:_____

Case Manager's Name:_____

Phone Number:_____ Email Address:_____

_____ Date:_____
Signature of Case Manager Authorizing Services

SFFA (ATA 1) (4/1/2016)

SC DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
STATE FUNDED FOLLOW ALONG (SFFA)
Authorization/Request for Assistive Technology and Appliances
Financial Management Board/Provider Purchase

TO:_____
(Financial Management Board/Provider)

Re: Name:_____

*Address:_____

Date of Birth:_____

The individual noted above participates in DDSN's SFFA program. The individual referenced above has been determined to need the following employment related item(s) which is considered:

Assistive Technology and Appliances

Name of Item:_____

Description/Specifications*:_____

Maximum Allowable Cost:_____

***Include sufficient information/specifications such as printed material from manufacturer's website or other supplier (e.g., Amazon, etc.) for the Financial Management Board/Provider to purchase appropriate products. Attach pages if needed*.

The individual noted above/representative can arrange for item to be picked up from one of the Financial Management Board/Provider's locations: ☐Yes ☐No

Contact number for item pick-up:_____

Address to which item should be shipped if different than participant address noted above:

Shipping address:_____

Case Management Board/Provider:_____

Case Manager's Name:_____

Phone:_____ Email Address:_____

_____ Date:_____
Signature of Case Manager Authorizing Services

SC DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
STATE FUNDED FOLLOW ALONG (SFFA)
Authorization/Request for Assistive Technology and Appliances Consultation

TO:_____
(Consultant)

Re: Name:_____

Address:_____

Date of Birth:_____

Beginning on the date noted below, you are hereby authorized to provide the following service to the individual named above. Only the cost for services rendered may be billed. *Please note: This nullifies any previous authorization to this provider for this service(s).*

Assistive Technology and Appliances - Consultation

Description:_____

Maximum Allowable Cost:_____

The individual noted above participates in DDSN's SFFA program. Through this program, when authorized services are provided, payment for services, up to the amount authorized above, will be made by the Financial Management Board/Provider serving the participant. For the individual noted above, please request payment from and direct questions regarding payment to:

Financial Management Board/Provider:_____

Address:_____

Name of Individual to Contact:_____

Phone Number:_____ Email Address:_____

Case Management Board/Provider:_____

Case Manager's Name:_____

Phone:_____ Email Address:_____

_____ Date:_____
Signature of Case Manager Authorizing Services

SC DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
STATE FUNDED FOLLOW ALONG (SFFA)
Notice of Reduction or Termination

Effective:_____
(Date the authorization for the service will end)

The following service *(check one)*:

☐Assistive Technology/Appliances:_____
☐Assistive Technology/Appliances - Consultation

Which is authorized through the State Funded Follow Along program to be provided to:

_____
(Name of the SFFA participant and his/her date of birth)

Is being *(check one)*: ☐Reduced ☐Terminated

Payment for the service indicated above will not be made for services rendered after the effective date of this Notice.

Comments:_____

Direct any questions regarding this notice to:

Case Manager's Name:_____

Phone Number:_____ Email Address:_____

_____ Date:_____
Case Manager's signature

In accordance with DDSN Directive 535-11-DD: Appeal and Reconsideration Policy and Procedures, SFFA participants have the right to appeal any decisions with which he/she disagrees. Appeals should be in writing and mailed to the DDSN State Director, PO Box 4706, Columbia, SC 29240.

Behavior Support Services

Definition: Behavior Support Services, when necessary for employment, are those services which use current empirically validated practices to identify causes of, intervene to prevent, and appropriately react to problematic behavior. These services include initial assessment for determining the need for and appropriateness of behavior support services; behavioral assessment (i.e., functional assessment and/or analysis) that includes direct observation, interview of key individuals, collection of objective data; analysis of behavioral/functional assessment data to determine the function of the behaviors (and later to assess success of intervention and any needed modifications) and behavioral intervention based on the functional assessment that is primarily focused on prevention of the problem behavior(s) based on their function.

