Department of Behavioral Health & Developmental Services Community Transition Guide

An Information Handbook for
Individuals and Families
Preparing to Transition to New Homes in the Community

January 2022

Virginia Department of Behavioral Health & Developmental Services

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Introduction

Transitioning from children's services to adult services can be overwhelming for the individual as well as for the parents/legal guardian. Change is not easy and can be intimidating when you do not know what to expect. Don't worry, you are not alone during this process. The Community Transition Guide was designed to provide practical information to families regarding the discharge process, available service options, and resources in the community. Additionally, your loved one will have a transition team that will include the facility's treatment team, a Community Services Board (CSB) Support Coordinator, and a Department of Behavioral Health and Developmental Services (DBHDS) staff (Family Resource Consultant, Community Integration Manager, or a Community Transition Nurse). This team will help guide you as you begin your child's transition to more integrated options in the community.

Department of Justice Settlement Agreement

In 2008, the Department of Justice (DOJ) began an investigation of Central Virginia Training Center (CVTC) according to the Civil Rights of Institutionalized Persons Act (CRIPA). The investigation was expanded to cover Virginia's whole system of services for individuals with intellectual and developmental disabilities, including all five state training centers and community based services.

DOJ issued a findings letter to Governor McDonnell in 2011 concluding that Virginia is not providing services in the most integrated and appropriate setting, not developing a sufficient quantity of community services, and that Virginia has a flawed discharge process at training centers. Virginia then began good-faith negotiations to reach a settlement agreement with DOJ while not subjecting the Commonwealth to a costly and lengthy legal battle.

In 2012, Virginia and DOJ reached a settlement agreement. This agreement will ultimately provide the necessary services so more individuals with intellectual and developmental disabilities can live successfully in their home communities and it will lead to a more effective use of public funds.

In March of 2012, Judge John A. Gibney signed a temporary order for approval of the settlement agreement. In August 2012, Judge John A. Gibney signed the permanent order for approval of the settlement agreement.

How Does This Affect My Child?

The settlement agreement focuses on individuals with a developmental disability who meet any of the following additional criteria: (1) currently live at any of the training centers, (2) meet the

criteria for the Statewide Developmental Disability (DD) waiver wait lists, or (3) currently live in a nursing home or Intermediate Care Facility (ICF).

DBHDS will ensure that the personal support teams, working with the CSB case manager/support coordinator, provide individuals and their authorized representatives with specific options for types of community placements, services and supports based on the individual's needs and desires.

Children's Intermediate Care Facilities (ICF/IID)

Preparing for discharge takes time and proper planning. There is no cookie cutter approach or one size fits all to planning for your loved one's future. It is the goal of the Department of Behavioral Health and Developmental Services (DBHDS) to ensure that individuals transitioning from institutional-based services to community-based services have a safe and nurturing environment to live and grow. To that end, several processes are in place to help ensure a successful transition for all individuals.

Family Outreach Plan

A Family Resource Consultant (FRC) will contact the families of children residing in an ICF/IID to develop a Family Outreach Plan. The plan is intended to gather individualized information regarding the child's past experiences with receiving community services and to discuss any preferences, concerns, and questions the families may have regarding discharge. The plan is updated yearly and is used to help guide discharge planning efforts when the family is ready. At any time, the family can request information regarding community options. Ideally, discharge planning begins on the first day of admission. Our goal is to ensure that the discussion regarding discharge planning is ongoing and that each family is provided with the resources and information needed to make an informed decision regarding their child's care.

Aging Out

When a child is about to "age out" of a facility (meaning he/she will no longer qualify for children's services), notification is sent to the home Community Services Board (CSB) of the impending discharge. The notification is sent approximately 120 days prior to the child's "age out" date. In the event that a child is not "aging out" but rather the family is ready to begin discharge planning, the notification will be sent immediately by the FRC. After the notification is sent, the parent/legal guardian will be contacted by the CSB to complete the intake process. Also during this time, an FRC will contact the family to discuss discharge options. The FRC will provide the family with a list of community options to begin their search. It is important that the families call the providers to ask questions and arrange tours of the homes to assist in making an informed decision. Once intake is completed by the CSB, your support coordinator can further assist in this process.

