NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

ADMINISTRATIVE DIRECTIVE MEMORANDUM

Transmittal:	ADM-2022-02**R**
To:	Executive Directors of Voluntary Provider Agencies Developmental Disabilities Regional Office Directors Developmental Disabilities State Operations Office Directors Care Coordination Organizations/Health Homes (CCO/HHs)
Issuing OPWDD Office:	Division of Program Implementation
Date:	March 10, 2022 **Revised, June 27, 2022, effective date – July 1, 2022**
Subject:	Family Support Services (FSS) Reimbursement Guidelines
Suggested Distribution:	Executive Directors of Voluntary Provider Agencies Developmental Disabilities Regional Office Directors State Operations Office Directors Central Office Leadership Team Care Managers and Care Manager Supervisors
Contact:	FamilySupportServices@opwdd.ny.gov
Attachments:	A) Family Reimbursement Application B) Respite Verification Form C) Family Reimbursements Tracker D) Medicaid **and Non-Medicaid Services Chart** **E) Family Satisfaction Survey**

Related ADMs	Releases Cancelled	Regulatory Authority	MHL & Other Statutory Authority	Records Retention
None	None		MHL §§ 13.07; 13.09; 13.15; 13.17; 16.00; 16.03; 16.05; 16.13; 41.43	(10) years from the date the service was provided or when the service was billed, whichever is later.

Purpose

This Administrative Directive Memoranda (ADM) sets forth the requirements for the New York State Office for People with Developmental Disabilities' (OPWDD) Family Support Services (FSS) Family Reimbursement program. FSS reimbursement is available, subject to the requirements contained herein, to enhance a family's ability to provide in-home care to their family members with an intellectual or developmental disability. This ADM contains the eligibility requirements for FSS reimbursement, sets forth the roles and responsibilities of FSS provider agencies, individuals, and families, and outlines how to request and process FSS reimbursement.

This ADM has been revised, effective July 1, 2022, with changes bolded and underlined.

Background

FSS is available to families to enhance a family's ability to provide in-home care to their family members with an intellectual or developmental disability. FSS includes goods, services and subsidies, as determined appropriate by the family, FSS provider and OPWDD. **Family reimbursement through the FSS program is a resource for families who do not have access to other funding sources and as a limited state resource, is intended to be funded when other options are not available.**

Reimbursement through FSS may only be provided after families have sought funding through all other funding sources (e.g., private sources, early intervention or school services). FSS services are to be prioritized to support families of individuals who are not enrolled in the OPWDD HCBS Waiver.

Reimbursement through FSS is, pursuant to Section 41.43 of the NYS Mental Hygiene Law, provided to meet the goals of:

(i) providing a quality of life comparable, to the extent practicable, to that of similarly situated families without a family member having a developmental disability;
(ii) maintaining family unity;
(iii) preventing premature or inappropriate out-of-home placement;
(iv) reuniting families;
(v) enhancing parenting skills; and
(vi) maximizing the potential of the family member with a developmental disability.

When considering whether or not to provide reimbursement or services through the FSS program, FSS providers consider these statutory objectives in making their determinations.

As a state paid service, any goods or services must be cost effective meaning whenever a comparable item is available at a lesser cost, the lesser cost item must be purchased or utilized.

Discussion

A. Family Reimbursement

Family reimbursement through the FSS program is provided to help families by easing the expenses of providing care for family members with intellectual or developmental disabilities. For certain children, FSS may be the only service needed to support a child residing at home. Additionally, similar community and private services should be explored to support children residing at home. When an individual has Medicaid and is enrolled in HCBS Waiver the use of Family Support Services must not be duplicative. FSS goods and services must be:

1. Related to the individual's intellectual or developmental disability; and
2. Deemed appropriate and necessary to meet the needs of the individual by the FSS provider.

The family must provide the FSS provider with a justification that indicates a significant, definable, positive impact on the individual/family directly relating to health, safety and emotional well-being, normalization of life, accessibility to needed services, personal growth and/or development of the individual.

FSS cannot be used to supplement an individual's services funded through the HCBS Waiver. For example, if an individual is receiving camp waiver services, they cannot also receive FSS reimbursement to supplement the costs associated with camp.

B. Eligibility

To be eligible for consideration for FSS reimbursement, individuals must:

1. Have established eligibility for OPWDD services; and
2. Reside with one or more non-paid family member (i.e., biological, adoptive, or extended family or non-paid caregiver in the absence of biological, adoptive or extended family).

FSS providers must confirm and document an individual's eligibility for FSS before approving or providing reimbursements.

