



State of California—Health and Human Services Agency
Department of Health Care Services



GAVIN NEWSOM
GOVERNOR

September 28, 2022

THIS LETTER SENT VIA EMAIL

Mr. James G. Scott, Director
Division of Program Operations
Medicaid and CHIP Operations Group
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 0300
Kansas City, MO 64106-2898

STATE PLAN AMENDMENT 22-0048: PUBLIC HEALTH EMERGENCY (PHE)
FLEXIBILITIES MADE PERMANENT AND ADDITIONAL SERVICES

Dear Mr. Scott:

The Department of Health Care Services (DHCS) is submitting a 1915(i) State Plan Amendment (SPA) 22-0048 for your review and approval. This SPA proposes to make various flexibilities under the PHE permanent, as well as adding additional services, and a new provider type. DHCS is seeking an effective date of November 1, 2022.

The purpose of SPA 22-048 is to extend provisions of technology services, self-directed support services, incentive payments for paid internship programs, and to allow some services to be self-directed past the end of the PHE. Additionally, some services may be able to be provided via telehealth, and Group Homes for Children with Special Health Care Needs will be a new provider under Community Living Arrangements.

The Tribal no-notice was approved on July 13, 2022.

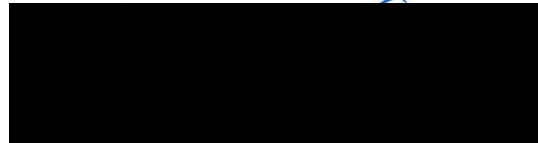
DHCS is submitting the following SPA documents for your review and approval:

- CMS 179 - Transmittal and Notice of Approval of State Plan Material
- Attachment 3.1-I (Clean)
- Attachment 3.1-I (Redline)
- Standard Funding Questions
- Public Notice

Mr. James G. Scott
Page 2
September 28, 2022

If you have any questions or need additional information, please contact Joseph Billingsley, Assistant Deputy Director of Integrated Systems of Care Division, by phone at (916) 713-8389 or by email at Joseph.Billingsley@dhcs.ca.gov.

Sincerely,



Jacey Cooper
State Medicaid Director
Chief Deputy Director
Health Care Programs

Enclosures

cc: Ms. Susan Philip
Deputy Director
Health Care Delivery Systems
Department of Health Care Services
Susan.Philip@dhcs.ca.gov

Mr. Joseph Billingsley
Assistant Deputy Director
Health Care Delivery Systems
Department of Health Care Services
Joseph.Billingsley@dhcs.ca.gov

Ms. Cortney Maslyn, Chief
Integrated Systems of Care Division
Department of Health Care Services
Cortney.Maslyn@dhcs.ca.gov

Ms. Saralyn M. Ang-Olson, JD, MPP
Chief Compliance Officer
Office of Compliance
Department of Health Care Services
Saralyn.Ang-Olson@dhcs.ca.gov

Mr. Aaron Toyama
Senior Advisor
Health Care Programs
Department of Health Care Services
Aaron.Toyama@dhcs.ca.gov

Ms. Maricris Acon
Deputy Director
Federal Programs Division
Department of Developmental Services
Maricris.Acon@dds.ca.gov

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER

2 0 — 0 0 4 8

2. STATE

CA

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT

XIX XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

November 1, 2022

5. FEDERAL STATUTE/REGULATION CITATION

1915i of the Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)

a. FFY 2022-23 \$ 2,311,027
b. FFY 2023-24 \$ 2,371,474

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 3.1i: p.
1,8,9,19,28,29,36,37,57,58,59,69,77,80,101,104,106 (new
pages:111a-111c), 112, 113.
Attachment 4.19BL 78g

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)

Attachment 3.1i: p.
1,8,9,19,28,29,36,37,57,58,59,69,77,80,101,104,106 (new
pages:111a-111c), 112, 113.
Attachment 4.19BL 78g

9. SUBJECT OF AMENDMENT

Addition of technology services, self-directed support services, and incentive payments for paid internship programs. Expands eligibility for children three or four years of age, the provision for specified services to provide services remotely, and adds a new provider type for Community Living Arrangement. Day Services and supported employment can be a participant directed service.

10. GOVERNOR'S REVIEW (Check One)

- GOVERNOR'S OFFICE REPORTED NO COMMENT
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED:

Please note: The Governor's Office does not wish to review the State Plan Amendment.

11. SIGNATURE OF STATE AGENCY OFFICIAL

[Redacted Signature]

12. TYPED NAME

Jacey Cooper

13. TITLE

State Medicaid Director

14. DATE SUBMITTED

September 28, 2022

15. RETURN TO

Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR CMS USE ONLY

16. DATE RECEIVED

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

1915(i) State plan Home and Community-Based Services Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit for elderly and disabled individuals as set forth below.