Discharge Meeting

After the intake process has been completed, the facility will schedule a discharge meeting. This meeting is attended by your child's treatment team, the parents/legal guardian, your child's assigned CSB support coordinator, the new provider, and an FRC. During the meeting, your child's care will be discussed. The facility's social worker will review a list of equipment and supplies needed for your child's care. Routines and best practices performed by staff will be shared with the new provider. The meeting provides a great opportunity for the new provider to hear about your child's care and to ask questions. During the meeting, it is customary to schedule several day visits and occasionally an overnight visit for your child to spend time at the new provider home. Additionally, the provider is invited to visit with your child at the facility to observe his/her care, for training, and to ask more questions. At the end of the discharge meeting, a tentative discharge date is scheduled.

What's Next

The next couple of weeks will consist of orders being signed and sent off to a Durable Medical Equipment (DME) provider where they will be subjected to Medicaid approval. Once approval is received, the orders for equipment and supplies will be filled by the DME provider. This process takes time and occasionally has resulted in a delayed discharge date. This is why it is so important to not wait until the last minute to begin discharge planning. Also during this time, the support coordinator will meet with the new provider and the family to develop a person-centered plan. The plan will guide services for your individual once discharged.

Unexpected Delays

During active discharge, it is not uncommon to experience minor hiccups. Those hiccups may range from a delay in receiving required equipment and supplies needed to care for your loved one to changes with the provider. Again, don't worry. Your team is here to help. The transition team will work quickly to address any issues that may arise so that your loved one has every opportunity to be successful in the community.

Post Move Monitoring (PMM)

The Family Resource Consultant (FRC) will coordinate post move monitoring contacts with the Community Services Board (CSB) and other involved parties after your loved one has been discharged from the facility. The contacts are intended to check on the individual's well-being and to ensure that all essential supports are in place. Contacts occur at the 10 and 90 day mark. Additional contacts may occur if deemed appropriate by the FRC. Your CSB Support Coordinator will also provide additional monitoring visits. Please inquire with your Support Coordinator for their schedule of visits.

DBHDS Contact Information- Children's ICF/IID

Benita Holland, PhD
Family Resource Consultant Manager
DBHDS- Division of Developmental Services

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Family Resource Consultant
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Southeastern Virginia Training Center (SEVTC)

The Department of Behavioral Health and Developmental Services (DBHDS) has established policies and procedures to ensure person-centered principles and practices are used to help individuals living in training centers consider more integrated residential and day activity options and make informed decisions for discharge planning. Upon admission to SEVTC, the Personal Support Team (PST), which includes the Legal Guardian/Substitute Decision Maker (LG/SDM), Community Services Board (CSB) Support Coordinator (SC), and SEVTC staff, work collaboratively to identify the supports that are essential for maintaining the individual's health and safety. The PST also identifies those things that are important to the individual and contribute to his/her happiness and general satisfaction with life. This information is critical in developing the discharge plan and is used to guide the evaluation of community options as well as the creation of goals for the Individual Support Plan (ISP).

Transition Planning

DBHDS is committed to supporting individuals to successfully transition from training centers to more integrated community homes. The steps required to achieve this have been broken down into a 12-week process and includes meetings, tours, visits, and training as well as a robust post move monitoring process. The individual's health, safety and wellbeing are closely monitored during each part of the transition process. Although the steps included in the 12 week process are mandatory, the order, timeframes and manner in which they are accomplished may be altered to accommodate the needs of the individual or other circumstances that are unique to a particular service provider or transition. The process must be person-centered.