C. FSS Spending Cap

Individuals may apply for up to $3,000 of FSS reimbursement per contract year (for those not in receipt of the benefit through their Self-Direction Budget). Contract years run from:

- July 1st – June 30th for New York City (Region 4); and
- January 1st – December 31st for the rest of the state.

Applications for reimbursement must be made during the contract year in which the item or service was purchased. Reimbursement will not be provided for items and services purchased in a previous or upcoming contract year. It is strongly encouraged that all reimbursement requests that occur towards the end of the contract year should be submitted within 90 days of the start of a new contract year. This timely submission will help support the processing of reimbursements within appropriate contract years.

In some cases, individuals who have been authorized for reimbursements during the contract year do not use all authorized reimbursements during the year. In these cases, unused authorized reimbursements cannot be carried over by a receiving family from one contract year to the next.

D. Application Process

1. Requesting Reimbursement

a. General Reimbursement

Reimbursement applications may be submitted by individuals, families, care managers, or advocates. The individual's life plan must also be submitted along with the reimbursement application in order to verify all services the individual is receiving to prevent duplication of services. For those that are enrolled in a Care Management Service (FSS) should be listed in Section V of the Life Plan. When applicable, care Managers must help individuals and families complete and submit applications. Applications must be submitted to the FSS provider in their district. In cases where FSS providers within the same district only provide certain services (e.g., family reimbursed respite vs. other goods and services), the DDRO does not need to give prior approval to the individual or family. If there are no FSS providers in the individual's district, or the providers in district cannot reimburse the individual due to lack of funds, the individual may seek written approval from the DDRO to apply to a different FSS provider for reimbursement. Individuals can receive services outside of their district of residence.

Incomplete or incorrect applications for reimbursement may be returned to be corrected, which could cause a delayed payment. Applications for reimbursement must be submitted no later than ninety (90) days after the purchase of goods or provision of services. Applications submitted more than ninety (90) days after the purchase of goods or provision of services will only be reimbursed at the discretion of FSS provider.

FSS reimbursement applications must include:

i. Completed application;
ii. Verification of OPWDD eligibility;
iii. Verification that the individual resides with a non-paid family member or non-paid caregiver;
iv. Receipts for the items/services to be reimbursed (*see* Section **M**);
v. Medicaid denial letters (for items that can be funded by Medicaid) (*see* attachment D);
vi. Additional documentation if requesting reimbursement for emergency items/services (*see* Section (e)(1)(b)), respite (*see* Section G), camp (*see* section H), electronic devices (*see* Section K) or medical/clinical devices or services (*see* section **N**); and
vii. Any other relevant information.

b. Emergency Reimbursement

Supports available through natural or community resources, and typically funded through other mechanisms, may be allowed on a short-term basis as a result of a crisis or because the individual or family is in great need of specialized assistance with appropriate supporting justification and

approval (e.g., subsidies for housing, utilities, or food, durable medical goods). Family Reimbursement is not intended to cover chronic, ongoing crisis situations.

Emergency reimbursements may be awarded once per lifetime per family for each type of emergency. Emergency requests must include all information as outlined in section (**D**)(1)(a) above. Additionally, emergency requests must include:

i. Documentation substantiating the need (e.g., eviction notice, letter of justification from Care Managers, verification of service by exterminator);
ii. Description of how the request addresses an immediate, **short-term** crisis that impacts the health and safety of the individual; and
iii. a plan to prevent reoccurrence of the crisis.

The application must also reflect emergency reimbursement need by indicating "yes" to the question in section five (5) of the application.

Please note, emergency request funding is separate from the $3,000 statewide cap for Family Reimbursement

Refer to section D2c for additional information regarding emergency reimbursement requests.

2. Requirements for FSS Provider Agencies

a. Family Reimbursement Committee

FSS providers must have a Family Reimbursement Committee (the "Committee") to review reimbursement requests. Committees must contain at least four (4) members, and must include:

i. Individual(s) with developmental disabilities; or
ii. Family members or advocates of individuals with developmental disabilities; and
iii. At least two (2) people not employed by the FSS provider agency.

b. Committee Application Review

The Committee must meet as needed to review applications. The Committee can only approve applications for reimbursements through FSS where the application establishes that the:

i. Individual has established eligibility for OPWDD services;
ii. Individual/family meets FSS eligibility criteria;
iii. Reimbursement request cannot be funded by any other funding mechanism;
iv. Reimbursement request does not exceed contractual limits and/or individual spending cap;
v. Requested item or service:
    a. Is related to the individual's intellectual or developmental disability;
    b. Supports a quality of life comparable, to the extent practicable, to that of similarly situated families without a family member having a developmental disability;
    c. Maximizes the potential of the individual; and
    d. Supports the individual to remain at home with their family.

c. Reimbursement Approval Process

Providers must submit a DDP1 to the DDRO for processing prior to releasing any reimbursement payments to families.

