

GENERAL POLICY & PROCEDURES MANUAL

OF THE

CLINTON COUNTY BOARD

OF

DEVELOPMENTAL DISABILITIES

Policy and Procedure
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COUNTY BOARD and BOARD MEMBERSHIP

- A. Each county shall have its own county board of developmental disabilities subject to section 5126.02 of the Ohio Revised Code (ORC).
 - 1. The Clinton County Board of Developmental Disabilities shall operate as a separate administrative and service entity.
 - 2. The functions of the board shall not be combined with the functions of any other entity of county government.

- B. The board may share administrative functions or personnel with one or more other county boards.

- C. The board shall consist of seven members. The board of county commissioners of the county shall appoint five members and the senior probate judge of the county shall appoint two members in accordance with ORC 5126.022.

- D. None of the following individuals may serve as a member of the Board:
 - 1. An elected public official, except for a township trustee, township fiscal officer, or individual excluded from the definition of public official or employee in division (B) of ORC 102.01;
 - 2. An immediate family member of another Clinton county board member;
 - 3. An employee of any county board or an immediate family member of a Clinton County Board employee;
 - 4. A former employee of the Clinton county board whose employment with the county board ceased less than four calendar years before the former employee would begin to serve as a member of the Clinton county board; and a former employee of another county board whose employment with the county board ceased less than two calendar years before the former employee would begin to serve as a member of the county board;
 - 5. Unless there is no conflict of interest, an individual who or whose immediate family member is a board member of an agency licensed or certified by the department of developmental disabilities to provide services to individuals with or developmental disabilities or an individual who or whose immediate family member is an employee of such an agency;
 - 6. An individual with an immediate family member who serves as a county commissioner of a county served by the county Agency unless the individual was a member of the county board before October 31, 1980.

- E. **CONFLICT OF INTEREST:** A board member shall not vote on any matter before the board concerning a contract agency of which the member or an immediate family member of the member is also a board member or an employee.

- F. The board shall direct all questions relating to the existence of a conflict of interest for the purpose of this policy to the local prosecuting attorney for resolution. The board shall direct all other questions of ethics to The Ohio Ethics Commission.
- G. Prior to appointment or reappointment to the board all individuals must provide to the appointing authority a written declaration specifying both of the following:
 - 1. That no circumstance described paragraph D above exists that bars the individual from serving on the board;
 - 2. Whether the individual or an immediate family member of the individual has an ownership interest in or is under contract with an agency contracting with the board, and, if such an ownership interest or contract exists, the identity of the agency and the nature of the relationship to that board.
- H. Board members shall complete in-service training requirements in accordance with OAC 5123:2-1-13.
- I. Clinton County Board member time and terms of appointment, reappointment & vacancies shall be in accordance with ORC sections 5126.025 - 5126.027.

Reference: ORC 5126.02, 5126.021, 5126.0210, 5126.0211, 5126.0212 5126.023, 5126.024, 5126.028

Revised: 10/21/14

BOARD MEMBER IN-SERVICE TRAINING

- A. In-service training means training of board members pursuant to ORC 5126.0210 that may include, but is not limited to, training arranged by the superintendent, statewide conferences sponsored by the Ohio association of county boards serving people with developmental disabilities or other organizations, webinars offered by the department, training completed on-line, and presentations by outside speakers.

- B. In-service training requirements:
 - 1. Within three months after a board member's initial appointment to the Agency, the board member shall complete an orientation that addresses duties of the county board, role and requirements of board members, confidentiality, and the ethics laws of the state of Ohio. The orientation completed in accordance with this paragraph may count toward the hours of in-service training specified in paragraphs B.2 and B.3 of this procedure.
 - 2. During each calendar year of a board member's term, the board member shall complete a minimum of four hours of in-service training, except as provided in paragraph B.3 of this procedure.
 - 3. Board members appointed after the county board's annual organizational meeting and board members appointed for the remainder of a former board member's term shall complete in-service training during the first calendar year of the board member's appointment in accordance with the following schedule:
 - a. Board members appointed on or before March thirty-first shall complete a minimum of four hours of in-service training.
 - b. Board members appointed after March thirty-first but prior to July first shall complete a minimum of three hours of in-service training.
 - c. Board members appointed after June thirtieth but prior to October first shall complete a minimum of two hours of in-service training.
 - d. Board members appointed after September thirtieth but prior to the succeeding January first shall complete a minimum of one hour of in-service training.
 - 4. The county board and the superintendent shall jointly develop the county board's plan for in-service training for the calendar year which:
 - a. Reflects the topics identified by the director of DODD with consideration of priorities within the county;
 - b. Includes perspectives from outside the county; and
 - c. Recognizes that training for specific board members may vary based on board members' background and experience.
 - 5. The superintendent shall make board members aware of opportunities to complete in-service training.
 - 6. The superintendent shall maintain documentation of board members' completion of in-service training which shall include:
 - a. An outline or description that details the content of the training;
 - b. The date, time, location, and duration of the training; and

- c. A sign-in sheet or email in which the board member attests to completing the training.
- 7. In-service training sessions shall not be considered regularly scheduled meetings of the county board.

Reference: OAC 5123:2-1-13

Approved: 10/21/14

PHILOSOPHY

Services promoting the well being of persons with developmental disabilities (DD) in our community shall be promoted through the Board's active commitment to the following principles:

- Each person with DD is a human being first and an individual with disabilities secondarily; he/she should have access to all the general community services that he/she can use in common with others. Only when integrated services fail to meet his/her needs, should there be specialized services.
- Every person with developmental disabilities and his/her family is entitled to the concern and assistance of the community, expressed through public and voluntary resources. This is their right as citizens.
- It is the Philosophy of the Board that all staff members receive and be familiar with the rights enumerated in section 5123.62 of the Revised Code and observes those rights in their contacts with persons receiving services. Every provider of services to persons with developmental disabilities shall ensure they have policies and programs to ensure that all their staff members are familiar with those rights and observe those rights in their contacts with persons receiving services.

There is potential for growth in every human being. For each person, society should provide the opportunity to develop to the limits of his/her capabilities.

Services shall be planned and provided as part of a continuum which means that the pattern of facilities and eligibility shall be completed as to meet the needs of each person with DD, regardless of age or disability, and at each stage of life development. It also means continuity, including uniform eligibility standards, to ensure that no individual is lost in the transition from one service to another.

Services for persons with DD should be close to their communities, home and families when possible. Home and community based services should always be the first option for individuals with DD.

Provision of training for professional persons to work with individuals with DD should be built into service programs whenever appropriate and possible. Professional training is an essential component of the total program and a pattern of service is incomplete without this training.

The Board's philosophy of provision of services to eligible individuals and their families is implemented through the adoption of Board policy.

The execution of Board policy and the administration of the program shall be the responsibility of the Superintendent and the administrative staff. To this end, there shall be continuous effort by the administration and the Board to improve and refine the policies of the system to develop clear, precise administrative and operational

procedures and to provide means by which the Board can direct the operation of the program in accordance with its legal obligations and prerogatives.

Revised: 10/21/14

DUTIES OF THE BOARD OF DD

Subject to the rules established by the Director of the Ohio Department of Developmental Disabilities (DODD) for programs and services offered pursuant to Chapter 5126 of the Ohio Revised Code (ORC), and subject to the rules established by the Ohio State Board of Education for programs and services offered pursuant to Chapter 3323 of the ORC, the Clinton County Board of Developmental Disabilities (henceforth called the Agency) shall:

- A. Administer and operate facilities, programs, and services as provided by Chapter 5126 and Chapter 3323 of the ORC and establish policies for their administration and operation;
- B. Coordinate, monitor, and evaluate existing services and facilities available to individuals with developmental disabilities;
- C. Provide early childhood services, supportive home services, and Employment First services, according to the plan and priorities developed under Section 5126.04 of the ORC;
- D. Provide or contract for special education services pursuant to Chapters 3317 and 3323 of the ORC and ensure that related services, as defined in section 3323.01 of the ORC are available according to the plan and priorities developed under section 5126.04 of the ORC;

On or before the first day of February prior to the school year, the Board may elect not to participate during that school year in the provision of or contracting for educational services for children ages six through twenty-one years of age, provided that on or before that date the Board gives notice of this election to the superintendent of public instruction, each school district in the county, and the educational service center serving the county. If a board makes this election, it shall not have any responsibility for or authority to provide educational services that school year for children ages six through twenty-one years of age. If a board does not make an election for a school year in accordance with this division, the board shall be deemed to have elected to participate during that school year in the provision of or contracting for educational services for children ages six through twenty-one years of age.

- E. Pursuant to ORC 5126.0219, provide for a qualified Superintendent by either employing a Superintendent or obtaining the services of the Superintendent of another county board.
- F. Adopt a budget, authorize expenditures for the purposes listed in this section and do so in accordance with section 319.16 of the ORC, approve attendance of board members and staff at professional meetings and approve expenditures for attendance, and exercise such powers and duties as are prescribed by the DODD;
- G. Submit annual reports of its work and expenditures, pursuant to sections 3323.09 and 5126.12 of the ORC, to the DODD, the Superintendent of Public Instruction, and the

Clinton County Board of County Commissioners at the close of the fiscal year and at such other times as may reasonably be requested;

- H. Authorize all positions of employment, establish compensation, including but not limited to salary schedules and fringe benefits for all Agency staff, approve contracts of employment for management staff that are for a term of more than one year, employ legal counsel under section 309.10 of the ORC, and contract for staff benefits;
- I. Provide service and support administration in accordance with section 5126.15 of the ORC;
- J. Certify respite care homes pursuant to rules adopted under section 5123.171 of the ORC by the Director of the ODDD;
- K. Enter into contracts with other such boards and with public or private, nonprofit, or profit making agencies or organizations of the same or another county, to provide the facilities, programs, and services authorized or required upon such terms as may be agreeable and in accordance with Chapter 5126 and Chapter 3323 of the ORC and rules adopted there under and in accordance with sections 307.86 and 5126.071 of the ORC;
- L. Purchase all necessary insurance policies. May purchase equipment and supplies through the Ohio Department of Administrative Services or from other sources, and may enter into agreements with public agencies or nonprofit organizations for cooperative purchasing arrangements;
- M. Receive by gift, grant, devise, or bequest any moneys, lands, or property for the benefit of the purposes for which the Agency is established and hold, apply, and dispose of the moneys, lands, and property according to the terms of the gift, grant, devise, or bequest;
- N. Receive all federal, state and local funds and deposit them to the appropriate accounts established by the County Auditor and provide such funds as are necessary for the operation of all Agency programs through the means as provided by the law. The Agency shall not expend public funds for purposes prohibited by the laws of the State of Ohio;
- O. Inform the public concerning the progress and needs of the programs for persons with developmental disabilities;
- P. Carry out all reasonably necessary negotiations with the DODD, the Ohio Department of Mental Health, the Ohio Department of Education, the Ohio Department of Administrative Services, the Clinton County Board of County Commissioners, and other agencies to effectively carry out the provisions of the law and the intent of any contract the Agency has made or may make with any other public or non-profit agency or organization;
- Q. Initiate questions of policy for consideration, research and follow up by its Superintendent;

R. Consider and act upon the recommendations of its Superintendent in matters of policy;

Policy adopted pursuant to 5126.04, 5126.05, and 5126.054, of the ORC and 5123:2-1-02 of the Ohio Administrative Code.

Revised: 10/21/14

EMPLOYMENT OF SUPERINTENDENT

- A. The Board (employing its own superintendent) shall employ the superintendent under a contract.
 - 1. The Board shall adopt a resolution agreeing to the contract.
 - 2. Each contract for employment or re-employment of a superintendent shall be for a term of not less than one and not more than five years.
 - 3. At the expiration of a superintendent's current term of employment, the superintendent may be re-employed.
 - 4. If the board intends not to re-employ the superintendent, the board shall give the superintendent written notification of its intention. The notice shall be given not less than ninety days prior to the expiration of the superintendent's contract, unless the superintendent's contract stipulates something different.

- B. The Board shall prescribe the duties of its superintendent and review the superintendent's performance. The superintendent may be removed, suspended, or demoted for cause pursuant to ORC 5126.23. The board shall fix the superintendent's compensation and reimburse the superintendent for actual and necessary expenses.

- C. If the superintendent position becomes vacant, the Board first shall consider entering into an agreement with another county board for the sharing of a superintendent under ORC 5126.0219. If the Board determines there are no significant efficiencies or it is impractical to share a superintendent, the Board may employ a superintendent.
 - 1. Two or more county boards may enter into an arrangement under which the superintendent of one county board acts as the superintendent of another county board.
 - 2. To enter into such an arrangement, each board shall adopt a resolution agreeing to the arrangement.
 - 3. The resolutions shall specify the duration of the arrangement and the contribution each board is to make to the superintendent's compensation and reimbursement for expenses.
 - 4. During the vacation The Board may appoint a person who holds a valid superintendent's certificate issued under the rules of the DODD to work under a contract for an interim period not to exceed one hundred eighty days until a permanent superintendent can be employed or arranged. The director of the DODD may approve additional periods of time for these types of interim appointments when so requested by a resolution adopted by the Board, if the director determines that the additional periods are warranted and the services of a permanent superintendent are not available.

Reference: ORC 5126.0219

Approved: 10/21/14

ELECTION OF OFFICERS

- A. The members of the Board shall elect the officers specified herein by voice vote, following nominations from the floor.
- B. The election of officers shall be at the annual organizational meeting.
- C. There shall be elected a president, vice-president, and recording secretary who shall be elected for one year and shall serve until their successors are elected.

Policy adopted pursuant to 5126.029 of the Ohio Revised Code.

DUTIES OF OFFICERS

- A. The duties of the President shall be to preside at all meetings of the Board and to perform such other duties as may be prescribed by law or by action of the Board.
- B. The Vice President shall preside in the absence of the president and shall perform such duties as may be assigned by the Board.
- C. The Recording Secretary shall record the minutes of all Board proceedings and arrange for public inspection of said records, upon the request of a citizen desiring to examine them at a mutually convenient time and place. The Recording Secretary shall also notify members of changes in meeting places and dates.

Policy adopted pursuant to 5126.029 and 121.22 of the Ohio Revised Code.

OFFICER VACANCY

In the event an officer vacancy occurs during a term of office, the members of the Board shall hold an election to fill that vacancy.

Policy adopted pursuant to 5126.029 and 121.22 of the Ohio Revised Code.

MEETINGS OF THE BOARD

- A. The board shall hold an annual organizational meeting no later than the 31st day of January. Notice of the annual organizational meeting will comply with section E below. During the organizational meeting the board will:
 - 1. appoint an Ethics Council and any other standing committees;
 - 2. elect its officers, consisting of a President, Vice President, and Recording Secretary;
 - 3. establish the dates and times for holding the regular board meetings.
- B. In accordance with law, the board shall hold its regular meetings at least ten (10) times annually.
- C. Special or emergency meetings may be called. No business shall be transacted that does not come within the purpose or purposes set forth in the call for the special or emergency meeting.
- D. Notice of regular board meetings, including time and place, will be provided to the local news media for public notice and posted on the board's website. Any person may, upon request, obtain reasonable advance notification of all meetings at which any public business is to be discussed. Provisions for advance notice may include, at no charge, emailing the agenda of meetings to all subscribers on an email list or mailing notices in a self-addressed, stamped envelope provide by the requestor.
- E. Notice of a special meeting, including time, place, and purpose of the meeting, will be provided at least 24 hours in advance of the special meeting to local news media, as well as to all media outlets that have requested such advance notice, except in the event of an emergency requiring immediate official action. No business shall be transacted that does not come within the purpose or purposes set forth in the call for the special meeting. In the event of an emergency meeting, the Board President or Superintendent/designee shall notify the news media that have requested notification immediately of the time, place, and purpose of the meeting. Board members will be notified of the emergency meeting by a telephone call from the Board President or Superintendent/designee. No business shall be transacted that does not come within the purpose or purposes set forth in the call for the emergency meeting.
- F. All meetings of the board shall be held at the Agency's Administrative Offices unless conditions make it advisable that another place be selected, or as otherwise determined by a majority vote of the board. Notice of meeting location change will be provided to the local news media for public notice and posted on the board's website. In addition, at least twenty-four hours advance notice will be given to the news media that have requested such notification.
- G. The board will keep a record of board proceedings, which shall be open for public inspection.
- H. A majority of the board shall constitute a quorum. Meetings of the board shall be held in compliance with the requirements of Section 121.22 of the Ohio Revised Code (Ohio Open Meetings Act).
- I. A member of the board may attend a meeting of the board or a meeting of a committee of the board via means of electronic communication if all of the following apply:

1. The means of electronic communication permits board members attending the meeting via means of electronic communication, board members present in person at the place where the meeting is conducted, and all members of the public present in person at the place where the meeting is conducted to simultaneously communicate with each other during the meeting; and
2. At least one-third of the board members attending the meeting are attending in person at the place where the meeting is conducted, as referenced in the table below; and
3. In the case of a regular meeting of the board, the member attending the meeting via means of electronic communication attends at least one-half of the annual regular meetings of the board in person at the place where the meeting is conducted; and
4. The member attending the meeting via means of electronic communication notified the Board President or Superintendent/designee of their intent not less than 48 hours before the meeting, except in the case of a declared emergency; and
5. All votes taken at the meeting are taken by roll call vote.

Any board member attending a meeting of the board or a meeting of a committee of the board via electronic means is considered present at the meeting, is counted for purposes of establishing a quorum, and may vote at the meeting.

For purposes of determining whether one-third of members are attending a meeting of the board or a committee meeting of the board in person, the following table can be used as a guide:

<u>Number of Meeting Participants</u>	<u>In-Person Attendance Required</u>
2 total	1 in-person
3 total	1 in-person
4 total	2 in-person
5 total	2 in-person
6 total	2 in-person
7 total	3 in-person

J. The President of the Board or a majority of the board members may extend to visitors the privilege of addressing the board. Procedures for citizen participation shall be developed by the Superintendent.

K. In-service training sessions are not considered a regularly scheduled Board meeting.

Policy adopted pursuant to 121.22, 5126.029, and 5126.0223 of the Ohio Revised Code.

Revised: 10/17/2023

PARTICIPATION BY CITIZENS PROCEDURE

- A. The president of the board or a majority of the members may extend to visitors the privilege of addressing the board and the order of business at any regular meeting shall include an opportunity for members of the public to address the board, provided, however, that the board does not obligate itself to consider any request or proposal unless submitted to the president, in writing, at least seven (7) days before the meeting, exclusive of Sundays and holidays.
- B. The board endorses the principle of open communication between the superintendent and his staff and free communication of all personnel with the program's organization through recognized channels of communication.
- C. Any individual or group may address the board concerning any subject that lies within the board's jurisdiction. Questions are to be directed to the board as a whole and may not be put to any individual member of the board or the administrative staff. Any matter upon which the board may be requested to act must be submitted in writing to the board not less than seven (7) days excluding Sunday and holidays, prior to the date of the meeting at which the subject is to be discussed.
- D. It shall be in order for members of the board to interrupt a speaker at any time to ask questions or make comments in order to clarify the discussion.
- E. Not more than fifteen (15) minutes shall be allotted to each individual speaker and/or group presenting on the same topic or subject under discussion.
- F. No person shall present orally at any meeting of the board, a complaint against an individual employee of the board. Such charge or complaint shall be presented to the Superintendent, in writing and signed by the person(s) making the charge or complaint for resolution. A charge or complaint concerning the Superintendent shall be presented to the board in writing and shall be signed by the person(s) making the charge.

ORDER OF BUSINESS AND RULES OF ORDER

- A. The order of business at a regular meeting of the Board may include:
 - 1. Call meeting to order
 - 2. Introduction of guests
 - 3. Board member roll call
 - 4. Approval of minutes from last meeting
 - 5. Financial report
 - 6. Committee meeting reports, as applicable
 - 7. Superintendent's report
 - 8. Discussion of unfinished business
 - 9. New business/resolutions
 - 10. Directors' reports, as applicable
 - 11. Public participation
 - 12. Adjournment

- B. The Board shall observe Roberts' Rules of Order Revised except as otherwise provided by administrative rules and regulations or by statute.

AUTHORITY OF MEMBERS

Board members have authority only when acting as a Board legally in session. The Board shall not be bound in any way by any statement or action on the part of any individual Board member or staff, except when such statement or action is in pursuance of specific instructions by the Board.

MINUTES

- A. Minutes of all Board meetings shall be kept by the Recording Secretary and shall be open to public inspection.
- B. The official minutes of the Board shall be kept in a safe place by the Recording Secretary, and shall be made available to any citizen desiring to examine them at a mutually convenient time and place.
- C. Copies of Board meeting minutes shall be prepared promptly after each meeting and shall be distributed to the Superintendent and Board members.

SPECIAL COMMITTEES

- A. The board shall authorize such special committees as are deemed necessary and the Members of such committees shall be appointed by the president. A special committee shall report its recommendations to the board for appropriate action.
- B. The following committees are to be appointed annually: Finance, Personnel, and Ethics.

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COMPENSATION: EXPENSES OF BOARD MEMBERS

Per Section 5126.028 of the Revised Code, members of the Board shall serve their term without compensation, but shall be reimbursed for necessary expenses in the conduct of Board business, including those incurred within the county of residence in accordance with an established policy of the county board.

ETHICAL CONDUCT

Members shall abide by ethical rules of conduct appropriate to public officials of the State of Ohio. No Board member shall seek special privileges, criticize staff publicly, disclose confidential information or consider a complaint by or against a staff member, service, or program of the Agency that is not first submitted to the Superintendent. No Board member, nor any immediate family members of a Board member, may serve as a board member of a contract agency in which there may be a conflict of interest.

ETHICS COUNCIL

- A. The Agency supports the belief that membership of a person on the Board, or employment of a person by the Agency, does not affect the eligibility of any Board member's or Agency staff member's family for services provided or paid for by the Agency. Therefore, the Board has created an Ethics Council to review all direct services contracts, meaning any legally enforceable agreement with an individual, agency or other entity that, pursuant to its terms or operation, may result in a payment from the Agency to an eligible individual or to a member of the family of an eligible individual for services rendered to the eligible individual. Direct services contracts may include, but not be limited to, Supported Living, reimbursement for transportation expenses, family consortiums and family resource services.
- B. The President of the Board shall appoint three members of the Board to the Ethics Council at its annual organizational meeting. The President may be one of those appointed and the Superintendent/designee shall be a nonvoting member of the council. The President shall not appoint a Board member to the Ethics Council if the member, or any member of his/her immediate family, will have any interest in any direct services contract under review by the council while the member serves on the council or during the twelve month period after completion of the member's service on the council.
- C. The role of the Ethics Council shall be to review all direct service contracts and develop, for recommendation to the Board, policies regarding ethical standards, contract audit procedures and grievance procedures with respect to the award and reconciliation of direct service contracts.
- D. The Ethics Council shall meet monthly or as needed prior to Board meetings to perform its functions. Ethics Council meetings shall comply with Ohio Revised Code (ORC) 121.22 (The Sunshine Law). The Ethics Council shall afford an affected party the opportunity to meet with the Ethics Council on matters under consideration by the Ethics Council. Official minutes will be taken at all Ethics Council meetings and shall be part of the public record of the Board.
- E. All contracts and information provided to the Ethics Council shall be sent by the Superintendent, or designee, with appropriate certification that the contracts are within available resources and appropriation made by the Agency. The Ethics Council, during its regular meeting, shall determine whether the amount to be paid under the contract is appropriate based on actual expenses or reasonable and allowable projections. The Ethics Council shall also determine whether the eligible individual who would receive services under the contract stands to receive any preferential treatment or any unfair advantage over other eligible individuals.
- F. If the amount to be paid is not acceptable, or the contract would result in preferential treatment or unfair advantage, the Ethics Council shall not approve a contract or shall suggest acceptable, specific revisions. The Board shall not ratify any contract that is not

approved by the Ethics Council or ratify any contract to which revisions are suggested if the contract does not include the specified revisions.

- G. The Board, by resolution, shall ratify each direct services contract that the Ethics Council approves or approves with specified revisions. The Board may request the prosecuting attorney to prepare a legal review of direct services contracts to determine compliance with state law.
- H. The Ethics Council shall in no way allow a Board member or Agency staff member to authorize, or use the authority of his/her office or employment to secure authorization of, a direct services contract that the Board member or Agency staff member may benefit from in any way.
- I. This policy shall be in full compliance with the relevant provisions of the ORC including Sections 5126.03 through 5126.034.

CONDITIONS FOR REMOVAL

- A. It shall be the policy of the Board to notify the Clinton County Board of County Commissioners or Probate Judge when a Board member should be removed from the Board for any of the reasons listed in ORC 5126.0213.
- B. The Board may pass a resolution urging the appointing authority to request that the DODD issue a waiver of the requirement that the member be removed. The member whose absences from the sessions or meetings are at issue may not vote on the resolution. The appointing authority may request the waiver regardless of whether the Board adopts the resolution.
- C. In the event of a mandatory removal of a Board member under this policy, Board shall supply the board member and the member's appointing authority with written notice of the grounds.
- D. A Board member may request a hearing on the proposed removal and shall not be removed from the Board before the conclusion of the hearing.
- E. A member of the Board who is removed is ineligible for reappointment to the board for at least one year. The appointing authority shall specify the time during which the member is ineligible for reappointment. If the member is removed under division (A)(5) of ORC 5126.0213, the Board shall specify the training the member must complete before being eligible for reappointment.

Reference: ORC 5126.0213 - 5126.0218

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BOARD GENERAL POLICY AND PROCEDURES

- A. The Clinton County Board of Developmental Disabilities shall establish policies and procedures for the administration and operation of the Agency's facilities, programs, and services in accordance with all applicable federal, state and local laws, rules and regulations. The Board shall approve all agency policies. The Superintendent shall establish necessary procedures.
- B. The Superintendent may appoint a Policy Review Committee to be responsible for the observance of laws, rules and regulations and to establish procedures for policy changes. The Superintendent shall submit proposed policies to the Board at a regularly scheduled meeting.
- C. The Agency policies shall be reviewed at least annually to assure continued compliance with laws, rules and regulations and the needs of individuals served.
- D. Agency policies shall be available to each member of the Board, employees and the general public. There may be a cost to any person who desires a personal copy of the policy manual.
- E. The General Policy and Procedure Manual of the Agency is written to be consistent with the provisions of law, but not necessarily to incorporate them verbatim. All staff are expected to know, and shall be held responsible for observing, all provisions of law pertinent to their activities as staff of the Agency. The Superintendent shall establish procedures for responding to Subpoenas and Search Warrants.
- F. In all cases not clearly covered by these policies and procedures, the Superintendent shall make a decision on the basis of the most nearly related provisions.
- G. The policies of the Agency may be amended or suspended by a majority vote of the Board at any meeting.
- H. The Superintendent may, in case of emergency, suspend any part of these policies provided, however, that the Superintendent shall report the fact of, and also reasons for, such suspension at the next meeting of the Board; and provided further that the suspension shall expire at the time of said report unless continued in effect by action of the Board.

STAFF RESPONSIBILITY FOR OBSERVANCE OF LAWS PROCEDURE

- A. The Superintendent is the focal point for all legal actions directed to the Agency. The Personnel Officer shall maintain a file on legal actions or any allegations of wrongdoing that have occurred.
- B. The Agency is also committed to supporting its staff when actions of the agency are being put under scrutiny. Staff will be given assistance during any investigative process.
- C. All staff will notify the Superintendent or designee of any legal actions and obtain instructions on how to proceed.
 - 1. Any legal documents delivered or personally served at any Agency facility or program site will be forwarded immediately to the Superintendent.
 - 2. It shall be the responsibility of the Superintendent or designee to promptly notify the Agency's legal counsel and the Agency's insurance carrier of pending litigation.
 - 3. Legal documents that are immediate in nature (search warrants, law enforcement investigations, subpoenas for records, etc.) shall be fully complied with according to law, and shall also be reported immediately to the Superintendent.
 - 4. In matters of litigation requiring subsequent follow up or investigation, the Superintendent or designee shall inform affected staff members on a need-to-know basis on follow up actions, and the individuals or agencies to which they are expected to provide assistance (Agency's insurance carrier, legal counsel, etc.).
 - 5. Staff members who have questions regarding their participation in matters relating to litigation should contact the Superintendent or designee.
- D. Responding to a Subpoena - an order directing the recipient to appear and testify at a specific time and place.
 - 1. If the subpoena is addressed to an individual employee, the agent of the court should be escorted to the conference room or private office while the employee is contacted. Employees who are served a subpoena involving a matter directly relating to their course of employment will notify their immediate supervisor and provide him/her with a copy of the subpoena.
 - a. In the event an employee is to appear and testify at a specific time and place, the original, as well as a copy of the subpoena should be brought with you.
 - 2. If the subpoena is addressed to the Agency an employee may accept/sign for the subpoena, and without viewing its contents, the subpoena should be given to the Superintendent.
 - 3. A copy of all subpoenas concerning the Agency shall be mailed to the Superintendent at the Clinton County Board of DD at the Nike Center; 4425 St. Rt. 730; Wilmington, OH 45177.
 - 4. Upon review of the subpoena, the Superintendent will confer with the appropriate Leadership Team member to assure compliance to the subpoena.
- E. Responding to a Search Warrant – written court order entitling law enforcement personnel to search a defined area and seize property described in the warrant.

1. All law enforcement personnel, state and federal agents should be escorted to a conference room or private office.
 2. Identify the agent in charge of executing the warrant. Ask for a business card or record the name, title, agency, and telephone number of the agent. Ask for a copy of the warrant and any affidavit submitted to the court to obtain the warrant. Have the agent identify the prosecutor by name and phone number, if that person is not indicated on the document.
 3. Carefully read the warrant. Make sure the warrant is signed by a judge or magistrate. If there is any discrepancy, notify the agent in charge.
 4. Determine the scope of the warrant, the area to be searched and type of evidence to be seized. A search warrant permits the designated agent to search and seize property. If there is any discrepancy between the scope of the search document and search actually conducted by the agent, notify the agent in charge. Attempt to assist the agent in retrieving those documents that are subject of the search.
 5. Identify those essential employees that are knowledgeable and can assist in retrieving the documents, computer information, etc. Notify the agent in charge that key employees are here to ease the search with minimal disruption of business and that other employees are permitted to leave.
 6. Advise employees that persons executing the warrant may ask questions. Advise employees it is their choice whether or not they want to speak with an agent, they are not required to do so.
 7. Monitor the search, but do not impede or obstruct.
 8. Photocopy each item seized. If the agent in charge refuses to permit you to photocopy, record in detail all items seized.
 9. Agents sometimes number the rooms that they enter. Record the numbering scheme.
 10. Request backup copies of all documents and computer disks, etc. before agents seize computers.
 11. If agents attempt to seize documents that you believe are outside the scope of the warrant, notify the agent in charge. Ask that the privileged material be segregated from the other materials and marked as "privileged".
 12. The agent in charge will prepare an inventory of the items seized. Ask for a copy of that inventory before the agent leaves, but do not sign anything verifying the content or accuracy.
 13. Instruct employees to not discuss the search warrant or any related events with the press or other employees.
 14. Contact the Superintendent and advise him of the situation.
- F. The Superintendent and staff shall reference the Agency's Confidentiality of Information Policy and Procedures in section 3.06 of the General Policy and Procedure Manual when legal proceedings pertain to the Agency's records of individual's served.
- G. The Superintendent shall assist in coordinating communications between the Agency and the Prosecutors Office, and between the Agency, the Prosecutor and any outside legal counsel that may be involved.
- H. The Superintendent will brief the Agency employees and Board on the current status of ongoing or newly initiated legal actions as deemed appropriate.

FISCAL AGENT

- A. Ohio statute designates that the Clinton County Board of County Commissioners shall be the fiscal agent of that county's Board of Developmental Disabilities. Therefore, the Board shall adhere to the fiscal management requirements of the Clinton County Board of County Commissioners in all matters except those for which the Board is granted authority under other sections of the Ohio Revised Code (ORC).

- B. Policies in which the Board may determine the necessity or desirability of variance from policies of the Clinton County Board of County Commissioners may include, but shall not be limited to, the following:
 - 1. Size and structure of the work force
 - 2. Assignments of duties and position requirements
 - 3. Hours of employment
 - 4. Ethics
 - 5. Compensation and benefits for all staff
 - 6. Selection of staff
 - 7. Discipline of staff
 - 8. Promotion of staff
 - 9. Transfer of staff
 - 10. The right to lay off staff for lack of work, lack of funds, reorganization and job abolishment
 - 11. Establishment of reasonable work rules and schedules of work

TAX LEVY FUNDS

- A. The Clinton County Board of Commissioners shall levy taxes and make appropriations sufficient to enable the Agency to perform its functions and duties. The Agency may utilize local, state, and federal funds, which have been authorized for such purpose.
- B. The Agency shall monitor all programs funded by the Tax Levy and operated by the contract agencies.
- C. All monies raised by the property tax levy shall be used for the purposes for which they were initially specified in the material that was prepared and released during the levy campaign, and the already established mechanisms for distributing these funds shall continue as in the past. Contract agencies shall be obligated to submit annually or, upon request, applications (proposals, requests, and budgets) for the services they anticipate providing.

COMMUNICATIONS AND PUBLIC RELATIONS

- A. The Agency shall disseminate information to the public in order to keep it informed of the various services which are provided by the Agency and financed by public funds.
- B. The Agency shall utilize a centralized response in all matters of communication and public relations regarding the Board's programs, services, employees, and contract providers. This includes routine and non-routine media inquiries, other external communications and public relations.
- C. The Agency shall make available to all individuals served, parents of minors, legal guardians, staff, and the public upon request:
 - 1. The Clinton County Board of Developmental Disabilities Strategic Plan and Annual Plan;
 - 2. Written information regarding eligibility for Agency services, a description of services offered how to access services, and waiting lists for services.
 - 3. Written policies and procedures concerning health, confidentiality, individual rights, behavior support, and due process.
- D. All communications or public relations efforts of the Agency shall be coordinated by the Superintendent or his designee.
- E. The centralized response shall incorporate all Board programs or affiliated programs, including but not limited to: Orion, Inc.; collaborating agencies; agency or independent providers under contract to the Board; individual or agency volunteers or any other facility, service or program operated by the Board.
- F. At all times, compliance with Board policies regarding individual's rights, confidentiality and use and disclosure of protected health information shall be maintained. Information concerning students or individuals served for any purpose not directly related to service delivery or administration of services shall not be disclosed.

GIFTS, GRANTS AND BEQUESTS

- A. In accordance with ORC 5126.05 (F), the Clinton County Board of Developmental Disabilities may receive or dispose of a gift, grant, or bequest, according to the terms of the gift, grant, or bequest.
- B. All money received by gift, grant, or bequest shall be deposited in the treasury to the credit of the Agency and shall be available for use by the Agency for the purposes determined or stated by the owner or grantor. The Agency shall utilize the same procedure for earnings or interest accruing from a gift, grant or bequest.
- C. Any person or organization desiring to give a gift, or make a grant or a bequest to the Board, shall contact the Superintendent.
- D. Solicitation of any gift or donation by employees or volunteers shall have prior approval of the Superintendent or designee.
- E. The Superintendent shall be advised of any gifts, grants or bequests so a record can be maintained and an acknowledgement be sent.

VOLUNTEER SERVICES

- A. The Agency shall encourage the use of qualified trained volunteers in appropriate program areas and include volunteers as an integral part of overall service delivery.
- B. Volunteers shall not be used to replace regular staff or be considered in the calculation of staffing ratios.
- C. The Agency shall require the completion of program-specific background checks on volunteers.
- D. Written procedures shall be developed for the recruitment, selection, training, assignment, evaluation and recognition of volunteers.

VOLUNTEER SERVICES PROGRAM

A. The Volunteer Program

1. Overall policy on use of volunteers

The achievement of the goals of the Agency is best served by the active participation of citizens of the community. To this end, the Agency accepts and encourages the involvement of volunteers at all levels in the Agency and within all appropriate programs and activities. All staff are encouraged to assist in the creation of meaningful and productive roles in which volunteers might serve and to assist in recruitment of volunteers from the community.

2. Purpose of the volunteer policy

The purpose of these procedures is to provide overall guidance and direction to staff and volunteers engaged in volunteer involvement and management efforts. These procedures are intended for internal management guidance only, and do not constitute, either implicitly or explicitly, a binding contractual or personnel agreement. The Agency reserves the exclusive right to change any aspect of these procedures at any time.

