LAKELAND CARE
Together, we build better lives.

Service Addendum: Community Based Residential Facility

The provision of contracted, authorized, and provided services shall be in compliance with the provisions of this agreement, the service description and requirements of this section and, if applicable, state certification and licensing criteria.

Section 1. Service Definition and Description

Residential Services are a combination of treatment, support, supervision, or care above the level of room and board provided to members residing in a community-integrated residential setting that meets HCBS settings requirements and includes 24-hour on-site response capability to meet scheduled or unpredictable member needs.

Services assist the member to reside in the most integrated setting appropriate to their needs and typically include supportive home care, personal care, and supervision. Services may also include social and recreational programming, daily living skills training, medication administration, intermittent skilled nursing services, and transportation.

Residential services also include coordination with other services and providers, including health care, vocational, or day services. Services may also include the provision of other waiver services as specified in the contract between the provider and Lakeland Care, Inc. (LCI).

Waiver funds may not be used to pay for the cost of room and board, items of comfort or convenience, or costs associated with building maintenance, upkeep, and improvement. Residential care services may be authorized only:

a) When a member's long-term care outcomes cannot be cost effectively supported in the member's home
b) When a member's health and safety cannot be adequately safe guarded in the member's home
c) When residential care services are a cost-effective option for meeting the member's long-term care needs

Community Based Residential Facilities (CBRF): are residences where five (5) or more adults not related to the operator or administrator of the facility, reside, and receive care, treatment, support, supervision, and training. An individual with an intellectual disability may only reside in a CBRF that is licensed for eight (8) or fewer residents, unless that person has been determined to require No Active Treatment (NAT) for the person's intellectual disability. Services may include supportive home care, personal care, supervision, behavior and social supports, daily living skills training, transportation and up to three hours per week of nursing care per resident. Waiver funds may not be used to pay for the cost of room and board. A licensed CBRF must comply with Wis. Admin. Code Ch. DHS 83 and must be HCBS compliant per 42 CFR 441.301.

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LCI follows the standards, guidelines, and descriptions for CBRF outlined within the Wisconsin DHS Family Care Contract, and Wisconsin Administrative Code DHS Chapter 83. Providers are subject to the same qualifications as providers under the Medicaid State Plan as defined in Wisconsin State Statute 1915 (c) Home and Community-Based Waiver services waivers #0367.90 and #0368.90 required under § 46.281 (1) (c). A licensed CBRF must comply with Wis. Admin. Code Ch. DHS 83.

Scope of Services: A contract for CBRF services with LCI incorporates, but is not limited to, the services and supports listed below.

Physical Environment:

a) Physical Space: sleeping accommodations in compliance with facility regulations including access to all areas of facility and grounds, individual lockable entrance and exit, kitchen including stove, individual bathroom, and living area.
    i. CBRF shall be physically accessible to all individuals residing there. Residents should be able to enter, exit and move about the CBRF to access their bedroom, bathroom, common space, dining area, and kitchen without difficulty.
b) Furnishings: all common area and bedroom furnishings including all of the following: bed, mattress with pad, pillows, bedspread, blankets, sheets, pillowcases, towels and washcloths, window coverings, floor coverings.
c) Equipment: all equipment that becomes a permanent fixture of the facility. This includes transfer devices (lifts, gait belts, etc.), grab bars, ramps and other accessibility modifications, alarms, or other shared equipment.
d) Housekeeping Services: including laundry services, household cleaning supplies, and bathroom toilet paper and paper towels.
e) Routine Housekeeping and Sanitation: a clean and sanitary environment in all areas, including member living spaces. This includes the prompt and appropriate cleanup of bodily fluids (e.g., urine, feces, vomit, blood) in accordance with infection control protocols. Providers must ensure that staff are trained and equipped to manage such incidents safely and in compliance with applicable health and safety regulations.
f) Building Maintenance: including interior and exterior structure integrity and upkeep, pest control, and garbage and refuse disposal.
g) Grounds Maintenance: including lawn, shrub, and plant maintenance, snow and ice removal.
h) Environmental Modifications: carpet pads, wall protectors, baseboard protectors, Lexan coverings, magnetic locks, etc.
i) Building Support Systems: including heating, cooling, air purifier, water, and electrical systems installation, maintenance, and utilization costs.
j) Fire and Safety Systems: including installation, inspection, and maintenance costs.