FSS providers must submit a Family Reimbursements Tracker (*see* attachment C) to the DDRO within seven (7) days of committee approvals of reimbursements. The tracker ensures, among other things, that individuals/families are not making requests for reimbursement from multiple agencies and that individuals are within their FSS spending cap. The DDRO may ask for additional information, as needed. FSS providers must not reimburse families until the DDRO has reviewed the tracker and verified that reimbursement is not, among other things, duplicative of other requests or in excess of the individual or family's spending cap.

When a FSS provider receives an emergency reimbursement request, they must contact the regional office immediately. The provider must submit the Family Reimbursements Tracker (see attachment C) and designate this as an emergency expenditure. The completed family reimbursement application must also be submitted.

d. FSS Provider Review

The FSS provider must document the committee's review of all applications. If the committee supports an FSS reimbursement, the provider must ensure that the request meets all FSS eligibility, reimbursement requirements, and FSS guidelines. Additional criteria must be reviewed for individuals who self-direct (*see* section Q pages).

3. Notification

Once the FSS provider approves or denies an application, they must give written notice to the individual/family and care manager. If an application is denied, the notice must include:

i. The reason for the denial (e.g., fails to meet eligibility criteria, improper documentation, FSS cap met); and
ii. Information about the reconsideration process (see below).

4. Reconsideration Process

FSS providers must develop reconsideration processes for individuals/families who would like their application to be reconsidered in the event that their application is denied, in whole or in part. The reconsideration processes must include:

i. Notification that the family or individual has fifteen (15) days from receipt of the FSS provider's written denial to request reconsideration of the denial;
ii. The opportunity for the family or individual to present additional documentation/justification to the FSS provider; and
iii. The opportunity for the family or individual to engage in informal dispute resolution with the provider to discuss concerns about the denial.

The FSS provider must give written notice to the individual/family and care manager about the result of the reconsideration process. If the FSS provider upholds the denial after the reconsideration process, the notice must state that the individual/advocate can appeal the

decision to the DDRO no later than seven (7) days from the receipt of the written notice. Contact information for the DDRO appeal must be included in the notice.

E. Prioritizing Applications

Applications for reimbursement must be prioritized based on need. FSS providers should prioritize applications as follows:

- Tier 1: Regardless of waiver status, requests for reimbursing costs related to an individual's immediate health and/or safety.
- Tier 2: Requests for reimbursements for individuals who are in the process of waiver enrollment, are enrolled in the waiver but currently unable to access waiver services, or who will not be enrolling in the waiver.
- Tier 3: Requests for reimbursements for individuals who are enrolled in the HCBS waiver.

Once the applications have been prioritized, the FSS provider must respond to all requests in Tier 1 before considering applications in Tier 2. Once all applications in Tier 2 have been considered and responded to, requests in Tier 3 can be considered. This tiered consideration is intended to prioritize individual/family requests based on greatest need.

F. Pre-Approval and Direct Purchasing

1. Pre-Approval

Pre-approval for specific items/services may be granted at the discretion of the FSS provider. If pre-approved, reimbursement will be provided once the purchase of the service/item is verified by the FSS provider and the receipt has been submitted by the applicant.

2. Direct Purchasing

In some instances, the individual/family may ask that the FSS provider pay the vendor directly for the goods or services ("direct purchasing"). In these cases, the family must submit an explanation with the request. This explanation should describe why the family cannot pay for the service or item first and receive reimbursement later. The FSS provider may consider the family's income, among other factors, in making its determination. Therefore, the family may be required to provide an attestation of household income and a bid/price sheet of the good or service being requested. This attestation must include household income from all sources, the number of people residing in the home and any other extraordinary financial obligations the individual/family is responsible for. Final decisions about direct purchasing are at the discretion of the FSS provider.

For any item that is reimbursed or paid to the vendor directly, the family/individual must maintain the item in their possession and use the item as originally intended in the application for the life of the item or an amount of time that is reasonable and appropriate under the circumstances. If the item is returned, sold, or is no longer in the family/individual's possession, the family must notify the FSS provider and make arrangements to reimburse the FSS provider for the cost of that

item. Non-compliance will jeopardize a family/individual's ability to receive future FSS direct purchasing.

G. FSS Reimbursement for Respite

Respite reimbursing is subject to the same rules outlined in section C.