1. Services. (Specify the state’s service title(s) for the HCBS defined under “Services” and listed in Attachment 4.19-B):

Habilitation- Community Living Arrangement Services; Habilitation- Day Services; Habilitation- Behavioral Intervention Services; Respite Care; Enhanced Habilitation- Supported Employment - Individual; Enhanced Habilitation- Prevocational Services; Homemaker Services; Home Health Aide Services; Community Based Adult Services; Personal Emergency Response Systems; Vehicle Modification and Adaptation; Speech, Hearing and Language Services; Dental Services; Optometric/Optician Services; Prescription Lenses and Frames; Psychology Services; Chore Services; Communication Aides; Environmental Accessibility Adaptations; Non-Medical Transportation; Nutritional Consultation; Skilled Nursing; Specialized Medical Equipment and Supplies; Transition/Set-Up Expenses; Community-Based Training Services; Financial Management Services; Family Support Services; Housing Access Services; Occupational Therapy; Self-Directed Supports Service; Technology Services; Physical Therapy; Intensive Transition Services; and Family/Consumer

2. Concurrent Operation with Other Programs. (Indicate whether this benefit will operate concurrently with another Medicaid authority):

Select one:

<input checked="" type="radio"/>	Not applicable
<input type="radio"/>	Applicable
Check the applicable authority or authorities:	
<input type="checkbox"/>	<p>Services furnished under the provisions of §1915(a)(1)(a) of the Act. The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may <i>voluntarily</i> elect to receive <i>waiver</i> and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. <i>Specify:</i></p> <p>(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);</p> <p>(b) the geographic areas served by these plans;</p> <p>(c) the specific 1915(i) State plan HCBS furnished by these plans;</p> <p>(d) how payments are made to the health plans; and</p> <p>(e) whether the 1915(a) contract has been submitted or previously approved.</p>
<input type="checkbox"/>	<p>Waiver(s) authorized under §1915(b) of the Act.</p> <p><i>Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:</i></p>

The individual meets the following need-based criteria:

- Requires assistance with at least three of the following areas of major life activity, as appropriate to the person’s age:
 - Receptive and expressive language;
 - Learning;
 - Self-care;
 - Mobility;
 - Self-direction;
 - Capacity for independent living.
- Additionally, children three or four years of age with a disability that is not solely physical in nature and includes significant functional limitations in at least two of the above listed areas of major life activity (does not apply to capacity for independent living, or economic sufficiency given the age of the person), as determined by the regional center are also provisionally eligible for services.
- Without habilitation services, as defined in Section 1915(c)(5) of the Social Security Act (42 U.S.C. § 1396 et seq.), requires assistance with learning new skills that have not previously been acquired, such as skills enabling the individual to respond to life changes and environmental demands; and

6. **Needs-based Institutional and Waiver Criteria.** *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)
The individual meets the following need-based criteria: <ul style="list-style-type: none"> • Requires assistance with at least three of the following areas of major life activity, as appropriate to the person’s age: 	Skilled nursing procedures provided as a part of skilled nursing care are those procedures which must be furnished under the direction of a registered nurse in response to the attending physician’s order. The need must	The individual must be diagnosed with a developmental disability and a qualifying developmental deficit exists in either the self-help or social-emotional area.	The individual requires: <ul style="list-style-type: none"> • Continuous availability of facilities, services, equipment and medical and nursing personnel for prevention, diagnosis or

<p>o Receptive and expressive language;</p> <p>o Learning;</p> <p>o Self-care;</p> <p>o Mobility;</p> <p>o Self-direction;</p> <p>o Capacity for independent living.</p> <p>o Additionally, children three or four years of age with a disability that is not solely physical in nature and includes significant functional limitations in at least two of the above listed areas of major life activity (does not apply to capacity for independent living, or economic sufficiency given the age of the person), as determined by the regional center are also provisionally eligible for services.</p> <p>o Without habilitation services, as defined in Section 1915(c)(5) of the Social Security Act (42 U.S.C. § 1396 <i>et seq.</i>), requires assistance with learning new skills that have not previously been acquired, such as skills enabling the individual to respond to life changes and environmental demands and</p>	<p>be for a level of service which includes the continuous availability of procedures such as, but not limited to, the following:</p> <ul style="list-style-type: none"> • Nursing assessment of the individuals' condition and skilled intervention when indicated; • Administration of injections and intravenous of subcutaneous infusions; • Gastric tube or gastronomy feedings; • Nasopharyngeal aspiration; • Insertion or replacement of catheters • Application of dressings involving prescribed medications; • Treatment of extensive decubiti; • Administration of medical gases 	<p>For self-help, a qualifying developmental deficit is represented by two moderate or severe skill task impairments in eating, toileting, bladder control or dressing skill.</p> <p>For the social-emotional area, a qualifying developmental deficit is represented by two moderate or severe impairments from a combination of the following; social behavior, aggression, self-injurious behavior, smearing, destruction of property, running or wandering away, or emotional outbursts.</p>	<p>treatment of acute illness or injury.</p>
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Recruiting, training, and hiring personal attendants;
 Acquiring, using, and caring for canine and other animal companions specifically trained to provide assistance; Acquiring, using and maintaining devices to facilitate immediate assistance when threats to health, safety, and well-being occur.