k) Nutrition: three meals plus snacks, including any special dietary accommodation, supplements, and thickeners and consideration for individual preferences, cultural or religious customs of the individual resident.
    i. Enteral feedings (tube feedings) are excluded from this requirement and are the responsibility of LCI. Providers cannot accept payment for board when members are receiving all nutrition via enteral feedings (tube feedings).
l) Telephone and Media Access: access to make and receive calls and acquisition of information and news (e.g., television, newspaper, internet).

Program Services:

a) Supervision: adequate qualified staff to meet the scheduled and unscheduled needs of members.
b) Personal Care, Assistance with Activities of Daily Living and Daily Living Skills Training.
c) Community Integration: planning activities and services with the members to accommodate individual needs and preferences. Providing opportunities for participation in cultural, religious, political, social, and intellectual activities within the home and community. Members may not be compelled to participate in these activities. Providers shall allow members to participate in all activities that the member selects and is capable of learning unless the member's Individual Service Plan (ISP) indicates otherwise.
d) HCBS Compliance: CBRF providers must maintain compliance with the HCBS settings rule. The settings rule is intended to ensure that people who receive services through Medicaid HCBS waiver programs will have access to the benefits of community living and will be able to receive services in the most integrated settings.
e) Health Monitoring: including coordination of medical appointments, accompanying, and transporting members to medical services when necessary.
f) Medication Management: including managing or administering medications and the cost associated with delivery, storage, packaging, documenting and regimen review. (the cost of bubble packaging, pre-drawn syringes, etc. are a Medicaid and/or Medicare Part D benefit and are not billable to members nor are they a cost that can be incurred by other funding sources, including LCI).
g) Behavior Management: including participation with LCI in the development and implementation of Behavioral Support Plans and Behavioral Intervention Plans.
h) Facility Supplies and Equipment: including first aid supplies, gauze pads, blood pressure cuffs, stethoscopes, oxygen monitors, thermometers, cotton balls, medication and specimen cups, gait belts, etc.
i) Personal Protective Equipment for staff use includes gloves, gowns, masks, etc.
j) OSHA and Infection Control Systems: including hazardous material bags, sharps disposal containers, disposable and/or reusable washcloths, wipes, bed pads, air quality - free of unpleasant odors and secondhand smoke etc.

k) Resident Funds Management: assistance with personal spending funds, not including representative payee services.
l) Transportation: The Provider is responsible for delivering all standard and routine transportation services for the Member, as outlined in their Member-Centered Plan. These services include, but are not limited to, transportation to:
    I. Medical appointments
    II. Social and recreational activities
    III. Religious services
    IV. Day services, prevocational training, and employment

    For Members enrolled with LCI who reside in Community-Based Residential Facilities (CBRFs) **with more than eight beds** or in Residential Care Apartment Complexes (RCACs), transportation to and from two scheduled and prior-authorized destinations per month is excluded from the standard care and supervision rate. Whenever feasible and appropriate for the member's needs, the provider should coordinate transportation with the member's natural support(s) and, if applicable, Medicare Part C benefits**. Transportation for two (2) scheduled trips may be funded by Lakeland Care** when other options have been explored. Prior authorization from Lakeland Care is required.

    I. The facility and Interdisciplinary Team (IDT) should first attempt to arrange transportation through natural support and Medicare Part C. If both natural support and Medicare Part C are not an option, Transportation may be separately authorized and reimbursed for up to two round trips per month.
    II. The facility must collaborate with the IDT to coordinate these services in advance of the date of transportation for the member. The two reimbursable trips are limited to each calendar month and do not accumulate or roll over into subsequent months.

    LCI IDT staff retain the discretion to authorize exceptional transportation needs based on the assessed needs of the members.