Community Integration Manager (CIM)

The **Community Integration Manager (CIM)** is responsible for coordinating the implementation of policies, procedures, regulations and other initiatives related to ensuring individuals residing in training centers are served in the most integrated setting appropriate to meet their needs. The CIM provides support and direction for all aspects of the individual's transition to the community, including the post move monitoring process.

Post Move Monitoring (PMM)

Training Center and other designated DBHDS community integration staff conduct Post Move Monitoring (PMM) visits and follow up for a minimum of one year for all individuals discharged from a training center to a community home. A minimum of four face-to-face visits with the individual are completed within the first 60 days to assess acclimation to the new home, ensure the provision of all identified essential supports and offer additional support or training as needed. PMM visits are also conducted by advocates with the Office of Human Rights and the CSB SC.

DBHDS Contact Information- SEVTC

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Community Integration Manager
DBHDS Facility Programs and Discharge Planning
804-297-1208
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Children's Nursing Facilities

When an child has begun the process of moving to the community from a Nursing Facility (NF) setting DBHDS is notified of a "pending discharge." The Community Transition Nurse then notifies the associated Community Service Board (CSB) of the "pending discharge" of a child through an Action Letter which offers the CSB Support Coordination Unit 120 days of funded case management services. In addition, a copy of the child's most recent Resident Review is attached to the Action Letter. The Resident Review is completed as part of the ongoing Preadmission Screening and Resident Review (PASRR) process and is attached to ensure the CSB is aware of the child's basic individual support needs. As the discharge date nears the Community Transition Nurse and the Omnibus Budget Reconciliation Act (OBRA) specialist work together to ensure any requests for specialized support(s) from the CSB are completed.

Discharge Meeting

The actual discharge from the Nursing Facility (NF) is coordinated by the NF Social Worker who ensures there is continuity of care which includes but is not limited to the transfer of durable equipment and assistive technology, orders for follow - up medical and therapy appointments, and coordination with educational services to achieve a safe transition to the community. The Community Transition Nurse remains available to provide support through the process.

Post Move Monitoring (PMM)

Once the child discharges from a nursing facility, the Community Transition Nurse reaches out to the child's home Community Services Board (CSB) in seven business days to ensure the discharge went smoothly and to offer assistance. After that, the Community Transition Nurse will again reach out to the home CSB six months later to monitor progress and to offer

assistance. If any needs are identified during the contact, the Community Transition Nurse will follow-up as needed.

DBHDS Contact Information- Children's Nursing Facilities

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Provider Selection Guide

The Department of Behavioral Health and Developmental Services (DBHDS) has assembled information from various sources to aid in the decision making process regarding residential supports for individuals transitioning to homes in the community. This shortened version has been created to use as a guide to discuss various topics or concerns that families/guardians will have while screening potential residential services providers. Please remember every individual will require their own set of supports so you may have to go into more detail with your questions or concerns. Feel free to modify this guide to meet the specific needs of your loved one as you begin your selection process.

What are some of the topics or issues I need to cover when screening potential residential services providers?

- **Section I – Provider Information:**

  Local & corporate – name, address, telephone number, contact person & title

  Licensure info – number of years in business, length of current certification, suspensions, revoked

  Homes – number operated by organization & locations

  Type of organization – for profit, not-for-profit, partnership, sole proprietorship, etc.

  Philosophy – mission statement of organization, philosophy of supports

- **Section II – Residential & Individual Information:**

  Appearance of home – well kept, clean, free of hazards, smell, adequate space, comfortable space, single level (if needed)

  Safety – fenced yard, front & back, type of locks on doors, alarms, safety rails, ramps, plan to keep individuals safe, evacuation process, smoke alarms, entries & exits (easily accessible)

Individuals – number, age range, sex, special needs, appearance, cleanliness, interactions with individuals and staff, personal items, grievance policies

Kitchen – adequate equipment and safety precautions

Bedrooms/Baths – private or shared and number, individual/families decorate

Modifications - wheelchair accessible (if needed)

Laundry room – where located, easily accessible, persons responsible for laundry, individuals encouraged to participate