3. Scope of the volunteer procedures

Unless specifically stated, these procedures apply to all volunteers in all programs and projects undertaken by or on behalf of the organization, and to all departments and sites of operation of the organization.

4. Role of the Personnel Department in volunteer services

The productive use of volunteers requires a planned and organized effort. The function of the Personnel Department is to provide a central coordination point for effective volunteer involvement within the Agency, and to direct and assist staff and volunteer efforts jointly to provide more productive services. The Department Director is responsible for recruiting suitable volunteers and for tracking and evaluating the contribution of volunteers to the Agency. *Reference: "Clinton County Board of Developmental Disabilities Volunteer Packet"*

5. Definition of "volunteer"

A 'volunteer' is anyone who, without compensation or expectation of compensation beyond reimbursement of expenses incurred in the course of his or her volunteer duties, performs a task at the direction of and on behalf of the Agency. A "volunteer" must be officially accepted and enrolled by the Agency prior to performance of any tasks. Unless specifically stated, volunteers shall not be considered as "staff" of the Agency.

6. Special case volunteers

The Agency also accepts as volunteers those participating in student community service activities, staff volunteering programs, and other volunteer referral programs. In each of these cases, however, a special agreement must be in effect with the agency, school, company, or program from which the special case volunteers originate and must identify responsibility for management and care of the volunteers.

7. Group Volunteers

Special arrangements will be undertaken when members of a group or an organization volunteer their time as a group effort. These arrangements will include changes in

normal orientation, training, screening and record-keeping requirements as determined necessary by the Personnel Department.

8. Staff as volunteers

The Agency accepts the services of its own staff as volunteers. This service is accepted provided that the volunteer service is provided totally without any coercive nature, involves work which is outside the scope of normal staff duties, and is provided outside usual working hours. Family members of staff may also volunteer with the Agency, and they shall be treated as volunteers defined in section A-5 above.

9. Individuals served as volunteers

Individuals served by the Agency may be accepted as volunteers, where such service does not constitute an obstruction to or conflict with provision of services to the individual or to others.

10. Service at the discretion of the Agency

The Agency accepts the services of volunteers with the understanding that such service is at the sole discretion of the Agency. Volunteers agree that the Agency may at any time, for whatever reason, decide to terminate the volunteer's relationship with the Agency or to make changes in the nature of their volunteer assignment. A volunteer may, at any time and for any reason, decide to sever the volunteer's relationship with the Agency. Notice of such a decision should be communicated as soon as possible to the volunteer's supervisor.

11. Volunteer rights and responsibilities

Volunteers are viewed as a valuable resource to this Agency, its staff, and those it serves. Volunteers shall be extended the right to be given meaningful assignments, the right to be treated as equal co-workers, the right to effective supervision, the right to full involvement and participation and the right to recognition of work done. In return, volunteers shall agree to actively perform their duties to the best of their abilities and to remain loyal to the values, goals and policies of the Agency.

12. Scope of volunteer involvement

Volunteers may be involved in all programs and activities of the Agency. Volunteers should not, however, be used to displace any paid staff from their positions.

B. Volunteer Management Procedures

1. Maintenance of records

A system of records will be maintained on each volunteer, including description of services/duties, dates of service, evaluation of work, and awards received. Volunteers and appropriate staff shall be responsible for submitting all appropriate records and information to the Personnel Department in a timely accurate fashion.

2. Conflict of interest

No person who has a conflict of interest with any activity or program of the organization, whether personal, philosophical or financial shall be accepted or serve as a volunteer.

3. Representation of the Agency

Prior to any action or statement which might significantly affect or obligate the Agency, volunteers should seek prior consultation and approval from appropriate staff. These actions may include, but are not limited to, public statements to the press, lobbying efforts with other organizations, collaborations or joint initiatives, or any

agreements involving contractual or other financial obligations. Volunteers are authorized to act as representatives of the Agency as specifically indicated within their job descriptions and only to the extent of such written specifications.

4. Confidentiality

Volunteers are responsible for maintaining the confidentiality of all proprietary or privileged information to which they are exposed while serving as a volunteer, whether this information involves a single member of staff, volunteer, individual served, or other person, or involves the overall business of the organization. Failure to maintain confidentiality may result in termination of the volunteer's relationship with the Agency.

5. Worksite

An appropriate worksite shall be established prior to the enrollment of any volunteer. This worksite shall contain necessary facilities, equipment, and space to enable the volunteer to effectively and comfortably perform his or her duties.

6. Dress code

As representatives of the Agency, volunteers, like staff, are responsible for presenting a good image to individuals served and to the community. Volunteers shall dress appropriately for the conditions and performance of their duties.

7. Volunteer Hours

Supervisors will require volunteers keep records of the time donated on volunteer timesheets. Supervisors will review timesheets and forward to personnel.

C. Volunteer Recruitment and Selection

1. Description of Services/Duties

Department Directors will write a description of services/duties and forward to personnel. Copies of outside agency forms that require a description is acceptable for Board volunteer files.

2. Staff requests for volunteers

Requests for volunteers shall be submitted in writing to the Department Directors; approved by the Director and forwarded to the Personnel Department by interested staff, complete with a description of services needed and a requested timeframe.

3. Recruitment

Volunteers shall be recruited by the Agency on a pro-active basis, with the intent of broadening and expanding the volunteer involvement of the community. The primary qualification of volunteer recruitment shall be suitability to perform a task on behalf of the Agency. Volunteers may be recruited either through an interest in specific functions or through a general interest in volunteering which can later be matched with a specific function. No final acceptance of a volunteer shall take place without a specific, written volunteer description of services/duties for that volunteer.

4. Recruitment of minors

Volunteers who have not reached the age of eighteen (18) must have the written consent of a parent or legal guardian prior to volunteering. The volunteer services assigned to a minor should be formed in a non-hazardous environment and should comply with all appropriate requirements of child labor laws.

5. Interviewing

Prior to being assigned or appointed to a position, all volunteers will be interviewed to ascertain their suitability for and interest in that position. The interview should determine the qualifications of the volunteer, their commitment to fulfill the requirements of the position, and should answer any questions that the volunteer might have about the position. Interviews may be conducted either in person or by other means.

6. Criminal records check

Criminal background checks will be conducted on those serving more than 40 hours per calendar year, per rule.
7. Placement

In placing a volunteer in a position, attention shall be paid to the interests and capabilities of the volunteer and to the requirements of the volunteer position. No placement shall be made unless the requirements of both the volunteer and the organization can be met. No volunteer should be assigned to a “make-work” position, and no position should be given to an unqualified or uninterested volunteer.
8. Staff participation in interviewing and placement

Wherever possible, staff who will be working with the volunteer should participate in the design and conduct of the placement interview. Final assignment of a potential volunteer should not take place without the approval of a supervisor with whom the volunteer will be working.
9. Acceptance and appointment

Service as a volunteer with the Agency shall begin with an official notice of acceptance or appointment to a volunteer position. Notice may only be given by an authorized representative of the Agency. No volunteer shall begin performance of any position until he or she has been officially accepted for that position and has completed all necessary screening and paperwork. At the time of final acceptance, each volunteer shall complete all necessary enrollment paperwork and shall receive a copy of his or her description of services/duties and agreement of service with Agency.
10. Professional services

Volunteers shall not perform professional services for which certification or a license is required unless they are currently certified or licensed to do so. The Personnel Department shall maintain a copy of such certificate or license.

D. Volunteer Training and Development

1. Orientation

All volunteers will receive a general orientation to the nature and purposes of the Agency, an orientation on the nature and operations of the program or activity for which they are recruited and specific orientation on the purposes and requirements of the position which they are accepting.
2. On-the-job training

Volunteers will receive specific on-the-job training to provide them with the information and skills necessary to perform their volunteer assignment. The timing and methods for delivery of such training should be appropriate to the complexity and demands of the position and the capabilities of the volunteer. Any volunteer

authorized to serve more than 40 hours in a calendar year will receive trainings as specified in rule.

3. Staff involvement in orientation and training
Staff members with responsibility for delivery of services should have an active role in the design and delivery of both orientation and training of volunteers. Staff who will be in a supervisory capacity to volunteers shall have primary responsibility of design and delivery of on-the-job training to those volunteers assigned to them.
4. Continuing education
Just as with staff, volunteers should attempt to improve their levels of skill during their terms of service. Additional training and educational opportunities will be made available to volunteers during their connection with the Agency where deemed appropriate.
5. Conference attendance
Volunteers may be authorized to attend conferences and meetings which are relevant to their volunteer assignments, including those provided by the Agency and by other organizations. Prior approval from the volunteer's supervisor shall be obtained before attending any conference or meeting.
6. Risk management
Volunteers will be informed of any hazardous aspects, materials, equipment, processes or persons which they may encounter while performing volunteer work and will be trained and equipped in methods to deal with all identified risks.

E. Volunteer Supervision and Evaluation

1. Requirement of a supervisor
Each volunteer who is accepted to a position with the Agency must have a clearly identified supervisor who is responsible for direct management of that volunteer. This supervisor shall be responsible for day-to-day management and guidance of the work of the volunteer, and shall be available to the volunteer for consultation and assistance. The supervisor will have primary responsibility for developing suitable assignments of the volunteer, for involving the volunteer in the communication flow of the agency, and for providing feedback to the volunteer regarding his or her work.
2. Volunteer-staff relationships
Volunteers and paid staff are considered to be partners in implementing the mission and programs of the Agency, with each having an equal but complementary role to play. It is essential to the proper operation of this relationship that each person understands and respects the needs and abilities of the other.
3. Volunteer management training for members of staff
An orientation on working with volunteers will be provided to all staff. In-service training on effective volunteer deployment and use will be provided to those staff who are highly involved in volunteer management.
4. Volunteer involvement in staff evaluation
Examination of their effective use of volunteers may be a component in the evaluation of staff performance where that member of staff is working with volunteers. In such cases, supervisors should ask for the input and participation of those volunteers in evaluating staff performance.
5. Staff involvement in volunteer evaluation

Affected staff should be involved in any evaluation and in deciding work assignments of volunteers with whom they are working.

6. Lines of communication

Volunteers are entitled to all necessary information pertinent to the performance of their work assignments. Accordingly, volunteers should be included in and have access to all appropriate information, memos, materials, meetings, and records relevant to the work assignments. Primary responsibility for ensuring that the volunteer receives such information will rest with the direct supervisor of the volunteer. Lines of communication should operate in both directions, and should exist both formally and informally. Volunteers should be consulted regarding all decisions which would substantially affect the performance of their duties.

7. Absenteeism

Volunteers are expected to perform their duties on a regular schedule and a punctual basis. When expecting to be absent from a scheduled duty, volunteers should inform their staff supervisor as far in advance as possible so that alternative arrangements may be made. Continual absenteeism will result in a review of the volunteer's work assignment or term of service.

8. Evaluations

Volunteers shall receive periodic evaluation to review their work. It shall be the responsibility of each staff member in a supervisory relationship with a volunteer to schedule and perform periodic evaluations and to maintain records of the evaluations. The evaluation session will review the performance of the volunteer, suggest any changes in work style, seek suggestions from the volunteer on means of enhancing the volunteer's relationship with the Agency, convey appreciation to the volunteer, and ascertain the continued interest of the volunteer in serving in that position. Evaluations should include both an examination of the volunteer's performance of his or her responsibilities and a discussion of any suggestions that the volunteer may have concerning the position or project with which the volunteer is connected. The evaluation session is an opportunity of both the volunteer and the organization to examine and improve their relationship.

9. Termination

Volunteers may have their service terminated if the Agency determines their services are no longer needed.

10. Resignation

Volunteers may resign from their volunteer service with the Agency at any time. It is requested that volunteers who intend to resign provide advance notice of their departure and a reason for their decision.

11. Exit interviews

Exit interviews, where possible, should be conducted with volunteers who are leaving their positions. The interview should ascertain why the volunteer is leaving the position, suggestions the volunteer may have to improving the position, and the possibility of involving the volunteer in some other capacity with the Agency in the future.

12. Communication with the Personnel Department

Staff supervising volunteers are responsible for maintaining regular communication with the Personnel Department on the status of the volunteers they are supervising,

and are responsible for the timely provision of all necessary paperwork to the Department. The Department should be informed immediately of any substantial change in the work or status of a volunteer and should be consulted in advance before any corrective action is taken.

13. Evaluation of the Agency's volunteer usage

The Personnel Department shall conduct an annual evaluation of the use of volunteers by the Agency. This evaluation will include information gathered from volunteers, staff, and individuals served.

F. Volunteer Support and Recognition

1. Reimbursement of expenses

Volunteers may be eligible for reimbursement of reasonable expenses incurred while undertaking business for the Agency. The Personnel Department shall distribute information to all volunteers regarding specific reimbursable items. Prior approval from the supervisor must be obtained for any expenditure.

2. Access to organization property and materials

As appropriate, volunteers shall have access to property of the Agency and those materials necessary to fulfill their duties, and shall receive training in the operation of any equipment. Property and materials shall be used only when directly required for the volunteer task. This policy includes access to and use of the Agency's vehicles.

3. Insurance

Liability insurance is provided for all volunteers engaged in the Agency's business. Volunteers are encouraged to consult with their own insurance agents regarding the extension of their personal insurance to include community volunteer work. Specific information regarding such insurance is available from Administration Department.

4. Recognition

Recognition of volunteers shall occur in a formal and informal manner each year. Recognition of staff who works well with volunteers shall also occur throughout the course of each year.

Revised: 8/6/18

RECORDS RETENTION

- A. The Agency administration shall develop a records retention schedule to identify the duration of time each type of record shall be maintained by the agency. The Agency shall also identify who is responsible for maintaining and retaining those records.
- B. Each program of the Agency shall be responsible for the development, maintenance, and destruction of program specific records, including case records of individuals served, in accordance with the Agency's approved records retention schedule.
- C. Agency Administration shall be responsible for development, maintenance, and destruction of records of an administrative nature, personnel and finance records, and records that cross divisions, in accordance with the Agency's approved records retention schedule.
- D. Records retention schedules shall include identification of the contents of the file and the length of time for retention of the file. A process for moving records from an active or working file to permanent storage shall be identified, as well as the location of the files.
- E. Record retention schedules shall be reviewed annually by the identified division for compliance with new rules or standards.
- F. Record retention schedules shall conform to requirements of the Ohio Historical Society, which is charged with the legal responsibility for promulgating record retention schedules, and the Clinton County Records Commission as stipulated in ORC 149.38(A) and ORC 149.38(B).
- G. The Agency shall also comply with all relevant federal and state mandates and accrediting bodies: Medicaid – Ohio Departments of DD, Job & Family Services, Education, Rehabilitation Services Commission, OSHA, Department of Labor, Bureau of Workers Compensation, and the Rehabilitation Accreditation Commission (CARF).
- H. Confidentiality of information shall be maintained by staff. Each division shall be responsible for assuring that only those staff with a legitimate program or business reason to access the information shall be permitted access.

LONG TERM AND PERMANENT RECORDS STORAGE PROCEDURE

All records will be retained in accordance with the approved records retention schedule. This procedure applies to records that are to be stored long term or permanently.

- A. Department records that are retained electronically will be stored on the agency's server.
 - 1. Department Directors are responsible for ensuring all records are entered, scanned, and filed in Intellivue or Gatekeeper.
 - 2. Paper documents (except Help Me Grow records) may be destroyed once records are stored electronically in software or on the Agency server. Staff must verify all pages and documents successfully scanned and entered into software or server.
 - 3. Help me grow staff must follow ODH guidelines for paper documents/records.

- B. Department records that are in paper form will be retained in the designated Agency storage area. Staff must mark the storage boxes with a description of records or contents inside the box including year and dates of documents.

Revised: 10/14/14

PUBLIC RECORDS

- A. Pursuant to Section 149.43 of the Ohio Revised Code, the Clinton County Board of Developmental Disabilities hereby adopts this public records policy. It is the policy of the County Board that openness leads to a better-informed citizenry, which leads to better government and better public policy. It is the policy of the County Board to adhere to the state's Public Records Act.
- B. In accordance with the Ohio Revised Code, the County Board defines records as: Any document, device, or item – paper, electronic (including, but not limited to, e-mail), or other format – that is created or received by, or comes under the jurisdiction of the County Board, which documents the organization, functions, policies, decisions, procedures, operations, or other activities of the County Board. Records regarding individuals with developmental disability who are eligible for services from or who are served by the County Board are not public records and will be disclosed only in accordance with state and federal law.
- C. It is the policy of the County Board that, as required by Ohio law, records will be organized and maintained so that they are readily available for inspection and copying. Record retention schedules will be updated regularly and posted prominently at the County Board's administration office.
- D. A requester must at least identify the records requested with sufficient clarity to allow the County Board to identify, retrieve, and review the records. If it is not clear what records are being sought, the County Board may deny a request but will provide the requester an opportunity to to revise the request by informing the requester of the manner in which records are maintained by the County Board and accessed in the ordinary course of the County Board's business.
- E. The County Board may ask a requester to make the request in writing, may ask for the requester's identity, and may inquire about the intended use of the information requested, but may do so only after disclosing to the requester that a written request is not mandatory, that the requester may decline to reveal the requester's identity or the intended use, and when a written request or disclosure of the identity or intended use would benefit the requester by enhancing the ability of the County Board to identify, locate, or deliver the public records sought by the requester.
- F. Public records will be available for inspection during regular business hours, with the exception of published holidays. The County Board's regular business hours are 8:00 a.m. to 4:00 p.m. although these hours may change from time to time. Public records will be made available for inspection promptly. Copies of public records will be made available within a reasonable period of time. "Prompt" and "reasonable" take into account, among other things, the volume of records requested; the proximity of the location where the records are stored; and the necessity for any legal review of the records requested.

- G. The Ohio Revised Code contains certain exemptions from disclosure. With respect to each request, the County Board will determine whether an exemption applies to prohibit disclosure or permit non-disclosure of the requested records. If a record contains information that does not constitute a public record in accordance with federal or state law, such information will be redacted. The County Board will make the redaction plainly visible or notify the requester of the redaction. When a redaction is required or authorized by state or federal law, it is not considered a denial of a request. A denial of public records in response to a valid request will be accompanied by an explanation, including legal authority, as required by the Ohio Revised Code. If the request is in writing, the explanation must also be in writing.
- H. Those seeking public records will be charged only the actual cost of making copies. Charges for paper copies and computer files downloaded to a compact disc are on record in the Business Office. There is no charge for documents e-mailed.
- I. Requesters may ask that documents be mailed to them. They will be charged the actual cost of the postage and mailing supplies.
- J. Documents in electronic mail format are records as defined by the Ohio Revised Code when their content relates to the business of the County Board. E-mail is to be treated in the same fashion as records in other formats and will follow the same retention schedules.
- K. Records in private e-mail accounts used to conduct public business are subject to disclosure, and all employees or representatives of the County Board are instructed to retain their e-mails that relate to public business (see Section 1 Public Records) and to copy them to their business e-mail accounts and/or to the County Board's records custodian.
- L. The records custodian will treat the e-mails from private accounts as records of the public office, will file them in the appropriate way, will retain them pursuant to established schedules, and will make them available for inspection and copying in accordance with the Public Records Act.
- M. DISCLAIMER

Notwithstanding the existence of this policy, the County Board hereby informs the public that it shall comply with the requirements of the Ohio Public Records Act, including, but not limited to, Section 149.43 of the Ohio Revised Code, and that the provisions of the Ohio Public Records Act, and any amendments thereto, supercede and take precedence over this policy. The County Board retains the right to amend this policy at any time in accordance with the Ohio Public Records Act.

PAYER OF LAST RESORT

- A. This policy is adopted by the Agency to show fiscal responsibility and to give individuals served and their families' encouragement and guidance in utilizing all other available resources before accessing county tax levy dollars for needed services and supports. With limited funding to serve new people, existing resources will have to be maximized to meet the needs of all individuals and families eligible for our services.
- B. Within applicable budgetary constraints, the Agency supports the provision of services to as many eligible individuals as possible. To this end, the Agency places the following conditions on persons receiving or seeking to obtain county-funded services:
1. Individuals shall utilize all available funding resources, including but not limited to private insurance and other funded programs and services, before requesting county tax levy dollars.
 2. Each individual who is eligible for Medicaid state plan or waiver services must apply for same and use to purchase/fund covered services.
 3. If the individual is determined ineligible for Medicaid state plan or waiver funding OR is unable to obtain a Medicaid waiver slot because no appropriate slot is available OR is determined eligible but health and safety is not able to be ensured OR is determined eligible but does not meet level of care OR other unique situations are approved by the Superintendent, the Superintendent shall have the authority to adjust the portion of costs to be paid by the Board.
 4. If the eligible individual refuses to apply for Medicaid state plan or waiver funding but still wants the services, he or she will be required to either pay the federal financial participation (FFP) portion of the total cost of such services (the part Medicaid would have paid), or only receive county funding for services in the amount of the local match.
 5. Payment of early intervention services are governed by OAC 5123:2-10-01 Early Intervention Services – System of Payments.
 6. Individuals who receive Supported Living services must share a residence with at least one other person. Any exceptions must be recommended by the individual's team, based upon an assessment of need, and approved by the Superintendent.
 7. The Superintendent may waive any requirements of this policy for a period of up to one hundred and eighty (180) days for any person determined by the Superintendent to be in emergency need of services.
 8. State and federal laws and rules shall take precedence over any contrary provisions of this policy.

NON-RETALIATION FOR REPORTING FRAUD, WASTE, ABUSE AND OTHER VIOLATIONS

- A. The Clinton County Board of DD (CCBDD) is committed to ensuring that all local, state and federal statutes, rules, or regulations are observed, that agency policies are followed and that agency property is not misappropriated, misused, or destroyed.
- B. Any agency employee or employee of a contracting entity who learns of:
 - 1. a violation of statute, rule or regulation related to the delivery of service;
 - 2. fraud, waste or abuse of government funds;
 - 3. false claims for payment of services rendered;
 - 4. a violation of agency policy; or
 - 5. the misappropriation, misuse or destruction of agency property, by agency personnel or the personnel of a contracting entity may report that violation or misuse by another without reprisal.
- C. Pursuant to the federal Deficit Reduction Act, CCBDD will inform its employees and contractors of this “no reprisal” policy as well as the requirements and protections contained in the federal False Claims Act (FCA) (31 U.S.C. 3729-3733). CCBDD also requires that all contracting entities have or establish a non-retaliation policy and that the entities inform its employees of the policy.
- D. The FCA holds liable for civil damages anyone who submits or causes someone else to submit a false or misleading claim for government funds. Anyone who knows about the filing of false claims may bring a civil action, and depending on the outcome and other factors, may be entitled to as much as thirty percent of the proceeds of the case.
- E. Under the Ohio Revised Code (ORC) 5111.03, anyone attempting to obtain payments to which they are not entitled can be also held liable under state law.
- F. The FCA also affords whistleblower protections for employees who report misconduct, including protection from retaliation by his/her employer. These protections are in addition to those found in the state’s whistleblower statutes, ORC 124.341 and 4113.52. These statutes provide protections for employees who follow statutory procedures in reporting any violation of federal or state statute, local ordinance, or regulation that is a felony or criminal offense likely to cause an imminent risk of physical harm to persons, and/or a hazard to public health and safety.
- G. Agency employees and employees of a contracting entity shall make reasonable efforts to determine the accuracy of any information reported under this policy. Agency employees may be disciplined for knowingly reporting false information.
- H. Agency employees are strongly encouraged to follow the procedures outlined in the procedural portion of this section.

NON-RETALIATION FOR REPORTING FRAUD, WASTE, ABUSE AND OTHER VIOLATIONS PROCEDURE

- A. The Agency has various methods for detecting fraud, waste and abuse of government funds. Overseeing these activities is the responsibility of the Business Manager.
- B. Agency employees or employees of contracting entities, who are reporting the filing of claims suspected to be false or other fraud, waste and/or abuse of government funds, shall file a written report to the Business Manager or to the Superintendent, if the suspected violation involves the Business Manager. Examples of falsifying claims include submitting false medical records, billing for services not rendered, and billing, certifying or prescribing services that are medically unnecessary.
- C. Agency employees or employees of contracting entities, who are identifying other problems or violations of federal, state or local statute, rules or regulations, including agency policies, rules or regulations, or misuse of public resources not involving government funds, shall file a written report with the appropriate Agency supervisor, building administrator, or department director. An agency employee or employee of a contracting entity who believes that the Agency supervisor, building administrator, or department director has taken insufficient corrective action should promptly file a written report with the Superintendent. Such a report should also be filed with the Superintendent, if the agency employee or employee of a contracting entity believes that any supervisor or manager is in any way involved in the violation or misuse.
- D. For fraud, waste and abuse of government funds, the Business Manager or designee shall conduct an investigation of the allegation or turn the investigation over to proper authorities, and take remedial action, if indicated. For all other allegations, the appropriate department director or designee shall conduct an investigation of the allegation and take remedial action, if indicated.
- E. A written response shall be issued to the employee filing the report within a reasonable amount of time following the investigation. Interim reports may be provided to the employee if needed.
- F. Agency employees or employees of a contracting entity who follow statutory procedures in reporting any violation of state or federal statute, or local ordinance, or regulation that they believe to be true, whether they use agency procedures or file with the appropriate outside agency, shall not be subject to disciplinary or other retaliatory actions for such referrals. Any Agency employee found to have committed such disciplinary or other retaliatory action shall be subject to discipline.

FEES FOR SERVICES

- A. The Clinton County Board of Developmental Disabilities shall adopt the most current rate structure as defined in Ohio Administrative Code as the usual and customary rate for services.
- B. The Agency will make reasonable efforts to identify third party payors who may be available to provide payment for services provided to individuals by the Agency and to collect payment from such third party payors in accordance with the rate structure.
- C. The rate structure and the effective dates of the rate structure may be amended by Board action in accordance with Agency policy.
- D. The Superintendent shall maintain procedures for implementing this policy.

FEES FOR SERVICES PROCEDURE

- A. Fees from third party payors for services provided by the Agency: Except as stated in these procedures, the Agency will make reasonable efforts to identify third party payors who may be available to provide payment for services provided to individuals by the Agency and collect payment from such third party payors in accordance with the rate structure.
- B. Determination of available Third Party Payors
 - 1. Determinations of Third Party Payors which may be available for coverage of services provided by the Agency shall be made at the time of initial enrollment and repeated at least once per year thereafter at the time of the ISP team meeting.
 - 2. All individuals or their families shall be instructed to notify the Agency of any change in such third party payors.
- C. Reasonable Efforts to Seek Reimbursement: The Agency will be deemed to have made reasonable efforts to seek reimbursement if the Agency submits claims to third party payors identified as available to the individual in accordance with procedures adopted by such payors. If the claim is denied, an appeal is not required if the Agency determines that there is no reasonable likelihood of success if an appeal were filed.
- D. Rules by DODD

These procedures are subject to rules promulgated by DODD pursuant to ORC Section 5126.045. In the event that DODD adopts rules under this section and any part of this policy is inconsistent with such rules, the provision of such rules shall apply.

ELECTRONIC SIGNATURE POLICY

- A. Electronic Signature Purpose: To facilitate the usage of electronic signatures for any and all records where applicable.
- B. Policy Statement: electronic signature, an automated function which replaces a handwritten signature with a system generated statement, will be utilized for records as a means for authentication of transcribed documents, computer generated documents and/or electronic entries. System generated electronic signatures are considered legally binding as a means to identify the author of record entries and confirm that the contents are what the author intended.
- C. Employees and other applicable entities will be allowed to utilize electronic signature in accordance with this policy, State and Federal regulations regarding such, and developed and corresponding procedures, as applicable.

ELECTRONIC SIGNATURE PROCEDURE

- A. Employees and other applicable entities will be allowed to utilize electronic signature in accordance with this procedure.
- B. Confidentiality statement – Anyone authorized to utilize electronic signatures shall be required to sign a statement attesting that he or she is the only one who has access to his/or her signature / log-on password, that the electronic signature will be legally binding and that passwords will not be shared and will be kept confidential. (Refer to Attachment Electronic Signature and Password Acknowledgement)
- C. Passwords – All users shall have their own user ID and password to access the county board remote server. No one may enter the server without this ID and password. Users will also have a user ID and password to enter applicable software programs. Passwords will expire and must be reset per policy.
- D. Anyone authorized to use electronic signature shall use additional controls to ensure the security and integrity of each user’s ID and password per policy 3.06.
- E. Creating, Maintaining, an Electronic Signature
 - 1. Electronic signatures can be used wherever handwritten signatures are used except where stated by a specific law or rule.
 - 2. All who use a system that uses electronic signatures shall be required to review their entries and/or documentation.
 - 3. Once an entry and or document has been signed electronically, it shall not be altered. If errors are later found in the entry or if information must be added, this shall be done by means of an addendum to the original entry. The addendum shall also be signed electronically.
- F. Auditing Electronic Signature
 - 1. As applicable programs and systems shall use a secure, computer-generated time-stamped audit trail that records independently the date and time of user entries, including actions that create, modify or delete electronic records. Record changes shall not obscure previously recorded information. Audit trail documentation shall be retained in accordance with our retention policy.
 - 2. Any misuse or disregard of this electronic signature procedure will be reviewed and acted upon by the Superintendent.

ELECTRONIC SIGNATURE AND PASSWORD ACKNOWLEDGEMENT

1. I have selected a unique password in accordance with policy for each program or system accessed.
2. When I enter my password I attest that my entries to the computer are my entries and my entries alone.
3. I will not share my password with any other staff member.
4. My password shall be kept confidential.
5. I am responsible to review my entries and sign electronically.
6. I understand that electronic signatures are legally binding.

Printed Name: _____ Date: _____

Signature: _____

CONTRACTS

- A. The Board has the authority to contract with any other board, agency or organization to provide facilities, programs, and services authorized in Chapters 3323 and 5126, Revised Code.
- B. All contracts entered into by the Board with any other board, agency or organization to provide the services authorized in Chapters 3323 and 5126, Revised Code, must be between the contractor and the County Board.
- C. Every contract entered into by the Board must be reduced in writing and formally executed. It should be clear and definite regarding each item, including the duties of all parties, the amount of each payment to be made (or the bases upon which each payment is to be calculated), the total amount to be expended under the contract, any preconditions to payment and the time at which payments are to be made. If any other documents, programs, or plans are incorporated by reference into the contract, they should be clearly identified and, if they cannot be attached to the contract, their location should be clearly stated in the contract.
- D. All contracts should be approved as to form by the Board's legal advisor (county prosecutor). If it proves impractical to have contracts approved individually, consideration should be given to preparation of a standard contract, approved by the Board's legal advisor, which may be used in most instances. Deviations from this standard contract may then be approved by the legal advisor on an individual basis.
- E. Direct service contracts shall comply with Policy 1.15 and ORC sections 5126.03 – 5126.034.
- F. The contract must be signed by authorized representatives of all parties to the contract. An executed copy of the contract should be retained by all parties. The Board shall retain the original copies of all contracts in the business office.

ORC 5126.034; 5126:037; Auditor of State Handbook

Revised: 10/21/14

PROFESSIONAL SERVICES

- A. The Board shall submit to the Clinton County Board of County Commissioners in accordance with the normal budget process and as part of its budget request, a list identifying the total expenditures projected for any of the following:
 - 1. Any membership dues of the members or employees of the county board, in any organization, association, or other entity;
 - 2. Any professional services of the county board, its members or employees, or both;
 - 3. Any training of the members or employees of the county board.

- B. "Professional Services" means all of the following services provided on behalf of the Board, members or employees of a county board, or both:
 - 1. Lobbying and other governmental affairs services;
 - 2. Legal services other than the legal services provided by a county prosecutor or provided for the purpose of collective bargaining;
 - 3. Public relation services;
 - 4. Consulting services;
 - 5. Personnel training services, not including tuition or professional growth reimbursement programs for county board members or employees.

Reference: ORC 5126.038

ANNUAL PLANNING

- A. The Agency shall develop and adopt a strategic plan in accordance with OAC 5123:2-1-02.
- B. The strategic plan shall meet the requirements of ORC 5126.04 and 5126.054 and include the Agency's mission and vision. The plan shall also address the Agency's strategy for:
 - 1. Promoting self-advocacy by individuals served by the county board;
 - 2. Ensuring that individuals receive services in the most integrated setting appropriate to their needs;
 - 3. Reducing the number of individuals in the county waiting for services;
 - 4. Increasing the number of individuals of working age engaged in community employment; and
 - 5. Taking measures to recruit sufficient providers of services to meet the needs of individuals receiving services in the county.
- C. The Agency shall plan and set priorities based on available resources for the provision of facilities, programs, and other services to meet the needs of Clinton County residents who are individuals with developmental disabilities, former residents of the county residing in state institutions or placed under purchase of service agreements under section 5123.18 of the Revised Code, and children subject to a determination made pursuant to section 121.38 of the Revised Code.
- D. The Agency shall assess the facility and service needs of the individuals with developmental disabilities who are residents of the county or former residents of the county residing in state institutions or placed under purchase of service agreements under section 5123.18 of the Revised Code.
- E. The Agency shall prepare a strategic plan progress report at least once per year.
- F. The strategic plan and progress report shall be made readily available to individuals and families who receive services, employees of the county board, citizens of the county, and any other interested persons.
- G. The Agency shall have a mechanism for accepting public feedback regarding the strategic plan and strategic plan progress reports.

Reference: OAC 5123:2-1-02, ORC 5126.04

Revised: 10/14/14

Policy and Procedure
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ELIGIBILITY DETERMINATION

- A. The Agency's Service and Support Administration shall make eligibility determinations for residents of Clinton County in accordance with rules adopted by DODD.
- B. The CBDD shall complete eligibility determination within forty-five days of the request for services or after all necessary information has been received from the referring party or applicant except that:
 - 1. For children under age three, the eligibility report completed by or for "Help Me Grow" shall be used for eligibility determination; and
 - 2. For children age three through age five, the evaluation completed by or for the school district for preschool special education may be used for eligibility determination.
- C. For persons age six through age fifteen, a substantial functional limitation in a major life area is determined through completion of the children's Ohio eligibility determination instrument (available at <https://doddportal.dodd.ohio.gov/cnt>) or an alternative instrument issued by the department for use in determining eligibility for county board services and application of criteria found therein. The children's Ohio eligibility determination instrument or an alternative instrument issued by the department for use in determining eligibility for county board services is used in the eligibility determination process for the county board for all services and supports other than special education services.
- D. For persons age sixteen or older, a substantial functional limitation in a major life area is determined through completion of the Ohio eligibility determination instrument (available at <https://doddportal.dodd.ohio.gov/cnt>) or an alternative instrument issued by the department for use in determining eligibility for county board services and application of criteria found therein.
- E. Except as provided in paragraph G, an eligible individual must have a developmental disability as defined in ORC 5126.01. Developmental disability means a severe, chronic disability that is characterized by all of the following:
 - 1. It is attributable to a mental or physical impairment or a combination of mental and physical impairments, other than a mental or physical impairment solely caused by mental illness as defined in division (A) of Section 5122.01 of the Revised Code;
 - 2. It is manifested before age twenty-two;
 - 3. It is likely to continue indefinitely;
 - 4. It results in one of the following:
 - a. In the case of a person under age three, at least one developmental delay or a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay;
 - (1) Developmental delay means that a child has not reached developmental milestones expected for his or her chronological age as measured by qualified professionals using appropriate diagnostic instruments and/or procedures.
 - (2) For children under age three, developmental delay shall be established in accordance with Part C of the Individuals with Disabilities Education Act, 20 U.S.C. 1431 through 1445, as in effect on the effective date of this rule, 34 C.F.R.

303.10, as in effect on the effective date of this rule, and rules promulgated by the Ohio department of health.

(3) For children age three through age five, developmental delay shall be established in accordance with rules promulgated by the Ohio department of education.

