

July 25, 2007

Dear State SLS participants and families,

Over the past year I have been advising recipients of Medicaid Supported Living Services (SLS-Waiver) on changes to the SLS-Waiver program. Prior informational letters are available for your review on our website, [www.developmentalpathways.org](http://www.developmentalpathways.org), under the “Services” menu, “Supported Living Services” category.

**This letter focuses on 2 recent clarifications from the Division for Developmental Disabilities (DDD) that may impact individuals enrolled in State SLS.**

If you or your family member enrolled in State SLS receive Medicaid benefits, both clarifications will apply to you/your enrolled family member.

If you or your family member enrolled in State SLS do not receive Medicaid benefits, the camp clarification applies at this time, but please review the entire letter as important information is included about professional recommendation requirements for State SLS recipients. The clarifications relate to: (1) recommendations for equipment, modifications, and alternative therapies; and (2) funding of camps with SLS funds.

**Recommendations for Equipment; Modifications and Alternative Therapies**

1. Alternative therapies or professional services/treatments that cannot be billed directly to Medicaid or other Insurance must be recommended by licensed Medicaid approved Physicians/Therapists (OT, PT, Speech)/Psychiatrists.
2. Alternative therapies or professional services/treatments must be related to an identified behavioral or medical need. The recommending Physician/Therapist must identify a goal for the treatment and be willing to monitor the progress towards the goal. The progress must be documented and submitted to the CCB on a regular basis, more frequently than annually.
3. Assistive technology items and/or home modifications of any type that cannot be billed directly to Medicaid or other Insurance must be recommended by a licensed Medicaid approved Physician/Therapist, including the justification for and expected use/outcome of the item/modification. Assistive technology or modifications must genuinely relate to the individual’s disability, and be adaptive in nature; not typical needs.

If you are not receiving Medicaid benefits at this time, the same basic requirements apply. The only difference is that Licensed Therapists/Physicians do not have to be Medicaid-approved.

If you are receiving Medicaid benefits, it remains your choice to utilize Licensed, non-Medicaid approved Physicians/Therapists, but recommendations and treatment plans from them will not meet the requirements and the services and supports they recommend will not be funded with SLS funds.

We recognize that it can be difficult at times to find available Physicians/Therapists, including those that are Medicaid-approved, and that it may take more time to ensure the required structure is in place (recommendation, goal, frequency of progress reports established, etc.) prior to approving these services.

It is important to work closely with your SLC to navigate through this process to insure you can receive the appropriate benefits of the program. We continue to require verification of professional licensing for providers of alternative therapies/professional services for both State and Medicaid SLS programs, and services must address identified needs on the Annual Individual Plan/IP Coversheet. If you receive Medicaid benefits, some items/services may require a Medicaid denial and subsequent denied appeal prior to approval of Waiver funding. Again, please work closely with your coordinator.

You can help by communicating the importance of these recommendations and the expansion of the goal and monitoring requirements to your/your family member's Physician/Therapist(s). We continue to work on ways to structure recommendations for these items and services, and will be focusing on ways to help the Licensed Physicians/Therapists provide the reports needed.

#### Funding of Camps with SLS funds

In order for CES/SLS funds to be used to pay for an overnight camp setting an individual's Annual Service Plan needs to indicate the need for 20-24 hours daily of on-site (home or community) supervision.

Individuals who do not need that level of supervision in their own home or community will not qualify for this level of supervision in any paid setting, including "camps". Supervision still may be a service noted in the Annual Plan to allow the primary caregiver(s) a break, but the level of supervision needed and described on the plan is what SLS funds may pay for, ranging from a daily check-in to full 24-7 supports. The setting must still be cost-effective within the realm of supervision services available.

In addition, SLS funds can only fund the supervision of the individual in services, not lodging or additional supports provided by parents or other family members.

We realize this clarification may be at odds with some past practice.

Please contact your SLC with your questions. We appreciate your continued cooperation during sometimes confusing and frustrating changes and are committed to navigate through them together as your needed services and supports continue.

Sincerely,

Shilo Carson  
Director, Supported Living Services

Cc: Bob Ward  
Director, Client and Family Relations