- **Section III – Program & Transportation Information:**

  Visits & vacations – policies on visits & telephone calls from families/guardians, announced or unannounced, overnight trips to visit families/guardians, vacations away from residence, length of stays

  Person centered practices – personal choice in development & implementation of support plan, age appropriate, unique needs identified

  Oversight – management reviews, procedures for handling problems with staff, grievance policies, supervision, monitoring

  Activities – planning for community involvement, access to desired house of worship, personal interests, daily/weekly schedules

  Transportation – types, distance to day support and employment, safety, costs, arrangements, repairs

- **Section IV – Financial Information:**

  Costs - services covered (food, cable, private phone), funding for program, resources, medical expenses, upkeep of specialized equipment, supplies, communication with families/guardians regarding finances

  Individual – policies on handling personal finances, incidental amounts, purchases for personal care items and clothing, payee for disability benefits

- **Section V – Staff Information:**

  Knowledge/Skills/Abilities – requirements for direct support professionals, initial and ongoing training, training to handle complex medical needs & positive behavior support plans, sign language, autism expertise, skilled nursing

  Staffing – individual/staff ratio per shift, average tenure of staff, policies for emergency coverage with open shifts, ability to provide proper supports, onsite supervision, overnight staffing

  Communication – types to relay changes & updates in medications & diets, information about individuals, schedule changes

Work relationships – interactions with other individuals, co-workers, management

- **Section VI – Day Support, Employment & Education Information:**

  Day support – requirements, location, visit

  Employment – requirements if individuals are capable, number of individuals employed, job skills training

  Education – school requirements if applicable, location, class set up, ratio of teachers to students, related services (therapies), connections with local colleges or universities

- **Section VII – Medical Information:**

  Medicines – qualifications to administer, training, storage location, security, nurse monitoring

  Medical care – physical exams, dental care, psychiatric care, etc., locations, annual appointments

  Emergencies – policies, 911, communication with families/guardians, staff coverage, hospitals

- **Section VIII – Nutrition Information:**

  Food - accessibility, refrigerator/freezer adequately stocked, pantry/cabinets adequately stocked, favorite foods/beverages of individuals

  Preparation – special diets, cooking, frozen vs. fresh foods, recipes, individual involvement

  Menus – nutritious & well balanced, visibility of menus, planning, staff & individual input, weekly or monthly

  Kitchen – adequate equipment & appliances, modifications, safety issues

  Costs – allocation of funds for meals & snacks, food budgets, shopping, dietician or nutritionist services available

- **Section IX – Community/Social Events Information:**

  Community – neighborhood & community /social activities, interactions with neighbors

  Events – staff and individual input/choices for planning special events, parties, religious activities, independent or group events, activity calendars

- **Section X – Family/Guardian Involvement:**

  Communication – open lines of communication with families/guardians, sudden illnesses or problems

Support plan – families/guardians involvement with support plan, level of support required, families/guardians involvement with major decisions such as medical care, behavioral issues

Problem areas – policies on handling conflict with provider or staff, areas of concern, grievance policies

Legal guardianship – assurance new residence is aware of legal guardianship roles in decision making

Waiver Options

A "waiver" is a way for the State Medicaid program to pay for your child's services in the community. States make applications for Medicaid Waivers with the federal Medicaid agency, known as the Centers for Medicare and Medicaid Services (CMS). This allows states to waive the usual requirement that individuals must live in an institution in order to receive Medicaid funding for services. As a result, Medicaid is able to fund certain community-based alternatives to institutional care.

Developmental Disabilities Waivers

Virginia's Development Disabilities (DD) Waivers consist of the Building Independence (BI) Waiver, Family and Individual Supports (FIS) Waiver, and the Community Living (CL) Waiver.