Providers: Those listed as providers of Behavior Support Services on the Qualified Provider Listing found on DDSN's website at: http://ddsn.sc.gov/consumers/findaprovider/Pages/QualifiedServiceProvidersList.aspx. These providers must be used.

Arranging for the Service: If it is determined that those who support the participant need support to know how to respond to the problem behavior(s) engaged in/displayed by the participant, Behavior Support should be authorized. The participant or his/her family or guardian should be provided with a listing of available Behavior Support Service providers. The offering of the choice of service providers must be clearly documented. The initial authorization should be sufficient to cover the functional assessment and development of the Behavior Support Plan. Once the assessment is completed and the plan developed, an authorization can be issued so that those who will implement the plan can be trained and the effectiveness of the Behavior Support Plan can be monitored.

One unit of Behavior Support Services equals 30 minutes of professional time. The SFFA (BSS 1) must be used to authorize the service. The SFFA (BSS 1) instructs the provider to bill the participant's Financial Management Board/Provider for services rendered. The SFFA (BSS 1) will remain in effect until a new authorization is issued or until a Notice of Reduction or Termination (Form1) is issued.

The cost of Behavior Support Services must be added to the SFFA Budget Calculator. Under no circumstances may the annual cost limit of SFFA be exceeded.

Monitoring: The CMAP, which will include the Behavior Support Services, when necessary for employment, must be monitored in accordance with DDSN Case Management Standards. When monitoring, it will be important to know if the assessment and plan are completed with a reasonable amount of resources used and once the plan is completed, it will be important to know whether or not those who support the individual understand the strategies they are to use and whether or not they find the strategies to be effective.

Reduction or Termination of Services: When Behavior Support Services are being reduced or terminated the Notice of Reduction or Termination (Form 1) must be used to notify the participant/representative, the provider and the Financial Management Board/Provider. See the Case Management section for more information.

SC DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
STATE FUNDED FOLLOW ALONG (SFFA)
Authorization/Request for Behavior Support Services

TO:_____
(Behavior Support Services Provider)

Re: Name:_____

Address:_____

Date of Birth:_____

Beginning on the date noted below, you are hereby authorized to provide the following service to the individual named above. Only the number of units rendered may be billed. *Please note: This nullifies any previous authorization to this provider for this service(s).*

Behavior Support Services

Number of Units for Assessment & Plan Development:_____[one unit =30 minutes]

Number of Units for Training, Monitoring, Revisions:_____[one unit =30 minutes]

Frequency of Units (e.g., monthly or yearly):_____

The individual noted above participates in DDSN's SFFA program. Through this program, when authorized services are provided, payment for services, up to the amount authorized above, will be made by the Financial Management Board/Provider serving the participant. For the individual noted above, please request payment from and direct questions regarding payment to:

Financial Management Board/Provider: _____

Address:_____

Representative:_____
(*Name of Individual to Contact)*

Phone:_____ Email Address:_____

Case Management Board/Provider:_____

Case Manager's Name:_____

Phone:_____ Email Address:_____

_____ Date:_____
Signature of Case Manager Authorizing Services

SFFA (BSS 1) (4/1/2016)

SC DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
STATE FUNDED FOLLOW ALONG (SFFA)
Notice of Reduction or Termination

Effective:_____
(Date the authorization will end)

The authorization(s) for service (s) issued to:_____
(Name of provider authorized to provide the service)

For service (s) to be provided to:_____
(Name of the individual receiving the service and his/her date of birth)

Is/are being *(check one)*: ☐Reduced ☐Terminated

Payment will not be made units of service (s) rendered after the effective date of this Notice for the following service(s): ☐Behavior Support

Comments:_____

Direct any questions regarding this notice to:

Case Manager's Name:_____

Phone Number: Email Address:_____

_____ Date:_____
Case Manager's signature

In accordance with DDSN Directive 535-11-DD: Appeal and Reconsideration Policy and Procedures, State Funded Follow Along participants have the right to appeal any decisions with which he/she disagrees. Appeals should be in writing and mailed to the DDSN State Director, PO Box 4706, Columbia, SC 29240.