When an individual/family applies for FSS reimbursement for respite, they must submit:

i. Respite verification form;
ii. Justification for any payments that are less than minimum wage; and
iii. All other required application documentation (see section D1a).

Respite reimbursement rates are capped at the rate set by New York State's Department of Health (DOH). Therefore, reimbursement cannot exceed DOH's respite hourly fee schedule. (For more information visit www.health.ny.gov).

Respite providers must be at least eighteen (18) years of age in order to provide respite.

H. FSS Reimbursement or Payment for Camp

Whenever possible, the FSS provider should pay the provider of camp services directly if the family is unable to cover the cost upfront. FSS providers must prioritize individuals not enrolled in the waiver or receiving waiver camp respite for camp reimbursement.

When an individual/family applies for FSS reimbursement for camp, they must submit:

i. Verification that the individual attended camp, if the FSS provider did not pay the provider of camp services directly; and
ii. The date of the invoice (not date of camp attendance).

In order for camp to be reimbursed through FSS, the camp must have a permit issued by the New York State Department of Health and/or Local Department of Health pursuant to Subpart 7 of the New York State Sanitary Code (*see* 10 NYCRR Subpart 7) **unless the camp is operated or certified by OPWDD.** FSS will not reimburse out of state camps.

I. Reimbursable Goods and Services

1. Reimbursable FSS Goods and Services

Goods and services that are reimbursable through the FSS program include, but are not limited to:

- Items/Services that are not covered or available through other means and are reviewed and approved by the committee;
- Respite;
- Camp;
- Recreation programs (other than camp);

- Electronic devices; (*see* section **J**, page **9** for more information)
- Supplements approved by a clinician and outlined in the individual's treatment plan;
- Legal fees related to guardianship and special needs trusts;
- Clothing as a necessity or if there are specific needs related to the intellectual/developmental disability (I/DD) (e.g., excessive chewing, destruction due to behavior or urination) as clinically indicated (i.e., included in the Life Plan or with other appropriate documentation requested by the DDRO); and
- Other items as deemed appropriate and reimbursable by the DDRO.

2. Non-reimbursable FSS Goods and Services

Goods and services that are **not** reimbursable through the FSS program include, but are not limited to:

- Real property (e.g., home or apartment related costs);
- Finance charges;
- Tax bills;
- Sales tax;
- Fines;
- Luxury items (e.g., swimming pools);
- Shipping fees;
- Vehicles (e.g., cars, motorcycles);
- Co-pays;
- Experimental treatments;
- CBD or marijuana products;
- Upgrades to items/services covered by HCBS Waiver or other sources, including self-direction budgets (e.g., upgrading fencing materials, additional funding for a higher cost camp);
- Items and services that an individual is eligible for in the context of their educational services (e.g., occupational therapy, physical therapy);
- Funeral expenses; and
- Other items deemed not appropriate for reimbursement by the DDRO.

3. Allowable One-Time Reimbursements

Some goods and services are allowed to be reimbursed through FSS reimbursement only once per the lifetime of the individual. These goods and services include:

- Rent, mortgage, and utilities payment (*see* section M, page 10 for more information);
- Rent arrears;
- Utility bills;
- Food;
- Pest control (*see* section M, page 10 for more information)
- Home maintenance; and
- Emergency respite.

J. Electronic Devices

Clinical justification is required for FSS reimbursement of electronic devices (e.g., laptop, tablet, GPS). The clinical justification must specify how the device will be used (i.e., applications or programs used and for what purpose) and how it relates to the individual's needs. Electronic devices required for a student's Free and Appropriate Public Education as required under the Individuals with Disabilities Education Act are not reimbursable and should be provided by the individual's school district.

The individual and/or their family must agree to purchase protective cases/covers and maintain warranty for the life of device. Individuals are limited to reimbursement of no more than one electronic device every three years.

K. Rent, Mortgage, and Utilities

In order to receive reimbursement, the individual or family cannot be more than 2 months behind on their utilities payment. For rental reimbursement, the individual must show documentation that they are at risk of eviction. (e.g., written notice by landlord). Additionally, there must be a plan to prevent reoccurrence of the payment issue.

L. Pest Control

When pests or bed bugs pose a health and safety hazard or prevent access to OPWDD services, remediation of such pests may be considered for reimbursement through the FSS program, at the discretion of the FSS provider. A relevant factor in determining whether pest control services are reimbursable is if the family is at risk of becoming homeless due to the infestation. Families are responsible for ensuring that all required precautions are in place before, during and after the extermination or remediation process.