The following costs are *not typically provided* by a facility and are costs incurred by the individual member or LCI:

a) Medication and Medical Care Co-payments.
b) Personal Hygiene Supplies: including toothpaste, shampoo, soap, feminine care products.
c) Member Clothing: shirts, pants, undergarments, socks, shoes, coats.
d) Costs associated with community recreational activities: event fees, movie tickets, other recreational activities of the member's individual choosing.

The following services and costs are coordinated and paid by LCI or primary insurance coverage, *if determined appropriate* through the RAD process, outside of the residential rate:

a) Personal incontinence products related to a diagnosis: briefs, pull-ups, catheters, reusable, protective pads, etc.
b) Respiratory/oxygen products/equipment
c) Durable medical equipment and supplies for a specific individual
d) Sleep apnea-related products/equipment
e) Full Mechanical or Stand Lifts: The LCI IDT may authorize a full mechanical or stand lift when deemed appropriate through the RAD process. This decision is made on a case-by-case basis, considering the specific needs of the member beyond the provider's standard program services. Training on the proper use of this equipment is required and is the provider's responsibility.

NOTE: Any items or equipment funded by LCI are the property of the member for which they were purchased.

Section 2. Rate Setting and Billable Units

The services for which LCI is contracting with provider organizations are noted in the Rates and Service Codes chart attached to the LCI Service Provider Contract. Provider rates for provision of services will incorporate all administrative and business functions related to the provision of service. Contracted rates include the provision of administrative functions necessary for services and are not billable beyond units provided to each authorized member.

Providers are required to provide for all identified care needs during the provision of services and are specifically prohibited from billing fraudulently for additional services during the provision of these services. All aspects of services shall be discussed between the LCI IDT staff, member or legal representative, and provider to ensure proper collaboration.

Providers should use increments as listed in the rates and service codes chart to bill LCI up to the authorized number of units for the member. Providers can only bill for services rendered to the member. Providers will refund LCI the total amount of any/all units billed without services rendered to LCI members.

Family Care services administered by LCI are funded by state and federal tax dollars through the Medical Assistance program. As a publicly funded system, LCI strives to maintain the integrity of the program by ensuring that all services are billed as authorized by LCI, and as rendered to members. LCI ensures this protection by regularly conducting random reviews of claims submitted by its contracted providers. LCI reserves the right to request verification documentation from providers. This could include but is not limited to' case notes, files, documentation, and records. LCI may require Providers to present evidence of sufficient financial reserves to operate the

facility and meet member needs for at least 30 days without receiving payment for services rendered.

Rate Setting:
Residential services subcontracts or amendments shall be based on the tier-based rate setting model unless otherwise specified. Residential rates will be set for a period of not less than one year. Residential services provider agreements or amendments shall specify a contracted rate, include a fee schedule or reference an acuity-based tier rate setting model.

Rates may be adjusted:

a) Anytime, through mutual agreement between LCI and the provider.
b) When members move in or out of the CBRF, the rate will be effective on the date of the move.
c) When a member's change in condition warrants a change in the tier-based rate setting model.
d) An adjustment in payment rate due to a member's tier change, whether resulting in a state directed rate increase or rate decrease, shall not be considered a rate change for the purposes of this twelve (12) month period.
e) When a rate has been in effect for at least twelve (12) months, and a change is proposed for an individual member or facility:
f) LCI must provide sixty-day written notice to the provider prior to implementation of the new rate.
g) The rate change may apply to the entire contract or to specific rates within the contract, but only on a prospective basis.
h) Rates which are reduced using sub e) are protected from additional decreases during the subsequent twelve (12) month period.
i) A state directed increase shall not be considered a rate change for the purposes of this twelve (12) month period.

Bed Hold Policy:
Residential providers are required to request a bed hold authorization for a member's temporary absence from their facility. To do this, providers must contact the member's IDT within one business day to provide notification of the absence and request authorization. Bed hold charges will be paid per the LCI provider services contract when there is agreement on the part of LCI and the provider that the member is expected to return to the facility and provider has met the bed hold reporting requirements (within one business day). Requests made after the reporting requirements will not be paid.