- b. In the case of a person at least age three but under six, at least two developmental delays;
 - c. In the case of a person age six or older, a substantial functional limitation in at least three of the following areas of major life activity, as appropriate for his/her age:
 - (1) self-care,
 - (2) receptive and expressive language,
 - (3) learning,
 - (4) mobility,
 - (5) self-direction,
 - (6) capacity for independent living, and,
 - (7) if the person is at least age at least sixteen, capacity for economic self-sufficiency.
5. It causes the person to need a combination and sequence of special, interdisciplinary, or other type of care, treatment, or provision of services for an extended period of time that is individually planned and coordinated for the person.
- F. When a person who has been determined eligible for county board services after July 1, 1991 moves or wants to move to another county in Ohio, that person shall be deemed eligible by the new county board. CBDD, however, may review the person's eligibility. During the review, the person continues to be eligible to receive services according to the new county board's strategic plan and priorities.
- G. All persons who were eligible for services and enrolled in programs offered by a CBDD pursuant to ORC 5126.041 on July 1, 1991, shall continue to be eligible for those services and to be enrolled in those programs as long as they are in need of services.
- H. All persons who were eligible for case management services and receiving case management services pursuant to Chapter 5126. of the Revised Code on January 10, 1992, shall continue to be eligible for those services and to receive services as long as they are in need of services.
- I. A person who resided in a state institution on or before October 29, 1993, is eligible for programs and services offered by a CBDD, unless the person is determined by the county board not to be in need of those programs and services.
- J. CBDD shall keep on file the documents used to determine eligibility for county board services of all persons who apply after July 1, 1991, whether or not such persons are found to be eligible. Information on persons found to be ineligible shall be maintained for a minimum of five years after such determination is made.

- K. The Board shall refer persons not eligible for programs and services offered by the Board to other entities of state and local governments or appropriate private entities for services.
- L. Membership of a person on, or employment of a person by, the CCBDD does not affect the eligibility of any member of that person's family for services provided by the Agency or by any entity under contract with the CCBDD.
- M. All individuals shall have the right to the Board's *Administrative Resolution of Complaints/Due Process Policy and Procedure*.

ORC: 5126.041; 5126.01

Revised: 11/17/15

EARLY INTERVENTION ELIGIBILITY DETERMINATION PROCEDURE

Eligibility for children with developmental delays or disabilities:

- A. To be eligible for services and supports provided by the Agency's early intervention services, an infant or toddler shall be under three years of age with developmental delays or disabilities.

- B. Eligibility shall be determined as:
 - 1. Having a developmental delay in one or more of the following areas, as measured by a research-based developmental evaluation tool or informed clinical opinion as defined by the lead agency.
 - a. Cognitive development
 - b. Physical and sensory development, including vision and hearing
 - c. Communication development
 - d. Social or emotional development
 - e. Adaptive development (self help); or
 - 2. Having a diagnosed physical or mental condition that has high probability of resulting in a developmental delay or disability that is based on a written medical report per the Help Me Grow rule, or
 - 3. Having already been determined Part C eligible in the state of Ohio or from another state.

- C. To determine if an infant or toddler has a developmental delay or disability the evaluation to determine eligibility shall:
 - 1. Be completed within forty-five days.
 - 2. Be completed by a developmental evaluation team, which includes the parents and at least two appropriately licensed or certified professionals from two different disciplines, one of whom may be the service coordinator. It is recommended that one member of the evaluation team have specialized training or expertise with the child's suspected need or primary area of delay.
 - 3. Be based on at least one research- based developmental evaluation tool or informed clinical opinion. If a delay is not confirmed using a developmental evaluation tool, then informed clinical opinion can be used by the members of the developmental evaluation team to determine a delay.
 - 4. Include the five developmental areas specified in (2) of this rule with a focus on the child's unique strengths and needs in each domain.
 - 5. Include a vision, hearing, and nutrition screening completed by qualified personnel.
 - 6. Be provided at no cost to the family.
 - 7. Include a review of pertinent records related to the child's health, developmental and medical history. If a child has already had an evaluation in all or some of the domains including a medical evaluation within the past ninety days, this information must be used as part of the developmental evaluation.
 - 8. Be preceded by informed, written parental consent for the screening and evaluation.
 - 9. Be conducted in collaboration with the family in settings and at times that are selected by families.
 - 10. Be administered in the primary language of the child and family or other mode of

PROCEDURE 3.01.1

communication unless it is clearly not feasible to do so.

11. Be selected and administered so as not to be racially or culturally discriminatory.
 12. Be coordinated by the family's service coordinator.
 13. Be written and include the date or dates of the evaluation, evaluation method, summary of the child's unique strengths and needs in each domain, statement of eligibility, identification of the domains that are delayed, and each evaluator's agency, degree, certification and/or professional license.
 14. Be completed and a copy of the report shared with the family within forty-five calendar days of the initial referral to the system for a suspected delay. If the child is eligible, the IFSP is developed and signed within the same forty-five calendar days and without undue delay. If the family disagrees with the eligibility determination, their rights shall be explained and, upon consent, the appropriate referral made. In the event of exceptional family circumstances, which make it impossible to complete the developmental evaluation within forty-five calendar days, the service coordinator shall document the exceptional circumstances and that the parents were informed and understood that there is an alternative timeline and are in agreement.
- D. If the Agency is not involved in the evaluation to determine eligibility for HMG as described in this rule, the Agency shall request a copy of the written evaluation report for the child's record and shall maintain documentation if report unavailable.
- E. At this time, the Clinton County Board DD does not have a plan in place to serve children at risk for developmental delays or disabilities.

Revised: 11/17/15

ELIGIBILITY AND INTAKE FOR SERVICE AND SUPPORT ADMINISTRATION PROCEDURE

- A. The Agency shall provide service and support administration to the following:
1. Each individual, regardless of age, who is applying for or enrolled in an HCBS waiver;
 2. Each individual three years of age or older who is eligible for county board services, and requests, or a person on the individual's behalf requests pursuant to paragraph (C) of rule 5123:2-1-11;
 3. An individual residing in an intermediate care facility who requests, or a person on the individual's behalf requests pursuant to paragraph (C) of rule 5123:2-1-11, assistance to move from the intermediate care facility to a community setting.
 4. The Agency shall provide service and support administration in accordance with the requirements of section 5126.15 of the Revised Code.
 5. An individual who is eligible for service and support administration in accordance with paragraph (D) (1) of rule 5123:2-1-11; and requests, or a person on the individual's behalf requests pursuant to paragraph (C) of, rule 5123:2-1-11 service and support administration shall receive service and support administration and shall not be placed on a waiting list for service and support administration.
- B. Based on available resources the Agency may provide service and support administration to the following:
1. In accordance with the service coordination requirements of 34 C.F.R. 303.23, an individual under three years of age eligible for early intervention services under 34 C.F.R. part 303;
 2. An individual who is not eligible for other services of the board.
- C. For new individuals, the SSA/SSM is responsible for intake following eligibility: providing, obtaining and/or arranging for all entry criteria, referral, assessments and/or qualifications for needed residential, adult day, community supported employment services and initial Wait List assessment and placement.
1. There may be diagnoses that require additional supporting evidence that they meet the definition of a developmental disability, i.e. Attention Deficit/Hyperactivity Disorder, with or without hyperactivity (ADHD). Additional documentation to verify the diagnoses meet the definition of a developmental disability may be required for eligibility.
- D. The C/OEDI shall be completed within 45 days. After completion of the C/OEDI, the intake process will be initiated and completed within 30 days. Once intake is complete the case will be forwarded to the Director who will notify the SSA Manager. The SSD and the SSA Manager will then assign the case to an SSA. The SSA will then develop the Individual Service Plan and coordinate needed services within 45 days. All delays shall be documented in writing via case notes or letters.

ORC 5126.15; OAC 5123:2-1-11

Revised: 11/17/15

ELIGIBILITY FOR HCBS WAIVER PROCEDURE

- A. At the time an individual is being recommended for enrollment in an HCBS waiver the SSA, will explain to the individual about choice of waiver enrollment as an alternative to ICF/IID placement and feasible alternatives available upon enrollment in an HCBS waiver.
- B. The SSA will ensure and/or assist the individual with the submission of the application for HCBS waiver enrollment (JFS 02399) to the CDJFS. The SSA/SSM will conduct a Level of Care Assessment and then submit the assessment through DODD's online application.
- C. Upon authorization by the department to enroll individuals in HCBS waivers, the SSA will:
 - 1. Determine the individual's eligibility for Agency services. Individuals determined to have an ICF/IID level of care and who meet all other eligibility criteria shall be eligible for HCBS waiver enrollment even if determined not eligible for county board services.
 - 2. Complete the required assessments of the individual in accordance with 5123:2-9-01 and 5123:2-8-01 of the Administrative Code and
 - a. For the level one and SELF waivers, administer the prescreen tool to individuals who seek enrollment to identify any health and welfare needs that must be addressed before enrollment and, as necessary, to identify any non-waiver services and supports the individual needs to assure the individual's health and welfare. The SSA shall follow the protocol developed by the department in the administration of the prescreen tool, which shall address the circumstances in which the individual will be enrolled in the level one and/or SELF waiver.
 - b. For other HCBS waivers administered by the department, complete any assessment specific to those waivers in accordance with rules adopted by the department.
 - 3. Submit to the department all necessary enrollment information, including a request for an ICF/IID level of care determination with respect to the individual through DODD's online application.
- D. The SSA will submit an ICF/IID level of care redetermination to the department in accordance with rule 5123:2-8-01 of the Administrative Code.
- E. Once eligibility is determined the SSA will follow rule 5123:2-9-01 for enrollment and disenrollment from HCBS Waivers.

OAC 5123:2-9-01; 5123:2-8-01

Revised: 11/17/2015

WAITING LIST FOR HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVERS

- A. This policy sets forth requirements for the waiting list established pursuant to section 5126.042 of the Revised Code when the Clinton County Board of Developmental Disabilities (CCBDD) determines that available resources are insufficient to enroll individuals who are assessed to need and who choose home and community-based services (HCBS) in the Ohio Department of Developmental Disabilities (DODD) administered home and community-based services (HCBS) waivers.
- B. Definitions
1. "Alternative services" means the various programs, funding mechanisms, services, and supports, other than HCBS, that exist as part of the developmental disabilities service system and other service systems. "Alternative services" includes, but is not limited to, services offered through Ohio's Medicaid state plan such as home health services and services available at an intermediate care facility for individuals with intellectual disabilities.
 2. "Community-based alternative services" means alternative services in a setting other than a hospital, an intermediate care facility for individuals with intellectual disabilities, or a nursing facility.
 3. "Current need" means an unmet need for HCBS within twelve months, as determined by the CCBDD based upon assessment of the individual using the waiting list assessment tool. Situations that give rise to current need include:
 - a. An individual is likely to be at risk of substantial harm due to:
 - (1.) The primary caregiver's declining or chronic physical or psychiatric condition that significantly limits his or her ability to care for the individual;
 - (2.) Insufficient availability of caregivers to provide necessary supports to the individual; or
 - (3.) The individual's declining skills resulting from a lack of supports.
 - b. An individual has an ongoing need for limited or intermittent supports to address behavioral, physical, or medical needs, in order to sustain existing caregivers and maintain the viability of the individual's current living arrangement.
 - c. An individual has an ongoing need for continuous supports to address significant behavioral, physical, or medical needs.
 - d. An individual is aging out of or being emancipated from children's services and has needs that cannot be addressed through community-based alternative services.
 - e. An individual requires waiver funding for adult day services or employment related supports that are not otherwise available as vocational rehabilitation services funded under section 110 of the Rehabilitation Act of 1973, 29 U.S.C. 730, or as special

- education or related services as defined in section 602 of the Individuals with Disabilities Education Improvement Act of 2004, 20 U.S.C. 140.
4. "Date of request" means the earliest date and time of any written or otherwise documented request for HCBS made prior to September 1, 2018.
 5. "Immediate need" means a situation that creates a risk of substantial harm to an individual, caregiver, or another person if action is not taken within thirty (30) calendar days to reduce the risk. Situations that give rise to immediate need include:
 - a. A resident of an intermediate care facility for individuals with intellectual disabilities has received notice of termination of services in accordance with rule 5123:2-3-05 of the Administrative Code.
 - b. A resident of a nursing facility has received a thirty-day (30 day) notice of intent to discharge in accordance with Chapter 5160-3 of the Administrative Code.
 - c. A resident of a nursing facility has received an adverse determination in accordance with rule 5123:2-14-01 of the Administrative Code.
 - d. An adult is losing his or her primary caregiver due to the primary caregiver's declining or chronic physical or psychiatric condition or due to other unforeseen circumstances (such as military deployment or incarceration) that significantly limit the primary caregiver's ability to care for the individual when:
 - (1.) Impending loss of the caregiver creates a risk of substantial harm to the individual; and
 - (2.) There are no other caregivers available to provide necessary supports to the individual.
 - e. An adult or child is engaging in documented behavior that creates a risk of substantial harm to the individual, caregiver, or another person.
 - f. There is impending risk of substantial harm to the individual or caregiver as a result of:
 - (1.) The individual's significant care needs (i.e., bathing, lifting, high-demand, or twenty-four-hour care); or
 - (2.) The individual's significant or life-threatening medical needs.
 - g. An adult has been subjected to abuse, neglect, or exploitation and requires additional supports to reduce a risk of substantial harm to the individual.
 6. "Status date" means the date on which the individual is determined to have a current need based on completion of an assessment of the individual using the waiting list assessment tool.
 7. "Transitional list of individuals waiting for home and community-based services" means the list maintained in DODD's web-based individual data system, which includes the name and date of request for each individual waiting for HCBS prior to September 1, 2018, under the previous rule 5123:2-1-08 of the Administrative Code.

8. "Waiting list assessment tool" means the Ohio assessment for immediate need and current need, which will be used for purposes of making a determination of an individual's eligibility to be added to the waiting list for HCBS defined in paragraph (B) (10) of this policy and administered by persons who successfully complete training developed by the DODD.
 9. "Waiting list date" means, as applicable, either:
 - a. The date of request for an individual whose name is included on the transitional list of individuals waiting for HCBS; or
 - b. The earliest status date for an individual whose name is not included on the transitional list of individuals waiting for HCBS.
 10. "Waiting list for home and community-based services" means the list established by the CCBDD and maintained in the DODD's web-based waiting list management system which includes the name, status date, date of request (as applicable), waiting list date, and the criteria for current need by which an individual is eligible based on administration of the waiting list assessment tool, for each individual determined to have a current need on or after September 1, 2018.
- C. The CCBDD, in conjunction with development of its plan described in section 5126.054 of the Revised Code and its strategic plan described in rule 5123-4-01 of the Administrative Code, will identify how many individuals to enroll in each type of locally-funded HCBS waiver during each calendar year. The determination will be based on projected funds available to pay the nonfederal share of Medicaid expenditures and the assessed needs of those on the waiting list for HCBS waivers. This information will be made available to any interested person upon request.
- D. Waiting list for home and community-based services (HCBS).
1. An individual or the individual's guardian, as applicable, who thinks the individual, has an immediate need or a current need may contact the CCBDD to request an assessment of the individual using the waiting list assessment tool.
 - a. CCBDD will initiate an assessment of the individual using the waiting list assessment tool within thirty (30) calendar days.
 - b. An individual or the individual's guardian, as applicable, will have access to the individual's completed waiting list assessment tool maintained in the DODD's web-based waiting list management system and upon request, will be provided a copy by the CCBDD.
 2. Meeting the criteria for immediate need and/or current need does not guarantee enrollment in a locally-funded HCBS waiver within a specific timeframe.
- E. When an individual on the waiting list for a HCBS waiver moves from one county to another and the individual or the individual's guardian, as applicable, notifies the receiving county board, the receiving county board will within ninety (90) calendar days of receiving notice, review the individual's waiting list assessment tool.

- F. The CCBDD will remove an individual's name from the waiting list for HCBS:
1. When the CCBDD determines that the individual no longer has a condition described in paragraph (D)(2)(a) OAC 5123:9-04;
 2. When the CCBDD determines that the individual no longer has a current need;
 3. Upon request of the individual or the individual's guardian, as applicable;
 4. Upon enrollment of the individual in a HCBS waiver that meets the individual's needs;
 5. If the individual or the individual's guardian, as applicable, declines enrollment in a HCBS waiver or community-based alternative services that are sufficient to meet the individual's needs;
 6. If the individual or the individual's guardian, as applicable, fails to respond to attempts by the CCBDD to contact the individual or the individual's guardian by at least two different methods, one of which will be certified mail to the last known address of the individual or the individual's guardian, as applicable;
 7. When the CCBDD determines the individual does not have a developmental disabilities level of care in accordance with rule 5123:2-8-01 of the Administrative Code;
 8. When the individual is no longer a resident of Ohio; or
 9. Upon the individual's death.
- G. Advancement from the transitional list of individuals waiting for HCBS to the waiting list for HCBS:
1. The DODD will maintain the transitional list of individuals waiting for HCBS as defined in paragraph (B) (7) of this policy until December 31, 2020.
 2. The CCBDD will administer the waiting list assessment tool to each individual residing in Clinton County whose name is included on the transitional list of individuals waiting for HCBS.
 3. The CCBDD or the DODD will attempt to contact each individual whose name is included on the transitional list of individuals waiting for HCBS or the individual's guardian, as applicable, by at least two different methods, one of which will be certified mail to the last known address of the individual or the individual's guardian, as applicable. The DODD will remove an individual's name from the transitional list of individuals waiting for HCBS when the individual or the individual's guardian, as applicable:
 - a. Fails to respond to attempts by the CCBDD or the DODD to establish contact; or
 - b. Declines an assessment of the individual using the waiting list assessment tool.

H. There are three possible outcomes of administration of the waiting list assessment tool:

1. The CCBDD determines the individual has an immediate need, in which case the individual will receive services in accordance with OAC 5123-9-04.
2. The CCBDD determines the individual has a current need, in which case the CCBDD will use community-based alternative services to meet the individual's needs or if the individual's needs cannot be met by community-based alternative services, the CCBDD will add the individual's name to the waiting list for HCBS; or
3. The CCBDD determines the individual has neither an immediate need nor a current need.

I. Due process

1. Due process will be afforded to an individual aggrieved by an action of the CCBDD related to:
 - (1.) The approval, denial, withholding, reduction, suspension, or termination of a service funded by the state Medicaid program;
 - (2.) Placement on, denial of placement on, or removal from the waiting list for HCBS or the transitional list of individuals waiting for HCBS; or
 - (3.) A dispute regarding an individual's date of request or status date.
2. Due process will be provided in accordance with section 5160.31 of the Revised Code and Chapters 5101:6-1 to 5101:6-9 of the Administrative Code.

ORC 5126.042; ORC 5125.054; ORC 5160.31

OAC 5123-9-04, OAC 5123:2-3-05; OAC 5123:2-14-01; OAC 5123-4-01; OAC Chapters 5101:6-1 to 5101:6-9; and OAC Chapter 5160-3

Revised: 8/21/18

WAITING LIST FOR HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVERS

A. Waiting List for home and community-based services (HCBS):

1. An individual or the individual's guardian, as applicable, who thinks the individual has an immediate need or a current need may contact the CCBDD to request an assessment of the individual using the waiting list assessment tool.
2. The CCBDD will initiate an assessment of the individual using the waiting list assessment tool within thirty (30) calendar days.
3. An individual or the individual's guardian, as applicable, will have access to the individual's completed waiting list assessment tool maintained in the DODD's web-based waiting list management system and upon request, will be provided a copy by the CCBDD.

B. Placement on the Waiting List for HCBS:

1. The CCBDD will place an individual's name on the waiting list for HCBS when, based on assessment of the individual using the waiting list assessment tool, the individual:
 - a. Has been determined to have a condition that is:
 - (i) Attributable to a mental or physical impairment or combination of mental and physical impairments, other than an impairment caused solely by mental illness;
 - (ii) Manifested before the individual is age twenty-two; and
 - (iii) Likely to continue indefinitely; and
 - b. Has a current need, which cannot be met by community-based alternative services in the county where the individual resides (including a situation in which an individual has a current need despite the individual's enrollment in a HCBS waiver).

C. The CCBDD will NOT place an individual's name on the waiting list for HCBS when the individual:

1. Is a child who is subject to a determination under section 121.38 of the Revised Code and requires HCBS; or
2. Has an immediate need, in which case the CCBDD will take action necessary to ensure the immediate need is met by:
 - a. The CCBDD will provide the individual or the individual's guardian, as applicable, with the option of having the individual's needs met in an intermediate care facility for individuals with intellectual disabilities or through community-based alternative services. Once an individual or individual's guardian chooses the setting in which he or she prefers to receive services, the CCBDD will take action to ensure the individual's immediate need is met, including by enrollment in a HCBS waiver, if necessary.

- b. Such action may also include assisting the individual or the individual's guardian, as applicable, in identifying and accessing alternative services that are available to meet the individual's needs.

D. When the CCBDD places an individual's name on the waiting list for HCBS, the CCBDD will:

- 1. Record, in the DODD's web-based waiting list management system:
 - a. The individual's status date; and
 - b. The individual's date of request, for an individual on the transitional list of individuals waiting for HCBS as defined in paragraph (B) (7) of CCBDD's policy 3.02.
- 2. Notify the individual or the individual's guardian, as applicable, that the individual's name has been placed on the waiting list for HCBS.
- 3. Provide contact information to the individual or the individual's guardian, as applicable, for a person at the CCBDD who can assist in identifying and accessing alternative services that address, to the extent possible, the individual's needs.

E. Annually, the CCBDD will:

- 1. Review the waiting list assessment tool and service needs of each individual whose name is included on the waiting list for HCBS with the individual and the individual's guardian, as applicable; and
- 2. Assist the individual or the individual's guardian, as applicable, in identifying and accessing alternative services.

F. When CCBDD determines an individual's status has changed with regard to having an immediate need and/or having a current need or an individual's status date has changed, the CCBDD will update the individual's record in the DODD's web-based waiting list management system.

G. Order for enrolling individuals in locally-funded HCBS waivers:

- 1. Individuals will be selected for enrollment in locally-funded HCBS waivers in this order:
 - a. Individuals with immediate need who require waiver funding to address the immediate need.
 - b. Individuals who have met multiple criteria for current need for twelve or more consecutive months and who were not offered enrollment in a HCBS waiver in the prior calendar year. When two or more individuals meet the same number of criteria for current need, the individual with the earliest of either the status date or date of request will be selected for enrollment.
 - c. Individuals who have met multiple criteria for current need for less than twelve consecutive months. When two or more individuals meet the same number of criteria

for current need, the individual with the earliest of either the status date or date of request will be selected for enrollment.

- d. Individuals who meet a single criterion for current need. When two or more individuals meet a single criterion for current need, the individual with the earliest of either the status date or date of request will be selected for enrollment.
- H. Individuals with immediate need and individuals with current need may be enrolled in locally-funded HCBS waivers concurrently.
- I. When an individual is identified as next to be enrolled in a locally-funded HCBS waiver, the CCBDD will determine the individual's eligibility for enrollment in a HCBS waiver. When the CCBDD determines an individual is eligible for enrollment in a HCBS waiver, the CCBDD will determine which type of locally-funded HCBS waiver is sufficient to meet the individual's needs in the most cost-effective manner.
- J. Order for enrolling individuals in state-funded HCBS waivers:
- 1. The DODD will determine the order for enrolling individuals in state-funded HCBS waivers.
 - 2. Meeting the criteria for immediate need and/or current need does not guarantee enrollment in a state-funded HCBS waiver within a specific timeframe.
- K. Change in an individual's county of residence:
- 1. Within ninety (90) calendar days of receiving notice, CCBDD will review the individual's waiting list assessment tool after receiving notification that the individual moved into the county of Clinton.
 - a. When the CCBDD determines that an individual has moved to Clinton County and has a current need which cannot be met by community-based alternative services (including a situation in which an individual has a current need despite the individual's enrollment in a HCBS waiver); the CCBDD will update the individual's county of residence in the department's web-based waiting list management system without changing the status date or date of request assigned by the previous county board.
 - b. When the CCBDD determines that an individual that has moved to Clinton County has a current need, which can be met by community-based alternative services, the CCBDD will assist the individual or the individual's guardian, as applicable, in identifying and accessing those services.
- L. Advancement from transitional list of individuals waiting for home and community- based services to waiting list for HCBS:
- 1. The CCBDD will administer the waiting list assessment tool to each individual residing in the county whose name is included on the transitional list of individuals waiting for HCBS who receives SSA services when the individual service plan is next scheduled for review starting September 1, 2018 (per rule 5123-9-04).

2. The CCBDD will administer the waiting list assessment tool to each individual residing in the county whose name is included on the transitional list of individuals waiting for HCBS who does not receive service and support administration no later than December 31, 2020. CCBDD may request and the DODD may provide assistance to identify, locate, contact, or administer the waiting list assessment tool to individuals residing in the county but unknown to the CCBDD.

M. Removal from transitional list:

1. Once the waiting list assessment tool has been administered to an individual whose name is included on the transitional list of individuals waiting for HCBS and a determination made, the CCBDD will notify the DODD. The DODD will remove the individual's name from the transitional list of individuals waiting for HCBS.

N. Due Process:

1. Due process will be provided in accordance with section 5160.31 of the Revised Code, Chapters 5101:6-1 to 5101:6-9 of the Administrative Code and CCBDD Policy 3.02.

ORC 5126.042; ORC 5125.054; ORC 5160.31, ORC 121.38
OAC 5123-9-04, OAC 5123:2-3-05; OAC 5123:2-14-01; OAC 5123-4-01; OAC Chapters 5101:6-1 to 5101:6-9; and OAC Chapter 5160-3

Revised: 08/21/2018

NONDISCRIMINATION OF INDIVIDUALS SERVED

- A. Clinton County Board of Developmental Disabilities shall provide benefits, services and opportunities to all individuals eligible for services equally, without regard to race, color, national origin, religion, spiritual beliefs, age, sex, sexual orientation, socioeconomic status, language or disability in accordance with the determined needs of the individual.
- B. There is no distinction made in determining eligibility for, services because of race, color, national origin, religion, spiritual beliefs, age, sex, sexual orientation, socioeconomic status, language or disability.
- C. In keeping with the Agency's commitment to be responsive to individual needs and preferences, within available resources, every effort to match staff with service needs and accommodate individual/family requests will be made when possible.
- D. All persons and organizations having occasion to refer or recommend individuals to this agency are advised to do so without regard to the individual's race, color, national origin, religion, spiritual beliefs, age, sex, sexual orientation, socioeconomic status, language or disability.
- E. Any individual served, parent, guardian, or daily representative who believes that an individual has been treated in a discriminatory manner may make a verbal or written complaint of discrimination to the Superintendent.
- F. No persons served shall be retaliated against, offered negative repercussion nor endure any barriers to services because of race, color, national origin, religion, spiritual beliefs, sex, age, sexual orientation, socioeconomic status, language or disability or pursuit of due process or administrative resolution of complaints.

Revised: 11/17/15

**NON DISCRIMINATION FOR INDIVIDUAL'S SERVICES PROCEDURE
HEARING ENROLLEE COMPLAINTS OF DISCRIMINATION**

The following process shall be followed by individuals and/or their representatives when filing a complaint of discrimination by the Agency.

A. Registering a Complaint

The individual or his/her representative may register a complaint of discrimination on the basis of race, color, national origin, religion, spiritual beliefs, place of origin, sex, age or handicap with the local Civil Rights/Section 504 Coordinator, or the person assigned by the provider to ensure compliance with civil rights regulations. The complaint must be filed within 180 days of the alleged act of discrimination. The deadline for filing may be extended by the Ohio Department of Developmental Disabilities (DODD) State Civil Rights Coordinator given justifying circumstances.

B. Acknowledgment of Complaints

Within fifteen (15) days from the receipt of a complaint, the local Civil Rights/Section 504 Coordinator will, in an acknowledgment letter:

1. Confirm the date the complaint was received;
2. Request an informal meeting, providing the purpose of the meeting, the date, the time and the place of the proposed meeting;
3. Inform the complainant of the right to bring counsel, or have representation at the informal meeting. The local Civil Rights/Section 504 Coordinator will forward a copy of each complaint with the acknowledgment letter to the DODD's State Civil Rights Coordinator.

C. Informal Meeting with Complainant

An informal meeting between the local Civil Rights/Section 504 Coordinator and the complainant will be held in an attempt to define the problems surrounding the complaint and to resolve the problems. The informal meeting shall take place within fifteen (15) days of the written acknowledgment of the receipt of the complaint. Following the informal meeting, the local Civil Rights/Section 504 Coordinator will have fifteen (15) days to notify the complainant in writing to confirm the resolution of the matter or any recommendations reached. If the meeting indicates a need for an investigation in order to resolve the complaint, the local Civil Rights/Section 504 Coordinator will have thirty (30) days to conduct the investigation.

D. Investigation

The local Civil Rights/Section 504 Coordinator shall conduct such investigation of a complaint that is appropriate to determine its validity. This mandate contemplates informal, but thorough, investigations, affording all concerned individuals and their representatives, if any, an opportunity to submit statements/documents/information. The local Civil Rights/Section 504 Coordinator will issue to the complainant a written decision concerning the validity and resolution of the complaint not later than thirty (30) days following the written decision of the informal hearing. The local Civil Rights/Section 504 Coordinator will forward a copy of the written decision, which

informed the complainant of the agency's determination regarding the complaint, to DODD's Civil Rights Coordinator.

E. Request for Formal Hearing

After receipt of the local Civil Rights/Section 504 Coordinator's written decision, the complainant has fifteen (15) days to request a formal hearing if it is felt that the decision was inappropriate. The request for a hearing shall be directed in a letter to the local Civil Rights/Section 504 Coordinator.

F. Formal Hearing

Within fifteen (15) days of a request for a formal hearing, the local Civil rights/Section 504 Coordinator shall hold a hearing before the Civil Rights/Section 504 Committee of the Agency, the licensed residential facility, or the developmental center where the discrimination is alleged to have taken place. Three (3) disinterested persons from the committee shall hear the evidence and testimony presented and shall arrive at a decision concerning the discrimination complaint. At least one (1) person from outside the agency shall be on the hearing body and one (1) individual with a disability (or advocate for individuals with disabilities) if the complaint involves handicap discrimination. No person rendering a previous decision on the pending complaint shall be used. A tape recording of the testimony and cross-examination and all evidence shall be kept. Both parties may be represented by counsel, if desired. Within fifteen (15) days of the conclusion of the hearing, the written decision or recommendation of the hearing body shall be mailed to the complainant.

G. Appeal to DODD

If the complainant believes that the discriminatory conditions leading to the complaint continue, that the decision rendered by the local service provider is inappropriate, or that the hearing process was improperly carried out, the complainant may ask for a review of the case by the DODD Civil Rights Coordinator. The appeal must be made, in writing, no more than fifteen (15) days following receipt of the formal hearing decision. The service provider may also request an appeal within fifteen (15) days, if justification for the appeal is sent to the DODD Civil Rights Coordinator. The DODD Civil Rights Coordinator must acknowledge to both parties receipt of any appeal request within fifteen (15) days, and shall have from thirty (30) up to forty-five (45) days to review evidence from the local investigation/hearings or to investigate further.

The DODD Civil Rights Coordinator shall do one of the following:

1. Sustain the previous decision;
2. Recommend a different solution;
3. Recommend that the complainant report the discrimination complaint to the Office for Civil Rights (H.H.S.)

H. Result of Appeal Review

Written notification of the DODD Civil Rights Coordinator's decision shall be mailed to both parties immediately (maximum forty-five (45) days) following the decision. If the decision mandates some changes of policy or practice by the service provider, the

changes shall be implemented and reported to the Ohio Department of DD's Civil Rights Coordinator within thirty (30) days of receipt of the DODD Civil Rights Coordinator's decision letter.

I. Notification of Complainant's Rights

The complainant shall be notified at the time the original complaint is filed that at any time during the process the complainant may report the alleged discrimination to the Office for Civil Rights (OCR), U.S. Department of Health and Human Services. The local Civil Rights/Section 504 Coordinator shall assist the complainant in reporting to OCR, if necessary.

**HOME AND COMMUNITY-BASED SERVICES WAIVERS
FREE CHOICE OF PROVIDERS**

A. The Clinton County Board of Developmental Disabilities will follow the free choice of provider process for assuring an individual's right to obtain home and community-based services from any qualified and willing provider in accordance with the Ohio Administrative Rule 5123-9-11, 42 C.F.R. 431.51, sections 5123.044 and 5126.046 of the Ohio Revised Code.

B. Notification of free choice of providers, assistance with the provider selection process, and procedural safeguards

(1) The Clinton County Board of Developmental Disabilities will notify each individual at the time of enrollment in a home and community-based services waiver and at least annually thereafter, of the individual's right to choose any qualified and willing provider of home and community-based services. The notification will specify that:

(a) The individual may choose agency providers, independent providers, or a combination of agency providers and independent providers;

(b) The individual may choose providers from all qualified and willing providers available statewide and is not limited to those currently providing services in a given county;

(c) The individual may choose to receive services from a different provider at any time;

(d) The service and support administrator will assist the individual with the provider selection process if the individual requests assistance.

(2) A service and support administrator will assist an individual enrolled in a home and community-based services waiver with one or more of the following, as requested by the individual:

(a) Accessing the department's website to conduct a search for qualified and willing providers;

(b) Providing the individual with the department's guide to interviewing prospective providers;

(c) Sharing objective information with the individual about providers that includes reports of provider compliance reviews conducted in accordance with section 5123.162 or 5123.19 of the Revised Code, approved plans of correction submitted by providers in response to compliance reviews, number of individuals currently served, and any information about services offered by the provider to meet the unique needs of a specific group of individuals such as aging adults, children with autism, or individuals with intense medical or behavioral needs;

- (d) Utilizing the statewide, uniform format to create a profile includes the type of services and supports the individual requires, hours of services and supports required, the individual's essential service preferences, the funding source of services, and any other information the individual chooses to share with prospective providers;
- (e) Making available to all qualified providers in the county that have expressed an interest in serving additional individuals, the individual-specific profile created in accordance with paragraph (C)(2)(d) of this policy to identify willing providers of the service;
- (f) Contacting providers on the individual's behalf;
- (g) Developing provider interview questions that reflect the characteristics of the individual's preferred provider; and
- (h) Scheduling and participating as needed in interviews of prospective providers. The service and support administrator may participate in this interview as directed by the individual.

(3) The Clinton County Board of Developmental Disabilities will document the alternative home and community-based services settings that were considered by each individual and ensure that each individual service plan reflects the setting options chosen by the individual.

(4) The county board will document that each individual has been offered free choice among all qualified and willing providers of home and community-based services.

(5) If the Clinton County Board of Developmental Disabilities receives a complaint from an individual regarding the free choice of provider process, the county board will respond to the individual within thirty days and provide the department with a copy of the individual's complaint and the county board's response. The department will review the complaint and the county board's response and take actions it determines necessary to ensure that each individual has been afforded free choice among all qualified and willing providers of home and community-based services.

(C) Commencement of services

The Clinton County Board of Developmental Disabilities will adopt written procedures to ensure that home and community-based services begin in accordance with the date established in the individual service plan. The procedures will include a requirement for the county board to monitor the service commencement process and implement corrective measures if services do not begin as indicated.

(D) Department training and oversight

- (1) The department will periodically provide training and assistance to familiarize county boards and individuals with the rights and responsibilities set forth in rule 5123:2-9-11.
- (2) The department will investigate or cause an investigation when an individual alleges that the individual is being denied free choice of providers for home and community-based services.
- (3) The department will utilize the accreditation process in accordance with rule 5123-4-01 of the Administrative Code to monitor county board compliance with requirements of rule 5123-9-11.

(E) Due process and appeal rights

- (1) Any recipient of or applicant for home and community-based services may utilize the process set forth in section 5101.35 of the Ohio Revised Code (ORC), in accordance with division 5101:6 of the Ohio Administrative Code (OAC), for any purpose authorized by that statute and the rules implementing the statute, including being denied the choice of a provider who is qualified and willing to provide home and community-based services. The process set forth in section 5101.35 of the ORC is available only to applicants, recipients, and their lawfully authorized representatives.
- (2) Providers may not utilize or attempt to utilize the process set forth in section 5101.35 of the ORC or appeal or pursue any other legal challenge to a decision resulting from the process set forth in section 5101.35 of the ORC.
- (3) The Clinton County Board of Developmental Disabilities will inform the individual, in writing and in a manner the individual can understand, of the individual's right to request a hearing in accordance with division 5101:6 of the OAC.
- (4) The Clinton County Board of Developmental Disabilities will immediately implement any final state hearing decision or administrative appeal decision relative to free choice of providers for home and community-based services issued by the Ohio Department of Medicaid, unless a court of competent jurisdiction modifies such a decision as the result of an appeal by the Medicaid applicant or recipient.