CLAS may include additional activities, as appropriate, to meet the recipients’ unique needs. These activities include those that address social, adaptive, behavioral, and health care needs as identified in the individual program plan. CLAS may also include the provision of medical and health care services that are integral to meeting the daily needs of residents. Medical and health care services such as physician services that are not routinely provided to meet the daily needs of residents are not included.

The specific services provided to each recipient vary based on the residential setting chosen and needs identified in the individual program plan. This service can be provided via all forms of telehealth or other forms of remote service delivery as agreed upon by the consumer and provider.

Payments will not be made for the routine care and supervision which would be expected to be provided by a family, or for activities or supervision for which a payment is made by a source other than Medi-Cal. Payments for CLAS in licensed/certified settings do not include the cost for room and board. The method by which the costs of room and board are excluded from payment in these settings is specified in Attachment 4.19-B.

Additional needs-based criteria for receiving the service, if applicable (*specify*):

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

Categorically needy (*specify limits*):

Medically needy (*specify limits*):

Provider Qualifications (*For each type of provider. Copy rows as needed*):

Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Foster Family Agency (FFA)- Certified Family Homes (Children Only)	FFA licensed pursuant to Health and Safety Code §§1500-1567.8 provides	Certified Family Homes; Title 22, CCR, § 88030 establishes requirements for FFA	Title 22, CCR §§ 88000-88087. Regulations adopted by DSS to specify requirements for licensure of FFA’s, certification and use of homes, FFA administrator qualifications:

			<p>(b) A direct care staff person must:</p> <ul style="list-style-type: none"> (1) Have at least six months prior experience providing direct care to individuals with developmental disabilities, with a focus on behavioral services; and (2) Become a registered behavior technician within twelve months of initial employment; or be: <ul style="list-style-type: none"> (A) Be a licensed psychiatric technician.
<p>Group Homes for Children with Special Health Care Needs (GHCSHN)</p>	<p>Licensed Group Home for Children with Special Health Care Needs by the Department of Social Services pursuant to Health and Safety Code §1567.51(b)</p> <p>As appropriate, a business license as required by the local jurisdiction where the business</p>	<p>Per Health and Safety Code §1567.51, the State Department of Developmental Services shall be responsible for granting the certificate of program approval.</p>	<p>Welfare and Institutions Code, § 4684.50 et seq.</p> <p>The administrator must:</p> <ul style="list-style-type: none"> 1. Complete the 40-hour administrator certification program pursuant to paragraph (1) of subdivision (c) of Section 1522.41 of the Health and Safety Code without exception 2. Has at least one year of administrative and supervisory experience in a licensed residential program for persons with developmental disabilities, and is one or more of the following: <ul style="list-style-type: none"> a. A licensed registered nurse. b. A licensed nursing home administrator. c. A licensed psychiatric technician with at least five years of experience serving individuals with developmental disabilities. d. An individual with a bachelor’s degree or more advanced degree in the health or human services field and two years of experience working in a licensed residential program for persons with developmental disabilities and special health care needs.

A) Community-Based Day Services – (Providers identified with “CB” below)

These services provide assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which may take place in a residential or non-residential setting. Services may be furnished four or more hours per day on a regularly scheduled basis, for one or more days per week unless provided as an adjunct to other day activities included in an individual’s plan of care. These services enable the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation service may serve to reinforce skills or lessons taught in school, therapy, or other settings. Day habilitation services may include paid/volunteer work strategies when the individualized planning process determines that supported employment or prevocational services are not appropriate for the individual.

B) Activity-Based/Therapeutic Day Services – (Providers identified with “AT” below) These services provide assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills through therapeutic and/or physical activities and are designed to:

- Gain insight into problematic behavior
- Provide opportunities for expression of needs and feelings
- Enhance gross and fine motor development
- Promote language development and communication skills
- Increase socialization and community awareness
- Improve communication skills
- Provide visual, auditory and tactile awareness and perception experiences
- Assist in developing appropriate peer interactions

C) Mobility Related Day Services – (Providers identified with “MT” below)

These services foster the acquisition of greater independence and personal choice by teaching individuals how to use public transportation or other modes of transportation which will enable them to move about the community independently.

The above described services are not available under a program funded under section 110 of the Rehabilitation Act of 1973 (29 USC Section 730) or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 USC 1401(16 and 17)).