Building Independence Waiver	Family & Individual Supports Waiver	Community Living Waiver
For adults (18+) able to live independently in the community. Individuals own, lease, or control their own living arrangements and supports with the option of non-waiver-funded rent subsidies.	**For individuals living with their families, friends, or in their own homes,** including supports for those with some medical or behavioral needs. Available to both children and adults.	**24/7 services and supports for individuals with complex medical and/or behavioral support needs through licensed services.** Includes residential supports and a full array of medical, behavioral, and non-medical supports. Available to adults and some children.

The Role of the Community Services Board

The Community Services Board (CSB) plays an important role in the waiver process. They are responsible for adding your loved one to the statewide DD waiver waitlist, completing required paperwork, and presenting your loved one to the Waiver Slot Assignment Committee (WSAC). The WSAC consists of an impartial body of trained volunteers responsible for assigning waiver slots according to urgency of need. Your loved one will be reviewed by the WSAC based on meeting priority one status meaning he/she lives in an institutional setting and has a viable

discharge plan. The need for slots often exceeds what is available during any given review. In the event that occurs, the Department of Behavioral Health and Developmental Services (DBHDS) will work with the CSB to ensure that appropriate services are provided.

Do I get to select which waiver I receive?

Families are not able to select which waiver they will receive. Allocation of waiver slots is based solely on need. For example, if the goal is for your child to return home with supports in place, a Family & Individual Supports Waiver is an appropriate option. On the other hand, if your loved one is unable to return home and will require a residential setting, a Community Living Waiver is the most appropriate option.

Where can I learn more?

Visit http://www.mylifemycommunityvirginia.org/ for more information on resources that will help in your transition to your new home in the community.

DD Waiver Services

Employment and Day Options	Building Independence	Family & Individual	Community Living
Individual Supported Employment	✓	✓	✓
Group Supported Employment	✓	✓	✓
Workplace Assistance Services		✓	✓
Community Engagement	✓	✓	✓
Community Coaching	✓	✓	✓
Group Day Services	✓	✓	✓

- **Individual/Group Supported Employment-** Training and support in a competitive job where persons without disabilities are employed.
- **Workplace Assistance-** Includes support to individuals who have completed job development and job placement training (or near completed) but require more than typical follow-along services to maintain stabilization in their employment.
- **Community Engagement-** Provides a wide variety of opportunities to facilitate and build relationships and natural supports in the community, while utilizing the community as a learning environment. These activities are conducted at naturally occurring times and in a variety of natural settings in which the individual actively interacts with persons without disabilities (other than those paid to support the individual).

- **Community Coaching-** Designed for people who need 1:1 support to build a skill or set of skills to address a barrier to participating in Community Engagement. This service takes place solely in community settings.

- **Group Day Services-** At no more than 1:7 ratio, includes skill-building and support for the acquisition or retention of self-help, socialization, community integration, employability and adaptive skills.

Residential Options	Building Independence	Family & Individual	Community Living
Independent Living Supports	✓		
Shared Living	✓	✓	✓
Supported Living		✓	✓
In-Home Support Services		✓	✓
Sponsored Residential			✓
Group Home Residential			✓

- **Independent Living Supports-** A service provided to adults (18 and older) that offer skill building and support to secure a self-sustaining, independent living situation in the community and/or may provide the support necessary to maintain those skills.

- **Shared Living-** Medicaid payment for a portion of the total cost of rent, food, and utilities that can be reasonably attributed to a person who has no legal responsibility to support the individual and resides in the same household as the individual. The live-in person cannot be a parent or spouse.

- **Supported Living-** Residential supports are provided in a licensed or DBHDS authorized apartment and enables the individual to have access to round the clock support, a timely response when needed, and support to develop skills needed for daily life.

- **In-Home Support Services-** Residential services that take place in the individual's home, family home, or community settings and typically supplements the primary care provided to the individual by family or other unpaid caregivers.

- **Sponsored Residential-** Residential supports provided to no more than two individuals in a licensed or DBHDS authorized sponsored residential home and enables the individual to: improve or maintain his or her health, live at home and use the community, improve abilities and acquire new skills, and be safe at home and in the community.