Reference: ORC: 5123.04, 5123.044, 5126.046, 5126.055, 5126.15, 5166.21 and
OAC: 5123-9-11
Revised: 01/04/2024

**HOME AND COMMUNITY-BASED SERVICES WAIVERS
FREE CHOICE OF PROVIDERS**

A. Purpose:

The Clinton County Board of Developmental Disabilities will follow the Free Choice of Provider process for ensuring individuals are notified of their right to choose from any qualified and willing provider in accordance with rule 5123:2-9-11.

B. Notification of Free Choice of Provider Process:

(1) All Individuals served will be notified of their right to choose any qualified and willing statewide provider by the Service and Support Administrator (SSA) upon enrollment in a home and community-based services program, annually at the time of re-determination, and at any other time the individual/guardian expresses an interest in or makes a request to choose a new, different, or additional provider.

(2) The Clinton County Service and Support Administrator (SSA) will follow the free choice of provider process, by notifying individuals of their right to choose any provider, or multiple providers for each service specified in an individual's ISP.

(3) The notification will be reviewed and provided annually in writing as part of the person-centered service planning process.

C. The SSA will assist with Free Choice of Provider Process by:

(1) Offering to assist the individual in accessing the DODD website to conduct a search of potential providers;

(2) Providing the DODD guide on interviewing providers when an individual has expressed an interest in pursuing adding a new or different service provider;

(3) Sharing objective information with the individual about providers, i.e. compliance reviews, approved plans of correction, number of individuals currently served, and other pertinent information about services offered;

(4) Utilizing the statewide, uniform format for developing a "Free Choice of Provider Profile" in order to share information about the individual with prospective providers;

(5) Contacting providers on the individual's behalf;

(6) Assisting the individual by developing provider interview questions; and

(7) Scheduling and participating in interviews of prospective providers.

- (8) Maintaining documentation of the contacts made to potential providers, interviews, etc.
 - (i) Documentation will include the list of providers contacted and the date(s) on which the notifications occurred.
 - (ii) Dates and case notes of any provider interviews that are completed will be maintained in the individual's file.
- (9) Honoring the individual's request when he or she chooses a specific provider independently without assistance. During these times the Free Choice of Provider Process would not need to be followed; however, the individual's choice of provider will be documented.
- (10) Documenting the alternative home and community-based services settings that were considered by each individual and ensure that each individual service plan reflects the setting options chosen by the individual.

D. Complaints:

- (1) If an individual makes a complaint regarding the Free Choice of Provider Process, the SSA will respond in writing within thirty days in a manner that the individual can understand and explain the individual's right to a hearing.
- (2) A copy of the individual's complaint will be provided to the department along with a copy of the county board's response.

E. Commencement of services:

- (1) The SSA will complete the commencement of services form within 10 days after the effective date of a new provider service.
- (2) The SSA will document on the commencement of services form any corrective measures to be implemented if applicable, or if services do not begin as indicated.

Reference: ORC: 5123.04, 5123.044, 5126.046, 5126.055, 5126.15, 5166.21 and

OAC: 5123-9-11

Revised: 01/04/2024

RESOLUTION OF COMPLAINTS AND APPEALS OF ADVERSE ACTIONS

- A. The Clinton County Board of Developmental Disabilities (CCBDD) will protect the rights of individuals receiving, or applying to receive services. Individuals, parents, guardians, and/or caregivers will be given annual notice of this policy. This policy is in addition to any other rights, which an individual, parent of a minor, guardian, or agency may have pursuant to the Ohio Revised Code or any other applicable state or federal law.
- B. All individuals are encouraged to first resolve complaints through the CCBDD's Informal Resolution of Complaints Procedures. The Clinton County Board authorizes the Superintendent to appoint one or more persons to conduct an informal hearing of such disputes. The Superintendent and persons conducting the hearing will seek to resolve the issue within thirty days.
- C. Most questions, concerns and complaints can be answered simply and quickly through the informal process. However, if the Informal Resolution of Complaints Procedure has not been successful, or if an individual disagrees with a decision to change a service, the Formal Resolution of Complaints Procedure will be initiated.
- D. Any individual or person, other than an employee of the CCBDD may file a complaint using the process set forth in this policy or as indicated in procedures of 3.05.2 of the CCBDD. An individual may appeal an adverse action using the process set forth in this policy or as indicated in the procedures 3.05.2. The resolution of complaints process established under OAC 5123-04-04, within this policy, and within the CCBDD procedures 3.052, will be followed before commencing a civil action.
- E. This policy will not be applicable:
1. When the CCBDD is a vendor or subcontractor for service delivery.
 2. To education services arranged by the local education agency. Complaints or appeals concerning such services will follow rules adopted by the Ohio department of education.
 3. To services provided under Part C of the Individuals with Disabilities Education Act, 34 C.F.R. 303. Complaints or appeals concerning such services will follow rules in Chapter 5123-10 of the Administrative Code.
 4. To Medicaid services including home and community-based waiver services and targeted case management services. Complaints or appeals concerning such services will follow rules adopted by the Ohio department of Medicaid. The CCBDD will not require the use of the process set forth in this policy for issues regarding Medicaid services. Individuals receiving services and supports through the Medicaid TCM program and the Home and Community-Based Services Waiver program will be informed of due process rights at the time of application for services, annually, and when it is proposed that services be denied, reduced or terminated.
 5. To performance of health-related activities and administration of medication by developmental disabilities personnel pursuant to the authority granted under section 5123.42 of the Revised Code or compliance with Chapter 5123:2-6 of the Administrative Code. Complaints or appeals concerning such matters will be made to the department using the process established in rule 5123:2-17-01 of the Administrative Code.

6. To services provided to a resident of an intermediate care facility for individuals with intellectual disabilities by that facility, or provided on behalf of or through a contract with an intermediate care facility for individuals with intellectual disabilities. Complaints or appeals concerning such services will follow regulations governing intermediate care facilities for individuals with intellectual disabilities.
- F. Individuals, parents of a minor, guardians, service providers, and any entity contracting with the CCBDD will be informed a minimum of annually regarding the process for the Resolution of Complaints and Appeals of Adverse Action and the right to Medicaid Due Process.
1. The "Complaint or Appeal of Adverse Action Explanation Form" will be provided by the CCBDD to an individual at the time of the individual's initial request for services, at least annually to each individual receiving or on a waiting list for non-Medicaid services, and at the time a complaint within the scope of this policy is received or the CCBDD proposes an adverse action.
 2. The "Complaint or Appeal of Adverse Action Explanation Form" will be given at annual ISP and IFSP meetings.
 3. The "Complaint or Appeal of Adverse Action Explanation Form" will be given to contracted entities when each contract is initiated and renewed.
 4. In addition, the "Complaint or Appeal of Adverse Action Explanation Form" is available on the CCBDD website.
 5. Individuals receiving Part C services will receive notice at least annually of their parent rights (includes information regarding how to file a complaint).
- G. Areas subject to a complaint or an appeal include, but are not necessarily limited to, eligibility determination, arranging appropriate services for eligible individuals, or any denial, reduction, or termination of services by the CCBDD.
- H. Only issues under the control of the CCBDD are subject to a complaint or an appeal. Any appeal filed with the CCBDD will not cancel any other rights to services. If an individual, parent of a minor, or guardian is appealing a termination or reduction of services or change in services, current services will continue to be provided pending final resolution.
- I. An individual who wishes to file a complaint or to appeal a decision may be given assistance by an advocate who may speak on behalf of the individual at the individual's request.
- J. The CCBDD will inform the individual served, parents of a minor, or guardian that a CCBDD representative is available to assist the individual with the appeal process.
- K. The CCBDD and the Ohio Department of Developmental Disabilities (DODD) will at all times maintain confidentiality concerning the identities of individuals, complainants, witnesses, and other involved parties who provide information unless the individual or his/her representative, in writing, authorizes the release of information.
- L. Timelines may be extended if mutually agreeable to all involved parties.

- M. The toll-free number for the Ohio Department of Developmental Disabilities and Disability Rights Ohio will be posted in a visible place at all locations in which the CCBDD provides or contracts to provide services.
- N. The CCBDD will develop procedures for the Resolution of Complaints and Appeals of Adverse Action, Informal Resolution of Complaints, and Medicaid Due Process.

Reference: OAC 5123-4-04
Board Approved: 8/20/2019

INFORMAL RESOLUTION OF COMPLAINTS AND APPEALS OF ADVERSE ACTIONS

- A. The Clinton County Board of Developmental Disabilities (CCBDD) will support continuous improvement of quality services for individuals with disabilities. In an effort to informally resolve disputes with complainants or individuals, the CCBDD will follow this informal complaint resolution procedure.
- B. The CCBDD encourages individuals and families to make suggestions for the improvement of services provided by the CCBDD.
- C. The CCBDD encourages individuals and families to use the following guidelines to informally resolve disputes and/or complaints. The CCBDD staff will assist the individual or family through these guidelines. The individual or family member will:
 1. **Start with the people you know best:** The people you know, such as the direct service staff and department managers may be able to assist you. If they cannot answer your concerns, they will help you find someone who can.
 2. **Issues need to be addressed promptly:** The best time to correct a problem or consider a new idea is when the details are fresh in your mind. It can be difficult to do anything about a problem that happened many days or weeks prior.
 3. **Be specific:** Tell us your concerns, involved individuals, what did or did not happen, and what you want to see happen in the future.
 4. **Address one issue at a time:** Some concerns can be addressed quickly and completely. Other concerns will take more time. Remember, at any time you can go straight to the Formal Resolution of Complaints and Appeals process per CCBDD's Policy 3.05.
- D. Filing of such complaints under this procedure will not affect the rights of the complainant or individual to file an appeal through the Resolution of Complaints and Appeals Procedures under the CCBDD's Resolution of Complaints and Appeals Policy. Notice of this right will be provided upon initiation of the informal process via supplemental issuance of the Resolution of Complaints and Appeals Policy.
- E. The Superintendent will appoint one or more persons to conduct an informal hearing of such complaints or appeals. The persons conducting the hearing will seek to resolve the issue within thirty calendar days.
- F. Annual notice of the Informal and Formal Resolution of Complaints and Appeals Procedure will be given to all Individuals, parents of minor, guardians, service providers and any entity contracting with the CCBDD.
 1. The "Complaint or Appeal of Adverse Action Explanation Form" will be provided by the CCBDD to an individual at the time of the individual's initial request for services, at least annually to each individual receiving or on a waiting list for non-Medicaid services, and at the time a complaint within the scope of this Procedure and Policy 3.05 is received or the CCBDD proposes an adverse action.
 2. The "Complaint or Appeal of Adverse Action Explanation Form" will be given at annual ISP and IFSP meetings.

3. The "Complaint or Appeal of Adverse Action Explanation Form" will be given to contracted entities when each contract is initiated and renewed.
4. In addition, the "Complaint or Appeal of Adverse Action Explanation Form" is available on the CCBDD website.
5. Individuals receiving Part C services will receive notice at least annually of their parent rights (includes information regarding how to file a complaint).

Reference: OAC 5123-4-04

Revised: 8/20/2019

RESOLUTION OF COMPLAINTS AND APPEALS OF ADVERSE ACTIONS**A. Purpose**

This procedure sets forth the process for resolution of complaints involving the programs, services, policies, or administrative practices of the Clinton County Board of Developmental Disabilities (CCBDD) or an entity under contract with the CCBDD; the process for individuals to appeal adverse actions proposed or initiated by the CCBDD; and the requirement for the CCBDD to give notice of the process to be followed for resolution of complaints and appeals of adverse action.

B. Scope

1. Any individual or person, other than an employee of the CCBDD, may file a complaint using the process set forth in this procedure. An individual may appeal an adverse action using the process set forth in this procedure. The process set forth in this procedure will be followed before commencing a civil action.
2. If the CCBDD determines that a complaint or an appeal of adverse action filed with the CCBDD is not subject to this procedure, the CCBDD will provide information to the individual or person filing the complaint or appeal, including the name and telephone number, if available, of the appropriate entity with which to file the complaint or appeal of adverse action.
3. An individual receiving non-Medicaid supported living services will follow the terms of the contract of the service provider, as required by section 5126.45 of the Revised Code, prior to beginning the process for resolution of complaints or appeals of adverse action established in this procedure.
4. If the complaint is regarding the denial, reduction or termination of services funded by Medicaid, the individual or complainant and the Superintendent/designee will follow the procedures outlined in the Medicaid Due Process procedure.

C. General Provisions

1. Complaints and appeals of adverse action will be filed in writing. When an individual or person expresses dissatisfaction with an outcome subject to complaint or appeal in accordance with this procedure, the CCBDD will, to the extent necessary, assist the individual or person in filing a complaint or appeal.
2. At all times throughout the resolution of complaints and appeals of adverse action process, the CCBDD will maintain the confidentiality of the identities of individuals unless an individual gives written permission to share information.
3. An advocate may assist an individual at any time during the resolution of complaints and appeals of adverse action process.

4. The CCBDD will make all reasonable efforts to ensure that information regarding resolution of complaints and appeals of adverse action, including all notices and responses made pursuant to this procedure, is presented using language and in a format understandable to affected individuals and persons. All notices and responses made pursuant to this procedure will include an explanation of the individual's or person's opportunity to file a complaint with or appeal to a higher authority, as applicable.
5. The time lines set forth in this procedure may be extended if mutually agreed upon in writing by all parties involved.
6. Initiation of the formal process set forth in this procedure does not preclude the resolution of a complaint or an appeal of adverse action at any point, as long as the outcome is mutually agreed upon in writing by all parties involved.

D. Requirements for the CCBDD to provide information about the process for resolution of complaints and appeals of adverse action and to give notice of adverse action

1. General information about the process for resolution of complaints and appeals of adverse action.
 - a. The CCBDD will give the "Complaint or Appeal of Adverse Action Explanation Form" to an individual at the time of the individual's initial request for services, at least annually to each individual receiving or on a waiting list for non-Medicaid services, and at the time a complaint within the scope of this procedure is received or the CCBDD proposes an adverse action.
 - b. Upon request, the CCBDD or contracting entity will provide a copy of this procedure.
 - c. The CCBDD will publicly post the "Complaint or Appeal of Adverse Action Explanation Form".
2. Specific notice of adverse action.
 - a. Except when it is necessary to suspend an individual's services without delay to ensure the health and safety of the individual or other individuals in accordance with paragraph (D) (3) of this procedure, the CCBDD will provide written notice to the affected individual of the CCBDD's decision to deny, reduce, suspend, or terminate services at least fifteen calendar days prior to the effective date of such action. The notice will include:
 - (i) An explanation of the CCBDD's policy and/or authority for taking the adverse action;
 - (ii) A description of the specific adverse action being proposed or initiated by the CCBDD;
 - (iii) The effective date for the adverse action;
 - (iv) A clear statement of the reasons for the adverse action including a description of the specific assessments and/or documents that are the basis for the adverse action;

- (v) An explanation of the individual's right to appeal the adverse action;
 - (vi) An explanation of the steps the individual must take to appeal the adverse action;
 - (vii) A statement that the individual has ninety calendar days to appeal the adverse action;
 - (viii) A statement that the individual must file his or her appeal prior to the effective date for the adverse action to keep his or her services in place during the appeal process;
 - (ix) The name and contact information for the staff member of the CCBDD who can assist the individual with his or her appeal; and
 - (x) The "Complaint or Appeal of Adverse Action Explanation Form".
- b. The CCBDD will retain written evidence of the date the notice is personally delivered or sent by certified mail to the individual or for an individual who has selected email as his or her preferred method of communication, the date of electronic confirmation that the individual has read the email.
3. Specific notice of adverse action when it is necessary to suspend an individual's services without delay to ensure the health and safety of the individual or other individuals.
- a. When it is necessary to suspend an individual's services without delay to ensure the health and safety of the individual or other individuals, the CCBDD will:
 - (i) Determine what immediate steps are necessary to ensure the health and safety of the individual and other individuals; and
 - (ii) Provide written notice to the affected individual immediately. The notice will include:
 - (a) An explanation of the CCBDD's policy and/or authority for suspending the individual's services;
 - (b) A description of the specific services being suspended;
 - (c) The effective date for the suspension of services;
 - (d) A clear statement of the reasons for the suspension of services including a description of the specific circumstances that jeopardize the health and safety of the individual or other individuals;
 - (e) An explanation that the CCBDD will arrange for appropriate alternative services and a description of the specific alternative services available to the individual;
 - (f) An explanation of the steps the CCBDD will take in accordance with paragraphs (D)(3)(c) and (D)(3)(d) of this procedure;
 - (g) The name and contact information for the staff member of the CCBDD who can answer questions about the suspension of services; and
 - (h) The "Complaint or Appeal of Adverse Action Explanation Form".
 - b. The CCBDD will retain written evidence of the date the notice is personally delivered or sent by certified mail to the individual or for an individual who has selected email as his or her preferred method of communication, the date of electronic confirmation that the individual has read the email.

- c. Within five calendar days of the notice of suspension of services, the CCBDD will convene a team meeting to identify measures that may be implemented to eliminate the circumstances that jeopardize the health and safety of the individual or other individuals.
- d. Within five calendar days of the team meeting, the CCBDD will:
 - (i) With the consent of the individual, implement measures to eliminate the circumstances that jeopardize the health and safety of the individual or other individuals as necessary and restore the suspended services; or
 - (ii) With the consent of the individual, continue to arrange for appropriate alternative services; or
 - (iii) Provide written notice that includes the components described in paragraphs (D)(2)(a)(i) to (D)(2)(a)(x) of this procedure to the individual of the CCBDD's decision to terminate the individual's services at least fifteen calendar days prior to the effective date of such action. If the individual files an appeal prior to the effective date of the termination of services, the CCBDD will keep the individual's alternative services in place until the appeal process is completed.

E. Informal process for resolution of complaints and appeals of adverse action

The CCBDD will adopt a written procedure describing an informal process that will take no longer, than thirty calendar days for resolution of complaints and appeals of adverse action. An individual or person may elect to participate in the informal process or may initiate the formal process set forth in paragraph (F) of this procedure.

F. Formal process for resolution of complaints and appeals of adverse action

- 1. Step one: filing a complaint or appeal of adverse action with the supervisor or manager responsible for the program, service, policy, or administrative practice of the CCBDD.
 - a. An individual or person must file a complaint with the supervisor or manager of the CCBDD within ninety calendar days of becoming aware of the program, service, policy, or administrative practice that is the subject of the complaint.
 - b. An individual must file an appeal of adverse action with the supervisor or manager of the CCBDD within ninety calendar days of notice of the adverse action or within ninety calendar days of conclusion of the informal process set forth in paragraph (E) of this procedure. If the individual appeals an adverse action within the prior notice period (i.e., the period of time between notice of the intended adverse action and the effective date of the adverse action), the individual's services will not be reduced, suspended, or terminated until the appeal process is completed or the appeal is withdrawn by the individual. An individual who appeals during the prior notice period may voluntarily consent in writing to the reduction, suspension, or termination of services during the appeal process.
 - c. The supervisor or manager of the CCBDD will conduct an investigation of the complaint or appeal, which will include meeting with the individual or person who filed the complaint or appeal.

- d. Within fifteen calendar days of receipt of the complaint or appeal, the supervisor or manager of the CCBDD will provide and thereafter be available to discuss a written report and decision with the individual or person who filed the complaint or appeal. The written report and decision will include the rationale for the decision and a description of the next step in the process if the individual or person is not satisfied with the decision of the supervisor or manager.
2. Step two: filing a complaint or appeal of adverse action with the superintendent of the CCBDD.
 - a. If the individual or person filing the complaint or appeal of adverse action is not satisfied with the outcome of the process set forth in paragraph (F)(1) of this procedure, the individual or person may file a complaint or appeal with the superintendent of the CCBDD.
 - b. The complaint or appeal of adverse action must be filed with the superintendent of the CCBDD within ten calendar days of notice of the decision of the supervisor or manager of the CCBDD. If no decision is provided by the supervisor or manager of the CCBDD within fifteen calendar days in accordance with paragraph (F)(1)(d) of this procedure, the complaint or appeal of adverse action must be filed with the superintendent of the CCBDD within twenty-five calendar days of filing the complaint or appeal with the supervisor or manager.
 - c. The superintendent of the CCBDD or his or her designee will, within ten calendar days of receipt of the complaint or appeal, meet with the individual or person and conduct an administrative review.
 - d. As part of the administrative review, the superintendent of the CCBDD or his or her designee may ask questions to clarify and review the circumstances and facts related to the supervisor's or manager's decision and will provide the individual or person the opportunity to present reasons why the supervisor's or manager's decision should be reconsidered.
 - e. Within fifteen calendar days of receipt of the complaint or appeal, the superintendent of the CCBDD or his or her designee will send by certified mail, a copy of his or her decision to the individual or person who submitted the complaint or appeal. Such decision will include the rationale for the decision and a description of the next step in the process if the individual or person is not satisfied with the decision of the superintendent of the CCBDD or his or her designee.
3. Step three: filing a complaint or appeal of adverse action with the president of the CCBDD.
 - a. If the individual or person filing the complaint or appeal of adverse action is not satisfied with the outcome of the process set forth in paragraph (F)(2) of this procedure, the individual or person may file a complaint or appeal with the president of the CCBDD.
 - b. The complaint or appeal of adverse action must be filed with the president of the CCBDD within ten calendar days of notice of the decision of the superintendent of the CCBDD or his or her designee. If no decision is provided by the

- superintendent of the CCBDD or his or her designee within fifteen calendar days in accordance with paragraph (F) (2) (e) of this procedure, the complaint or appeal of adverse action must be filed with the president of the CCBDD within twenty-five calendar days of filing the complaint or appeal with the superintendent.
- c. The president of the CCBDD will ensure that a hearing is conducted within twenty calendar days of receipt of the complaint or appeal at a time and place convenient to all parties. At such hearing:
 - (i) The CCBDD may hear the complaint or appeal;
 - (ii) A committee of two or more CCBDD members appointed by the president of the CCBDD with agreement of the CCBDD, may hear the complaint or appeal. The committee will issue a report and recommendation to the CCBDD within ten calendar days of the conclusion of the hearing; or
 - (iii) A hearing officer appointed by the CCBDD may hear the complaint or appeal. The hearing officer will have the same powers and authority in conducting the hearing as granted to the CCBDD. The hearing officer will not be an employee or contractor of the CCBDD providing any service other than that of hearing officer. The hearing officer need not be an attorney, but will possess qualifications to be able to make neutral and informed decisions about the complaint or appeal. The CCBDD may ask the department to decide if a person is qualified to be a hearing officer. The hearing officer will issue a report and recommendation to the CCBDD within ten calendar days of the conclusion of the hearing.
 - d. Upon request, the individual or person filing the complaint or appeal will be provided access to all records and materials related to the complaint or appeal no less than ten calendar days before the hearing.
 - e. To the extent permitted by law, the hearing will be private unless the individual or person requesting the hearing wants it open to the public.
 - f. During the hearing, both parties may present evidence to support their positions.
 - g. The individual or person requesting the hearing and the CCBDD have the right to be represented by an attorney.
 - h. The individual or person requesting the hearing will have the right to have in attendance at the hearing and question any official, employee, or agent of the CCBDD who may have evidence upon which the complaint or appeal is based.
 - i. Evidence presented at the hearing will be recorded by stenographic means or by use of an audio recorder at the option of the CCBDD. The record will be made at the expense of the CCBDD and, upon request, one copy of a written transcript will be provided, at no cost, to the individual or person requesting the hearing.
 - j. In making its decision, the CCBDD may request or consider additional information with notice to all affected parties, may request a presentation in writing and/or in person from each party, or take other action necessary to make a determination.
 - k. Within fifteen calendar days of conclusion of a CCBDD hearing or the CCBDD's receipt of the report and recommendation from a CCBDD- appointed committee or a hearing officer, the president of the CCBDD or his or her designee will send by certified mail, a copy of the CCBDD's decision to the individual or person who

requested the hearing. Such decision will include the rationale for the decision and a description of the next step in the process if the individual or person is not satisfied with the decision of the CCBDD.

4. Step four: filing a complaint or appeal of adverse action with the director.
 - a. If the individual filing the complaint or appeal of adverse action is not satisfied with the outcome of the process set forth in paragraph (F)(3) of this procedure, the individual may file a complaint or appeal with the director.
 - b. The complaint or appeal of adverse action must be filed with the director within fifteen calendar days of notice of the decision of the CCBDD. If no decision is provided by the president of the CCBDD within fifteen calendar days in accordance with paragraph (F)(3)(k) of this procedure, the complaint or appeal of adverse action must be filed with the director within fifty-five calendar days of filing the complaint with the president of the CCBDD.
 - c. The director will send a copy of the complaint or appeal of adverse action to the superintendent and president of the CCBDD.
 - d. The president of the CCBDD or his or her designee will send the director the written transcript of the CCBDD hearing, copies of any exhibits, and a copy of the CCBDD's decision within fifteen calendar days of receiving the copy of the complaint or appeal of adverse action from the director.
 - e. Upon request by an affected party or at the director's initiation, the director may request or consider additional information with notice to all affected parties, may request a presentation in writing and/or in person from each party, or take other action necessary to make a determination.
 - f. Within thirty calendar days of receipt of the written transcript of the CCBDD hearing, copies of any exhibits, and a copy of the CCBDD's decision from the president of the CCBDD, the director will send by certified mail, a copy of his or her decision to all affected parties. The director will uphold the decision of the CCBDD if the director determines that the decision is in accordance with applicable statute and administrative rule. The director's decision will include the rationale for the decision.

G. Other remedies

After exhausting the administrative remedies required by this procedure, an individual or person may commence a civil action if the complaint or appeal of adverse action is not resolved to his or her satisfaction. This procedure is not intended to provide any right or cause of action that does not exist absent this procedure.

H. The CCBDD will not take any retaliatory steps against the complainant during this process as specified under HIPAA privacy rules 45 CFR 160.310(b).

I. The CCBDD will retain all documentation of complaints related to the uses and disclosure of related protected health information, and the disposition of those complaints, in accordance with their Confidentiality policy and procedures as defined under the HIPAA privacy rules 45 CFR 164.530(j).

Reference: OAC 5123-4-04
Revised: 8/20/2019

MEDICAID DUE PROCESS AND APPEALS

Individuals receiving services through the CCBDD may, when eligible, have their services funded through Medicaid (TCM, HCBS Waiver). Whenever services funded through Medicaid are initiated, the Service and Support Administrator will provide written information to the individual, the parent of a minor, or the legal guardian regarding his/her Medicaid Due Process Rights.

A. ODJFS Medicaid Forms for Due Process/Appeal Rights:

1. When notifying the individual, parent of a minor, legal guardian or authorized representative of his/her Medicaid Due Process/Appeal Rights, the Service and Support Administrator will include the appropriate ODJFS form:
 - a) ODJFS Form #4065 “Prior Notice of Right to a State Hearing” will be used when Medicaid funded services are suspended, terminated, reduced, or changed (i.e. provided if HCBS Waiver Services are reduced or services outlined in the Individual Service Plan are changed, etc.).
 - b) ODJFS Form #7334 “Notice of Denial of Your Application for Assistance” will be used when the initial request for Medicaid funded services is denied or when an increase in frequency/duration of services is denied (i.e. provided if individual is placed on the waiting list or individual is on a HCBS waiver and requests additional waiver services but the SSA feels that the assessments do not indicate a need, etc.).
 - c) ODJFS Form #4074 “Notice of Approval of Your Application for Assistance” will be used when Medicaid services are approved (i.e. provided for all approved Individual Service Plans or if offering a HCBS Waiver, etc.).
 - d) ODJFS Form #4059 “Explanation of State Hearing Procedures” will be used to provide general information on State Hearing Procedures (i.e. provided with waiting list notifications along with ODJFS Form #7334 or provided when someone is removed from the waiting list, etc.).

B. Adverse Actions:

1. Adverse Actions include any denial, reduction, suspension, or termination of Medicaid services or denial of eligibility.
2. The Service and Support Administrator will provide written notification of Medicaid Due Process/Appeal Rights (including the CCBDD’s Resolution of Complaints Policy and Procedures) to the affected individual, parent of a minor, or legal guardian whenever any Adverse Action(s) regarding services funded through Medicaid are proposed:
 - a) The written notification will include:
 1. A clear and understandable statement of the proposed action by the CCBDD,
 2. The reasons for it, citing the applicable regulations
 3. Explain the individual's right to and the method of obtaining a County Conference and a State Hearing,
 4. Explain the circumstances under which a timely hearing request will result in continued benefits,
 5. A telephone number to call about free legal services.

- b) The written notification will be made either by certified mail or by hand delivery at least fifteen (15) days prior to the effective date of the proposed action.
- 3. The individual, the parent of a minor or the legal guardian will be informed that he/she may appeal the proposed Adverse Action directly to the Ohio Department of Jobs and Family Services (ODJFS), as found in Chapters 5101:6-1 to 5101:6-9 of the ORC.
- 4. If the Service and Support Administrator believes that the individual, parent of a minor or legal guardian will have difficulty understanding the mechanisms that can be used to appeal Adverse Actions, the Service and Support Administrator will assist in identifying an authorized representative.

C. County Conference:

- 1. In order to avoid unnecessary State Hearings, the CCBDD and the Clinton County Department of Jobs and Family Services (CCDJFS) will provide an opportunity for the individual to discuss and/or resolve disagreements with the CCBDD's actions or inaction in a County Conference.
- 2. The CCBDD Service and Support Administrator will provide information to assist the individual with initiating the process.
- 3. The CCBDD will convene a conference presided over by the CCDJFS Director or a Designee.
- 4. Both the CCBDD and the individual may bring whomever each reasonably wants to be at the conference.
- 5. The issue to be decided by the presiding person will be whether the CCBDD can show, by a preponderance of the evidence, that its action or inaction was in accordance with applicable regulations. If not, the presiding person will retract the notice of Adverse Action and/or decide the question of the individual's entitlement to benefits/services, or arrange to make that determination as quickly as possible.
- 6. The outcome of the County Conference will be recorded, in writing, in the case record.
- 7. The individual does need not to have a County Conference in order to have a State Hearing, nor does the holding of a County Conference, or the individual's failure to appear for one, diminish the right to a State Hearing.
- 8. A State Hearing must still be held if requested, unless a resolution is reached at the County Conference and the individual withdraws the hearing request in writing.
- 9. Any such withdrawal will be signed and dated by both the individual, parent of a minor or legal guardian, and the CCBDD,
- 10. The withdrawal will clearly set forth the resolution upon which the withdrawal is based and will be forwarded to the assigned Bureau of State Hearings (BSH) within two (2) business days.
- 11. The CCBDD will give one copy of the withdrawal to the individual and retain one copy in the case file.

D. State Hearings:

- 1. Only the individual, parent of a minor or legal guardian, or the authorized representative may request a State Hearing.

2. If the individual, parent of a minor, legal guardian or authorized representative makes a verbal request for a State Hearing due to a proposed Adverse Action, the CCBDD Service and Support Administrator will transcribe or complete the Appeal Summary on ODJFS Form #04067, "Form for Appeal Summary".
 - a) The Appeal Summary", will include a summary of all facts and documents relevant to the issue under appeal.
 - b) The Appeal Summary must be filed with the Bureau of State Hearings (BSH) at least three (3) business days prior to hearing.
 - c) The CCBDD Service and Support Administrator, if proposing the Adverse Action will make a copy of the appeal and Appeal Summary available to the individual, parent of a minor, legal guardian or the authorized representative in a manner prescribed by Bureau of State Hearings (BSH). Failure to make the material available to the individual, parent of a minor, legal guardian, or authorized representative within a reasonable period before the hearing may be considered good cause for postponing or continuing the hearing, if the individual has been materially disadvantaged by the failure.
 - d) Written authorization in the form of the signature of the individual, parent of a minor or legal guardian, or the authorized representative must accompany all requests for a State Hearing.
3. If the individual, parent of a minor, legal guardian, or authorized representative requests a State Hearing within the fifteen (15) day prior notice period; the services/benefits will not be reduced, suspended, or terminated until a State Hearing decision is rendered.
4. If the individual, parent of a minor, legal guardian or authorized representative does not request a hearing within the fifteen (15) day period, he/she may request a State Hearing within the ninety (90) day period following notification; however, services may be reduced or denied until such time that a decision is rendered regarding the appeal. If the individual, parent of a minor, legal guardian or authorized representative has "good cause" for missing the fifteen (15) day appeal period, services that were reduced, suspended, or terminated will be reinstated.
5. The individual, parent of a minor, legal guardian, or the authorized representative has the right to be represented by legal counsel at the State Hearing. The CCBDD Service and Support Administrator will provide the individual with a telephone number for free legal services
6. **Postponement of Hearings:** The CCBDD may request one postponement no later than seven (7) days prior to the hearing. No postponement will be granted if it will prevent the Bureau of State Hearings (BSH) from issuing the decision within applicable time limits. The individual, parent of a minor, legal guardian, or authorized representative requesting the hearing has broader rights for postponement.
7. **Telephone hearings:** Hearings are often held with the hearing officer participating by phone. Documents from the CCBDD and the individual must be provided to the Bureau of State Hearings (BSH) in advance. If all relevant documents are not available, they may be submitted at the hearing or the record can be held open until all documents are received.

8. Once scheduled, a State Hearing will take place unless the individual, the parent of a minor, legal guardian, or the authorized representative completes and submits a written withdrawal of the hearing request as indicated in (D)(4) of this procedure.
9. All hearings are recorded electronically.
10. During the hearing, each party may present and cross-examine witnesses.
11. The CCBDD has the burden of proof, which means it is the CCBDD's responsibility to show by a preponderance of evidence that the action or inaction was in accordance with ODJFS rules of the Ohio Administrative Code. During the State Hearing the CCBDD will:
 - a) Explain the reasons for the CCBDD's action
 - b) Cite the regulations upon which the action was based,
 - c) Provide relevant case information and documents, and
 - d) Answer relevant questions from the Individual and the hearing officer.
12. The individual and authorized representative will be provided with the written State Hearing decision via ODJFS Form #04005.
13. The decision will provide notice of the right to and the method of obtaining an Administrative Appeal.
14. A copy of the decision will be sent to the CCBDD electronically, as an e-mail attachment.
15. The CCBDD has no right to appeal an adverse decision by the hearing officer.

Reference: ORC 5101: 6-1 through 5101: 6-9 & OAC 5123-4-04
Revised 8/20/2019

POLICY 3.06

Confidentiality & Computer Security Policies

HIPAA, FERPA, IDEA & Ohio Law Compliance

Effective November 17, 2015

Policies governing confidentiality of the information regarding the individuals we serve, their privacy rights, and safeguarding the availability and integrity of electronic records.

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

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CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

CONFIDENTIALITY & PRIVACY POLICIES

POLICIES FOR ALL STAFF

1000 Confidentiality, Privacy and Computer Security Definitions

Adopted: 11/17/2015

Effective: 11/17/2015

POLICY

The following definitions shall apply to all Confidentiality, Privacy, and Computer Security Policies, numbered 1000 through 4000.

AUDIENCE

All Staff

AUTHORITY

The definitions below are adapted from the federal HIPAA regulations, FERPA regulations, the Ohio Revised Code, and Ohio Administrative Code. In some cases, a definition in a regulation is adjusted in order to facilitate these policies. For example, the definition of PHI, in these policies, is adapted to include both the information protected by the HIPAA regulations and the information protected by the FERPA regulations.