This service can be provided via all forms of telehealth or other forms of remote service delivery as agreed upon by the consumer and provider.

Additional needs-based criteria for receiving the service, if applicable (*specify*):

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

Categorically needy (*specify limits*):

	required by the local jurisdiction where the business is located.		
Sports Club: (e.g. YMCA, Community Parks and Recreation Program, Community-based recreation program) (AT)	As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	All community recreational program providers shall possess the following minimum qualifications: 1. Ability to perform the functions required by the individual plan of care; 2. Demonstrated dependability and personal integrity; 3. Willingness to pursue training as necessary based upon the individual consumer’s needs.

Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):

Provider Type (Specify):	Entity Responsible for Verification (Specify):	Frequency of Verification (Specify):
All Habilitation – Day Services providers	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.
Licensed Community Care Facilities	Department of Social Services – Community Care Licensing Division (DSS-CCLD) and regional centers	Annually

Service Delivery Method. (Check each that applies):

<input checked="" type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/>	Provider managed
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Service Specifications (Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):

Service Title:	Habilitation - Behavioral Intervention Services
Service Definition (Scope):	
Habilitation—Behavioral Intervention Services include two components:	

A) Individual/Group Practitioners - May provide Behavioral Intervention Services in multiple settings, including the individual's home, workplace, depending on the individual's needs. These practitioners may also provide non-facility-based crisis services when needed. Use of state-operated mobile crisis services are available for individuals continuing to experience crises and have exhausted all other available crisis services. Crisis teams are unique in providing partnerships, assessments, training and support to individuals experiencing crisis and who are at risk of having to move from their own or family home, or from an out-of-home placement to a more restrictive setting. Mobile crisis teams' services are available for deployment 24-hours a day, 7 days a week after individualized assessments are completed. Participants have the choice of either a state-operated or vendor operated crisis team.

B) Crisis Support – If relocation becomes necessary, emergency housing in the person's home community is available. Crisis Support provides a safe, stable highly structured environment by combining concentrated, highly skilled staffing (e.g. psychiatric technicians, certified behavior analysts) and intensive behavior modification programs. Conditions that would qualify an individual for crisis support include aggression to others, self-injurious behavior, property destruction, or other pervasive behavior issues that have precluded effective treatment in the current living arrangement.

While the location and intensity of the components of this service vary based on the individual's needs, all components of behavioral intervention services include use and development of intensive behavioral intervention (see #1 below) programs to improve the recipient's development; and behavior tracking and analysis. This service can be provided via all forms of telehealth or other forms of remote service delivery as agreed upon by the consumer and provider. The intervention programs will be restricted to generally accepted, evidence-based, positive approaches. Behavioral intervention services are designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. Services may be provided to family members if they are for the benefit of the recipient. Services for family members may include training and instruction about treatment regimens and risk management strategies to enable the family to support the recipient.

The participation of parent(s) of minor children is critical to the success of a behavioral intervention plan. The person-centered planning team determines the extent of participation necessary to meet the individual's needs. "Participation" includes the following meanings: Completion of group instruction on the basics of behavior intervention; Implementation of intervention strategies, according to the intervention plan; If needed, collection of data on behavioral strategies and submission of that data to the provider for incorporation into progress reports; Participation in any needed clinical meetings; provision of suggested nominal behavior modification materials or community involvement if a reward system is used. If the absence of sufficient participation prevents successful implementation of the behavioral plan, other services will be provided to meet the individual's identified needs.

(1) "Intensive behavioral intervention" means any form of applied behavioral analysis (ABA) based treatment (see #2 below) that is comprehensive, designed to address all domains of functioning, and provided in multiple settings, depending on the individual's needs and progress. Interventions can be delivered in a one-to-one ratio or small group format, as appropriate.

The above described services are not available under a program funded under section 110 of the Rehabilitation Act of 1973 (29 USC Section 730) or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 USC 1401(16 and 17)).

The reimbursement for Supported Employment (Individual Services) includes incentive payments for measurable milestones identified below:

1. A one-time payment made to a provider when an individual obtains competitive integrated employment and is still employed after 30 consecutive days.
2. An additional one-time payment made to a provider when an individual obtains competitive integrated employment and is still employed after six consecutive months.
3. An additional one-time payment made to a provider when an individual has been employed consecutively for one year.

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or
2. Payments that are passed through to users of supported employment services.

This service can be provided via all forms of telehealth or other forms of remote service delivery as agreed upon by the consumer and provider.