- **Group Home Residential-** Consists of skill-building, routine supports, general supports, and safety supports provided primarily in a licensed or approved residence that enables an individual to acquire, retain, or improve the self-help, socialization, and adaptive skills needed to reside successfully in a home and community-based settings.

Medical & Behavioral Options	Building Independence	Family & Individual	Community Living
Skilled Nursing		✓	✓
Private Duty Nursing		✓	✓
Therapeutic Consultation		✓	✓
Personal Emergency Response System (PERS)	✓	✓	✓

- **Skilled Nursing**- Defined as part-time or intermittent care that may be provided concurrently with other services due to the medical nature of the supports provided. Medical services that are ordered by a physician, nurse practitioner or physician assistant and that are not otherwise available under the State Plan for Medical Assistance.
- **Private Duty Nursing**- Individual and continuous care for individual with a medical condition and/or complex health care needs, certified by a physician, nurse practitioner, or physician assistant as medically necessary to enable the individual to remain at home, rather than in a hospital, nursing facility, or ICF-IID.
- **Therapeutic Consultation**- Provide expertise, training, and technical assistance in the home or community, to assist family members, caregivers, and other service providers in supporting the individual and to facilitate the individual's desired outcomes as identified in the ISP
- **Personal Emergency Response System (PERS)** - Personal Emergency Response System (PERS) is an electronic device that enables certain individuals to secure help in an emergency. When appropriate, PERS may also include medication-monitoring.

Self-Directed Options	Building Independence	Family & Individual	Community Living
Consumer-Directed Services Facilitation		✓	✓
CD Personal Assistance Services*		✓	✓
CD Respite*		✓	✓
CD Companion*		✓	✓

- **Consumer-Directed Services Facilitation**- Supports individual or Employer of Record (EOR) to arrange, direct, and manage their own services. **Service can also be agency-directed.*

- **Consumer-Directed Personal Assistance Services-** Direct support with personal needs, typical daily tasks, community involvement, and health & safety. **Service can also be agency-directed.*
- **Consumer-Directed Respite-** Provides temporary supports during emergencies and at other times as needed by an unpaid caregiver. Can be in the individual's home, a provider's home, or other community locations. **Service can also be agency-directed.*
- **Consumer-Directed Companion-** Provides non-medical care, socialization, or support to adults. This service is provided in an individual's home or at various locations in the community. **Service can also be agency-directed.*

Crisis Support Options	Building Independence	Family & Individual	Community Living
Community-Based Crisis Supports	✓	✓	✓
Center-Based Crisis Supports	✓	✓	✓
Crisis Support Services	✓	✓	✓

- **Community-Based Crisis Supports-** Provides services to individuals experiencing crisis events which put them at risk for homelessness, incarceration, hospitalization, and/or danger to self or others.
- **Center-Based Crisis Supports-** Provide long term crisis prevention and stabilization in a residential setting (Crisis Therapeutic Home) through utilization of assessments, close monitoring, and a therapeutic milieu.
- **Crisis Support Services-** Provide intensive supports by appropriately trained staff in the area of crisis prevention, crisis intervention, and crisis stabilization. This service is designed to stabilize the individual and strengthen the current living situation so the individual can be supported in the community during and beyond the crisis period.

Additional Options	Building Independence	Family & Individual	Community Living
Assistive Technology	✓	✓	✓
Benefits Planning Services	✓	✓	✓
Community Guide	✓	✓	✓
Peer Mentoring	✓	✓	✓
Electronic Home-Based Services	✓	✓	✓
Environmental Modifications	✓	✓	✓
Non-Medical Transportation	✓	✓	✓
Transition Services	✓	✓	✓

- **Assistive Technology-** Specialized equipment that increased abilities in daily living or assists with enhancing communication. May also include items for life support.