The bed hold timeframe begins on the first day following the day the member last resided in the original facility and extends up to 14 days, or until the member returns or it is determined that they will not return, whichever occurs first. This maintains the timeline for the transition of the bed hold payment, if desired and appropriate, from LCI

to the member or legal decision maker on day 15. The provider should work with the member or legal decision maker to determine an amount to be paid directly to the facility by the member or legal decision maker. Bed hold authorizations will not be backdated beyond five business days of notification to IDT staff.

For member absences of 14 days or less, when the member is not receiving services from another provider source funded by Medicaid or Medicare (such as vacations or overnight visits with family), a Bed Hold Authorization is not necessary, and the provider can continue to bill on current service authorizations. For absences of over fourteen days, the provider will need to notify the member's care team and coordinate as appropriate.

LCI would not reimburse under the following circumstances:

1. When a member is discharged from the setting at the provider's request
2. A member elects to move to a different setting.
3. A member becomes disenrolled from LCI
4. The death of member
5. A provider does not meet the 5 business day reporting requirement

A day includes the start of service, but not the day of termination of service. Day of disenrollment of a Family Care member is not a paid service day. All aspects of services shall be discussed between the LCI IDT, member or legal representative, and provider to ensure proper collaboration.

Service Code	Modifier	Description	Unit
T2033	U1, U7	CBRF up to 8 Beds Tier 1	Daily
T2033	U2, U7	CBRF up to 8 Beds Tier 2	Daily
T2033	U3, U7	CBRF up to 8 Beds Tier 3	Daily
0229	G1	CBRF 8 bed or less Bed hold	Daily
T2033	U1, U8	CBRF 9 Bed and Over Tier 1	Daily
T2033	U2, U8	CBRF 9 Bed and Over Tier 2	Daily
T2033	U3, U8	CBRF 9 Bed and Over Tier 3	Daily
0229		CBRF 9 bed and over Bed hold	Daily

*Additional modifiers based on individual rate agreements

Section 3. HCBS Settings Rule

General Compliance All settings and locations must comply with Home and Community-Based Services (HCBS) rules and be determined compliant prior to eligibility for service provision under the Family Care waiver program.

Community-Based Settings Compliance is required for both facility-based and community-based settings, unless the setting operates 100% in the community. A setting is considered 100% community-based if participants:

a) Are never present at a designated service location
b) Only meet at the location in the morning before proceeding into the community for the remainder of the day.

The setting may serve as a pickup/drop-off point but must not provide any services or support on-site.

Location-Specific Compliance is tied to a specific, approved location. Any change of address requires prior DHS approval and determination of compliance. Providers must submit a copy of the determination letter and update the contract before services may be funded at the new location.

Residents have the right to:

a) Experience full access to the community. This includes chances to seek employment and work in integrated settings, take part in community life, control personal resources, and get services in the community. They get access to the community to the same degree as people not getting Medicaid HCBS.
b) Decide where they live. Options include non-disability-specific locations. Their long-term care person-centered service and support plan provides options based on their needs, preferences, and resources.
c) Be treated with dignity and respect. They also have the right to privacy and freedom from coercion and restraint.
d) Live with independence. They are encouraged to make their own choices about life, daily activities, friendships, and the places they visit.
e) Choose services and supports. They also choose who provides them.
f) Enter into legal agreements with the provider to own, rent, or occupy a residence. This also protects them from eviction.
g) Have a physically accessible residence.
h) Privacy of living space. They have doors that lock and can choose their roommates. They can also choose their furniture and decorate if it doesn't break the rules of the lease or agreement.
i) Control their schedules. They also have access to food at any time.
j) Visitors of their choice, at any time.

Residential settings must meet these rules to be considered compliant.

Modifications to HCBS Requirements Modifications to HCBS settings rules are permitted to address health and safety risks. Such exceptions must be documented in

the members' Person-Centered Plan (MCP) and the provider's Individual Service Plan (ISP) and referred to as a Modification of Rights (MOR) Plan. All modifications must involve the members, Legal Decision Maker (LDM) if applicable, Interdisciplinary Team (IDT), and provider.