DEFINITIONS

- 1) **Access** – means the ability or the means necessary to read, write, modify, or communicate data/information or otherwise use any system resource. (Taken from HIPAA regulations.)
- 2) **Administrative safeguards** – are administrative actions, and policies and procedures, to manage the selection, development, implementation, and maintenance of security measures to protect electronic protected health information and to manage the conduct of the covered entity's workforce in relation to the protection of that information.
- 3) **Applicable Requirements** – Applicable requirements mean applicable federal and Ohio law and the contracts between the CCBDD and other persons or entities which conform to federal and Ohio Law.
- 4) **Authentication** – means the corroboration that a person is the one claimed.
- 5) **Availability** – means the property that data or information is accessible and useable upon demand by an authorized person.
- 6) **Breach** – the acquisition, access, use, or disclosure of protected health information in a manner not permitted by the HIPAA Privacy rules which compromises the security or privacy of the protected health information.
Breach excludes:
 - A) Any unintentional acquisition, access, or use of protected health information by a workforce member or person acting under the authority of a covered entity or a business associate, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted by the HIPAA privacy rules.
 - B) Any inadvertent disclosure by a person who is authorized to access protected health information at a covered entity or business associate to another person authorized to access protected health information at the same covered entity or business associate, or organized health care arrangement in which the covered entity participates, and the information received as a result of the disclosure is not further used or disclosed in a manner not permitted by the HIPAA Privacy rules.
 - C) A disclosure of protected health information where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

Except for the three exclusions above, any unintentional acquisition, access, use or disclosure of PHI that is a violation of the Privacy Rule is PRESUMED TO BE A BREACH, unless a risk assessment demonstrates that there is a low probability that the PHI has been compromised. The risk assessment must include at least the following factors:

- A) The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;

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- B) The unauthorized person who used the PHI or to whom the disclosure was made;
 - C) Whether the PHI was actually acquired or viewed; and
 - D) The extent to which the risk to the PHI has been mitigated.
- 7) **Business Associate (BA)** – A Business Associate basically is a person or entity which creates, uses, receives or discloses PHI held by a covered entity to perform functions or activities on behalf of the covered entity. The complete definition is included in [Appendix A - Identifying Business Associates](#).
- 8) **Confidentiality** – means the property that data or information is not made available or disclosed to unauthorized persons or processes.
- 9) **Covered Entity** – Covered entity means a health plan, a health care clearinghouse or a health care provider who transmits any health information in electronic form in connection with a transaction covered by HIPAA transaction rules.
- 10) **Designated Record Set** – Designated record set means:
A group of records maintained by or for a covered entity that is:
B) The medical records and billing records about individuals maintained by or for a covered health care provider;
C) The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or
D) Used, in whole or in part, by or for the covered entity to make decisions about individuals.
For purposes of this definition, the term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.
- 11) **Directory Information** -- as defined in FERPA, means information contained in an education record of a student that would not generally be considered harmful or an invasion of privacy if disclosed. It includes, but is not limited to, the student's name, address, telephone listing, electronic mail address, photograph, date and place of birth, major field of study, dates of attendance, grade level, enrollment status (e.g., undergraduate or graduate; full-time or part-time), participation in officially recognized activities and sports, weight and height of members of athletic teams, degrees, honors and awards received, and the most recent educational agency or institution attended.
- 12) **Disclosure** – Disclosure means the release, transfer, provision of access to, or divulging in any manner (orally, written, electronically, or other) of information outside the entity holding the information.
- 13) **DODD** – the Ohio Department of Developmental Disabilities
- 14) **Early Intervention Records**. – means all records regarding a child that are required to be collected, maintained, or used under Part C of the Act and the regulations in this part. These are essentially equivalent to FERPA Education Records
- 15) **Education** – Education means activities associated with operating the school including instruction, IHP/IEP preparation, administration, behavioral intervention, extra-curricular activities and other normal school functions. Education shall also include activities associated with early intervention programming.
- 16) **Education Records** – As defined in the FERPA regulations, means records that are:
A) Directly related to a student; and
B) Maintained by an educational agency or institution or by a party acting for the agency or institution.
i) The term does not include:
1) Records that are kept in the sole possession of the maker, are used only as a personal memory aid, and are not accessible or revealed to any other person except a temporary substitute for the maker of the record.
2) Records of the law enforcement unit of an educational agency or institution, subject to the provisions of § 99.8.
C)
i) Records relating to an individual who is employed by an educational agency or institution, that:
1) Are made and maintained in the normal course of business;
2) Relate exclusively to the individual in that individual's capacity as an employee; and
3) Are not available for use for any other purpose.
ii) Records relating to an individual in attendance at the agency or institution who is employed as a result of his or her status as a student are education records and not excepted under paragraph (b)(3)(i) of this definition.

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- D) Records on a student who is 18 years of age or older, or is attending an institution of postsecondary education, that are:
 - i) Made or maintained by a physician, psychiatrist, psychologist, or other recognized professional or paraprofessional acting in his or her professional capacity or assisting in a paraprofessional capacity;
 - ii) Made, maintained, or used only in connection with treatment of the student; and
 - iii) Disclosed only to individuals providing the treatment. For the purpose of this definition, “treatment” does not include remedial educational activities or activities that are part of the program of instruction at the agency or institution.
- E) Records created or received by an educational agency or institution after an individual is no longer a student in attendance and that are not directly related to the individual's attendance as a student.
- F) Grades on peer-graded papers before they are collected and recorded by a teacher.
- 17) **Employee** – Employee means any person employed by the board, volunteers, board members and other persons whose conduct, in the performance of work for the DD Board, is under the direct control of the DD Board, whether or not they are paid by the DD Board.
- 18) **Encryption** – means the use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without use of a confidential process or key.
- 19) **Facility** – means the physical premises and the interior and exterior of a building(s).
- 20) **FERPA** – FERPA means the Family Educational Rights and Privacy Act, which are federal regulations that govern the privacy of records maintained by schools, as well as the rights of parents and students to access those records. These regulations are codified in [CFR Title 34 Part 99](#).
- 21) **Guardian of the Person** – Guardian of the Person means an individual appointed by the Probate Court to provide consent for and make decisions for the ward
- 22) **Health care** – means care, services, or supplies related to the health of an individual. Health care includes, but is not limited to, the following:
 - A) Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and
 - B) Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.
- 23) **Health Care Clearinghouse** – A Health Care Clearinghouse is a public or private entity, including a billing service, community health management information system or community health information system that does either of the following functions:
 - A) Processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.
 - B) Receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.
- 24) **Health care operations** – means any of the following activities of the covered entity to the extent that the activities are related to covered functions:
 - A) Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; patient safety activities (as defined in 42 CFR 3.20); population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;
 - B) Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;
 - C) Except as prohibited under §164.502(a)(5)(i), underwriting, enrollment, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance), provided that the requirements of §164.514(g) are met, if applicable;
 - D) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

- abuse detection and compliance programs;
- E) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and
 - F) Business management and general administrative activities of the entity, including, but not limited to:
 - i) Management activities relating to implementation of and compliance with the requirements of this subchapter;
 - ii) Resolution of internal grievances;
 - iii) The sale, transfer, merger, or consolidation of all or part of the covered entity with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and
 - iv) Consistent with the applicable requirements of §164.514, creating de-identified health information or a limited data set, and fundraising for the benefit of the covered entity.
- 25) **Health Oversight Agency** – Health oversight agency means an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is authorized by law to oversee the health care system (whether public or private) or government programs in which health information is necessary to determine eligibility or compliance, or to enforce civil rights laws for which health information is relevant.
- 26) **Health Plan** – Health plan means an individual or group plan that provides, or pays the cost of medical care. A partial list of entities that are health plans (edited based on relevance to DD Boards) includes the following, singly or in combination:
- A) The Medicaid program under title XIX of the Act, [42 U.S.C. § 1396](#), et seq.
 - B) Any other individual or group plan, or combination of individual or group plans, that provides or pays for the cost of medical care.
 - C) A group health plan, that is, an employee welfare benefit plan (as defined in section 3(1) of the Employment Retirement Income and Security Act of 1974 (ERISA), 29 U.S.C. 1002(1), including insured and self-insured plans, to the extent that the plan provides medical care, including items and services paid for as medical care, to employees or their dependents, that:
 - i) Has 50 or more participants; or
 - ii) Is administered by an entity other than the employer that established and maintains the plan.
 - D) An employee welfare benefit plan or any other arrangement that is established or maintained for the purpose of offering or providing health benefits to the employees of two or more employers
- 27) **HIPAA** – HIPAA means the Health Insurance Portability and Accountability Act of 1996, codified in [42 USC §§ 1320 - 1320d-9](#) and at 42 CFR Parts 160, 162 and 164. In common terms, this includes the HIPAA Enforcement Rule, Transactions Rule, Privacy Rule, Breach Notification Rule and Security Rule.
- 28) **IDEA** – Individuals with Disabilities Education Act. Part C details rights and safeguards for infants aged 0-2 involved with Early Intervention programs, and Part B details rights and safeguards for children aged 3-18.
- 29) **Incidental Disclosure** – An unintentional disclosure of PHI, that occurs as a result of a use or disclosure otherwise permitted by the HIPAA Privacy Rule. An Incidental Disclosure is NOT a violation of the Privacy Rule. However, in order for incidental disclosures to not be a violation, the covered entity must be in compliance with the requirement for implementation of the minimum necessary principle, and also in compliance with the requirement to implement physical, technical, and administrative safeguards to limit incidental disclosures.
- 30) **Individual, or Individual Receiving Services** – Means a person who receives services from the County Board. In the event that the individual is a minor, the term “individual” in these policies may also include the parent or guardian of the individual. In addition, in regard to any privacy rights, individual may also mean an individual’s “personal representative” as it is defined under HIPAA regulations.
- 31) **Individually Identifiable Health Information** – is information that is a subset of health information, including demographic information collected from an individual, and:
- A) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
 - B) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

- i) That identifies the individual; or
 - ii) With respect to which there is a reasonable basis to believe the information can be used to identify the individual.
- 32) **Information system** – means an interconnected set of information resources under the same direct management control that shares common functionality. A system normally includes hardware, software, information, data, applications, communications, and people.
- 33) **Integrity** – means the property that data or information have not been altered or destroyed in an unauthorized manner.
- 34) **Limited Data Set** – means protected health information that excludes the following direct identifiers of the individual or of relatives, employers, or household members of the individual:
- A) Names;
 - B) Postal address information, other than town or city, state and zip code;
 - C) Telephone numbers;
 - D) Fax numbers;
 - E) Electronic mail addresses;
 - F) Social Security numbers;
 - G) Medical record numbers;
 - H) Health plan beneficiary numbers;
 - I) Account numbers
 - J) Certificate/license numbers;
 - K) Vehicle identifiers and serial numbers, including license plate numbers;
 - L) Device identifiers and serial numbers;
 - M) Web Universal Resource Locators (URLs);
 - N) Internet Protocol (IP) address numbers;
 - O) Biometric identifiers, including finger and voice prints; and
 - P) Full face photographic images and any comparable images.
- 35) **Malicious software** – means software, for example, a virus, designed to damage or disrupt a system.
- 36) **MOU** – MOU means a Memorandum of Understanding between governmental entities, which incorporates elements of a business associate contract in accordance with HIPAA rules.
- 37) **Parent** – Parent means either parent. If the parents are separated or divorced, "parent" means the parent with legal custody of the child. "Parent" also includes a child's guardian, custodian, or parent surrogate. At age eighteen, the participant must act in his or her own behalf, unless he/she has a court-appointed guardian
- 38) **Password** – means confidential authentication information composed of a string of characters.
- 39) **Payment** – means, in the context of a County Board:
- A) Both:
 - i) Activities by the board required to determine if an individual is eligible for services, and
 - ii) Activities of the Board either to reimburse contracted providers for services rendered to individuals served or seeking reimbursement, for example from Medicaid or DODD, for services rendered to an individual served.
 - B) The activities in paragraph (A) of this definition relate to the individual to whom health care is provided and include, but are not limited to:
 - i) Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;
 - ii) Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related health care data processing;
 - iii) Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
 - iv) Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services.
- 40) **Personal Representative** – Personal Representative means a person who has authority under applicable law to make decisions related to health care on behalf of an adult or an emancipated minor, or the parent, guardian, or other person acting in loco parentis who is authorized under law to make health care decisions on behalf of an unemancipated minor, except where the minor is authorized by law to consent, on his/her own or via court approval, to a health care service, or where the parent, guardian or person acting in loco parentis has assented to

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

an agreement of confidentiality between the CCBDD and the minor.

- 41) **Physical safeguards** – are physical measures, policies, and procedures to protect a covered entity's electronic information systems and related buildings and equipment, from natural and environmental hazards, and unauthorized intrusion.
- 42) **Protected Health Information, or PHI** – means individually identifiable information that is: (i) transmitted by electronic media; (ii) Maintained in electronic media; or (iii) transmitted or maintained in any other form or medium. Records of individuals deceased for more than 50 years are not PHI. For the purposes of this manual, and the board's compliance program, PHI shall also include "Education Records" as defined by FERPA. This creates a consistent set of policies for both types of confidential information.
- 43) **Provider** – Provider means a person or entity, which is licensed or certified to provide services, including but not limited to health care services, to persons with DD, in accordance with applicable requirements. A Covered Provider is a Health Care Provider who transmits any health information in electronic form.
- 44) **Public Health Authority** – Public health authority means an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate.
- 45) **Security or Security measures** – encompass all of the administrative, physical, and technical safeguards in an information system.
- 46) **Security incident** – means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
- 47) **Social Engineering** – means "an outside hacker's use of psychological tricks on legitimate users of a computer system, in order to obtain information he needs to gain access to the system" or "getting needed information (for example, a password) from a person rather than breaking into a system" . . . social engineering is generally a hacker's clever manipulation of the natural human tendency to trust. The hacker's goal is to obtain information that will allow him/her to gain unauthorized access to a valued system and the information that resides on that system.
- 48) **Subcontractor** – means a person to whom a business associate delegates a function, activity, or service, other than in the capacity of a member of the workforce of such business associate.
- 49) **Technical safeguards** – means the technology and the policy and procedures for its use that protect electronic protected health information and control access to it.
- 50) **Treatment** – means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.
- 51) **TPO** – TPO means treatment, payment or health care operations under HIPAA rules. For the purposes of this policy manual, TPO shall also include "Education" as defined above.
- 52) **Unsecured protected health information** – protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology in guidance specified by the Secretary of the Department of HHS in guidance issued under section 13402(h)2 of Public Law 111-5.
- 53) **Use** – Use means, with respect to individually identifiable health information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.
- 54) **User** – means a person or entity with authorized access.
- 55) **Violation, or violate** – means, as the context may require, failure to comply with a provision of either the HIPAA Privacy or Security rules.
- 56) **Workforce Member** – Workforce Member means the same as Employee. See definition above.
- 57) **Workstation** means an electronic computing device, for example, a laptop or desktop computer, or any other device that performs similar functions, and electronic media stored in its immediate environment.

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

1010 Confidentiality – General Rules

Adopted: 11/17/2015

Effective: 11/17/2015

POLICY

All information in an enrollee's records, including information electronic information, is confidential. Further, all conversations involving individually identifiable information is confidential.

The CCBDD shall conform to all requirements for privacy and confidentiality set forth by the State of Ohio, the federal HIPAA, FERPA and IDEA regulations, and any other applicable law. Safeguards will be implemented for the use, disclosure, collection, storage, retention and destruction of individually identifiable information. The CCBDD shall not use or disclose individually identifiable information except in accordance with applicable requirements.

AUDIENCE

All Staff

AUTHORITY

[45 CFR Part 160](#) and [164](#) (current as of 3/27/2013)

[45 CFR 164.504\(g\)](#) for entities with multiple functions

[ORC § 5126.044](#) Ohio law on confidentiality (effective 9/22/2000)

[OAC § 5123:2-1-02\(I\)\(7\)](#) General DD Board confidentiality requirements (3/21/2002)

[OAC § 5123:2-4-01\(C\)\(2\)\(b\)](#) General requirements for DD Board confidentiality policies (effective 4/12/2001)

[45 CFR 164.502\(a\)\(1\)\(iii\)](#) incidental uses and disclosures

[OAC § 3301-51-04](#) Confidentiality (effective 7/1/2008), for schools

[34 CFR 99](#) FERPA (current as of 1/2012)

[34 CFR 300](#) and 301 Part B IDEA (Individuals with Disabilities Education Act, ages 3-21)

[34 CFR 303 Part C](#) IDEA (individuals with Disabilities Education Act, ages 0-2)

[34 CFR 303.402 - 416](#) Early Intervention Confidentiality and Family Rights Provisions

[34 CFR 300.610 - 627](#) Children with Disabilities Confidentiality and Parent Rights Provisions

PROCEDURES

- 1) Staff of the CCBDD may use or [disclose PHI](#) only as follows:
 - A) For education, treatment, payment and health care operations, including to contracted Business Associates. This information is to be used by employees who are official members of a habilitation/educational team, with the goal of serving the enrollee. In an exception, explicit parent authorization is required for any Medicaid billing for children.
 - B) In accordance with a release or authorization of the individual in accordance with policy and procedure set forth in [Policy 1050 Authorizations](#).
 - C) As permitted in [Policy 1040 Speaking with the Family or Friends of an Individual Receiving Services](#).
 - D) As permitted by in [Policy 1090 Disclosures that do Not Require an Authorization](#).
- 2) For all of the above, the minimum amount of information should be disclosed, and specific procedures followed as detailed in [1020 Minimum Necessary Policy](#).
- 3) All employees are responsible for safeguarding the information regarding individuals we serve, as detailed in
 - A) [Policy 1030 Confidentiality Safeguards \(Oral & Written\)](#)
 - B) [Policy 3080 Computer Usage](#)
 - C) [Policy 3082 Social Media Use](#)
 - D) [Policy 3085 Portable Computing Devices and Home Computer Use](#)
- 4) Rights of individuals served by CCBDD may be exercised by parents, guardians and personal representatives as detailed in [Policy 1070 Minors, Personal Representatives and Deceased Individuals](#).
- 5) Confidentiality and Computer Security are everyone's responsibility – all staff must understand and follow procedures detailed in [Policy 1080 Duty to Report Violations and Security Incidents](#).
- 6) Supervisors, managers and certain staff have specific duties, rights, and obligations as specified elsewhere in these policies.

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

1020 Minimum Necessary Policy

Adopted: 11/17/2015
Effective: 11/17/2015

POLICY

The use and disclosure of PHI must be limited to the minimum necessary to satisfy the request or to complete the task, except in situations specifically identified by the HIPAA rules. The Privacy Officer shall implement safeguards and protocols to implement this policy. All employees shall follow those protocols.

AUDIENCE

All Staff

AUTHORITY

[45 CFR 164.502](#)(b)(1) minimum necessary standard
34 CFR 300.623(d) IDEA Part B
34 CFR 303.415(d) IDEA Part C
34 CFR 99.31(a)(1)(i)(A) FERPA
OAC 3301-51-04(N)(4) OAC Confidentiality Safeguards

PROCEDURES

FOR THE PRIVACY OFFICER

- 1) **Implementation Approach.** The Privacy Officer will implement the minimum necessary requirement with the steps detailed below. Measures to limit workforce access, and procedures for both routine disclosures and requests for PHI will be created and documented as detailed below:
 - A) **Limiting Workforce Access to PHI:** Access to the PHI will be granted based on the individual's role and determined by the Director and Privacy Officer of CCBDD. CCBDD will identify:
 - i) Those persons or classes of persons, who require access to PHI to carry out their duties, in the workforce, including interns and trainees, will be listed according to job classification with the necessary minimal necessary PHI required for successful job performance to serve the individuals, and
 - ii) For each such person or class of persons, the category or categories of PHI to which access is needed and any conditions appropriate to such access.
 - iii) Safeguards will be developed and documented to restrict workforce access to the minimum necessary.
 - iv) The Privacy Officer will document the results of this analysis in [Appendix E – Minimum Necessary – Workforce, Disclosures and Requests](#). This report will be available for public inspection.
 - B) **Procedures for Routine Disclosures and Requests.** The HIPAA Privacy Officer will identify all routine disclosures made by Board employees, for which the minimum necessary requirement applies, and create procedures to implement these. The same shall be done for routine requests for PHI. [Note that minimum necessary does not apply for disclosures or requests related to “treatment”; consequently no procedures must be created in these situations.] These results shall be documented in [Appendix E – Minimum Necessary – Workforce, Disclosures and Requests](#).
 - C) **Implementation.** The Privacy Officer shall take the steps to implement the results of the analysis above, including configuring access control on software, staff training for routine requests and disclosures, and any other measures necessary.

FOR ALL EMPLOYEES

- 2) **Minimum Necessary Requirement.**
 - A) **Basic Requirement.** When using or disclosing PHI, or when requesting PHI from another entity, employees must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure or request.
 - B) **Exceptions.** The minimum necessary requirement does NOT apply to:
 - i) Disclosures to or requests by a health care provider for treatment
 - ii) Uses or disclosures made to the individual served, including but not limited to any requests for their records or requests for an accounting of disclosure

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

- iii) Uses of disclosures made pursuant to an Authorization
 - iv) When the disclosure is required by law, is to the Secretary of HHS, or for compliance with HIPAA regulations
- 3) **Routine Requests or Disclosures.** Staff shall be familiar with and follow procedures detailed in [Appendix E – Minimum Necessary – Workforce, Disclosures and Requests](#) when making requests for PHI or disclosures.
- 4) **Procedures for Non-Routine Disclosures or Requests**
- A) **For non-routine disclosures,** when subject to the minimum necessary provision, the individual making the disclosure will apply the minimum necessary principle. He or she may seek the guidance, if necessary, of the Privacy Officer (or his/her designee).
 - B) **For non-routine requests,** the requesting party will utilize the minimum necessary principle, seeking the guidance, if necessary, of the Privacy Officer (or his/her designee).
 - C) **Good Faith Reliance** – CCBDD staff may rely on the belief that the PHI requested is the minimum amount necessary to accomplish the purpose of the request when:
 - i) The disclosure is made to a **public official**, permitted to receive information, and the public official represents that the request is for the minimum necessary information;
 - ii) The request is from another **covered entity**;
 - iii) The request is from a **professional** at CCBDD, or a business associate, and the professional or business associate asserts that the request is for the minimum necessary

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

1030 Confidentiality Safeguards (Oral & Written)

Effective Date: 11/17/2015

Approved: 11/17/2015

Amended: 5/16/2017

POLICY

CCBDD shall utilize appropriate physical, technical, and administrative safeguards to safeguard Paper and Oral PHI.

REFERENCES

[45 CFR 164.530\(c\)](#) – Administrative, Technical, and Physical Safeguards

34 CFR 99.31(a)(1)(ii) Safeguards

[ORC § 5126.044](#) Ohio law on confidentiality

[OAC § 5123:2-1-02\(I\)](#) Safeguard requirements for confidential DD Board records

[OAC § 5123:2-4-01\(C\)\(2\)\(b\)](#) General requirements for DD Board confidentiality policies

[OAC § 5123:2-3-13\(B\)](#) Safeguards for records in licensed facilities

PROCEDURES:

1) General Procedures

A) Employees shall be familiar with security and access plans regarding staff, individuals receiving services, parent and other visitor access to the facility.

B) Employees shall escort visitors through the premises.

2) Safeguards for Electronic PHI. The HIPAA Security policies detail physical, technical and administrative safeguards to protect electronic PHI. In addition, these policies detail some of the physical security measures for paper records.

3) Oral Privacy

A) Employees shall be aware of safeguarding oral communications. This includes being aware of surroundings, and using appropriate volume when speaking to prevent others from overhearing conversations.

B) Employees shall refrain from holding conversations in common areas where individuals receiving services or visitors can overhear PHI.

C) Discussions concerning individuals should be done in a private area and discussions must be limited to “need to know” information for purposes of providing the best services.

D) Overheard conversations are not to be shared or repeated.

E) When in a public place, any cell phone conversations should be conducted in a manner so as not to divulge PHI to bystanders.

4) Safeguards for Written PHI

A) Control of the Original Paper Records

i) The HIPAA Privacy Officer shall be responsible for administering the security controls for paper record storage.

ii) Case and School records shall be kept locked and secured. Employees requiring access to these records shall have a key and/or combination for the storage room or cabinet.

iii) Paper files shall be put away promptly when not being used.

iv) Original paper records shall not be removed from the building without the authorization of the superintendent, privacy officer or designee.

v) Individual records shall be retained per the Board’s General Policy 2.07 and retention schedule.

B) Other use and storage of paper records

i) Employees should minimize the use of hardcopy PHI.

ii) Personal appointment books with names of Individuals being served should be safeguarded while away from the office. It is best to avoid putting last names in appointment books if possible.

iii) Hardcopy reports and redundant copies of records personally maintained should be kept in a locked file drawer.

C) Faxing Procedure

i) When faxing a document with PHI, use a cover sheet which indicates that information is confidential, protected under state and federal laws, and not to be re-disclosed.

ii) Care should be taken to transmit fax to the proper recipient.

iii) Faxed documents should not be left at a common fax machine.

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- D) **Printing and Copying PHI**
 - i) Printers and copiers used for printing of PHI should be in a secure, non-public location. If the equipment is in a public location, the information being printed or copied is required to be strictly monitored.
 - ii) PHI printed to a shared printer should be promptly removed.
 - iii) The Security Officer shall monitor all printer and photocopier acquisitions. In the event that this equipment includes internal storage devices, which retain images of photocopies made, the asset shall be managed by the IT department, especially upon disposal to insure destruction of any PHI contained in its storage.
 - E) **Transportation/outside use of documents with PHI**
 - i) Caseworkers and other employees who remove documents from the facility, to conduct fieldwork, for example, are responsible for safeguarding these documents.
 - ii) When leaving paper documents or electronic documents on an encrypted device unattended in a vehicle, the vehicle should be locked. Preferably, the documents and/or their container and device should not be visible.
 - iii) If any documents with PHI are lost or stolen, the incident should be immediately reported to a supervisor.
 - F) **Visibility of records and other PHI.** All employees using records for individuals and other paperwork with PHI shall arrange these items so that PHI is not readily visible to other individuals receiving services/visitors, especially in high traffic areas such as reception area.
 - G) **Shredding.** Unneeded paper documents containing PHI shall be destroyed by shredding.
 - H) **Destruction of PHI in non-paper formats.** Any written PHI in non-paper formats, such as imprints on carbon films used in fax machines, should be destroyed appropriately.
 - I) **When leaving for the night,** all employees shall clean their desks of PHI to reduce exposures to cleaning personnel and others who may have access to the facilities at night.
 - J) **Confidentiality with Cleaning Personnel.** Cleaning personnel with access to the facility should be placed under a confidentiality agreement.
- 5) **Compliance Audits/Facility Review.** At least annually, the HIPAA Privacy Officer shall audit staff compliance with these guidelines. The audit shall consist of a walk-through of the facility, with observations recorded, such as placement of desks, location of computer equipment, any papers with PHI that would be visible to a visitor, etc. The results shall be discussed with the appropriate employee, and any appropriate actions taken.
 - 6) **Enforcement.** All supervisors are responsible for enforcing this policy. Employees who violate this policy will be subject to the appropriate and applicable disciplinary process, up to and including termination or dismissal.
 - 7) **Annual Review.** These safeguards shall be reviewed and updated annually.

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

1040 Speaking with the Family and Friends of an Individual Receiving Services

Adopted: 11/17/2015

Effective: 11/17/2015

POLICY

CCBDD personnel are allowed to verbally disclose protected health information to family, friends, caregivers and other individuals involved with the care an individual being served, in specific situations, after giving the Individual receiving services the opportunity to either agree to or object to the disclosure.

AUDIENCE

All Staff

AUTHORITY

[45 CFR 164.510\(b\)](#)

PROCEDURES

1) **If the individual is present**

- A) **Permitted disclosure to family or friend present.** If a family member, or friend of the individual is present while services are being rendered, an employee serving the individual may disclose PHI after one of the following:
- i) verbally seeking permission for the disclosure, and the individual the agrees; or
 - ii) giving the Individual the opportunity to object to the disclosure, and the individual does not express an objection; or
 - iii) the staff member reasonably infers from the circumstances, based on the exercise of professional judgment, that the individual does not object to the disclosure.

2) **If the individual is not present**

A) **Communications about the individual's care**

- i) In the event of a phone call or other discussion with a family member or one involved with the care of the Individual being served by CCBDD, where the Individual is not present, the employee may use their professional judgment to determine if the disclosure is in the best interests of the Individual and, if so, disclose only the PHI that is directly relevant to the person's involvement with the individual's care.

B) **Notifications**

- i) An employee may disclose PHI to notify a family member, a personal representative of the individual, or another person responsible for the care of the individual of the individual's location or general condition.

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1050 Authorizations

Adopted: 11/17/2015

Effective: 11/17/2015

POLICY

All disclosures of PHI beyond those otherwise permitted or required by law require a signed authorization. CCBDD will use an authorization form that conforms with Ohio Laws, and the federal FERPA, IDEA and HIPAA regulations.

AUDIENCE

All Staff

AUTHORITY

[45 CFR 164.508](#) – HIPAA requirements for authorizations

[ORC § 5126.044](#) – Ohio Statute on confidentiality of records

[OAC § 5123:2-1-02\(I\)\(7\)](#) – Ohio Rule on confidentiality of records

[34 CFR 99.30](#) – FERPA requirements for prior consents to disclose information

[34 CFR 99.32](#) – FERPA recordkeeping requirements concerning requests and disclosures

LEGAL NOTES

- FERPA applies for records created for education; HIPAA applies to all other records. The term used in the FERPA regulations is “consent”. The HIPAA term “authorization” is used in these policies.

PROCEDURES

- 1) **Valid Authorization.** Unless otherwise authorized by CCBDD policy and/or state or federal law operations requires specific authorization by the Individual being served or his/her legal representative. A [standard authorization form](#) is included as an Appendix. In the event that authorizations are received on other forms, note that a valid authorization must include the following:
 - A) Full Name of the individual.
 - B) A specific description of the information to be released. For example, a range of dates, or category of record.
 - C) The purpose or need for the disclosure.
 - D) The name of the individual, person, or agency disclosing the information.
 - E) Names of the individual, person, or agency to whom the disclosure is to be made.
 - F) The date, event, or condition upon which the authorization expires (which can be no longer than 180 days from the date of signing).
 - G) Statement of the individual’s right to revoke the authorization, an explanation of how to revoke it, and any exceptions to the right to revoke.
 - H) Statement that CCBDD may not condition treatment on whether the individual signs the authorization.
 - I) A statement informing the individual of the potential that information disclosed could be redisclosed if the recipient is not subject to federal or state confidentiality restrictions.
 - J) Signature and date of the Individual or personal representative.
 - K) If the authorization is signed by a guardian or personal representative, a description of that person's relationship to the individual and authority to sign the authorization.
 - L) Written in plain language.
- 2) **Invalid Authorization.** A PHI authorization is considered invalid if authorization has the following defects:
 - A) Authorization is incomplete.
 - B) Authorization is not dated or time has elapsed.
 - C) Authorization does not contain required elements as explained above.
 - D) CCBDD is aware authorization has been revoked.
 - E) CCBDD is aware information is false.
 - F) Authorizations to release PHI cannot be combined with other documents.
- 3) **For authorizations presented in person for immediate release,** the staff member shall verify the identity of the recipient according to [Policy 1060 Verification](#), after which the information may be released.

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- 4) **Proper Completion of Authorization Form by Staff.** The staff person handling the request should complete the following steps, and annotate the bottom of the [Authorization Form](#):
 - A) The employee should write their name on the completed authorization form.
 - B) The original signed authorization shall be saved in the individual's master record, and a copy must be given to the Individual.
 - C) A record of the release shall be maintained in the individual's main record, using the [Disclosure Log](#) included as an Appendix, detailing the following information:
 - i) The date of the disclosure.
 - ii) The name of the entity or person who received the PHI, and, if known, the address of such entity or person.
 - iii) A brief description of the PHI disclosed.
 - iv) A brief statement of the purpose of the disclosure.
 - v) If the disclosure was due to a health or safety emergency, a description of the significant threat to health or safety.
- 5) **Retention Period for Written or Electronic Copy of Authorization.** The CCBDD must retain the written or electronic copy of the authorization for a period of six (6) years from the later of the date of execution or the last effective date.
- 6) **Revocation of Authorization.** Upon instructions of revocation of authorization, CCBDD employees shall locate the original authorization form, annotate it as revoked, and take appropriate steps to prevent any further disclosure.
- 7) Note that information from other service providers contained in the Individual's record may be released with the Individual's written authorization.

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

1060 Verification

Adopted: 11/17/2015

Effective: 11/17/2015

POLICY

CCBDD will take reasonable steps to verify the identity and/or the authority of the person requesting protected health information (PHI) of an individual.

AUDIENCE

All Staff

AUTHORITY

34 CFR 99.31(c) Verification

45 CFR 164.514(h) Verification

PROCEDURES

REQUESTS FROM A PUBLIC OFFICIAL OR AUTHORITY

(IDENTITY AND AUTHORITY ARE VERIFIED):

- 1) **Verifying Identity and Authority.** In verifying the identity and legal authority of a public official or a person acting on behalf of the public official requesting disclosure of PHI, CCBDD personnel may rely on the following, if such reliance is reasonable under the circumstances, when disclosing PHI:
 - A) Documentation, statements, or representations that, on their face, meet the applicable requirements for a disclosure of PHI.
 - B) Presentation of an agency identification badge, other official credentials, or other proof of government status if the request is made in person.
 - C) A written statement on appropriate government letterhead that the person is acting under the government's authority.
 - D) Other evidence of documentation from an agency, such as a contract for services, memorandum of understanding, or purchase order, that establishes that the person is acting on behalf of the public official.
 - E) A written statement of the legal authority under which the information is requested.
 - F) If a written statement would be impracticable, an oral statement of such legal authority.
 - G) A request that is made pursuant to a court order and subpoena or other legal process issued by a grand jury or a judicial or administrative tribunal that is presumed to constitute legal authority.
- 2) The following issues should be addressed before releasing PHI once a request is received:
 - A) Is the requestor who she/he claims to be.
 - B) Does the requestor have the authority to request PHI. If the request involves a court order, subpoena, or other legal request, follow the procedures outlined in the [Policy 1090 Disclosures that do Not Require an Authorization](#).

REQUESTS FROM AN INDIVIDUAL RECEIVING SERVICES, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

(ONLY IDENTITY IS VERIFIED):

- 1) **Verifying Identity of Unknown Person.** Individuals receiving services and parents often are all known to staff. In the event that the individual or parent is not known, or a Personal Representative who is unknown requests protected health information, the employee shall verify the identity of the personal representative:
 - A) Ask another employee if they know the person.
 - B) Question the personal representative regarding their knowledge of information in the record of the individual being served, such as birth date, social security number, etc., which only an authorized person would typically know.

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

1070 Minors, Personal Representatives and Deceased Individuals

Adopted: 11/17/2015

Effective: 11/17/2015

POLICY

Staff must follow applicable legal requirements to maintain confidentiality and to permit the legal release of protected health information (PHI) to minors and personal representatives, and for the release of PHI of deceased individuals.

AUTHORITY

[ORC 5126.044](#)

[ORC 3109.051\(H\)](#)

[ORC 1337.13](#)

45 CFR 164.502(g)(1) Personal representatives

45 CFR 164.502(g)(2) Adults and emancipated minors

45 CFR 164.502(g)(3) Unemancipated minors

45 CFR 164.502(f) Deceased Individuals

45 CFR 164.510(b)(5) Uses and disclosures when the individual is deceased

NOTES

Federal HIPAA law changes issued 1/25/2013 relax confidentiality requirements upon death of an individual. These include 45 CFR 164.502(f) which eliminates all protections of information 50 years after the death of an individual, and 45 CFR 164.510(b)(5) which allow for disclosures to people involved with the care of the individual prior to death for information that is relevant to the person's involvement. While HIPAA rules preempt contrary state law, state laws which offer greater privacy safeguards, more rights of access to information, or less coercion shall prevail. No changes have been made to these policies to implement the relaxed HIPAA provisions; consult with your prosecutor regarding whether to change these policies.

PROCEDURES:

- 1) **Rights of legally Consenting Minors.** Individuals being served, who are minors, and who are legally allowed to consent to treatment under Ohio Law may exercise all rights regarding access to, requests for amendment to, and release of their PHI pursuant to a written authorization.
- 2) **Rights of an Individual's Personal Representative.** CCBDD recognizes an individual's personal representative as a person authorized to exercise rights of access and/or inspection of PHI, rights to request amendment of PHI, and the right to sign the CCBDD [Authorization Form](#) which permits release of PHI.
- 3) **Recognized Personal Representative.** CCBDD recognizes the following persons to be personal representatives:
 - A) The parent of a child younger than 18 years old
 - B) The non-custodial parent of a child younger than 18 years old ([ORC 3109.051\(H\)](#)),
 - C) An individual who is recognized through durable power of attorney to have authority to act on the behalf of the Individual ([ORC § 1337.13](#))
 - D) The legal guardian of the individual
 - E) Any other person authorized by law except in Abuse, Neglect, and/or Endangerment situations, or where CCBDD has received a court order or other documentation limiting privileges of a non-custodial parent as provided below.
 - i) Abuse, Neglect, and/or Endangerment Situations. Notwithstanding a state law of any requirement of this paragraph to the contrary, CCBDD may elect not to recognize a person as a personal representative of an individual. In order for CCBDD to choose not to recognize a person as a personal representative, CCBDD must decide that it is not in the best interest of the individual to treat the person as the individual's personal representative and must believe that one of the following conditions exist:
 - 1) The individual has been or may be subjected to domestic violence, abuse, or neglect by a parent, guardian, or personal representative.
 - 2) Treating such person as the personal representative could endanger the individual.
 - ii) Receipt of a court order limiting privileges of a non-custodial parent. In the event that CCBDD receives from the custodial parent a court order limiting the privileges of the non-custodial parent to

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act in the capacity of the child's personal representative, CCBDD shall adhere to the restrictions in the court order.