Additional needs-based criteria for receiving the service, if applicable (*specify*):

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

<input type="checkbox"/>	Categorically needy (<i>specify limits</i>):
<input type="checkbox"/>	Medically needy (<i>specify limits</i>):

Provider Qualifications (*For each type of provider. Copy rows as needed*):

Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Supported Employment Programs	No state licensing category.	Programs must initially meet the Department of Rehabilitation Program certification	N/A

	Federal/State Tax Exempt Letter. As appropriate, a business license as required by the local jurisdiction where the business is located.	standards and be accredited by CARF within four years of providing services pursuant to Title 17 § 58810(f)(1)(2).	
Individual	No state licensing category. Federal/State Tax Exempt Letter. As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Providers of supported employment shall be an adult who possesses the skill, training, and experience necessary to provide services in accordance with the individual program plan.
Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):			
Provider Type (Specify):	Entity Responsible for Verification (Specify):		Frequency of Verification (Specify):
Supported Employment Programs	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.		Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.
Supported Employment Programs	Commission on Accreditation of Rehabilitation Facilities (CARF)		Within four years at start-up; every one-to-three years thereafter
Service Delivery Method. (Check each that applies):			
<input checked="" type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/>	Provider managed

Services are intended to develop and teach the following general skills that lead to competitive and integrated employment: the ability to communicate effectively with supervisors, co-workers and customers; generally accepted community work place conduct and dress; ability to follow directions; ability to attend to asks; work place problem solving skills and strategies; general work place safety and mobility training. Additionally, both work adjustment and supportive habilitation services as defined in Title 17 CCR § 58820 (c)(2), should allow for the development of productive skills, physical and psychomotor skills, interpersonal and communicative skills, health and hygiene maintenance, personal safety practices, self-advocacy training, and other skills aimed at maintaining a job and as outlined in the individual’s person-centered services and supports plan. Individuals may be compensated based upon their performance and upon prevailing wage. However, compensation is not the sole purpose of participation in this service.

Prevocational services are designed to prepare individuals in non-job-task-specific strengths and skills that contribute towards obtaining a competitive and integrated employment, as opposed to vocational services whose sole purpose is to provide employment without habilitation goals geared towards skill building.

Transportation services are not included under Prevocational Services.

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or payments that are passed through to users of supported employment services.

The above-described services are not available under a program funded under section 110 of the Rehabilitation Act of 1973 (29 USC Section 730) or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 (16 and 17)).

This service can be provided via all forms of telehealth or other forms of remote service delivery as agreed upon by the consumer and provider.

Additional needs-based criteria for receiving the service, if applicable (*specify*):

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

<input type="checkbox"/>	Categorically needy (<i>specify limits</i>):
<input type="checkbox"/>	Medically needy (<i>specify limits</i>):

Provider Qualifications (*For each type of provider. Copy rows as needed*):

	the local jurisdiction for the adaptations to be completed.	of Automotive Repairs.	
Verification of Provider Qualifications <i>(For each provider type listed above. Copy rows as needed):</i>			
Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>		Frequency of Verification <i>(Specify):</i>
Vehicle Modification and Adaptation	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.		Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.
Service Delivery Method. <i>(Check each that applies):</i>			
<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/>	Provider managed
Service Specifications <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):</i>			
Service Title:	Speech, Hearing and Language Services		
Service Definition (Scope):			
<p>Speech, Hearing and Language services are defined in Title 22, California Code of Regulations, Sections 51096, 51098, and 51094.1 as speech pathology, audiological services, and hearing aids, respectively. Speech pathology services mean services for the purpose of identification, measurement and correction or modification of speech, voice or language disorders and conditions, and counseling related to such disorders and conditions. Audiological services means services for the measurement, appraisal, identification and counseling related to hearing and disorders of hearing; the modification of communicative disorders resulting from hearing loss affecting speech, language and auditory behavior; and the recommendation and evaluation of hearing aids. Hearing aid means any aid prescribed for the purpose of aiding or compensating for impaired human hearing loss.</p> <p>These services will be provided to individuals age 21 and older as described in the approved Medicaid State plan for individuals under the age of 21. The provider qualifications listed in the plan will apply and are hereby incorporated into this request by reference. 1915(i) HCBS SPA Speech, Hearing and Language services will not supplant services available through the approved Medicaid State plan or the EPSDT benefit.</p> <p>This service can be provided via all forms of telehealth or other forms of remote service delivery as agreed upon by the consumer and provider.</p>			
Additional needs-based criteria for receiving the service, if applicable <i>(specify):</i>			

	applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	through oversight and monitoring activities.
Dispensing Optician	Medical Board of California	Biennially
Service Delivery Method. <i>(Check each that applies):</i>		
<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/> Provider managed