Section 4. Standards of Service

Providers of services shall meet the standards of this agreement; and if applicable, agree to retain licensing in good standing during the contract period.

Providers of long-term care services are prohibited from influencing members' choice of long-term care program, provider, or Managed Care Organization (MCO) through communications that are misleading, threatening, or coercive. LCI and/or the Wisconsin Department of Health Services (DHS) may impose sanctions against a provider that does so. Per DHS, any incidents of providers influencing member choice in a Family Care program must be reported to DHS immediately.

Service must be provided in a manner which honors members' rights such as consideration for member preferences (scheduling, choice of provider, direction of work), and consideration for common courtesies such as timeliness and reliability.

Providers must incorporate practices that honor members' beliefs, being sensitive to cultural diversity and diverse cultural and ethnic backgrounds, including supporting members with limited English proficiency or disabilities, and regardless of gender, sexual orientation, or gender identity. This includes fostering attitudes and interpersonal communication styles in staff and providers which respect members' cultural backgrounds.

Section 5. Staff Qualifications, Training, and Competency

Caregiver Background Checks:

Providers will comply with all applicable standards and/or regulations related to caregiver background checks in accordance with Wis. Admin. Code ch. DHS 12. This includes all staff, including prospective substitute staff.

These checks must include the following documents:

a) A completed Background Information Disclosure (BID), F-82064.
b) A criminal history search from the records of the Wisconsin Department of Justice Wisconsin Online Record Check System Wisconsin Department of Justice Wisconsin Online Record Check System (WORCS).
c) A search of the Caregiver Registry maintained by DHS.
d) A search of the status of credentials and licensing from the records of the Wisconsin Department of Regulation and Licensing, if applicable.

Providers shall review any certifications or licensure held by an individual staff and used in the care of LCI members. Review should occur at regular intervals based on expiration date or annually. This includes validation of driver's license and driving record if staff will be transporting members.

Training:
Providers shall ensure the competency of individual employees performing services to LCI members. Competency shall include maintaining any required certifications or licenses as well as assurance of the general skills and abilities necessary to perform assigned tasks.

Training of staff providing services shall occur within the first 90 days, or earlier if necessary to ensure safe service delivery. Training must cover:

a) Provider Agency Policies and Procedures, including:
   i. LCI member and provider rights and responsibilities
   ii. Record keeping and reporting requirements to include incident reporting
   iii. Arranging backup services if a caregiver is unavailable
   iv. Other necessary and appropriate information
b) Understanding Individuals Served, including:
   i. Individual-specific disabilities, abilities, needs, functional deficits, strengths, and preferences
   ii. Person-specific and general training on the target population
c) Health and Safety Protocols, including:
   i. Recognizing and responding to conditions that may impact a member's health and safety
   ii. Recognizing abuse and neglect and reporting requirements
   iii. Emergency response and member-related incident procedures
d) Professional Skills and Conduct, including:
   i. Interpersonal and communication skills for effectively working with members
   ii. Confidentiality laws and procedures
   iii. Handling complaints appropriately

If applicable to service provision, training on restraint seclusion and unplanned use of restrictive measures and reporting.

Section 6. Staffing Assignment and Turnover

The provider's staff to member ratio shall be in accordance with state licensure and certification requirements as expressed by ordinance, state and federal rules and regulations applicable to the services covered by this contract. The provider shall ensure adequate staffing to meet members' needs as identified in assessments, individual service plans, temporary health or safety situations, the Rate and Service Agreement, and as otherwise necessary to support member well-being. The provision of successful services is attributable in large part to the strength of the relationship between a member and the staff directly providing the service. Given this, the provider agrees to make every effort to match and retain direct care staff under this agreement in

a manner that optimizes consistency. Changes in staff assignments to specific members and within the organization are at the discretion of the provider. The provider agrees to take member requests for specific staff into consideration when assigning or reassigning staff to specific members and will notify LCI IDT in their reporting of any changes to staff providing services