4) Deceased Individuals

- A) **Disclosure of PHI After Death.** PHI generated during the life of an individual is protected from disclosure after death unless disclosure is for treatment or payment (with a valid consent), quality assurance or other auditing or program review functions. CCBDD and its employees cannot release PHI regarding a deceased individual unless a valid personal representative has been established and has requested the PHI through the proper authorization process.
- B) **Disclosure of PHI to Administer Estate.** PHI may be disclosed to the executor or administrator of the estate when the information is necessary to administer the estate ([ORC § 5126.044](#)).
- C) **Proper Party to Authorize Release of PHI Absent Executor, Administrator, or Court Appointed Representative.** Absent an executor, administrator, or other court-appointed representative for the deceased individual's estate, the following persons listed below may authorize the release of PHI in order of priority. An entire category must be exhausted (i.e., no people in the category exist or are still alive) before moving to the next category.
 - i) Spouse (if married)
 - ii) The person's children
 - iii) The Person's parents
 - iv) The Person's brothers or sisters
 - v) The person's uncles or aunts;
 - vi) The person's closest relative by blood or adoption
 - vii) The person's closest relative by marriage

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

1080 Duty to Report Violations and Security Incidents

Adopted: 11/17/2015

Effective: 11/17/2015

POLICY

Confidentiality of individual information, and the computer security required to protect information regarding individuals receiving services is taken very seriously at o. Employees are required to follow all rules in these policies. Any employee who becomes aware of a violation of either confidentiality or computer security rules is obligated to immediately report this violation. Violations will be investigated and appropriate action will be taken.

REFERENCES:

HIPAA Privacy Rules, [45 CFR Part 164.530](#)(e)(1) – Sanctions

PROCEDURES:

- 1) **Employees Duty to Report Violation.** Any employee observing a violation of any of the Confidentiality and Computer Security policies is to report the violation to his/her supervisor. Failure to report a Privacy Violation is in itself a disciplinable offense.
- 2) **Investigation.** The supervisor should refer the incident to the Privacy Officer and/or the Security Officer. The Privacy and/or Security Officer shall, in conjunction with other management personnel as he/she deems appropriate, investigate the matter through discussing the matter with staff, individuals receiving services, or others, and/or review of computer or paper audit trails.
- 3) **Procedure for Security Breach.** For security [breaches](#), the Privacy and/or Security Officer will follow any procedures detailed in [Policy 3035 Breach Reporting](#).
- 4) **Procedure for Privacy Violation.** For Privacy Violations, the Privacy Officer will follow procedures in [Policy 3085 Mitigation](#).
- 5) **Filing of Written Report by Privacy and/or Security Officer.** A written incident report will be written by the Privacy and/or Security Officer. It will be filed in:
 - A) the Privacy Officer's Privacy Violations file; and
 - B) the employee's personnel file.
- 6) **Employee Discipline**, if appropriate, will be taken and documented in accordance with Chapter 13 of the board's Personnel Policies.
- 7) **Post-Incident Review.** A post-incident review will be conducted by the Privacy and/or Security Officer, with any corrective action taken, such as a change in policy, additional training, or other appropriate action.

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

1090 Disclosures that do Not Require an Authorization

Adopted: 11/17/2015

Effective: 11/17/2015

POLICY

CCBDD employees may use and disclose PHI in specific situations authorized by state and federal statute. In these cases, the individual's authorization is not required. Staff will carefully follow specific requirements for these unusual and infrequent disclosures. These disclosures include the following:

- When required by law.
- For public health purposes such as reporting communicable diseases, work-related illnesses, or other diseases and injuries permitted by law; reporting births and deaths, and reporting reactions to drugs and problems with medical devices.
- To protect victims of abuse, neglect, or domestic violence.
- For health oversight activities such as investigations, audits, and inspections.
- To accrediting organizations.
- For judicial and administrative proceedings.
- For law enforcement purposes.
- To coroners, medical examiners, and funeral directors.
- For organ, eye or tissue donation.
- To reduce or prevent a serious threat to public health and safety.
- For Specialized government functions.
- In connection with "whistleblowing".
- For workers' compensation or other similar programs if applicable.

AUTHORITY

[45 CFR § 164.512](#)

[34 CFR 99.31](#)

[34 CFR 99.36](#)

[ORC § 2151.421\(A\)](#) Reports of Child Abuse

[ORC § 2305.51](#) Disclosures to prevent harm to 3rd parties

[ORC § 2317.02\(B\)](#) Privilege for physicians, school guidance counselors, licensed social workers and licensed counselors

[ORC § 4732.19](#) Privilege for psychologists

[ORC § 5123.19](#) Licensure activities of DODD

[ORC § 5123.60](#) OLRs

[ORC § 5123.61\(C\)\(1\)](#) Duty to report abuse/neglect of persons with DD

[ORC § 5126.044](#) Confidentiality for DD Boards

[ORC § 5126.055](#) LMAA functions of DD Boards

[ORC § 5126.31](#) Case Review and Investigation

[OAC § 5123:2-15-10\(G\)](#) Access to documentation for CAFS payments

[OAC § 5123:2-17-02\(B\)](#) Incidents adversely affecting health/safety

[OAC § 5123:2-17-02\(D\)](#) Reporting MUIs

[OAC § 5123:2-3-04](#) Monitoring of licensed facilities

Ohio Rules of Civil Procedure Rule 45 Procedures for obtaining a subpoena

[ORC § 4113.52](#) Reporting Violations of law by employer or fellow employee

[34 CFR Part 99 Subpart D](#) May an Educational Agency Disclose Education Records

20 U.S.C. 7165(b) Section 4155(b) No Child Left Behind Act – Transfer of Disciplinary Records

[OAC 3301-51-04\(Q\)](#) Disciplinary Information

LEGAL NOTES

- [ORC § 5126.044](#) does not authorize any of the excepted disclosures detailed in HIPAA and FERPA. Other Ohio regulations reference disclosures otherwise allowed by federal and state law. HIPAA preempts contrary state law, except where state law offers greater privacy protections, greater rights of access to an individual's

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- records, or is less coercive. Consult your county prosecutor for review and approval of this policy.
- HIPAA and FERPA/IDEA maintain overlapping but different lists of disclosures permitted without authorization or parental consent. We use the term “Education Records” below to refer to FERPA/IDEA permitted disclosures, and “PHI” regarding HIPAA permitted disclosures.

PROCEDURES

CCBDD employees will follow the indicated procedures for the various special circumstances detailed below:

- 1) **Recordkeeping.** For all of the disclosures authorized below, the employee handling the disclosure will document the details of the disclosure on the [Disclosure Log](#) which will be maintained in the adult or school record. Copies of all paperwork requesting the disclosure and copies of the records sent will be maintained if practical.
- 2) **When required by law**
 - A) To officials at another school that an Individual served by the board intends to enroll in, or is already enrolled in, for the purposes of Individual’s enrollment or transfer. Any such disclosures must include records of any disciplinary actions.
 - B) The CCBDD may use or disclose PHI or Education Records to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.
 - C) For compliance with mandatory disclosures related to sex offenders
- 3) **For public health purposes** PHI may be used or disclosed to:
 - A) A public health authority authorized by law to collect or receive information for the purpose of preventing or controlling disease, injury or disability, reporting vital events, conducting public health surveillance, investigations or interventions.
 - B) A public health or other government authority authorized by law to receive reports of child abuse or neglect.
 - C) A person subject to the jurisdiction of the Food and Drug Administration (FDA) regarding his/her responsibility for quality, safety or effectiveness of an FDA regulated product or activity, to report adverse events, product defects or problems, track products, enable recalls, repairs or replacements, or conduct post-marketing surveillance.
 - D) A person who may have been exposed to a communicable disease or may be at risk of contracting or spreading a disease or condition.
 - E) To the extent that the CCBDD receives PHI disclosed under this section in its role as LMAA, the CCBDD may use the PHI to carry out its duties.
- 4) **To protect victims of abuse, neglect, domestic violence or other crime**
 - A) **Reports of child abuse**
 - i) Reports of child abuse shall be made in accordance with Ohio law.
 - ii) The CCBDD may disclose PHI related to the report of abuse to the extent required by applicable law. Such reports shall be made to a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect.
 - B) **Reports of abuse and neglect other than reports of child abuse or neglect.**
 - i) The CCBDD may disclose PHI about an individual believed to be a victim of abuse, neglect, or domestic violence to a governmental authority authorized to receive such reports if:
 - 1) the individual agrees; or
 - 2) the CCBDD believes, in the exercise of professional judgment, that the disclosure is necessary to prevent serious physical harm.If the individual lacks the capacity to agree, disclosure may be made if not intended for use against the individual and delaying disclosure would materially hinder law enforcement activity.
 - ii) The CCBDD staff member making the disclosure must promptly inform the individual whose PHI has been released unless:
 - 1) doing so would place the individual at risk of serious harm; or
 - 2) the CCBDD would be informing a personal representative, and the CCBDD reasonably believes the personal representative is responsible for the abuse, neglect, or other injury, and that informing such person would not be in the best interests of the individual as determined by the CCBDD, in the exercise of professional judgment.
- 5) **For health or education oversight activities such as investigations, audits, and inspections**
 - A) PHI may be used or disclosed for activities related to oversight of the health care system, government

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health benefits programs, and entities subject to government regulation, as authorized by law, including activities such as audits, civil and criminal investigations and proceedings, inspections, and licensure and certification actions.

- B) Specifically excluded from this category are investigations of an individual that are not related to receipt of health care, or the qualification for, receipt of, or claim for public benefits.
 - C) To the extent that the CCBDD receives PHI disclosed under this section in its role as LMAA, the CCBDD may use the PHI to carry out its duties.
 - D) Education Records may be disclosed to the Comptroller General of the US, Attorney General of the US, Secretary of Education and/or State of Ohio Education authorities subject to the requirements of 34 CFR 99.35 or to state officials involved with juvenile justice in accordance with 34 CF 99.38.
- 6) **To accrediting organizations**
- A) Information in Education Records may be disclosed to accrediting organizations without parental consent. For any disclosure of PHI, a HIPAA Business Associate agreement should be in place with the accrediting organization.
- 7) **For judicial and administrative proceedings**
- NOTE:** These policies do not detail all situations such as grand juries and other infrequent legal proceedings. Consult with legal counsel prior to disclosure for any unusual situations! Also note that HIPAA and FERPA requirements are similar but different in some situations.
- A) The CCBDD must always comply with a **court order**, but only in accordance with the express terms of the order.
 - B) For a **subpoena, discovery request or other lawful process**: the CCBDD may comply with such legal requests only if:
 - i) The CCBDD makes reasonable effort to notify the parent involved and/or receives satisfactory assurance from the party seeking the information that reasonable efforts have been made by such party to ensure that the individual who is the subject of the requested PHI has been given notice of the request; or
 - ii) The CCBDD receives satisfactory assurance from the party seeking the information that reasonable efforts have been made by such party to secure a qualified protective order.The CCBDD will consult with legal counsel, prior to any response to a subpoena to ensure compliance with applicable requirements of HIPAA or FERPA.
- 8) **For law enforcement purposes**
- A) **Conditions Allowing for Disclosure of PHI to Law Enforcement.** PHI may be disclosed for the following law enforcement purposes and under the specified conditions:
 - i) Pursuant to court order or as otherwise required by law, i.e., laws requiring the reporting of certain types of wounds or injuries; or commission of a felony, subject to any exceptions set forth in applicable law.
 - ii) Decedent's PHI may be disclosed to alert law enforcement to the death if entity suspects that death resulted from criminal conduct.
 - iii) The CCBDD may disclose to a law enforcement official protected health information that the CCBDD believes in good faith constitutes evidence of criminal conduct that occurred on the premises of the CCBDD.
 - B) **Reporting Commission and Nature of Crime.** PHI may be disclosed to law enforcement personnel to report the commission and nature of a crime; The location of such crime or of the victim(s) of such crime; and the identity, description, and location of the perpetrator of such crime. When responding to requests about the location of a suspect, fugitive, material witness, or missing person, the following PHI may be released:
 - i) Name and address
 - ii) Date and place of birth
 - iii) Social security number
 - iv) ABO blood type and RH factor
 - v) Type of injury
 - vi) Date and time of treatment
 - vii) Date and time of death, if applicable,
 - viii) A description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair scars, and tattoos
 - C) **Compliance/Enforcement of privacy regulations:** PHI must be disclosed as requested, to the Secretary of

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Health and Human Services related to compliance and enforcement efforts.

The CCBDD shall not respond to a court order, subpoena, or request for information from law enforcement without review by an attorney to ensure compliance with applicable requirements.

- 9) **To coroners, medical examiners, and funeral directors**
 - A) PHI may be disclosed to coroners, medical examiners and funeral directors, as necessary for carrying out their duties.
- 10) **Organ, eye or tissue donation**
 - A) PHI of potential organ/tissue donors may be disclosed to the designated organ procurement organization and tissue and eye banks.
- 11) **To reduce or prevent a serious threat to public health and safety and/or safety of individuals**
 - A) The CCBDD may disclose PHI or Education Records as follows, to the extent permitted by applicable law and ethical standards:
 - i) **Good Faith.** PHI may be used or disclosed if the entity believes in good faith:
 - 1) that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to a person or the public, and disclosure is to someone reasonably able to prevent or lessen the threat; or
 - 2) the disclosure is to law enforcement authorities to identify or apprehend an individual who has admitted to violent criminal activity that likely caused serious harm to the victim or who appears to have escaped from lawful custody.
 - B) **Disclosure of Individual's Admitted Participation in a Violent Crime.** Disclosures of admitted participation in a violent crime are limited to the individual's statement of participation and the following PHI: name, address, date and place of birth, social security number, blood type, type of injury, date and time of treatment, date and time of death, if applicable, and a description of distinguishing physical characteristics.
 - C) **Disclosure of Individual's Admitted Participation in a Violent Crime Learned in the Course of Treatment.** Disclosures of admitted participation in a violent crime are not permitted when the information is learned in the course of treatment entered into by the individual to affect his/her propensity to commit the subject crime, or through counseling, or therapy or a request to initiate the same.
 - B) **Disclosure of Individual's Admitted Participation in a Violent Crime Learned in the Course of Treatment.** Disclosures of admitted participation in a violent crime are not permitted when the information is learned in the course of treatment entered into by the individual to affect his/her propensity to commit the subject crime, or through counseling, or therapy or a request to initiate the same.
- 12) **Specialized government functions**
 - A) **National Security and Intelligence:** PHI may be disclosed to authorized federal officials for the conduct of lawful intelligence, Counterintelligence, and other activities authorized by the National Security Act.
 - B) **Protective Services:** PHI may be disclosed to authorized federal officials for the provision of protective services to the President, foreign heads of state, and others designated by law, and for the conduct of criminal investigations of threats against such persons.
 - C) **Correctional Institution or Law Enforcement Official.** The CCBDD may disclose to a correctional institution or a law enforcement official having lawful custody of an inmate or other individual protected health information about such inmate or individual, if the correctional institution or such law enforcement official represents that such protected health information is necessary for:
 - i) The provision of health care to such individuals;
 - ii) The health and safety of such individual or other inmates;
 - iii) The health and safety of the officers or employees of or others at the correctional institution;
 - iv) The health and safety of such individuals and officers or other persons responsible for the transporting of inmates or their transfer from one institution, facility, or setting to another;
 - v) Law enforcement on the premises of the correctional institution; and
 - vi) The administration and maintenance of the safety, security, and good order of the correctional institution.The provisions of this section do not apply after the individual is released from custody.
 - D) **Public Benefits:** PHI relevant to administration of a government program providing public benefits may be disclosed to another governmental program providing public benefits serving the same or similar populations as necessary to coordinate program functions or improve administration and management of program functions.
- 13) **In connection with "whistleblowing".** In connection with "whistleblowing", or reporting of a violation of law or ethics, an employee of CCBDD may disclose PHI to his/her attorney, and to other parties specified in Ohio Revised Code § 4113.52, while following the procedures outlined in that statute. See also General Policy 2.10.
- 14) **For workers' compensation or other similar programs if applicable.**
 - A) PHI may be disclosed as authorized and to the extent necessary to comply with laws relating to workers'

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compensation and other similar programs.

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INDIVIDUAL RIGHTS

1200 Individual's Right to Access Records

Adopted: 11/17/2015

Effective: 11/17/2015

POLICY

Individuals served by CCBDD, and their personal representatives, have the right to access and/or inspect the PHI and/or Education Records contained in the designated record set, subject to any limitations imposed by law.

AUDIENCE

Privacy Officer, Supervisors

AUTHORITY

[45 CFR 164.524](#)(e) individual's right to access PHI

[45 CFR 164.524](#)(b) Time limits on response to access

[45 CFR 164.524](#)(c) Form of access

34 CFR 99.4 Rights of Parents

34 CFR 300.613(c) IDEA Rights of parents

[ORC § 1347.08](#)(A)(2) individual's right to access records

[OAC § 3301-51-04](#) Confidentiality, for Education of Students with Special Needs

[OAC § 5123:2-1-02](#)(I)(7)(d) County Board Administration – Record Policy – Right of Access

[OAC § 5123:2-1-02](#)(I)(7)(a)(iv) County Board Administration – Records policy – Informing individuals receiving services about types and locations of records kept

LEGAL NOTES

- State laws, HIPAA, and FERPA all provide that individuals receiving services have access to their records.
- State law offers greater right of access than HIPAA, which includes exceptions; consequently the state law applies with no restrictions to an individual's access.

PROCEDURES

1) **Who May Access Records**

- A) An individual served by the board above the age of 18, the parent/guardian of a child, the guardian of an adult not able to act on their own behalf, or any "personal representative", of any of those individuals may access the records. See [Policy 1070 Minors, Personal Representatives and Deceased Individuals](#).
- B) **3rd Party Review.** An individual or parent may include any 3rd party of their choosing, including an attorney, to review the records.
- C) **Presumption of Parental Right to Access Records.** CCBDD may presume that either parent of a minor may have access unless presented with documentation that the parent does not have authority under applicable state law governing such matters as guardianship, separation, or divorce.

2) **Procedure, form and method of access**

- A) **Requests for Access.** Requests for access to records shall be directed to the Privacy Officer or his/her designee.
- B) **Verification Procedure.** The Privacy Officer shall follow the Verification Procedure to verify the identity of the requestor. For any grant of access to someone other than the parent, the authority of the requestor to access the information shall also be verified. This might include documentation of guardianship or documentation that the individual was appointed a "Personal Representative" under HIPAA.
- C) **Forms of Access Requested by the Individual.** The CCBDD shall provide the individual with access to their records in any of the following ways requested by the individual:
 - i) **By inspection.** CCBDD shall provide a private room for the individual to review the records under the supervision of a CCBDD staff member who will insure that the record is not altered.
 - ii) **Photocopy.** CCBDD shall provide a photocopy of the entire record or portion of the record requested.
 - iii) **Electronic format.** CCBDD shall provide an electronic copy of the information requested if this is

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feasible; if not, the Security Officer or his/her designee shall negotiate an electronic format and transmission method acceptable to both parties and fulfill the request.

- 1) If the individual requests the information via email and only unsecured email is available, the individual shall be notified that this method is subject to electronic eavesdropping. If the individual is willing to accept the risks, the info shall be sent via email.
- 2) The board shall honor requests for commonly used media, such as USB Flash drives.
- D) **Record of Parties Accessing Records.** The Privacy Officer or his/her designee shall maintain a record of parties accessing records (except the access by the individual or their parent) including the name of the party, the date access was given, and the purpose of access. These shall be maintained on the Disclosure Log illustrated in the Appendix.
- 3) **Other services/rights of individuals, parents, and guardians**
 - A) **Explanation and Interpretation of Records.** CCBDD will respond to reasonable requests for explanation and interpretation of the records.
 - B) **List of Types and Locations of Records Maintained by CCBDD.** Upon request, CCBDD must provide individuals, parents and guardians a list of the types and locations of records maintained or used by CCBDD.
 - C) **Known Records Not Maintained by CCBDD.** If the CCBDD does not maintain the PHI that is the subject of the individual's request for access, and the CCBDD knows where the requested information is maintained, the CCBDD must inform the individual where to direct the request for access.
- 4) **Transfer of rights at Age of Majority**
 - A) Rights of parents under these policies and under FERPA and IDEA transfer to the individual served once that individual reaches age 18 years. Once a child reaches age 17 years, the child must be informed of this transfer, and the IEP must include a statement that the child has been informed regarding the transfer of rights.
- 5) **Time for response to request for access**
 - A) Access shall be granted without unnecessary delay. In particular, requests should be honored prior to any scheduled IEP meeting, hearing, or administrative procedure. Requests in all cases shall be honored within 5 business days.
- 6) **Fees for copying/electronic media**
 - A) CCBDD at present has no fees for photocopies, postage or electronic media used to provide records.

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1210 Individual's Right to Request Amendment of Records

Adopted: 11/17/2015

Effective: 11/17/2015

POLICY

Individuals receiving services have the right to request that CCBDD amend PHI in the designated record set, or Education Records, that they believe are erroneous. CCBDD will use procedures compliant with HIPAA, FERPA and/or IDEA in process any requests for correction.

AUDIENCE

Privacy Officer, Supervisors

AUTHORITY

[45 CFR 164.526\(f\)](#) Individual's right to request amendment

[OAC § 3301-51-04](#) Confidentiality, for Education of Students with Special Needs

[ORC § 1347.09](#) Disputing of Records

[34 CFR 99.20](#) FERPA – Requesting amendment of records

[34 CFR 99.21](#) FERPA – Rights to a Record Hearing

[34 CFR 99.22](#) FERPA – Requirements for a Records Hearing

LEGAL NOTES

These policies are designed to simultaneously comply with Federal HIPAA and FERPA regulations as well as Ohio regulations. All these regulations are similar; where they differ, policies are written to follow the regulations that provide the greatest degree of privilege and right of appeal to the individual.

PROCEDURES

REQUESTS FOR AMENDMENTS

- 1) **Amending Statements Believed to be Inaccurate, Misleading or in Violation of Individual's Rights.** An individual, parent, guardian, or other person acting as a HIPAA personal representative may request amendment of PHI about the individual (and exercise rights for hearing and statements of disagreement), which they believe is inaccurate, misleading, or violates the rights of the individual, and is held by the CCBDD or any Business Associate. Such request shall be in writing and shall be subject to the requirements set forth in these procedures.
- 2) **Responsibility of Privacy Officer.** The Privacy Officer of the CCBDD is responsible for receiving requests for amendment, processing the requests, arranging for any hearings, and completing required documentation.
- 3) **Time to Act on a Request for Amendment.** The CCBDD will act on a request for amendment without unnecessary delay and no later than 60 days after the date of the request.
- 4) **Accepted Request for Amendments.** If the CCBDD accepts the requested amendment, in whole or in part,
 - A) the CCBDD must make the appropriate amendment, and inform the individual and other persons or entities who have had access to the information.**Denied Request for Amendments.** Otherwise, if the CCBDD believes the existing record is correct as is, it may deny the amendment:
 - A) **Written Notice.** If an amendment is denied, the CCBDD will give written notice in plain language which includes the following:
 - i) The basis for the denial;
 - ii) The individual's right to submit a written statement disagreeing with the denial and how the individual may file such a statement;
 - iii) A statement that, if the individual does not submit a statement of disagreement, the individual may request that the CCBDD provide the individual's request for amendment and the denial with any future disclosures of the protected health information that is the subject of the amendment; and
 - iv) The individual's right for a hearing to challenge the information.
 - B) **Statement of Disagreement.** If the individual submits a statement of disagreement, the Privacy Officer will insert this statement into the appropriate portion of the record. Otherwise, the Privacy officer will

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insert into the record that the individual requested an amendment and the CCBDD's denial.

- C) **Written Rebuttal.** The CCBDD may prepare a written rebuttal to the individual's statement of disagreement. Whenever such a rebuttal is prepared, the CCBDD must provide a copy to the individual who submitted the statement of disagreement.
- D) **Permanent Record.** The inserted statement of disagreement and any rebuttal become a part of the permanent record and must be included with all future disclosures of the covered records.
- E) **Individual's Request for Copy of Changed Record.** At the individual's request, CCBDD will send a copy of the changed record to any party requested by the individual (per [ORC 1347.09](#)).
- F) **Separate Transmission of Information in EDI Format.** If the disclosure which was the subject of amendment was transmitted using a standard EDI format, and the format does not permit including the amendment or notice of denial, the CCBDD may separately transmit the information to the recipient of the transaction in a standard EDI format.

RECORDS HEARINGS

CCBDD must offer a Records Hearing to any individual who is denied a requested amendment of their records.

1) Hearing Procedures

- A) The HIPAA Privacy Officer will arrange the Records Hearing.
- B) The Privacy Officer must schedule the hearing within a reasonable time upon receiving a request.
- C) CCBDD shall give the individual notice of date, time and place reasonably in advance of the hearing.
- D) To conduct the hearing, the Privacy Officer may appoint any individual, including an official of CCBDD, who does not have a direct interest in its outcome.
- E) During the hearing, the parent shall have a full and fair opportunity to present evidence relevant to their objection. The individual or parent may obtain assistance of any individual(s), including an attorney hired at their own expense, to assist them.
- F) The decision shall be based solely on the evidence presented.
- G) The decision shall be documented in writing, within a reasonable time of the hearing, and shall include a summary of the evidence presented and the reasons for the decision.

2) Results of Hearing

- A) If, as a result of the hearing, CCBDD decides that the information in its records is inaccurate, misleading, or otherwise in violation of the privacy or other rights of the individual, it must amend the information accordingly and inform the individual in writing.
- B) If, as a result of the hearing, CCBDD decides that the information is not inaccurate, misleading, or otherwise in violation of the privacy or other rights of the individual, it must inform the individual of their right to place in the record a statement commenting on the information or setting forth any reasons for disagreeing with the decision of CCBDD.
- C) Any information placed in the record as a result of this hearing, CCBDD must maintain this statement as part of its permanent record, and include it with any subsequent disclosure.

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1220 Individual's Right to Receive an Accounting of Disclosures

Adopted: 11/17/2015
Effective: 11/17/2015

POLICY

CCBDD will provide, upon request, an "Accounting of Disclosures," in accordance with HIPAA Regulations, to Individuals who receive services from the Board.

AUDIENCE

Privacy Officer, Supervisors

REFERENCES

[45 CFR §164.528](#)

[45 CFR 164.528\(d\)](#) Individual's right to an accounting of disclosures of PHI

[34 CFR 99.32](#) FERPA Recordkeeping requirements concerning requests and disclosures

PROCEDURES

- 1) **Proper Records.** The Privacy Officer shall be responsible for insuring that proper records are kept to allow for proper and complete responses to any requests for accountings of disclosures. See also procedures listed in [1090 Disclosures that do Not Require an Authorization](#) and [1050 Authorizations](#) which detail the use of the [Disclosure Log](#).
- 2) **Individual's Right to Request Accounting of Disclosures of PHI.** Generally, an individual has the right to request an accounting of disclosures of their PHI by CCBDD and its business associates during a time period of up to six years prior to the date of the individual's request. Most disclosures are **not** required to be included in the accounting. The types of disclosures which are **not** required to be accounted for are:
 - A) For the purposes of treatment, payment and health care operations ([45 CFR §164.502](#));
 - B) To the individual receiving services, or to a parent, guardian or personal representative, of the individual's own PHI ([45 CFR §164.502](#));
 - C) Incidental disclosures, as detailed in ([45 CFR §164.502](#));
 - D) Pursuant to an authorization ([45 CFR §164.508](#));
 - E) To persons involved in the individual's care or other notification purposes ([45 CFR §164.510](#));
 - F) For national security and intelligence purposes, as detailed in ([45 CFR §164.512\(k\)\(2\)](#));
 - G) Disclosures to prisons and other law enforcement agencies regarding an individual who is in custody, as detailed in ([45 CFR §164.512\(k\)\(5\)](#)).
- 3) **Employee Documentation of Disclosures.** Any employee who makes a disclosure other than listed above shall document the disclosure in the Individual File, with all information described in step 5b below. More specifically, the following types of disclosures must be documented:
 - A) To public health authorities
 - B) Birth and death reporting
 - C) To law enforcement regarding crime on premises
 - D) To law enforcement in emergencies where crime is suspected
 - E) For cadaveric organ, eye, tissue donation purposes
 - F) For judicial and administrative proceedings
 - G) For research with an IRB waiver
 - H) To military command authorities
 - I) For Workers Comp purposes
 - J) To correctional institutions except as detailed in 2G above
 - K) About decedents to medical examiners, funeral directors, coroners
 - L) For public health activities
 - M) About victims of abuse
 - N) Regarding child abuse or neglect
 - O) To the FDA
 - P) To a person who may have been exposed to a communicable disease

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- Q) To health oversight agencies for audits, civil or criminal investigations, inspections, licensure or disciplinary actions
 - R) In response to a court order
 - S) In response to a subpoena or discovery request
 - T) As required by law for wound or injury reporting
 - U) For identification & locating suspect or fugitive
 - V) Unlawful and unauthorized disclosures we have knowledge of
- 4) **Requests to Suspend Individual's Right to Disclosure.** Health oversight agencies and law enforcement officials may request a suspension of an individual's rights to disclosure. If such a request is received, follow procedures in [45 CFR § 164.528](#).
- 5) **Compliance with Request for Accounting Within 45 Days.** The HIPAA Privacy Officer shall comply with an individual's request for an accounting within 45 days of the request. The CCBDD does not charge a fee for accountings.
- 6) **The written accounting must meet the following requirements:**
- A) All disclosures of the Individual's PHI during the 6 years prior to the request (or such shorter period as is specified in the request) as stated above.
 - B) As to each disclosure, the accounting must include:
 - ii) The date of the disclosure.
 - iii) The name of the entity or person who received the PHI, and, if known, the address of such entity or person.
 - iv) A brief description of the PHI disclosed.
 - v) A brief statement of the purpose of the disclosure that reasonably informs the individual of the basis of the disclosure, or as an alternative, a copy of the request for the disclosure.
 - vi) If during the time period for the accounting, multiple disclosures have been made to the same entity or person for a single purpose, the accounting may provide the information as set forth above for the first disclosure, and then summarize the frequency, periodicity, or number of disclosures made during the accounting period, and the date of the last such disclosure during the accounting period.
 - vii) If the accounting request includes school records, consult legal counsel regarding the need to obtain records of redisclosures by state or local school officials (see [34 CFR 99.32](#)).
 - C) CCBDD will retain documentation (in written or electronic format) for a period of 6 years:
 - i) All information required to be included in an accounting of disclosures of PHI.
 - ii) All written accountings provided to individual.

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1230 Individual's Right to Request Additional Restrictions

Adopted: 11/17/2015

Effective: 11/17/2015

POLICY

CCBDD supports Individual's right to request restrictions on the use or disclosure of protected health information which are more stringent than the restrictions defined in organizational policy. CCBDD maintains procedures compliant with HIPAA regulations to process any requests it receives and to insure that any requests it agrees to will be properly implemented.

AUDIENCE

Privacy Officer, Supervisors

REFERENCES

[45 CFR § 164.522\(a\)](#)

PROCEDURES:

- 1) **Refer the Request to CCBDD' Privacy Officer or Designee:** All requests for additional restrictions on the use or disclosure of PHI will be referred to the HIPAA Privacy Officer, or his/her designee. Upon receiving a request, the Privacy Officer shall consider the following factors, in the decision to grant or deny the request:
 - A) Whether the restriction might cause the organization to violate applicable federal or state law;
 - B) Whether the restriction might cause the organization to violate professional standards, including medical ethical standards;
 - C) Whether CCBDD' systems and organization make it very difficult or impossible to accommodate the restriction;
 - D) Whether the restriction might unreasonably impede the organization's ability to serve the Individual;
 - E) Whether the restriction appears to be in the best interests of the Individual.
- 2) **Decision Whether CCBDD will agree:** The CCBDD is not obligated to agree to any requests for restriction, except in the unlikely event that the request is not to bill the Medicaid program or other 3rd party payer and that the individual receiving services agrees to pay for the service themselves.
- 3) **Notify the Individual:** CCBDD will notify the Individual of its final decision (whether approving or denying the request) in writing. The notice will be maintained in the Main Individual Record.
 - A) **Granting the Request:** If CCBDD agrees to the restriction, the notice to the Individual will clearly state what restriction CCBDD is agreeing to in language the Individual will understand. This notice will state that the restriction will not apply if the information is needed for emergency treatment.
 - B) **Denying the Request:** If the request is denied, the notice will clearly state why the request cannot be complied with, in language the Individual will understand.
- 4) **Take Appropriate Action to Implement Restrictions:** If CCBDD agrees to the requested restriction, the Privacy Officer/designee will be responsible for taking appropriate action to implement the restriction.
- 5) **Modifying or Terminating a Restriction:** An Individual may request a restriction to be eliminated at any time. If CCBDD desires a modification, consult legal counsel regarding appropriate procedures.
- 6) **Documentation:** The Privacy Officer is responsible for maintaining the following documents, to assure that additional privacy protections are handled properly, and assure they are maintained for six years from the date of their creation:
 - A) Copies of Individual requests for restrictions.
 - B) Copies of any notice informing the Individual about CCBDD' decision to grant or deny a restriction.
 - C) Copies of any written Individual request to terminate a restriction, or alternatively, copies of any documentation in the Individual's record that the individual made such request orally.

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1240 Individual's Right to Request Confidential Communications

Adopted: 11/17/2015
Effective: 11/17/2015

POLICY

Individuals (or their parents) are entitled to request confidential communications, including for example, to not receive communications at their home address. These requests will be honored to the extent that they can be reasonably accommodated with our administrative systems.

REFERENCES

45 CFR 164.502(h) Confidential communications
45 CFR 164.522(b) Confidential communications requirements

AUDIENCE

Privacy Officer

PROCEDURES

- 1) **Individual's Right to Request Confidential Communications.** Individuals, or their personal representative, may make a request for confidential communications in writing to the Privacy Officer.
- 2) **Receiving a Request.** When the Privacy Officer receives a request, the privacy officer may not ask the reason for the request. The Privacy Officer shall contact the individual making the request to obtain an alternate means of contacting them (e.g. cell phone, PO Box, etc.). The individual will be informed at that time of steps CCBDD will take to implement the request.
- 3) **Implementing the Request.** If existing systems are capable of administering the request, the privacy officer shall take necessary steps to implement the request, such as adjusted phone numbers or addresses in computer files or mailing lists.
- 4) **Documenting the Request.** The Privacy Officer shall document the request, and disposition, in the Individual's Record.
- 5) **Recommending Necessary Improvements in Computer Systems or Administrative Procedures.** When needed, the Privacy Officer will make recommendations to the Superintendent of improvements necessary in computer systems or administrative procedures in order to implement reasonable requests for confidential communications.

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

1250 Individual's Right to Notice of Privacy Practices

Adopted: 11/17/2015

Effective: 11/17/2015

POLICY

Individuals (or their parents) are entitled to a notice detailing the privacy practices of the board. CCBDD will provide such notice to each Individual (or their parents), in a manner compliant with both the HIPAA and FERPA regulations

REFERENCES

45 CFR 164.520 Notice of privacy practices for protected health information

45 CFR 164.502(i) Uses and disclosures consistent with notice

34 CFR 99.7 Notice (FERPA)

34 CFR 300.612 Notice (IDEA Part B)

34 CFR 303.404 Notice (IDEA Part C)

[ORC § 1347.08](#)(A)(3) (Personal Information Systems)

OAC 3301-51-05

[OAC § 5123:2-1-02](#)(I) County Board Administration – Records, Informing individuals about policies

[34 CFR 99.7](#) FERPA Annual Notification

LEGAL NOTES

FERPA and IDEA require an annual notice. HIPAA requires a one-time notice, with redistribution upon change. HIPAA requires signed acknowledgement of receipt.