- **Benefits Planning Services-** The development of documents or guidance that assist individuals receiving Social Security benefits (SSI, SSDI, SSI/SSDI) to better understand the impact of working on all benefits. This service will enable individuals to make informed choices about work and support working individuals to make a successful transition to financial independence. **Service pending approval.*

- **Community Guide-** Direct assistance to persons in brokering community resources. Community Guides provide information and assistance that help the person in problem solving and decision making and developing supportive community relationships and other resources that promote implementation of the person-centered plan. This service involves face to face contact with the individual to determine the interests of the individual. In addition to direct service, there is a component of supporting the individual that may occur without him/her present.

- **Peer Mentoring-** Person-centered services offered to individuals by specifically trained Peer Support Mentors, who are or have been service recipients and have a developmental disability. Peer support is meant to assist with empowering the individual to advocate for opportunities and experiences in community living, working, socializing, and staying healthy and safe.

- **Electronic Home-Based Services-** Goods and services based on Smart Home technology. This includes the purchase of electronic devices, software, services, and supplies that enables individuals to access technology that can be used in the individual's residence to support greater independence and self-determination.

- **Environmental Modifications-** Physical adaptions to a home, vehicle, and in some instances, a workplace which provide direct medical or remedial benefit to the individual.

- **Non-Medical Transportation-** Enables individuals to gain access to waiver and other community services or events, activities and resources, inclusive of transportation to employment or volunteer sites, homes of family or friends, civic organizations or social clubs, public meetings or other civic activities, and spiritual activities or events as specified by the service plan and when no other means of access is available. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan.

- **Transition Services-** Nonrecurring set-up expenses for individuals who are transitioning from an institution or certified provider-operated living arrangement in a private residence where the person is directly responsible for his or her own living expenses.

Additional Funding Options

An individual does not require a Developmental Disabilities (DD) waiver to live in the community. Many of the services that your loved one may need can be accessed under the Commonwealth Coordinated Care (CCC) Plus Waiver and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). These programs usually do not have a waitlist and can be accessed without assistance from the Community Services Board (CSB).

CCC Plus

Commonwealth Coordinated Care Plus Waiver (CCC Plus), is a combination of the formerly known waivers: Elderly or Disabled with Consumer Direction Waiver (EDCD) and the Technology Assisted (Tech) waiver. CCC Plus offers Consumer Direction (CD) or Agency Direction (AD) services depending on individualized needs and program criteria met. CCC Plus Waiver is an integrated delivery model that includes medical services, behavioral health services, and long term services and supports. CCC Plus offers Care Coordination and person centered care with an interdisciplinary team approach. This waiver provides care in the home and community rather than in a nursing facility (NF) or other specialized care medical facility. Screenings for CCC Plus are completed by the local health department and social services. To learn more about CCC Plus, visit https//www.cccplusva.com .

Covered Services	
Respite Services (Agency and Consumer-Directed)	Personal Care Services (Agency and Consumer-Directed)
Personal Emergency Response System (PERS), includes Medication Monitoring	Skilled Private Duty Nursing (RN and LPN)
Services Facilitation	Adult Day Health Care
Assistive Technology (AT)	Environmental Modification (EM)
Transition Services	

EPSDT

Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) is a comprehensive and preventive child health program for individuals under the age of 21. EPSDT includes periodic screening, vision, dental and hearing services. In addition, under the Social Security Act Section 1905(r)(5), states are required to provide any medically necessary health care services listed at section 1905 (a) of the Social Security Act to correct and ameliorate physical and mental conditions even if the service is not included under the state's Medicaid plan.

Virginia's EPSDT program goals are to keep children as healthy as possible by:

• Assuring that health and developmental concerns are diagnosed as early as possible,

• Assuring that treatment is provided before problems become complex, and

• Assuring that medically justified services are provided to treat or correct identified problems

To learn more about EPSDT, visit https//www.dmas.virginia.gov/for-providers/maternal-and-child-healthy/early-and-periodic-screening-diagnostic-and-treatment-epsdt/ .