Service Specifications <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):</i>			
Service Title:	Psychology Services		
Service Definition (Scope):			
<p>Psychology Services are defined in Title 22, California Code of Regulations, Section 51099 as the services of a person trained in the assessment, treatment, prevention, and amelioration of emotional and mental health disorders.</p> <p>These services will be provided to individuals age 21 and older as described in the approved Medicaid State plan for individuals under the age of 21. The provider qualifications listed in the plan will apply and are hereby incorporated into this request by reference. 1915(i) HCBS SPA Psychology Services will not supplant services available through the approved Medicaid State plan or the EPSDT benefit.</p> <p>This service can be provided via all forms of telehealth or other forms of remote service delivery as agreed upon by the consumer and provider.</p>			
Additional needs-based criteria for receiving the service, if applicable <i>(specify):</i>			
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.			
<i>(Choose each that applies):</i>			
<input type="checkbox"/>	Categorically needy <i>(specify limits):</i>		
<input type="checkbox"/>	Medically needy <i>(specify limits):</i>		
Provider Qualifications <i>(For each type of provider. Copy rows as needed):</i>			
Provider Type <i>(Specify):</i>	License <i>(Specify):</i>	Certification <i>(Specify):</i>	Other Standard <i>(Specify):</i>

<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed
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Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: **Communication Aides**

Service Definition (Scope):

Communication aides are those human services necessary to facilitate and assist persons with hearing, speech, or vision impairment to be able to effectively communicate with service providers, family, friends, co-workers, and the general public. The following are allowable communication aides, as specified in the recipient’s plan of care:

1. Facilitators;
2. Interpreters and interpreter services; and
3. Translators and translator services.

Communication aide services include evaluation for communication aides and training in the use of communication aides.

This service can be provided via all forms of telehealth or other forms of remote service delivery as agreed upon by the consumer and provider.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

Categorically needy *(specify limits):*

Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed):*

Provider Type <i>(Specify):</i>	License <i>(Specify):</i>	Certification <i>(Specify):</i>	Other Standard <i>(Specify):</i>
Facilitators	No state licensing category. An appropriate business license as required by the local	N/A	Qualifications and training as appropriate.

<p>8. Providing the individual with continuous training in being a good tenant and lease compliance, including ongoing support with activities related to household management. Housing Access Services do not include payment for room and board. Persons receiving Health Homes or California Community Transitions services will not receive this service unless additional Housing Access through the 1915i is necessary to maintain the consumers' health, safety and wellbeing in the home and/or community. This service can be provided via all forms of telehealth or other forms of remote service delivery as agreed upon by the consumer and provider.</p>			
<p>Additional needs-based criteria for receiving the service, if applicable (<i>specify</i>):</p>			
<p>Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. (Choose each that applies):</p>			
<input type="checkbox"/>	Categorically needy (<i>specify limits</i>):		
<input type="checkbox"/>	Medically needy (<i>specify limits</i>):		
Provider Qualifications (<i>For each type of provider. Copy rows as needed</i>):			
Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Individual/ Business entity	As appropriate, a business license as required by the local jurisdiction where the business is located	N/A	N/A
Business entity	As appropriate, a business license as required by the local jurisdiction where the business is located	N/A	N/A
Verification of Provider Qualifications (<i>For each provider type listed above. Copy rows as needed</i>):			
Provider Type (<i>Specify</i>):	Entity Responsible for Verification (<i>Specify</i>):	Frequency of Verification (<i>Specify</i>):	
Individual	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential,	Verified upon application for vendorization and biennially thereafter.	

Service Specifications (<i>Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover</i>):			
Service Title:		Occupational Therapy	
Service Definition (Scope):			
<p>Occupational Therapy services are defined in Title 22, California Code of Regulations, Sections 51085, and 51309 as services designed to restore or improve a person’s ability to undertake activities of daily living when those skills are impaired by developmental or psychosocial disabilities, physical illness or advanced age. Occupational therapy includes evaluation, treatment planning, treatment, instruction and consultative services.</p> <p>All medically necessary occupational therapy services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. Occupational therapy in this 1915i is only provided to individuals age 21 and over and only when the limits of occupational therapy services furnished under the approved state plan are exhausted. Occupational therapy services in the approved state plan are limited to a maximum of two services in any one calendar month or any combination of two services per month from the following services: audiology, acupuncture, chiropractic, psychology, podiatry, and speech therapy or the amount determined medically necessary.</p> <p>This service can be provided via all forms of telehealth or other forms of remote service delivery as agreed upon by the consumer and provider.</p>			
Additional needs-based criteria for receiving the service, if applicable (<i>specify</i>):			
<p>Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.</p> <p>(Choose each that applies):</p>			
<input type="checkbox"/>	Categorically needy (<i>specify limits</i>):		
<input type="checkbox"/>	Medically needy (<i>specify limits</i>):		
Provider Qualifications (<i>For each type of provider. Copy rows as needed</i>):			
Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Occupational Therapist (Individual/Agency)	Occupational Therapist: Licensed Occupational Therapist by the California Board of Occupational Therapy pursuant to Business and		