AUDIENCE

Privacy Officer

PROCEDURES

- 1) **Drafting of Notice.** The Privacy Officer shall draft a notice which is compliant with the requirements of the HIPAA, FERPA and IDEA regulations as well as OAC 3301-51-04(C). This shall include translations as necessary based on the language needs of the individuals served. Further, the notice shall be consistent with the board's privacy practices as detailed in these policies. Notice is detailed in Appendix, [Notice of Privacy Practices](#).
- 2) **Updating Notice.** The Privacy Officer shall update the Notice as necessary based on changes in the board's privacy policies and/or the legal requirements as necessary. Upon update, the website and notices posted at each facility (see below) shall be updated. Additionally, an updated copy will be provided to all Individuals receiving services and/or parents.
- 3) **Distribution of Notice.** The Privacy Officer shall insure that Board policies and procedures are maintained to insure appropriate distribution of Notice:
 - A) All adults at intake, and children attaining age 18 as part of the Transfer of Parental Rights at Age of Majority, will be given a copy of the Notice of Privacy Practices. At the time that the Notice is provided, the Individual or guardian, shall sign an acknowledgement of his or her receipt of this Notice as part of the intake/transition of rights paperwork. This acknowledgement will be retained as part of the permanent record, for compliance with HIPAA requirements.
 - B) An additional copy of the Notice shall further be provided upon request by an individual or parent.
- 4) **Posting of Notice.** The Privacy Officer shall insure that the Notice is posted:
 - A) **Website.** On the board's website.
 - B) **At Each Facility.** At each facility, in a place where individuals served can be reasonably expected to see the notice, such as the reception areas of all board facilities.
- C) Copies of the notice will be maintained for 6 years, as detailed in the Board's General Policy 2.07 and retention schedule.

CONFIDENTIALITY POLICIES FOR SUPERVISORS

1300 Business Associate Contracts

Adopted: 11/17/2015

Effective: 11/17/2015

POLICY

CCBDD will obtain satisfactory assurance that Business Associates will safeguard PHI by maintaining appropriate HIPAA Business Associate agreements with businesses and MOUs with other governmental agencies.

REFERENCES:

[45 CFR 160.103](#)

[45 CFR § 164.502\(e\)](#)

[45 CFR § 164.504\(e\)](#)

34 CFR 99.31(a)(1)(i)(B)

[ORC § 5126.044](#) – Ohio Statute on confidentiality of records

PROCEDURES

- 1) **Business Associate Contract or Memorandum of Understanding.** CCBDD will have a written Business Associate Contract with every Business Associate. For a COG or other government agencies, a Memorandum of Understanding will be executed. See [Appendix A Identifying Business Associates](#).
- 2) **Annual Review of all Contractual Relationships.** On an annual basis, the HIPAA Privacy Officer will review all contractual relationships to and verify that up-to-date Business Associate contracts are in place.
- 3) **Satisfactory Assurances.** The Business Associate Contract will provide satisfactory assurances that the Business Associate will not use or disclose the PHI of CCBDD individuals receiving services other than as provided in the Business Associate Contract. The Business Associate Contract will conform to both the requirements of the HIPAA regulations. See [Appendix B - Sample HIPAA Business Associate Agreement](#).
- 4) **Material Breach or Violation of Business Associate Contract.** In the event CCBDD learns of a pattern of activity or practice of a Business Associate that constitutes a material breach or violation of the Business Associate Contract, CCBDD will take steps to cure the breach or end the violation. If CCBDD is unable to cure the breach or end the violation, CCBDD will terminate the Business Associate Contract.

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

1320 Non-intimidation and Non-retaliation

Adopted: 11/17/2015

Effective: 11/17/2015

POLICY:

CCBDD will not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against individuals receiving services who exercise any HIPAA-related right. Further, CCBDD will not intimidate or retaliate against staff or other individuals who express the opinion that CCBDD policies are not consistent with the law, or not being implemented properly, or who file a whistleblower action. CCBDD will not require any individual receiving services to waive any of his/her rights under HIPAA as a condition of education, treatment, or enrollment.

PROCEDURES

- 1) **CCBDD will not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against:**
 - A) **Individuals Receiving Services.** Any Individual for the exercise by the individual of any right under, or for participation by the individual in any process established by the HIPAA regulations;
 - B) **Individuals receiving Services and others.** Any Individual receiving services, or other person for:
 - i) Filing of a complaint with the Secretary regarding a HIPAA issue;
 - ii) Testifying, assisting or participating in an investigation, compliance review, proceedings or hearing under Part C of Title XI; or
 - iii) Opposing any act or practice made unlawful by the HIPAA regulations, provided the individual or person has a good faith belief that the practice opposed is unlawful, and the manner of the opposition is reasonable and does not involve a disclosure of protected health information.
- 2) **Retaliatory action is defined as doing any of the following:**
 - A) Removing or suspending the employee from employment;
 - B) Withholding from the employee salary increases or employee benefits to which the employee is otherwise entitled;
 - C) Denying the employee a promotion that would have otherwise been received;
 - D) Transferring or reassigning the employee;
 - E) Reducing the employee in pay or position.
- 3) **Non-retaliation statement.** A person who in good faith brings a complaint will not be subject to retaliation. Retaliation against any person who falls within this definition, either individual served or staff member of CCBDD, is strictly prohibited.
- 4) **Prohibition against Waiver of Rights.** No office, program, facility or employee of the CCBDD shall require individuals to waive any of their rights under HIPAA as a condition of treatment, payment, and enrollment in a health plan or eligibility for benefits. The board may require parents of children under age 18 receiving services reimbursed by Medicaid to sign an authorization granting the board permission to bill Medicaid.
- 5) CCBDD will also follow General Policy 2.10.

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

1330 HIPAA Assignments and Documentation

Adopted: 11/17/2015
Effective: 11/17/2015

POLICY:

CCBDD will maintain written Policies and Procedures, including a 6-year audit trail. In addition, all documentation required by HIPAA regulations will be maintained for 6 years. The HIPAA Privacy Officer shall be responsible for insuring the proper maintenance of all required documentation.

REFERENCES:

[Federal Law 45 CFR 164.530\(j\)](#) – Documentation requirement,
[164.520\(e\)](#) – Notices of Privacy Practices;
[164.524\(e\)](#) – Access of individuals to protected health information;
[164.526\(f\)](#) – Amendment to protected information;
[164.508\(b\)\(6\)](#) – Uses and disclosures for which an authorization is required;
[164.512\(i\)\(2\)](#) – Uses and disclosures for research purposes;
[164.522\(a\)\(3\)](#) – Rights to request privacy protection for protected health information;
[164.528\(d\)](#) – Accounting of disclosures of protected health information – Implementation specification
[ORC § 5126.044\(E\)](#) (General records of DD Boards)
[OAC § 5123:2-1-02\(I\)\(7\)](#) appointment of person responsible for ensuring the safekeeping of records and securing them against loss or use by unauthorized persons.

LEGAL NOTES

State law requires notice and approval prior to destruction of an individual's records which contain PHI. There is no comparable requirement in HIPAA.

PROCEDURES:

- 1) **Designating a Privacy Officer and Other Individuals to Assist HIPAA Committee.** The superintendent shall designate an individual to be the Privacy Officer, who is responsible for development, implementation, enforcement, and update of HIPAA Privacy policies and procedures. The superintendent may also designate other individuals to assist, a HIPAA committee, which may include representatives from each program (e.g. workshop, adult services, residential services, administration, SSA, information systems).
- 2) **Documenting Records Covered by HIPAA and FERPA.** The records covered by HIPAA and FERPA shall be detailed and documented following the procedures for the "Designated Record Set" of the HIPAA regulations.
- 3) **HIPAA Mandated records.** HIPAA Mandated records include the following:
 - A) HIPAA Required designations, including, Hybrid entity designation if applicable, description of records in Designated Record Set, the names of staff responsible for duties of Privacy Officer, receiving HIPAA complaints, providing access to Individual records, receiving requests for amendment of Individual records, answering questions about HIPAA policies and procedures.
 - B) Notice of Privacy Practices, as described in [Policy 1250 Individual's Right to Notice of Privacy Practices](#).
 - C) Restrictions on use or disclosure of PHI agreed to by CCBDD as described in the [Policy 1230 Individual's Right to Request Additional Restrictions](#).
 - D) Records of disclosures, as required by the [Policy 1220 Individual's Right to Receive an Accounting of Disclosures](#).
 - E) Any signed authorization as described in [Policy 1050 Authorizations](#).
 - F) All privacy-related complaints received, and their disposition, if any, as described in [Policy 1340 Privacy Complaints](#).
 - G) Any sanctions that are applied as a result of non-compliance with HIPAA-mandated policies as detailed in [Policy 1080 Duty to Report Violations and Security Incidents](#).
 - H) Incident Reports and other documentation specified by [Policy 3035 Breach Reporting](#) and [Policy 3090 Security Incident Response and Reporting](#).

The above records will be maintained for 6 years.

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

- 4) **Policy and Procedure Audit Trail.** When created or updated, all policies will be annotated with the approval date and revision history. Current policies will be maintained in a computer file folder designated "Main Policy and Procedure Manual" Any previous versions will be renamed with the creation date in the file name, and placed in a computer file folder designated "Old Policy Manuals."
- 5) **Updating Required Designations.** The Privacy Officer, will maintain and update HIPAA Required Designations as necessary.
- 6) **Compliance Notes.** The Privacy Officer and Security Officer will maintain records of compliance activity including meeting notes, vendor contracts, internal audit activities.
- 7) **Internal Audit.** The privacy officer shall conduct a periodic audit, as necessary, to insure proper maintenance of all documentation itemized in this policy.
- 8) See also the Board's General Policy 2.07 and retention schedule for retention periods and destruction procedures.

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

1340 Privacy Complaints

Adopted: 11/17/2015

Effective: 11/17/2015

POLICY

Any individual or employee to may complain about the CCBDD's Confidentiality and Privacy policies and procedures and/or the CCBDD's compliance with those policies and procedures. The CCBDD shall take action and document all such complaints.

AUDIENCE

All Staff

AUTHORITY

[45 CFR 164.530\(d\)](#) HIPAA complaint procedures

[ORC § 5123.64\(A\)](#) requires establishment of a complaint procedure

[OAC § 5123:2-1-12](#) administrative resolution of complaints involving the programs, services, policies, or administrative practices of a county board or the entities acting under contract with a county board

PROCEDURES

- 1) **The HIPAA Privacy Officer shall manage this complaint process**, and shall be designated in the Notice of Privacy practices as the individual to receive complaints.
- 2) The CCBDD will extend the provisions of General Policy 2.10 to all individuals who file confidentiality or privacy related complaint.
- 3) **Employee to File Written Complaint with Privacy Officer.** An employee or individual should file their complaint in writing to the privacy officer. Employees may review General Policy 2.10 which provides for alternate officials to receive the written complaint.
- 4) **Review and Investigation of Complaint.** Upon receipt of a complaint, the Privacy Officer (or the employee's supervisor or Superintendent) shall review and investigate the complaint.
- 5) **Corrective Action.** If warranted, the Privacy Officer shall take corrective action, which may include:
 - A) Change of policy and/or procedure.
 - B) Intervention with an employee who is not following procedures including additional training and/or sanctions.
 - C) Other action as appropriate.
- 6) **Communicating Results of Investigation and Corrective Action.** The Privacy Officer shall communicate the results of the investigation and any corrective action taken to the individual filing the complaint.
- 7) **Documentation of Complaints.** The CCBDD shall document all complaints received and the disposition of each complaint, if any. Documentation shall be maintained in accordance with [Policy 1330 HIPAA Assignments and Documentation](#).

REFERENCES

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

1350 Policy Updating and Staff Training

Adopted: 11/17/2015
Effective: 11/17/2015

POLICY:

CCBDD's HIPAA Privacy Officer and HIPAA Security Officer shall collaborate to insure that policies and procedures required by HIPAA, FERPA/IDEA and other laws are updated at least annually for compliance, and to train staff as necessary on these policies and procedures.

REFERENCES

[45 CFR 164.530\(b\)](#)

[45 CFR 164.530\(i\)](#)

[45 CFR 164.520](#)

[ORC § 5123.64](#)(A) training in rights

[OAC § 5123:2-3-08](#) staff training in licensed facilities

[OAC § 5123:2-5-01](#)(C)(12) training requirements for adult service workers

[OAC § 5123:2-5-02](#)(C)(12) training requirements for adult service workers

[OAC § 5123:2-5-05](#)(C)(13) training requirements for early intervention workers

[OAC § 5123:2-5-07](#)(C)(9) training requirements for investigative agents

OAC § 5123:2-7-01 training requirements for TISC Gone!

PROCEDURES:

- 1) **Annual Review and Update of All Policies.** The HIPAA Privacy Officer shall conduct an annual review of all policies, and update policies as necessary based on new circumstances, changes in federal regulations and any changes in Ohio state laws and regulations governing DD Boards. An audit trail of policy changes will be maintained as detailed in [Policy 1330 HIPAA Assignments and Documentation](#).
- 2) **Training New Staff on Confidentiality and Computer Security Policies.** The HIPAA Privacy Officer and HIPAA Security Officer shall collaborate to insure that all new staff will be receive training on CCBDD Confidentiality and Computer Security policies promptly after hiring. The two officers shall create an appropriate training program.
- 3) **Training All Staff When Policies are Substantially Changed.** The HIPAA Privacy Officer and HIPAA Security Officer shall collaborate to insure that staff receive training on Confidentiality and Computer Security policies when they are substantially changed.

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

HIPAA SECURITY POLICIES

POLICIES FOR EXECUTIVE MANAGEMENT & HIPAA SECURITY OFFICER

3000 Security Management Process

Adopted: 11/17/2015

Effective: 11/17/2015

POLICY

CCBDD will appoint a HIPAA Security Officer. The HIPAA Security Officer will orchestrate the board's security management process.

AUDIENCE

Executive Management

AUTHORITY

HIPAA Privacy and Security Rules, [45 CFR Part 164](#)

[164.308\(a\)\(2\)](#)

[OAC § 5123:2-1-02\(I\)\(7\)](#) appointment of person responsible for ensuring the safekeeping of records and securing them against loss or use by unauthorized persons.

PROCEDURES

- 1) **The Superintendent will designate a HIPAA Security Officer.** The job responsibilities for this individual are detailed in [Appendix C – Sample Job Descriptions for HIPAA Privacy Officer and Security Officer](#). The HIPAA Security officer will assume the duties detailed in [OAC § 5123:2-1-02\(I\)\(7\)\(a\)\(5\)](#), which include overall responsibility for safekeeping of all records, electronic and paper. Documentation of the designation of the HIPAA Security Officer will be retained with other HIPAA-mandated designations per [Policy 1330 HIPAA Assignments and Documentation](#).
- 2) **The HIPAA Security Officer will be responsible for security management process.** This will include:
 - A) **Security Team.** The HIPAA Security Officer may issue a request to the Superintendent to appoint a Security Team consisting of managers representing the different functional areas and facilities maintained by the board. The Security Team's charter would be defined by the board, to include assessing risks, recommending and implementing appropriate technical capabilities, drafting and deploying appropriate security policies and procedures, and periodically validating their effectiveness.
 - B) **Computer Security Risk Assessment.** The Risk Assessment is an accurate and thorough assessment of potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information held by the board. The Computer Security Risk Assessment will be handled as follows:
 - i) The county board will use the risk assessment methodology detailed in [NIST SP 800-30](#) (2012).
 - ii) As a component of this risk analysis, vulnerabilities will be identified using the annual security evaluation as specified in [Policy 3020 Annual Security Evaluation](#).
 - iii) The Risk Assessment shall be updated on an annual basis.
 - iv) The results of this assessment shall be documented and maintained for 6 years.
 - C) **Manage IT Infrastructure, Create and Deploy Security Policies.** On an ongoing basis, implement and maintain the IT infrastructure, create Security Policies and Procedures, and deploy them. More specifically, he/she will:
 - i) Evaluate any regulatory requirements including HIPAA Security regulations, other applicable regulations, and industry best practices.
 - ii) Prepare recommendations for the Superintendent for approval by the board including implementation of new and updated policies, acquisition of technical security measures, or physical security measures. The Board shall have final authority on risk management decisions.

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- iii) Implement security measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level so as to comply with HIPAA regulations.
 - iv) Train board staff regarding compliance.
 - v) Monitor Board compliance with the information security policies, and take action as appropriate based on this monitoring.
- D) **Information System Inventory.** The HIPAA Security Officer and/or Security Team shall maintain an inventory of the hardware, software and networking infrastructure.
- i) Content of Inventory:
 - 1) Hardware inventory will document all servers, routers and other networking equipment, desktop computers, laptops, smartphones and other portable computing devices, external disk drives, and USB flash drives. Inventory will include physical location, primary user, manufacturer / model / serial number.
 - 2) Network infrastructure documentation will include network topology and all other information necessary to recreate the network in the event of a catastrophic event.
 - 3) Software inventory will include hardware installed on, Software manufacturer, program name, version number, license/serial number and date.
 - ii) Update frequency. This inventory should be updated on an ongoing basis with a physical inventory no less frequent than annually for mobile devices.
 - iii) Network Monitoring. (Optional Best Practice.) Network access monitoring may be performed to validate that devices which access the network are included in the inventory. Corrective action should be taken when an unknown device appears.
 - iv) Backup copy. A copy of this inventory shall be maintained off-site to insure availability in the event of a fire or other disaster.
- E) **Change Management.** The HIPAA Security Officer shall proceed prudently with any changes to hardware or software.
- i) A full backup of any major software system will be performed prior to any software upgrade or movement of a server, to allow for restoration of a working copy in the event of malfunction. After upgrade, key functionality of system will be promptly verified so that the practice can revert to the previous version if necessary.
 - ii) Prior to patching operating system or DBMS software on a server, the application software vendor will be contacted for validation that functionality has been tested and that no compatibility issues have been found. Automatic patching shall not be enabled on servers.
 - iii) Interfaces will be monitored upon change of a software application on either end to validate proper functionality.

REFERENCES

[NIST SP 800-30, Risk Management Guide for Information Technology Systems](#), 2001

[NIST SP 800-26, Security Self-Assessment Guide for Information Technology Systems](#), 2001

SANS at www.sans.org. See SANS Top 20 Controls, Control #1 for additional information re: Inventory.

Center for Internet Security at www.cisecurity.org

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

3005 Data Backup

Adopted: 11/17/2015

Effective: 11/17/2015

POLICY

The HIPAA Security Officer will insure that a robust data backup regimen is in place and operational at all times. The HIPAA Security Officer shall personally insure that the procedures below are consistently maintained.

AUDIENCE

HIPAA Security Officer

AUTHORITY

HIPAA Privacy and Security Rules, [45 CFR Part 164.308\(a\)\(7\)](#)

PROCEDURES

- 1) **Data Criticality Analysis.** A Data Criticality Analysis shall be performed and updated as appropriate. The backup regimen must be developed in a manner consistent with the data criticality.
- 2) **Multiple Backup Generations.** Backups should include as many generations as is practical to store. One backup per day is appropriate.
- 3) **Backup Software.** Appropriate backup software shall be maintained, with appropriate scripting. These scripts shall be reviewed and adjusted as appropriate whenever hardware or software upgrades are performed to insure that appropriate data backup is maintained.
- 4) **Off-site storage.** Backup regimens for data determined by data criticality analysis to be “mission critical” or “important” should include an off-site backup, that is, in a separate facility from the one containing the physical hardware.
- 5) **Backup Documentation.**
 - A) A written description of the backup regimen must be maintained, including a description of the backup software utilized, the backup method used (e.g. full system or incremental), details of the generations maintained, naming conventions used, names of backup scripts, and other information necessary to understand the backup strategy.
 - B) User documentation, for use by a system administrator, shall be maintained to allow for an alternate person to verify the daily operation of the backup.
- 6) **Responsibility.** The HIPAA Security Officer shall designate the employee with primary responsibility to personally handle the backup. In the event that he/she is absent from work, an alternate individual shall be responsible. All individuals responsible for this critical function should be trained and familiar with the backup design and the procedure for daily verification.
- 7) **Backup Log.** A daily written log shall be maintained documenting the date, person, verification that backup was completed successfully, and any comments. Problems should be immediately reported to the HIPAA Security Officer, or if the HIPAA Security Officer is away from the office, to the superintendent.
- 8) **Backup Media Security.** Backup media shall be maintained in a secure location.
- 9) **Testing and Plan Revision.** REVIEW AND UPDATE OF THE DATA BACKUP PLAN SHOULD BE CONDUCTED WITH ANY SIGNIFICANT UPDATE OF THE TECHNICAL ENVIRONMENT. On at least a quarterly basis, a trial restore shall be performed from the backup to verify the proper function of the backup process. Based on the results of this test, and any other environmental changes, the Data Backup Policy and Disaster Recovery Plan shall be updated. The results of this process should be documented and maintained for 1 year.
- 10) **Data Recovery Plan.** The HIPAA Security Officer shall maintain a written plan for restoration of data in the event of various system failures.

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

3010 Disaster Recovery Plan and Emergency Mode Operation

Adopted: 11/17/2015

Effective: 11/17/2015

POLICY

Board personnel shall develop contingency plans to prepare for system failures, and for procedures for maintaining critical board operations in the event of system failure.

AUDIENCE

HIPAA Security Officer

AUTHORITY

HIPAA Privacy and Security Rules, [45 CFR Part 164](#)

[164.308\(a\)\(7\)](#)

[164.312\(a\)\(1\)](#)

PROCEDURES

- 1) **Disaster Recovery Team.** If appropriate, the HIPAA Security Officer shall establish a Disaster Recovery Team to assist in the preparation of contingency plans as well as to execute assigned tasks in the event of a disaster. The HIPAA Security Officer shall direct this team and is responsible for all tasks identified in this policy.
- 2) **Scenario Identification.** Contingency planning shall begin with identification of likely failure scenarios. These scenarios should include, at a minimum, failure of one or more servers, data corruption of one or more subsystems, and catastrophic loss of the entire facility due to fire or other natural disaster. These scenarios shall be included in the written plan, and serve as the basis for the measures outlined below.
- 3) **Preventative Measures.** The HIPAA Security Officer shall, on an ongoing basis, evaluate the activities that are critical to board operations and implement preventative measures to reduce the likelihood of system failure. These would include technical measures such as RAID arrays, backup power supplies, fire suppression systems, raised floors, security systems, database transaction logging and the like.
- 4) **System and Data Recovery Plan.** The HIPAA Security Officer shall maintain a written system and data recovery plan, and take reasonable steps to mitigate losses, for likely failure scenarios. The written plan should include:
 - A) Computer applications shall be reviewed and assessed as to their criticality for maintaining board operations. The results of this assessment shall be documented.
 - B) Development of written documentation of tasks and responsibilities for members of the Disaster Recovery Team in the event of various failure scenarios.
 - C) System configuration documentation, as specified in the policy "HIPAA Security Officer and Security Management Process" to facilitate replacement of vital equipment in the event of a catastrophic loss.
 - D) Complete and current employee information and vital records.
 - E) Identification of, and contact information for, vendors who will be used for replacing equipment following a disaster.Reasonable steps to assure rapid recovery and mitigate losses can include, if appropriate:
 - A) Contracts with any necessary consultants and/or vendors to facilitate recovery, if deemed necessary and prudent by board management.
 - B) Contracts with hot and/or cold system sites if deemed necessary and prudent by board management.
 - C) Steps to manage risk, such as insurance policies, as deemed appropriate, for possible losses to mitigate the financial impact of disasters.
- 5) **Emergency Mode Operations Plan.** The HIPAA Security Officer shall maintain a plan to maintain vital operations in the event of a partial or complete system failure. This should begin with an identification of likely failure scenarios as described above. Elements of this plan may include:
 - A) Identification of situations which occur where immediate access to Individual data is necessary, as in certain MUIs involving health emergencies,
 - B) Maintenance of Critical Individual Data from electronic in a paper chart, or other plan to protect against loss of access due to technical failure,

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

- C) People assigned to assist Case Managers or other individuals with immediate access to this information in the event of an emergency regarding an Individual (accident, medical incident, etc.)
 - D) Periodic training of staff, regarding how to access information in the event of simultaneous computer downtime and Individual emergency,
 - E) For non-emergency situations, procedures which allow staff to function, to the extent possible, in the event of system downtime.
- 6) **Plan Testing.** The HIPAA Security Officer shall be responsible for plan testing. He or she shall design the approach to testing and the level of resources which are appropriate to invest in these activities based on the risk analysis.
- 7) **Off Site Storage of Key Documents.** A copy of the key documents described in this policy shall be maintained off site, in either paper or electronic form, so that they are readily and quickly assessable in the event of catastrophic loss of the facility.

REFERENCES

[NIST SP 800-14](#)

[NIST SP 800-18](#)

[NIST SP 800-26](#)

[NIST SP 800-30](#)

[NIST SP 800-53](#)

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

3015 Facility Security and Access Control

Adopted: 11/17/2015
Effective: 11/17/2015
Amended: 01/15/2019

POLICY

All employees shall be aware of facility security and access policies to insure that only authorized personnel physical access to the facility and its equipment.

AUDIENCE

HIPAA Security Officer

AUTHORITY

HIPAA Privacy and Security Rules, [45 CFR Part 164.310\(a\)\(1\)](#)

PROCEDURES

- 1) **Facility Security Planning.** The HIPAA Security Officer shall periodically evaluate physical security vulnerabilities, identify corrective measures, and develop a written facility security plan. The plan should focus especially on security of:
 - A) Computer Servers
 - B) Telephone and Networking equipment
 - C) IT staff offices
 - D) Workstation locations
 - E) Individual Paper Records
 - F) Access Keycards and FobsAttention should be given to areas with public access, whether workstations are protected from public access or viewing, the security of entrances and exits, and normal physical protections (locks on doors, windows, etc.).
- 2) **Employee Training.** The HIPAA Security Officer shall be responsible for employee training on their duties and responsibilities for facility security as described in the facility security plan.
- 3) **Maintenance of Physical Security Equipment.** The Director of Operations shall be responsible for maintaining equipment necessary to secure the facility, including locks, alarm systems, doors, security lighting, etc. Records of repairs and modifications shall be maintained.
- 4) **Unauthorized Individuals.** Any staff who sees an unauthorized, unescorted person in the facility, except for those Public Access Areas, shall, in a polite manner, escort the person to a common area. Any suspicious incident shall be reported to the HIPAA Security Officer and/or police.

REFERENCES

[NIST SP 800-66](#)

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

3020 Annual Security Evaluation

Adopted: 11/17/2015

Effective: 11/17/2015

POLICY

Annually the HIPAA Security Officer shall conduct a technical evaluation of the board's security policies and procedures, including a revised risk assessment, and update policies as necessary in response to environmental or operational changes affecting the security of electronic protected health information.

AUDIENCE

HIPAA Security Officer

AUTHORITY

HIPAA Privacy and Security Rules, [45 CFR Part 164.308\(a\)\(8\)](#)

ORC § 5123:2-1-02(I) County Board Administration, Records, Annual Review of Safeguards

PROCEDURES

- 1) **Annual Review of Regulations, Statutes, and Technological Issues to Update Security Policies.** On an annual basis, the HIPAA Security Officer will review any updates to federal HIPAA regulations, other applicable federal and/or state statutes, and technological issues and update the organization's security policies as appropriate. This review may be conducted internally, or upon the HIPAA Security Officer's recommendation and approval by the superintendent and/or board, contracted to an outside firm.
- 2) **Annual Evaluation.** On at least an annual basis, an evaluation of the technical infrastructure and/or the organizations compliance with computer security regulations will be conducted. From year to year, type of evaluation(s) may vary and will be selected by the HIPAA Security Officer. Appropriate evaluations may include
 - A) Vulnerability scanning and remediation
 - a) a commercial or open-source vulnerability scanning tool is used and/or a service is employed
 - b) Vulnerability scanning is performed both from outside of the network (targeting public facing IP addresses) and from inside the network
 - c) Devices connected to the devices are compared to the IT Asset inventory to identify unknown devices connected to the network
 - d) Missing assets are identified
 - e) Vulnerabilities shall be prioritized for remediationRemediation shall be performed in a prioritized basis
 - B) Penetration tests
 - C) Social Engineering exercises/tests
 - D) IT Asset audits to identify missing assets
 - E) Audits of policies and procedures for compliance with the following standards/regulations
 - a) HIPAA
 - b) CARF
 - c) FERPA/IDEA
 - d) State laws
 - F) Audits of compliance with policies and procedures, including verification that the processes, procedures and documentation specified in the policies exist, and that the responsible personnel understand the policiesEvaluations may be done more frequently, if determined by the Security Officer. More frequent evaluations are appropriate upon introduction of new technologies, the emergence of new environmental risks, regulatory changes, change in personnel, or other factors. Evaluations may be targeted to a specific area.
- 3) **Report and Recommendations.** The HIPAA Security Officer shall submit their report to the Superintendent and/or Board including any recommendations.
- 4) **Documentation of Review.** The results of the review will be documented, and documentation shall be retained for 6 years.

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

3025 Audit Control and Activity Review

Adopted: 11/17/2015

Effective: 11/17/2015

POLICY

System capabilities for maintaining audit trails of system use shall be enabled to permit forensic analysis and periodic activity reviews. Periodic activity reviews should be conducted to identify inappropriate activity so that appropriate corrective action is possible.

AUDIENCE

HIPAA Security Officer

AUTHORITY

HIPAA Privacy and Security Rules, [45 CFR Part 164](#)

[164.312\(b\)](#)

[164.308\(a\)\(1\)](#)

[164.308\(a\)\(5\)](#) Log-in Monitoring

PROCEDURES

- 1) **System Activity Logs.** Activity logs shall be enabled at the following levels:
 - A) **Operating System** (Windows Server 20xx): Audit Policy should be set to log logon events, account management events, policy changes, and system events.
 - B) **Firewall Hardware and Software:** Logs should be enabled to track inbound and outbound activity, including internet access by individual.
 - C) **Application Software Logging:** All software which stores data on individuals served shall have audit trail capabilities. Logs should be enabled in application software such as clinical record software, billing software, or information systems which store information regarding Individuals being served.
- 2) **Security on Logs.** Appropriate security features and passwords should be used at all levels above to permit log file access only by the HIPAA Security Officer and/or an individual designated by him/her.
- 3) **Quarterly Audit of PHI Access.** A review of system activity will be conducted on at least a quarterly basis. The HIPAA Security Officer shall design an audit strategy to identify probable or anticipated violations. Suspicious and/or inappropriate activities include but are not limited to:
 - A) Access by individuals at unusual hours.
 - B) Higher access/usage levels than normal.
 - C) Accesses to records of relatives of celebrities, celebrities' children or employees.
 - D) Unauthorized changes to security settings.
 - E) Web sites viewed by employees to verify that they are work related.
 - F) Outside probe attempts and/or accesses via the internet connection.
 - G) Other Unusual patterns of activity.
- 4) **System Activity Review.** In a manner determined by the HIPAA Security Officer, he or she will monitor system activity to detect suspicious or unusual system activity.
- 5) **Corrective Action.** The HIPAA Security Officer will initiate corrective action, in conjunction with other members of the management staff, in the event any inappropriate PHI access, or if suspicious or unusual system activity is detected.
- 6) **Purge of Log files.** System Log files which grow large may be purged under the direction of the HIPAA Security Officer.
- 7) **Annual Policy Review.** Annual attention should be given this policy regarding audit controls, as the threat level varies and the cost of monitoring tools changes.

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

3030 Malicious Software Protection

Adopted: 11/17/2015

Effective: 11/17/2015

POLICY

All company computer systems will be protected by virus and malicious software protection capabilities.

AUDIENCE

HIPAA Security Officer

AUTHORITY

HIPAA Privacy and Security Rules, [45 CFR Part 164.308\(a\)\(5\)](#)

PROCEDURES

- 1) **Multi-Layered Defense Strategy.** The HIPAA Security Officer will insure that the computer network be protected from malicious software using a multi-layered defense strategy:
 - A) Appropriately configured, commercial-grade firewall (per Policy [3060 Technical Safeguards](#))
 - B) Centrally managed and updated anti-virus software
 - C) DNS filtering service to limit connections to malicious sites, phishing attacks, and botnets per Policy [3060 Technical Safeguards](#)
 - D) Patching of operating system and application software per [Policy 3060 Technical Safeguards](#)
 - E) Monitoring system logs per [Policy 3020 Audit Control and Activity Log Review](#)
- 2) **Special procedures** will be used, if appropriate, for any users who routinely access on-line banking accounts.
- 3) **Annual Review.** Annual review of this policy will be conducted to insure that the products, services, and configuration, and policies appropriately manage risk for this rapidly evolving threat.

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

3035 Breach Reporting

Adopted: 11/17/2015

Effective: 11/17/2015

POLICY

The board will notify Individuals receiving services, the Secretary of HHS and, when appropriate, the news media regarding breaches of protected health information.

AUDIENCE

HIPAA Security Officer

AUTHORITY

HIPAA Privacy and Security Rules, [45 CFR Part 164, Subpart D](#)
[164.400](#), [164.402](#), [164.404](#), [164.406](#), [164.408](#), [164.410](#), [164.412](#), [164.414](#)

PROCEDURES

- 1) Upon becoming aware of a privacy rule violation or security incident, the HIPAA Security Officer and HIPAA Privacy Officer shall jointly determine if the incident meets the definition of a breach. If a Security Incident Response Team (Team) has not been assembled, they may assemble a Team at this point. Legal counsel and other outside expert advice shall be obtained, if appropriate, for additional guidance on the Team. An investigation should be launched, with attention to preserving evidence. The Team shall follow the following 3 step procedure:
 - A) Was there acquisition, access, use, or disclosure of PHI that violates the Privacy rule? If “no”, there is no breach. Otherwise, proceed to the next step.
 - B) Does one of the statutory exceptions listed in the [breach](#) definition in Policy 1000 apply? If “yes”, there is no breach. Otherwise, proceed to the next step.
 - C) Unless the incident is clearly a breach, the Team shall conduct a risk assessment. The risk assessment, per HIPAA regulations, shall consider at least the following factors:
 - i) The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;
 - ii) The unauthorized person who used the protected health information or to whom the disclosure was made;
 - iii) Whether the protected health information was actually acquired or viewed; and
 - iv) The extent to which the risk to the protected health information has been mitigated.The results of this evaluation shall be documented and maintained for 6 years as detailed in [Policy 1330 HIPAA Assignments and Documentation](#). If the risk assessment demonstrates that there is a low probability that PHI has been compromised, then no breach has occurred and this process may stop. Otherwise, a breach has occurred and the Team should proceed with the steps that follow in the remainder of this policy.
- 2) **Public Relations Strategy.** The Team should develop a public relations strategy to include when and who should speak to the media and what should be said.
- 3) **Breach Notification.** In the event of a breach, the Team shall:
 - A) Notify Individuals affected by the breach without unreasonable delay (and in no case later than 60 calendar days after the discovery of the breach):
 - i) In the event of an urgent situation, the board may use telephone, email or other means to immediately notify individuals of the breach.
 - ii) Prepare formal written notification for approval by superintendent. The notification shall be written in plain language and include the following:
 - 1) A brief description of what happened, including the date of the breach and the date of discovery of the breach, if known;
 - 2) A description of the types of unsecured protected health information that were involved in the breach;
 - 3) Any steps that individuals should take to protect themselves from potential harm resulting from the breach;
 - 4) A brief description of what the board is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches; and

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

- 5) Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, web site or postal address.
- iii) Send the primary breach notification to:
 - 1) Individuals affected by the breach by first-class mail at their last known address, or by e-mail if agreed in advance by the individual for this type of notice, or
 - 2) Parent, guardian, or HIPAA Personal Representative of the Individual in the event the individual is a minor and/or not competent to make decisions, or
 - 3) next of kin or personal representative of the Individual in the event that the individual is deceased and the next of kin name and address are available.
- iv) Track returned mail and provide a substitute notice to Individuals who did not receive the primary notification (no further effort is necessary for unreachable next-of kin):
 - 1) In the event that fewer than 10 individuals, the HIPAA Security Officer shall research updated address and/or phone number and make best efforts to inform those individuals by either phone or mail.
 - 2) In the event that 10 or more individuals are not reachable by first class mail,
 - a) A toll-free phone number shall be established, and staffed with operators, for at least 90 days
 - b) a notice shall be conspicuously placed on the board's web site home page with details of the above details on the breach plus the phone number
- B) Notify the news media if more 500 Individual records are involved in the breach
 - i) Under direction of the board superintendent, a press release shall be prepared detailing the information in section 2Ab above, and other relevant information.
 - ii) Upon approval of the board superintendent, the press release shall be issued without unreasonable delay (and in no case later than 60 days after discovery of the breach) to the major print, broadcast and online media serving the county.
- C) Notify the Secretary of the Department of HHS regarding the breach
 - i) In the event that the breach involves 500 or more individuals, notice to the Secretary should be provided at the same time as the Individual notification in the manner detailed on the HHS Web site.
 - ii) For breaches involving fewer than 500 individuals, a log including at a minimum the information in 2Ab above, and other relevant information, should be maintained. At the end of the calendar year, the contents of the annual log should be provided to the secretary in the manner detailed on the HHS Web site.
- 2) **Breaches by Business Associates.** Breaches by business associates are handled in the same manner. Business associates are obligated to cooperate in providing necessary information; the board is responsible for issuing the notice detailed in this policy.
- 3) **Law Enforcement Delay.** The notices to Individuals and the media may be delayed if a request is received by a law enforcement official:
 - A) If written notice is received from a law enforcement official which specifies the time period of delay, the board shall comply with that request.
 - B) If the request is made orally, the notification shall be delayed but not longer than 30 days from the date of the oral request.
- 4) **Documentation.** Documentation, including any notices provided, incident reports, meeting notes, especially those which document the date of the breach, shall be maintained for 6 years. For the legal purposes, including the timelines in policy, the date of breach discovery shall be the date that the board should have become aware if it exercised reasonable diligence.