Covered Services	
Personal Assistance (Agency and Consumer-Directed)	
Skilled Private Duty Nursing (RN and LPN)	
Assistive Technology (AT)	

Available Resources

Individual & Family Support Program

The Individual and Family Support Program (IFSP) assists individuals with developmental disabilities and their families with accessing person-centered and family-centered resources, supports, services and other assistance. The program's primary target population is individuals on the waiting list for Virginia's Developmental Disabilities (DD) Medicaid waivers. The goal of the program is to support continued community living. IFSP consists of four major components:
1) The IFSP Funding Program

2) The IFSP Community Coordination Program

3) A partnership with Virginia Commonwealth University's Center for Family Involvement

4) A partnership with Senior Navigator through Disability Navigator

5) A partnership with The *ARC* of Virginia for Peer to Peer resources

Additional information on IFSP can be found at http://www.mylifemycommunityvirginia.org/ .

Dental Program

The Office of Integrated Health has a Dental Team that creates and implements various community dental programs including comprehensive dentistry, sedation and remote dentistry through participating contracted dentists and a mobile/remote dental program. The Dental programs are gap services that are funded through the Commonwealth of VA/Health Support Network. For more information or assistance email: dentalteam@dbhds.virginia.gov

Mobile Rehab Engineering (MRE)

The Office of Integrated Health developed the Mobile Rehab Engineering Team. The MRE Team performs DME-related services to include but not limited to pressure washing, safety assessments, repairs, custom adaptations and assistive technology consultation. The MRE Team is a gap service that is funded through the Commonwealth of VA/Health Support Network. Donations of equipment to be recycled or repurposed are accepted. For more information or assistance email: mreteam@dbhds.virginia.gov

Public Guardianship

Public Guardianship is the court ordered appointment of a public agency to make decisions on the behalf of a person diagnosed with an intellectual or developmental disability who is believed to be incapacitated, indigent, and in need of someone to make decisions for them. DBHDS, in partnership with the Department for Aging and Rehabilitative Services (DARS), oversees and manages requests for guardianship. Requests are organized based on public guardianship program service areas and prioritized by the date the individual is referred to DBHDS. A Community Services Board (CSB) Support Coordinator (SC) is responsible for initiating the process when an individual is encountered who is believed to be in need of this support. If you believe you or a member of your family is in need of this service, please contact your local Community Services Board. For more information or assistance email: Public.guardianship@dbhds.virginia.gov

Housing

Independent housing options are available to individuals who are 18 years or old or a legally emancipated minor and have a developmental disability as defined in the Code of Virginia. Additionally, they must meet one of the following criteria: be transitioning from a skilled nursing facility, intermediate care facility, state training center, a group home, or other congregate setting and meet the level of functioning criteria for a Developmental Services waiver; and either have or be eligible (on waitlist) for a Developmental Disability waiver. If you meet the criteria and you're interested in applying, contact your Support Coordinator with the Community Services Board. For more information or assistance: http://wwwmylifemycommunityvirginia.org/taxonomy/mlmc-menu-zone/independent-housing

Special Olympics Virginia

Provides year-round athlete services to individuals regardless of ability or disability. For more information or assistance: https://www.specialolympicsva.org

The disAbility Law Center

Provides protection and advocacy to individuals with disabilities experiencing abuse, neglect, and discrimination. For more information or assistance: https://www.dlcv.org

Virginia Board for People with Disabilities

Provides protection and advocacy for the civil and human rights of individuals with developmental disabilities. For more information or assistance: https://www.vaboard.org

disAbility Navigator

A useful tool for searches regarding local services and helpful tips for individuals with developmental disabilities. For more information or assistance: https://www.disabilitynavigator.org

The Arc of Virginia

An advocacy group of people with developmental disabilities, their families, and their allies working to achieve "A Life Like Yours" for Virginians with developmental disabilities. For more information or assistance: https://www.thearcofva.org

Family to Family Network of Virginia

Program providing support to the families of children and adults with disabilities and special health care needs. For more information or assistance: https://www.centerforfamilyinvolvement.org