Service Specifications <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):</i>			
Service Title:	Physical Therapy		
Service Definition (Scope):			
<p>Physical Therapy services are defined in Title 22, California Code of Regulations, Sections 51081, and 51309 as services of any bodily condition by the use of physical, chemical, and or other properties of heat, light, water, electricity or sound, and by massage and active, resistive or passive exercise. Physical therapy includes evaluation, treatment planning, treatment, instruction, consultative services, and application of topical medications.</p> <p>All medically necessary physical therapy services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. Physical therapy in this state plan amendment is only provided to individuals age 21 and over and only when the limits of physical therapy services furnished under the approved state plan are exhausted. Physical therapy services in the approved state plan are limited to six-month treatments and may be renewed if determined medically necessary.</p> <p>This service can be provided via all forms of telehealth or other forms of remote service delivery as agreed upon by the consumer and provider.</p>			
Additional needs-based criteria for receiving the service, if applicable <i>(specify):</i>			
<p>Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.</p> <p><i>(Choose each that applies):</i></p>			
<input type="checkbox"/>	Categorically needy <i>(specify limits):</i>		
<input type="checkbox"/>	Medically needy <i>(specify limits):</i>		
Provider Qualifications <i>(For each type of provider. Copy rows as needed):</i>			
Provider Type <i>(Specify):</i>	License <i>(Specify):</i>	Certification <i>(Specify):</i>	Other Standard <i>(Specify):</i>
Physical Therapist (Individual/Agency)	Physical Therapist: Licensed Physical Therapist by the Physical Therapy Board of California pursuant to Business and Professions Code §§2635-2639.1		

Service Specifications (Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):			
Service Title:	Self-Directed Support Services		
<p>Service Definition (Scope): This service guides and assists the individual and/or the participant’s family or representative, as appropriate, in arranging for, directing, and managing their services. With planning team oversight, providers assist the participant or family in identifying immediate and long-term needs, developing options to meet those needs, and accessing identified supports and services. Practical skills training is offered to enable families and participants to independently direct and manage waiver services. In addition, this service provides training on managing an annual budget for service expenditures.</p> <p>This service is available to consumers who have identified an interest in self-directing some or all their services. Assistance provided to participants and/or their families consists of guidance and advisement in ensuring a thorough understanding of responsibilities involved with self-direction of services, to make informed planning decisions about services and supports through the person-centered planning process, development of their initial budget and spending plan, and appropriate practices of hiring, managing, and communicating with staff. The extent of the assistance furnished to the participant or family is specified in the Individual Program Plan (IPP). This service does not duplicate, replace, or supplant other waiver services, including case management.</p>			
Additional needs-based criteria for receiving the service, if applicable (specify):			
<p>Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.</p> <p><i>(Choose each that applies):</i></p> <p>This service is limited to 40 hours. Additional hours must be reviewed by the Department and may be authorized if deemed necessary to meet the needs of the consumer.</p>			
Provider Qualifications (For each type of provider. Copy rows as needed):			
Provider Type (Specify):	License (Specify):	Certification (Specify):	Other Standard (Specify):
Agency	An appropriate business license as required by the local jurisdiction for the adaptations to be completed.	Completion of a training course about the principles of participant-directed services.	

Individual	An appropriate business license as required by the local jurisdiction for the adaptations to be completed.	Completion of a training course about the principles of participant-directed services.	
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Verification of Provider Qualifications *(For each provider type listed above. Copy rows as needed):*

Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>	Frequency of Verification <i>(Specify):</i>
Business entity	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	Verified upon application for vendorization and biennially thereafter.

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: **Technology Services**

Service Definition (Scope):

This service is intended to provide technology and/or equipment, in addition to the training and coordination of the use of such technology to assist consumers in accessing services remotely. This service does not duplicate any service currently available under the state plan. Technology is an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that will be used for the purposes of accessing the remote provision of services, in accordance with HIPAA requirements while ensuring health and welfare. Specific equipment includes computer monitors or electronic device that streams video, video cameras for use in video conferencing and intermittent remote check-in/monitoring of consumers in the home when in-person support is not possible, cell phone, tablet, and other similar handheld device used for communication such as augmentative and alternative communication (AAC) devices, software cost, maintenance, and installation needed for the use of AAC, microphones, speakers, headphones, hardware and/or tool(s) for the purpose of facilitating communication with a provider and to make possible the use of the equipment. Installation, removal, re-installation, maintenance and repair of technology is provided by this service. Allowable assistive technology services also include the evaluation of technology needs of a participant and the training or technical assistance for the participant, or where appropriate their family members or service providers to support the provision of remote services if determined beneficial for the participant, services for family members may include training and instruction about utilizing assistive technology to enable the family to support the recipient. The person-centered planning team determines the extent of participation