To establish and preserve this relationship, providers must have a process in place for:

a) Members to provide feedback on their experience with employees performing specific tasks and to respond as appropriate.
b) Written information indicating who within the organization to contact with concerns, or questions related to the provision of services or direct care staff.
c) Forwarding documentation and/or feedback to the IDT to allow members to express concerns to individuals other than the care staff whom perform the tasks.
d) Ensuring staff are supervised and assessed for effective collaboration with those they serve by conducting onsite supervision and review.
e) Addressing performance issues promptly and informing LCI IDT about significant issues that may impact members.
f) Maintaining effective collaboration and communication between members, IDT, and all other stakeholders.

Section 7. Communication, Collaboration, and Coordination of care

LCI regularly utilizes the following platforms to communicate with Providers:

a) Provider Relations Advisory Committee
b) Provider newsletter
c) LCI website
d) Email notifications
e) Provider portal
f) Postal mail

Provider agencies are required to ensure LCI Provider Relations staff, LCI IDT, legal representatives, and other identified individuals identified within the member's team have accurate and current provider contact information to include address, phone numbers, fax numbers, and email addresses.

Providers will notify LCI of formal complaints or grievances received from LCI members within 48 hours of receipt. Written notification of completed complaint investigations will be forwarded to the LCI IDT.

All aspects of services shall be discussed between the LCI IDT staff, member or legal representative, and provider to ensure proper collaboration.

The provider shall coordinate with the LCI team on:

a) Service coordination for Medical Equipment or Supplies

b) Plan of Care development and reevaluation
c) Transition difficulty, discharge planning
d) Ongoing Care Management
e) Changes in service provider(s)
f) The member or provider is not available for scheduled services (within 24 hours unless an alternate date is scheduled between provider and member)

Referrals/Admissions

Through the use of the Resource Allocation Decision (RAD) process, the LCI IDT staff shall assess the member's needs and outcomes to determine the level of services to be authorized. The IDT will then make a referral to the provider for an assessment. At this time, the IDT will share any pertinent information, assessment data, and/or historical data to assist the provider with their assessment and development of their care plan; the IDT will inform the provider of specific health and safety needs to be addressed. This information exchange shall include the assessed needs and the written service referral form which specifies the expected outcomes, amount, frequency, and duration of services.

> ***Note**: There may be instances where expedited admission occurs when necessary to meet the member's health and safety needs. LCI IDT may not be able to share all the pertinent information prior to admission in which case LCI IDT will ensure this is provided to the provider within three business days.*

Providers shall make all reasonable efforts to initiate service provision at the date and time requested by the LCI IDT on behalf of the member. If initiation of the service at the member's preferred time is not feasible, the provider will express such to the LCI IDT, who will arrange an alternative start date of services, or, if necessary, arrange to meet the member's needs by other means.

Member Incidents

Provider agencies shall report all member incidents to the LCI IDT. Providers must promptly communicate with the LCI IDT regarding any incidents, situations or conditions that have endangered or, if not addressed, may endanger the health and safety of the member. Acceptable means of communicating member incidents to the LCI team would be via phone, fax, or email within one (1) business day. The provider must include a description of the incident, factors leading up to the incident, and the actions and steps immediately taken by the provider to prevent further harm to or by the affected member(s).

Providers shall record and report:

a) Changes in:
   i. Condition (medical, behavioral, mental)
   ii. Medications, treatments, or MD order
b) Incidents or suspected incidents of:
   i. Abuse, neglect, or exploitation

ii. Medication errors (with or without harm)
iii. Falls (with or without injury)
iv. Urgent Care or Emergency Room visits or hospitalization
v. Death: anticipated or unexpected
vi. Suicide or attempted suicide
vii. Accidents
viii. Involvement of law enforcement
ix. Elopement or missing person
x. Emergency or unapproved use of restraints or restrictive measure
xi. Fire or other natural disaster affecting the home
xii. Any other circumstances warranting an agency incident or event report including news or social media story involving the member, facility, or staff.