M. Receipts

Families must submit receipts (photocopies and digital copies are acceptable) to the FSS provider for all items/services for which reimbursement is being sought. Receipts must include the date and name of the vendor (e.g., store, recreation program). Hand-written receipts must be signed by the vendor and verified by the provider.

N. Medical or Clinical Services or Supplies

Requests for medical or clinical services/supplies (e.g., diets, adaptive equipment) must include a current physician's order and/or clinical justification from an appropriate physician or clinician. Individualized Education Plans, Occupational, Physical or Speech-Language evaluation reports, or medical reports are not sufficient documentation. Requests for medical or clinical services must include documentation that the medical or clinical services will be provided by an appropriately licensed or certified practitioner.

O. Shared Items

Items to be shared by others in the household (e.g., toiletries, food) must directly relate to the needs of an individual with an intellectual or developmental disability and must be pro-rated based on the number of residents in the house.

P. Self-Direction

FSS reimbursement is available to individuals who are self-directing their services, provided they meet the eligibility requirements for FSS. The request and approval process for FSS reimbursement for individuals in the self-direction program follows the same process as all other FSS requests as outlined in this ADM. FSS reimbursement may be accessed while the individual is waiting for their Self-Direction budget to be approved.

The DDRO will verify that the FSS reimbursement, if appropriate, is included in the individual's current budget. Inclusion of funding in the budget does not guarantee that the request for reimbursement of any given service, good or item will be approved. Reimbursement requests (and approvals) must be consistent with the requirements set forth in this ADM.

1. Self-Direction Budget

Individuals who self-direct and are applying for FSS reimbursement must include FSS in their Self-Direction budget. Any FSS reimbursement is counted towards their total Personal Resource Account (PRA). Therefore, individuals who self-direct cannot receive FSS reimbursement outside of their Self-Direction budget.

Individuals who self-direct their services can be reimbursed via Individual Directed Goods and Services (IDGS), Other Than Personal Services (OTPS), or FSS. Individuals must seek to be reimbursed via IDGS first. If the goods/services cannot be funded under IDGS, the individual must then explore other funding mechanisms, such as OTPS and Family Reimbursed Respite (FRR), prior to requesting FSS reimbursement. For more information on IDGS, OTPS, and self-direction please view OPWDD's self-direction guidance available on opwdd.ny.gov.

Individuals can only request reimbursement through FSS if funding is not available via IDGS, OTPS, (FRR) or any other available funding mechanism. Including FSS reimbursement in a Self-Direction budget does not guarantee the reimbursement will be received. Approval is still required by the FSS Provider as described above.

2. Unused FSS Funds in a Self-Direction Budget

In circumstances where an individual's self-direction budget includes FSS funding and the individual cannot utilize that FSS funding as planned, the individual can amend their budget to change the unused allotted FSS funding toward another service so long as it does not exceed their Personal Resource Account.

Q. FSS Provider Oversight of FSS Reimbursement

FSS providers must ensure that the reimbursed goods and services are necessary and appropriate for the individual/family. These reimbursed goods and services must be substantiated with appropriate documentation. Therefore, FSS providers must establish a system for monitoring and verifying receipt of goods and services by the requesting party. FSS providers must investigate any suspected fraud or misuse of FSS reimbursement.

If the FSS provider is notified about or suspects potential fraud or misuse of FSS reimbursement, they must notify the DDRO within seven (7) days of discovering the potentially fraudulent activity. The FSS provider must conduct an investigation to determine whether or not fraud or misuse was attempted or took place. The entity to which that reimbursement application was submitted must be notified (if not the discovering entity). A report must be completed by the FSS provider and provided to the DDRO no later than seven (7) days from the completion of the investigation.

If the investigated activity is determined by the FSS provider to be fraudulent or if the FSS provider confirms that there was misuse of FSS reimbursement, the individual/family must repay the FSS provider the amount they were reimbursed, and the individual/family will be suspended from receiving any future FSS reimbursement. The individual/family may appeal the FSS provider's determination to the DDRO by submitting a letter to the DDRO Director.

The FSS provider must give written notice to the individual/family and care manager if the FSS provider concludes that fraudulent activity or misuse of FSS reimbursement occurred, with a copy sent to the DDRO. This notice must include:

i. A description of the allegedly fraudulent activity or misuse;
ii. The results of the provider's investigation;
iii. The amount of money that must be repaid to the FSS provider;
iv. Acknowledging the individual/family is suspended from future FSS reimbursement; and
v. Information about when and how to appeal the results of the provider's investigation an suspension of FSS reimbursement to the DDRO.

RECORDS RETENTION

These records must be contemporaneous and kept for ten (10) years from the date the service was provided or when the service was billed, whichever is later.