necessary to meet the individual’s needs.			
Additional needs-based criteria for receiving the service, if applicable <i>(specify)</i> :			
Specify limits (if any) on the amount, duration, or scope of this service.			
Limited to the least cost alternative that can meet the need of the consumer. Annual limit of \$5,000 with the option to exceed upon department authorization if deemed necessary to meet the needs of the consumer.			
<i>(Choose each that applies):</i>			
Provider Qualifications <i>(For each type of provider. Copy rows as needed):</i>			
Provider Type <i>(Specify):</i>	License <i>(Specify):</i>	Certification <i>(Specify):</i>	Other Standard <i>(Specify):</i>
Individual	An appropriate business license as required by the local jurisdiction for the adaptations to be completed		
Business	An appropriate business license as required by the local jurisdiction for the adaptations to be completed		
Verification of Provider Qualifications <i>(For each provider type listed above. Copy rows as needed):</i>			
Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>	Frequency of Verification <i>(Specify):</i>	
Business entity	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration for the performance or operation of the service; the staff qualifications and duty statements; and service design.	Verified upon application for vendorization and biennially thereafter.	

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction. *(Select one):*

<input type="radio"/>	The state does not offer opportunity for participant-direction of State plan HCBS.
<input type="radio"/>	Every participant in State plan HCBS (or the participant’s representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
<input checked="" type="radio"/>	Participants in State plan HCBS (or the participant’s representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. <i>(Specify criteria):</i> Participants who receive respite, financial management services, community-based training services, family support services, skilled nursing or non-medical transportation have the opportunity to direct those services.

2. Description of Participant-Direction. *(Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

In support of personal control over supports and services, self-direction is an option that enables participants to procure their own services. Self-direction of services empowers participants and families by giving them direct control over how and when the services are provided. As an alternative to only receiving services from regional center vendors, families and consumers will have decision-making authority and the freedom to directly control who provides their services and how they are provided.

For those participants who receive Enhanced Habilitation supported employment- Individual Services, habilitation day service, respite, financial management services, family support services, skilled nursing, non-medical transportation, and/or community-based training services identified as a need in their IPP, the opportunity to self-direct those services will be offered at the time of the IPP development. As required by Title 17, CCR section 58886, when the decision to self-direct services is made, the regional center is required to provide the consumer/family member with information regarding their responsibilities and functions, as either an employer or co-employer.

For those selecting to self-direct the indicated services, a Financial Management Service (FMS) provider, vendored by the regional center, will perform selected administrative functions such as payroll, taxes, unemployment insurance, etc. This relieves the participant of the burden of these administrative functions while still having the freedom to exercise decision making authority over

3. Limited Implementation of Participant-Direction. *(Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to state wideness requirements. Select one):*

<input checked="" type="radio"/>	Participant direction is available in all geographic areas in which State plan HCBS are available.
<input type="radio"/>	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-

	<p>directed service delivery options offered by the state, or may choose instead to receive comparable services through the benefit’s standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. <i>(Specify the areas of the state affected by this option):</i></p>

4. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
Respite	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Community-Based Training Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Skilled Nursing	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Non-Medical Transportation	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family Support Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Financial Management Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Enhanced Habilitation - Supported employment – Individual Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Habilitation – Day Service	<input checked="" type="checkbox"/>	<input type="checkbox"/>

5. Financial Management. *(Select one):*

<input type="radio"/>	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
<input checked="" type="radio"/>	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. Participant–Directed Person-Centered Service Plan. *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:

- Specifies the State plan HCBS that the individual will be responsible for directing;
- Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
- Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
- Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.

7. Voluntary and Involuntary Termination of Participant-Direction. *(Describe how the state facilitates an individual’s transition from participant-direction, and specify any circumstances when transition is involuntary):*

TN: 22-0048

Supersedes: 21-0002

Approved:

Effective: November 1, 2022

competitive integrated employment and is still employed after six consecutive months. 3) An additional one-time payment of \$3,000 made to a provider when an individual has been employed consecutively for one year.

Effective July 1, 2021, incentive payments will be paid for internship programs, which are job-readiness programs in integrated settings for the purposes of developing general strengths and skills that contribute to employability in paid employment in integrated community settings.

The incentive payments will be applied as follows:

- 1) A payment of seven hundred fifty dollars (\$750) shall be made to the regional center service provider if the individual remains in the internship after 30 consecutive days.
- 2) An additional payment of one thousand dollars (\$1,000) shall be made to the regional center provider for an individual as described above who remains in the internship for 60 consecutive days.

REIMBURSEMENT METHODOLOGY FOR TECHNOLOGY SERVICES

The rates for contractors providing this service are determined utilizing the Usual and Customary rate methodology as described on page 71, above.

REIMBURSEMENT METHODOLOGY FOR SELF-DIRECTED SUPPORT SERVICES

The rate for self-directed support services uses a fee-schedule. The rate schedule, in effect as of October 1, 2022, can be found at the following link.

https://www.dds.ca.gov/wp-content/uploads/2022/03/Self_Directed_Support_Services_Rates.pdf