***Note**: Provider staff will first follow their own established in-house protocols for reporting incidents. Staff will then inform the IDT of any member circumstance that would warrant family or physician notification that includes but is not limited to the above circumstances*.

All reported incidents will be entered into the Adult Incident Reporting System (AIRS) and reported to DHS in accordance with MCO contract requirements. Providers may be asked to provide any additional information or details necessary to complete the investigation of reported incidents. The provider will inform LCI when notifying their regulatory authority of incidents. A copy of the report may be submitted as a form of notification.

Termination of Services

Before a CBRF involuntarily discharges a resident, the licensee shall give LCI and the resident or legal representative a 30-day or until safe discharge plan is identified written advance notice. The notice shall explain to the residents or legal representative the need for and possible alternatives to the discharge. The CBRF shall provide assistance in relocating the resident and shall ensure that a living arrangement suitable to meet the needs of the resident is available before discharging the resident. The provider shall collaborate with the member/guardian, IDT staff and potential provider(s) to ensure a smooth transition for the member, providing service until a new placement is secured. Notice is not required due to death of a resident.

Regarding emergency terminations or temporary transfers, if a condition or action of a resident requires the emergency transfer of the resident to a hospital, nursing home or other facility for treatment not available from the CBRF, the CBRF may not involuntarily discharge the resident unless the requirements below are met.

The CBRF may not involuntarily discharge a resident except for any of the following reasons:

a) Care is required that is beyond the CBRF's license classification.

b) Care is required that is inconsistent with the CBRF's program statement and beyond that which the CBRF is required to provide under the terms of the admission agreement and this chapter.
c) Medical care is required that the CBRF cannot provide.
d) There is an imminent risk of serious harm to the health or safety of the resident, other residents, or employees, as documented in the resident's record.
e) As provided under s. 50.03 (5m), Stats. or otherwise permitted by law.

Notice requirements:

Every notice of involuntary discharge shall be in writing to the resident or resident's legal representative and shall include all of the following:

a) A statement setting forth the reason and justification for discharge listed under par.(b).
b) A statement that the resident or the resident's legal representative may ask the department to review the involuntary discharge by sending a written request within 10 days of receipt of the discharge statement to the department's regional office with a copy to the CBRF. The notice shall state that the request must provide an explanation why the discharge should not take place.
c) The name, address, and telephone number of the department's regional office director.
d) The name, address, and telephone number of the regional office of the board on aging and long-term care's ombudsman program. For residents with developmental disability or mental illness, the notice shall include the name, address and telephone number of the protection and advocacy agency designated under s. 51.62 (2) (a), Stats.

The LCI team or designated staff will notify the provider agency when services are to be discontinued. The LCI team will make every effort to notify the provider at least 30 days in advance.

Section 8. Documentation

Providers shall comply with documentation as required by this agreement and state licensure and certification requirements as expressed by ordinance, state and federal rules and regulations applicable to the services covered by this contract.

Each LCI member shall have a developed plan of care specific to their needs which addresses each area of service need being provided. A copy of this care plan shall be supplied to LCI IDT staff.

At any time, the IDT staff may request:

a) A written report to enhance the coordination and/or quality of care
b) Changes in members' activities

c) List of supportive tasks provided
d) Ongoing concerns specific to the member
e) Additional documentation of the services provided

The provider agency must maintain the following documentation and make available for review by LCI upon request:

a) Provider meets the required standards for applicable staff qualification, training, and programming
b) Verification of criminal, caregiver and licensing background checks as required.
c) Policy and procedure for responding to complaints, inappropriate practices or matters qualifying as member-related incidents.
d) Employee timesheets/visit records which support billing to LCI.

Section 9. Additional Considerations

- Services will be provided as identified and authorized by LCI IDT staff.
- Providers are required to comply with all applicable Wisconsin state law regarding Caregiver Background Checks and Wisconsin Administrative Rule DHS 12 as they pertain to services provided to LCI members.
- LCI pre-authorizes all its services. If providers bill for more units than authorized without prior authorization, these services may be denied.

Provider Tax ID: _____

Authorized Provider Name: _____

Authorized Provider Signature: _____

Date: _____