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

3040 Security Awareness Program

Adopted: 11/17/2015

Effective: 11/17/2015

Amended: 5/16/2017

POLICY

The HIPAA Security Officer will conduct an ongoing security awareness program to train and refresh staff on computer security behaviors and the board's security policies. Priority topics shall include recognizing and avoiding malicious software, avoiding "social engineering" ploys, using passwords effectively, and adhering to workstation use policies.

AUDIENCE

HIPAA Security Officer

AUTHORITY

HIPAA Privacy and Security Rules, [45 CFR Part 164.308\(a\)\(5\)](#)

PROCEDURES

- 1) **Security Training Program for All New Employees and Annual Training for All Employees.** The HIPAA Security Officer shall develop, and maintain, a security training program for all new employees and for all employees on an annual basis. This may include topics such as:
 - A) Password policies
 - B) Recognizing and avoiding malicious software
 - C) Understanding e-mail attachments
 - D) Safe web browsing practices
 - E) Dangers of downloading files from the internet
 - F) Understanding of "Social Engineering" and how to recognize such ploys
 - G) Knowledge of Workstation Use Policies
 - H) Consequences for non-compliance
 - I) Security Incident Reporting Procedures
 - J) Advisories regarding current threats
 - K) Issues with new technologies such as smartphone/tablet security.Other appropriate topics may be included at the discretion of the HIPAA Security Officer. The program may be conducted one-on-one, via e-learning system, or other media as determined by the HIPAA Security Officer.
- 2) The HIPAA Security Officer shall specify the scope of the program; the goals; the target audiences; the learning outcomes.
- 3) A variety of media and avenues should be explored such as sign-in banners, security reminder cards for posting at workstations, articles in employee newsletters, posting on bulletin boards, etc.

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3050 Device and Media Disposal and Re-Use

Adopted: 11/17/2015

Effective: 11/17/2015

Amended: 5/16/2017

POLICY

Electronic storage media and devices shall be cleaned of protected health information and other confidential information prior to disposal and/or re-use.

AUDIENCE

HIPAA Security Officer

AUTHORITY

HIPAA Privacy and Security Rules, [45 CFR Part 164.164.310\(d\)\(1\)](#)

PROCEDURES

- 1) **Media Disposal Handled by HIPAA Security Officer.** As specified in [Policy 3080 Computer Usage](#), Board employees are prohibited from storing Protected Health Information of the Board's on removable media. In the event of a legitimate requirement to store data on a device such as a CD or USB drive, the employee should be instructed to give it to the HIPAA Security Officer for disposal when it is no longer needed.
- 2) **Technical Guidance.** In accordance with instructions from the Secretary of HHS, technical guidance regarding media disposal should be obtained from [NIST SP 800-88 Guidelines for Media Sanitization](#). The Board requires that at a minimum, data from electronic media should be "cleared", that is, protected against a robust keyboard attack but not necessarily against a laboratory attack.
- 3) **Media Disposal and Re-use.** Procedures vary based on type of storage media:
 - A) **CDs, DVDs and Tapes:** CDs, DVDs and Tapes should be physically destroyed by a service who will issue a certificate of destruction.
 - B) **Hard Drives:** Hard drives should be randomized and reformatted prior to disposal or re-use.
 - C) **Other Media.** See [NIST SP 800-88](#) for disposal/recycling methods for other media.
- 4) **Records.** Records of Media disposal should be maintained for 6 years. The following records should be maintained:
 - A) Item Description
 - B) Make/Model
 - C) Serial number(s) / Property Number(s)
 - D) Backup Made of Information (Yes/No)
 - E) If Yes, location of backup
 - F) Item Disposition (Clear/Purge/Destroy)
 - i) Date Conducted
 - ii) Conducted by
 - iii) Phone #
 - iv) Validated By
 - v) Phone #
 - G) Sanitization Method used
 - H) Final disposition of media (Disposed/Reused Internally/Reused Externally/Returned to Manufacturer /Other)

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

3060 Technical Safeguards

Adopted: 11/17/2015

Effective: 11/17/2015

POLICY

Technical Safeguards will be employed as necessary to maintain the integrity of data, and to insure the security of data during transmission.

AUDIENCE

HIPAA Security Officer

AUTHORITY

HIPAA Privacy and Security Rules, [45 CFR Part 164](#)

[164.312\(c\)](#)

[164.312\(d\)](#)

[164.312\(e\)](#)

PROCEDURES

- 1) **Firewalls.** Commercial-grade hardware and/or software firewalls shall be employed to protect against network intrusions and to manage/monitor outbound traffic. Workstation-based software firewalls (e.g. Windows Firewall) should be used on laptop computers since they may be connected to an outside network.
- 2) **Secure Configurations.** Workstations and servers will be installed with a standard configuration that meets the following specifications:
 - A) A standard list of software to be installed will be maintained. Only vendor-supported versions of software should be used. Additional software may be installed for specific users based on unique requirements.
 - B) Windows, Microsoft Office, and Internet Explorer should be securely configured. Microsoft's security configuration guides shall be used, using the middle level of security, with modifications as necessary to allow for functionality.
 - C) Microsoft Security Compliance Manager and Active Directory will be used to maintain and enforce security configurations.
- 3) **Operating System and Application Software Patching.** Operating Systems, application software and hypervisors, if used, shall be patched regularly on both servers and workstations. Auto-update functionality may be employed and update servers. Centralized patch management software such as Microsoft WSUS and/or third party-software may be utilized.
- 4) **Virtualization Software and Environment.** If virtualization technology is employed, the virtualization-enabling software, aka "hypervisors", shall be secured as follows:
 - A) Unneeded capabilities shall be disabled to reduce potential attack vectors.
 - B) A strong password (minimum of 8 characters, 1 upper case, 1 lower case, 1 digit) shall be used for the management console.
 - C) Synchronize the virtualized infrastructure to a trusted authoritative time server, and synchronize the times of all guest OS's.
 - D) Harden the host OS of the hypervisor by removing unneeded applications, and setting OS configuration per the vendor's security recommendations.
 - E) Use separate logon credentials for each virtual server.
- 5) **DNS Filtering** shall be employed to reduce access to unsafe websites and to reduce phishing attacks, using OpenDNS or an alternative service.
- 6) **Wireless Networks.** Wireless networks, if employed, will be implemented with the following security options:
 - A) The beacon shall be enabled.
 - B) The SSID should be changed from the default.
 - C) WPA/WPA2 should be enabled.
 - D) WPS should be disabled.These security options should be reviewed annually and adjusted as appropriate as improved industry standards for wireless security are developed.
- 7) **E-mail.** For transmission of PHI, secure, encrypted e-mail should be employed.

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- 8) **Encryption of desktop, mobile devices and portable media.** When encryption of end-user devices is determined appropriate based on risk analysis, the Board shall employ the framework detailed in [NIST Special Publication 800-111, *Guide to Storage Encryption technologies for End User Devices*](#). Specifically, the Board should:
 - A) consider solutions that use existing system features (such as operating system features) and infrastructure;
 - B) use centralized management for all deployments of storage encryption except for standalone deployments; and very small-scale deployments;
 - C) select appropriate user authenticators for storage encryption solutions; and
 - D) implement measures that support and complement storage encryption implementations for end user devices.
- 9) **Transmission Security.** For data in motion, the HIPAA Security Officer implement solutions consistent with the Secretary of HHS's guidance on securing PHI. Valid encryption processes for data in motion are those that comply with the requirements of [Federal Information Processing Standards \(FIPS\) 140-2](#). These include, as appropriate, standards described in:
 - A) [NIST Special Publications 800-52, *Guidelines for the Selection and Use of Transport Layer Security \(TLS\) Implementations*](#).
 - B) [NIST 800-77, *Guide to IPsec VPNs*](#).
 - C) [NIST 800-113, *Guide to SSL VPNs*](#).
 - D) Other [FIPS 140-2](#) validated processes.
- 10) **Appropriate Audit Controls in Board-Used Software.** Software used by Board should be evaluated for the appropriate level of audit control, such as logging of all transactions or logging of key events such as creating, viewing, changing, or deleting PHI. In the event of deficiency of software currently in use, requests to vendors for enhancements should be made as appropriate. Appropriate audit controls should be a criteria for continued use of and/or procurement of any new operating or application software.
- 11) **Software utilizing Electronic Signatures.** The HIPAA Security Officer will review and approve any software that offers electronic signature capability prior to implementation at the county board. The HIPAA Security Officer shall be responsible for implementation and ongoing monitoring/auditing of the software as specified in [Policy 3070 Electronic Signatures](#).
- 12) **Automatic Log Off.** Appropriate measures shall be taken, based on the technology available, to enable the automatic log-off provisions as determined by the risk assessment. See also [Policy 3080 Computer Usage](#) and [Policy 3075 Employee System Access and Termination Procedures](#).
- 13) **Integrity Checks.** The HIPAA Security Officer shall attend to integrity of electronic data:
 - A) Periodic DBMS maintenance as recommended by the software vendor shall be performed.
 - B) Message digest integrity reports shall be reviewed with corrective action taken as necessary.
 - C) Monitoring any electronic interfaces, such as lab interfaces, to verify proper functionality.

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

3062 Technical Controls for Mobile Devices

Adopted: 01/15/2019

Effective: 01/15/2019

POLICY

Technical safeguards for agency-owned devices.

AUDIENCE

HIPAA Security Officer
IT Staff

AUTHORITY

HIPAA Privacy and Security Rules, [45 CFR § 164](#)

[45 CFR § 164.312\(b\) Standard: Audit Controls](#)

[45 CFR § 164.312\(c\)\(1\) Standard: Integrity](#)

[45 CFR § 164.312\(d\) Standard: Person or entity authentication](#)

[45 CFR § 164.312\(e\)\(1\) Standard: Transmission Security & \(2\) Implementation Specifications](#)

[45 CFR § 164.312\(a\)\(2\)\(iv\) Encryption and decryption](#)

[45 CFR § 164.308\(a\)\(5\)\(ii\)\(D\) Password Management](#)

[45 CFR § 164.308\(a\)\(5\)\(ii\)\(B\) Protection from Malicious Software](#)

DEFINITIONS

MDM – Mobile Device Management. Software that enables mobile devices to be encrypted, locked, or reset remotely in the event of a lost or stolen mobile device, in addition to standardizing settings and installations.

PROCEDURES

FOR THE HIPAA SECURITY OFFICER/IT DEPARTMENT

- 1) **Technical Controls.** The organization shall implement appropriate technical controls
 - A) Use of an appropriate mobile device management system to maintain inventory of devices, enforce security configurations, provide remote wipe/lock capability, geo-location, monitor policy compliance and other appropriate controls.
 - B) The use of appropriate security controls including secure communications, strong authentication, audit logging, control of third-party software, anti-malware, segregation of corporate from personal data, restricting the use of camera/microphone, restricting automatic backups of the organization's data to employee controlled backup services and other controls and backup of any corporate data.
- 2) **Eligibility Criteria.** All agency employees are eligible for agency-owned devices, provided that a need exists, and that the employee has no disciplinary procedures that would warrant the removal of eligibility from the mobile program.
- 3) **Technical Safeguards.** The MDM will enforce a secure configuration of the employee phone/tablet, and enable remote wiping of the device:
 - Encryption (required by HIPAA)
 - Strong password (required by HIPAA)
 - Anti-malware software (required by HIPAA)
 - Require strong authentication, use password controls
 - Disable and/or limit Bluetooth communications

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3065 Mitigation

Adopted: 11/17/2015

Effective: 11/17/2015

POLICY

In the event of an inappropriate use or disclosure of an individual's PHI, the CCBDD will take reasonable steps to mitigate the harmful effects of the disclosure.

AUDIENCE

Privacy Officer

AUTHORITY

HIPAA Privacy and Security Rules, [45 CFR Part 164](#)

[164.530](#)(f) – Mitigation

PROCEDURES

- 1) **Mitigating Harmful Effects of Privacy Violation.** In the event of a HIPAA Privacy rule violation, the Privacy Officer, in conjunction with other members of the management staff as he/she deems appropriate, shall take action to mitigate the harmful effects of the Privacy Violation, if this is reasonable and possible. The mitigation action should correspond to the nature of the violation. For example, if social security numbers are breached, it may be appropriate to purchase identity theft protection for 1 year.

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

3070 Electronic Signatures

Adopted: 11/17/2015

Effective: 11/17/2015

POLICY

Electronic signatures may be utilized at CCBDD by both employees and providers. Electronic signatures are legally binding as a means to identify the author and to confirm that the contents are what the author intended.

AUDIENCE

Employees Using Electronic Signatures; Managers

AUTHORITY

[ORC § 1306](#) Ohio Uniform Electronic Transactions Act

ORC § 304 Electronic Records and Signatures for Counties

ORC § 9.01 Official Records – Preserving and Maintaining

ORC § 117.111 State Audits shall review method, accuracy and effectiveness of electronic signature security procedures

DEFINITIONS

- 1) Electronic Signature, as defined by the Ohio Revised Code, means an electronic sound, symbol or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record.
- 2) Electronic facsimile. A computer image, such as one maintained in an electronic document imaging system, of a conventionally signed document is not an electronic signature. Rather, the electronic facsimile is legally equivalent to the original, traditionally signed document.

PROCEDURES

1) Security

- A) **Confidentiality statement.** Anyone authorized to utilize electronic signature will be required to sign a statement attesting that he or she is the only one who has access to his/her signature/ logon password, that the electronic signature will be legally binding and that passwords will not be shared and will be kept confidential.
- B) **Passwords.** All users will have their own user ID and password. Passwords must conform to complexity guidelines detailed in [Policy 3080 Computer Usage](#).
- C) **Personal Identification Numbers (PIN)/ Secondary Passwords.** PIN numbers and/or secondary passwords may be assigned when possible for use with electronic signatures to allow for another level of security (this is optional and county specific). PIN numbers or secondary passwords are not viewable on any screen.
- D) Vendors, outside agency or providers who have access to using an application requiring an electronic signature based upon the user's ID and password as described in this policy, shall use additional controls to ensure the security and integrity of each user's electronic signature:
 - i) Follow loss management procedures to electronically de-authorize lost, stolen, missing or otherwise compromised documents or devices that bear or generate identification code or password information and use suitable, rigorous controls to issue temporary or permanent replacements;
 - ii) Use safeguards to prevent the unauthorized use or attempted use of passwords and/or identification codes; and
 - iii) Test or use only tested devices, such as tokens or cards that bear or generate identification code or password information to ensure that they function properly and have not been altered.

2) Creating, Maintaining an Electronic Signature

- A) Electronic signatures can be used wherever handwritten signatures are used except where stated by a specific law or rule.
- B) All who use a system that uses electronic signatures are required to review their entries.
- C) Once an entry has been signed electronically, the computer system will prevent it from being deleted or altered. If errors are later found in the entry or if information must be added, this will be done by means of addendum to the original entry. The addendum should also be signed electronically and date/time stamped by the computer software.

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

D) System specific standards and procedures for use may vary by system and it will be required that the Board must establish and maintain system specific procedures for any system which also satisfies other current policies.

3) **Auditing Electronic Signature Procedures**

The computer software and anyone using the software system must use a secure, computer-generated, time-stamped audit trail that records independently the date and time of user entries, including actions that create, modify or delete electronic records. Record changes shall not obscure previously recorded information. Audit trail documentation shall be retained for a period at least as long as that required for the record and shall be made available as needed upon request. Any misuse or disregard of electronic signature policy will be reviewed and acted upon by the Superintendent or designee.

4) **Review and Approval Prior to Using Electronic Signatures**

The HIPAA Security Officer shall review the software utilized for electronic signatures, and other procedures utilized, for compliance with this policy prior to permitting the use of electronic signatures. This review shall be conducted for each transaction to be electronically signed.

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

SECURITY POLICIES FOR HR STAFF & SUPERVISORS

3075 Employee System Access and Termination Procedures

Adopted: 11/17/2015

Effective: 11/17/2015

POLICY

System access will be granted to employees in a manner consistent with the HIPAA Privacy laws and other state regulations, including specific policies for access control, granting access to new staff and staff with assignment changes, handling staff terminations, password selection, maintenance and use, and access to the system in the event of an emergency.

AUDIENCE

Human Resource Department, Supervisors, HIPAA Security Officer

AUTHORITY

HIPAA Privacy and Security Rules, [45 CFR Part 164](#)

[164.308\(a\)\(3\)](#)

[164.308\(a\)\(4\)](#)

[164.312\(a\)\(1\)](#)

[164.314\(d\)](#)

[164.308\(a\)\(5\)](#) Password Management

PROCEDURES

AUTHORIZATION TO SYSTEMS AND ROLE-BASED ACCESS CONTROLS

Audience: HIPAA Security Officer, Privacy Officer

- 1) **Minimum Necessary Analysis.** The HIPAA Security Officer shall coordinate with the Privacy Officer to maintain and document a current “minimum necessary” analysis, per [Policy 1020 Minimum Necessary Policy](#) which identifies the classes of persons (job descriptions) and the categories of Protected Health Information which they need access to.
- 2) **Access Profiles.** The HIPAA Security Officer shall utilize the security capabilities of the various network and application software systems at the Board and develop role-based “Access Profiles” for these different job descriptions. Vendors will be contacted for any enhancements necessary for appropriate implementation of these access profiles.
- 3) **Granting Access to Information Systems.** The authority to grant access to information systems rests with board of directors and is delegated to the human resources department. Implicit in a hiring decision is the provision of access to the information systems necessary for the job, as determined above based on the minimum necessary analysis and the Access Profiles.
- 4) **Granting Access Beyond the Standard Access Profile.** In certain situations, such as when employees are assigned special projects, information access may be required beyond what the job description would dictate. In these cases, the HIPAA Security Officer, after any necessary consultation with the management staff at the Board, shall have the authority to grant access to information systems which go beyond the standard Access Profiles described above. Access should be terminated when the need for access is completed.
- 5) **Inventory of Employees with Access to PHI.** The HIPAA Security Officer shall maintain an updated, inventory of employees with access to PHI and the access rights which are granted.
- 6) **Annual Audit of Access Controls.** On an annual basis, the HIPAA Security Officer shall audit the access controls to verify that the above policies have been implemented properly and consistently. Such an audit could include verification that recently terminated employees no longer have access, a review of access for employees with job changes in the previous year, and a random sampling of other employee access authorization. Based on the results of this audit, the HIPAA Security Officer shall adjust policies and/or staff training as appropriate.

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

SYSTEM AND FACILITY ACCESS FOR NEW HIRES

Audience: Supervisors, Human Resource Department

- 1) **Requests for Access to Information Systems.** Supervisors and/or the human resources department shall direct requests for access to information systems shall be directed to the HIPAA Security Officer or his/her designee. The HIPAA Security Officer shall verify with the human resources department in the event of any question regarding the accuracy of the job assignment.
- 2) **Assigning User ID and Password.** The HIPAA Security Officer will assign new hires requiring computer access a unique network User ID and password, and/or User IDs and passwords for other application systems. Security settings appropriate for the individual will be assigned in accordance with this policy, as described above.
- 3) **Communicating User ID and Password.** The HIPAA Security Officer shall communicate the User IDs and passwords in a manner which does not compromise security by revealing the passwords to another person.
- 4) **Documentation of System Access Rights.** As described above, the HIPAA Security Officer will maintain documentation of system access rights.
- 5) **User Data Area.** The HIPAA Security Officer will configure a User Data Area on the Server to provide data storage space for the employee. All data is to be stored on the server and not on individual workstations.
- 6) **Security Awareness Training.** Employees will receive Security Awareness Training, in the manner chosen by the HIPAA Security Officer, in accordance with the [Policy 3040 Security Awareness Program](#). In addition, new employees should receive a written copy of the [Policy 3080 Computer Usage](#), and they will sign written acknowledgement that they understand and will adhere to all policies. This will be maintained in the employee personnel file.

PASSWORDS and PASSWORD MANAGEMENT

Audience: HIPAA Security Officer

- 1) **Password Complexity.** Network policies shall be established to enforce password complexity as follows: 8 character minimum, minimum of 1 upper case letter, 1 lower case letter and 1 digit.
- 2) **Lockout.** The system shall lock accounts after 5 unsuccessful attempts.
- 3) **Password Reuse.** The system shall maintain the previous 5 passwords and prohibit re-use of any of these recent passwords.
- 4) **Password Changes.** The HIPAA Security Officer shall implement a mechanism to insure that all employees change their passwords at least every 6 months.

EMPLOYEE JOB CHANGES

Audience: Human Resources Department, HIPAA Security Officer

- 1) The Human Resource Department shall notify the HIPAA Security Officer of all job changes so that adjustments to system access can be made if necessary.

EMPLOYEE TERMINATION

Audience: Supervisors, Human Resource Department, HIPAA Security Officer

- 1) **Change Employee Password and Disable User ID.** On the last day of employment, employee passwords to the network and Application Software will be changed and/or their User IDs will be disabled.
- 2) **Documentation.** The HIPAA Security Officer shall document the disabling of system access.
- 3) **Security Precautions for Involuntary Terminations.** For involuntary terminations, in the event that any manager believes there is the potential for any retaliatory behavior, that manager should notify the head of human resources who shall coordinate with the Information Security Manager so that appropriate precautions will be taken to insure the integrity and security of confidential Board information. This could include such measures as:
 - A) Physically escorting the individual off the premises after notifying him/her of the termination.
 - B) Disabling system access as specified above on a timely basis.

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- C) Requiring all staff in the individual's workgroup to change passwords.
- D) Other measures as deemed appropriate by the Information Security Manager based on the technical sophistication of the individual and perceived threat.

EMERGENCY SYSTEM ACCESS

Audience: Supervisors, HIPAA Security Officer

In the event of an emergency, such as a MUI in which immediate access to PHI is required, a staff member who does not have appropriate system permission but requires access shall contact the HIPAA Security Officer (or another staff person in that department) who will provide the necessary access on an expedited basis.

HIPAA ADMINISTRATIVE REQUIREMENTS

SECURITY POLICIES FOR ALL STAFF

3080 Computer Usage

Adopted: 11/17/2015

Effective: 11/17/2015

Amended: 5/16/2017

POLICY

Each staff member is responsible for understanding and following the policies regarding workstation use and security.

AUDIENCE

All Staff

AUTHORITY

HIPAA Privacy and Security Rules, [45 CFR Part 164](#)

[164.310\(b\)](#) Workstation Use

[164.310\(c\)](#) Workstation Security

[164.308\(a\)\(5\)](#) Log in Monitoring

PROCEDURES

WORKSTATION USE

- 1) **System is for Job Duties.** Computer workstations, including use of internal systems, e-mail and the internet, are for use by employees to conduct their job responsibilities. These responsibilities include matters related to the individuals we serve: their treatment, care coordination, documentation, billing, financial accounting, internet access for matters such as access to DODD systems, regulatory and business affairs, facilitating payment by 3rd party payers, and other matters which are specifically job related.
- 2) **Personal Use of Computer Workstation, Including Internet Use.** Employees are expected to be productive and to perform their job duties during work hours. Limited use of computer workstations is allowed for personal use. "Limited use" is not easily defined so employees should contact their supervisors for clarification. In general, "limited use" means:
 - A) Employees may use their workstations for personal purposes on their "own time", which means before or after the workday, or during their lunch hour.
 - B) At other times, personal use should be limited to brief accesses such as quickly checking the weather forecast.
 - C) Workstations must never be used for any activity that would be embarrassing to the Board if it became public. It is difficult to provide a complete list of such activities; a partial list includes:
 - i) downloading or viewing pornographic, racist, profane or otherwise objectionable material
 - ii) conducting conversations of a sexual nature or relating to an illicit affair
 - iii) relating to any illegal activity
 - iv) political activity
 - v) operating a businessIf an employee has any questions about whether a personal use is allowed, he or she should obtain permission from his/her supervisor.
 - D) Personal use of Social Networking tools, such as Facebook, Twitter, LinkedIn and others is detailed separately.
 - E) Employees are discouraged from staying logged in to social networking sites, instant messaging sites/tools, and their personal email except during their own time.
- 3) **E-Mail Use.** Employees with Board e-mail accounts should check e-mail daily. Board E-mail accounts in general are to be used for Board purposes only. E-mail should be written in professional manner and should be courteous and respectful. Other policies when using e-mail:
 - A) Use of e-mail internally is acceptable for transmitting PHI. Be aware that e-mail to outside parties is not secure and must not be used Protected Health Information unless it is appropriately encrypted.

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- B) When participating in internet discussion groups, employees in general should clarify that their comments are their own and do not necessarily represent the Board.
- C) Employees should recognize that email are considered a public record and subject to disclosure to the general public as detailed in General Policy 2.08.
- D) For personal matters, employees must use a personal account such as Gmail or Yahoo mail.
 - i) In the event that any Board e-mail is received on a personal account, the employee must forward the email to the employee's Board account so that it is entered into the public record.
 - ii) In the event that a personal email is received on a Board account, redirect the discussion to a personal email account.
- 4) **Storage of PHI or Confidential material to Removable Media Prohibited.** Personnel may not copy to removable media, such as Flash drives, CDs, DVD or portable hard drives, or transmit via unencrypted e-mail or unsecured fax or other method, any Board confidential information or Protected Health Information on Board computer system, except when specifically authorized by the HIPAA Security Officer for Board purposes.
- 5) **All Usage is Logged.** THE BOARD RESERVES THE RIGHT TO MONITOR ALL USAGE OF BOARD WORKSTATIONS, THROUGH THE LOGGING AND STORAGE OF ALL ACTIVITY, INCLUDING ALL E-MAILS SENT OR RECEIVED, WEB SITES BROWSED, AND OTHER ACTIVITY, INCLUDING ANY PERSONAL USE OF BOARD COMPUTERS. All logs of employee activity are property of the Board.
- 6) **Data Storage on Server Only.** All data must be stored on the server. Employees must use proper procedures to store word processing files, spreadsheets, financial programs, and other data files in the appropriate User Directory on the server. The storage of large volumes of images is discouraged because of the large storage capacity used. Any staff unfamiliar with the proper procedure should contact the HIPAA Security Officer for instructions on how to access their User Directory on the server. **ANY DATA FOUND ON WORKSTATIONS MAY BE DELETED WITHOUT NOTICE. NO DATA ON WORKSTATIONS IS BACKED UP!**
- 7) **Duplication of copyrighted material prohibited.** No employee may duplicate copyrighted software or other media using Board equipment.
- 8) **Board approved hardware only.** Only Board approved and installed hardware may be utilized. No wireless networking equipment, smartphones, video cameras, or other hardware or software may be installed or used without permission of the systems department.
- 9) **Electronic signatures.** Employees using software that includes Board-approved electronic signature capabilities shall follow all procedures specified in [Policy 3070 Electronic Signatures](#)

WORKSTATION SECURITY

- 1) Except with specific approval of the HIPAA Security Officer, workstations must not be setup in a public access area.
- 2) All employees should understand how to avoid malicious software, and must not adjust any settings on anti-virus software installed on workstations.
- 3) Workstation monitors that are used to access PHI should not face in a direction that makes visual access available to unauthorized users.
- 4) Workstations should be configured with automatic logoff capability so that they will become inaccessible after 20 minutes of system inactivity. Employees must not install any software on their computer without authorization from the HIPAA Security Officer, and must not alter or reconfigure network settings, printers, logging software, audit controls, or security settings without permission of the systems staff.
- 5) All Board servers must be secured with a strong password (see "User IDs and Passwords" below) and setup to automatically lock out user access after a maximum of three (3) minutes of inactivity.

USER IDs and PASSWORDS

- 1) Each employee is assigned a unique User ID and Password. Employees must only use their User ID to access Board systems – and employees will be held accountable for all system activity performed using this User ID. Inappropriate use of systems attributable to an employee's User ID may result in employee sanctions, including termination, and in the event of violation of laws, civil and criminal prosecution. Consequently, passwords should be kept secure and confidential and not shared with anyone else. If an employee reveals a password, or if becomes known to someone else, that employee must change the password.
- 2) Passwords should be at least 8 characters long and include upper case letters, lower case letters and numbers. The letters should not spell a word in a dictionary or a person's name. The password should not be related to the person in any way, as in a birth date, spouse, pet name, or anything which can be easily guessed.

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- 3) In general, passwords should be memorized and not written. Any written reminder should not be maintained in the vicinity of the workstation.
- 4) Users are required to change all passwords at least every 6 months.
- 5) Users are not permitted to allow others to access the system with their User ID and/or divulge their password.

EMERGENCY SYSTEM ACCESS

- 1) In the event of an emergency where immediate access to system information is required but not immediately possible, employees should contact the HIPAA Security Officer, who has contingency plans to allow access to vital data in a wide variety of scenarios (system down, MUIs, Individual emergencies which mandate system access by personnel who otherwise are not permitted access.)

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3082 Social Media Use

Adopted: 11/17/2015

Effective: 11/17/2015

POLICY

Social networking sites, notably Facebook but including many others, have become a significant communication medium in our world. The Board mandates specific guidelines for the use of these sites both limiting certain activities to insure confidentiality and privacy of individuals being served while permitting other uses that advance the mission of the Board, for example with fundraising.

AUDIENCE

All Staff

DEFINITIONS

Social Networking Sites – means sites that enable linking with other people, sharing information, and communicating. Popular examples include Facebook, Twitter, LinkedIn, Google+ and others.

PROCEDURES

- 1) **Board Sponsored Use.** The HIPAA Privacy officer or Superintendent may approve the establishment of a Board sponsored Fan Page or Group. The Privacy Officer and/or superintendent will provide guidelines for use in the event of any Board sponsored use of Facebook or similar social network.
 - 2) **Personal use of Facebook and other social network sites by employees.**
 - A) Employee Personal use of Facebook.
 - i) **Employee Use During Work Hours.** During work hours, employees are expected to focus on work-related activities. Consequently, in general, they are expected to not keep Facebook open as management believes that this communication medium has the potential to be distracting and has the potential to reduce the employee's productivity.
 - ii) **Employee Use at any time.** Facebook is a popular communication medium. The medium is semi- public; while it includes many options for specifying levels of privacy, Facebook users often share private information in unintended ways. Further, the Facebook site has a history of malfunctions and security breaches. Consequently, any use of Facebook has the potential to become a public communication, so, employees of the Board must follow the following guidelines:
 - 1) **Sharing of work-related activities.** Employees should limit the sharing of any Board related information to information that they would be acceptable to be made public, for example, on the front page of a major newspaper.
 - a) Examples of information that would be appropriate to share on one's wall include:
 - i) The employee's excitement and satisfaction with the work and mission of the Board.
 - ii) Details of an upcoming public event sponsored by the Board, such as a local "special Olympics" day.
 - iii) The name of a friend who is a co-worker at the Board.
 - b) Examples of information that would be inappropriate to share on one's wall include:
 - i) The name of an Individual receiving services from the Board.
 - ii) A complaint about the Board such as displeasure with a supervisor or co-worker.
 - iii) Any Protected Health Information, or PHI, (which includes facial images of Individuals being served).
- Employees are further encouraged but not required to limit communications on Facebook to those that would portray them in a professional manner.

- 2) **Friending.** It is management's judgment that employees must not "friend" any individual being served by CCBDD, or the parent/guardian of an Individual being served. The Board expects employees to maintain an acceptable professional boundary with Individuals being served.

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- 3) **Messaging.** Employees must not use Facebook messaging for Board communications, especially if they involve PHI. Employees are reminded that all Board communications are subject to public records disclosure and our email system is used for our official record. Further, Facebook does not utilize encryption which is required by HIPAA for transmission of PHI over an open communications network.

CONFIDENTIALITY AND COMPUTER SECURITY POLICIES

3085 Portable Computing Devices and Home Computer Use

Adopted: 11/17/2015

Effective: 11/17/2015

Amended: 01/15/2019

POLICY

Employees who meet eligibility criteria may be issued agency-owned smartphones and tablets. Employees who are permitted to use an agency-provided device must follow all guidelines in this policy.

AUDIENCE

All Staff

AUTHORITY

HIPAA Privacy and Security Rules, [45 CFR § 164](#)

[45 CFR § 164.312\(b\) Standard: Audit Controls](#)

[45 CFR § 164.312\(c\)\(1\) Standard: Integrity](#)

[45 CFR § 164.312\(d\) Standard: Person or entity authentication](#)

[45 CFR § 164.312\(e\)\(1\) Standard: Transmission Security & \(2\) Implementation Specifications](#)

[45 CFR § 164.312\(a\)\(2\)\(iv\) Encryption and decryption](#)

[45 CFR § 164.308\(a\)\(5\)\(ii\)\(D\) Password Management](#)

[45 CFR § 164.308\(a\)\(5\)\(ii\)\(B\) Protection from Malicious Software](#)

PROCEDURES

AGENCY-PROVIDED MOBILE DEVICES

- 1) **Eligibility Criteria and Signed Agreement.** Employees who use Board provided laptop computers, smartphones, or other portable computing devices containing PHI shall use the encryption features to reduce the impact of disclosure in the event that the device is lost or stolen. The IT staff will use an encryption solution as detailed in [Policy 3060 Technical Safeguards](#).
- 2) **Training.** The HIPAA Security Officer will provide training, as necessary, to employees on how to implement the security features required while using these devices.
- 3) **Text Messaging.** Agency employees are not to use text messaging to send PHI or PII on Agency-owned, or employee owned devices.
- 4) **Reporting of Loss or Theft.** Employees must immediately report lost or stolen devices to their supervisor and the HIPAA Security Officer in accordance with the Security Incident procedure. [Policy 3090 Security Incident Response and Reporting](#).
- 5) **Proper Use.** Employees may not use their personal smartphones or other personal portable devices to organize Board activities. Employees shall not store PHI on their personally own portable computing devices.
- 6) **Use of Device by Other People Not Permitted.** Employees using agency-owned mobile devices under this policy must not allow anyone to use agency-owned mobile devices who is not permitted to use these devices under this policy.
- 7) **Work at home and use of employee's home computer.** Employees working at home and using their home computers for work purposes in general should avoid storing PHI on their home computers. Employees **must** consult with the HIPAA Security Officer regarding safeguards prior to storing any PHI on their home computers.
- 8) **Agency-Owned Mobile Devices May Not Be Sold, Transferred, Disposed of, Recycled or Damaged.** Employees must not sell, transfer, dispose of, recycle, or intentionally or recklessly damage agency-owned mobile devices.
- 9) **Sanctions for Violations.** Employees who violate any of the requirements of this policy will be subject to disciplinary action.
- 10) **Termination and/or Suspension from Employment.** Upon termination of employment or upon administrative leave, employee agrees to return the device to the IT department.

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3090 Security Incident Response and Reporting

Adopted: 11/17/2015

Effective: 11/17/2015

POLICY

The Board will monitor all electronic information systems for breaches of security, mitigate harmful effects of security incidents to the extent practicable, and document any such security incidents and their outcomes.

AUDIENCE

All Staff

AUTHORITY

HIPAA Privacy and Security Rules, [45 CFR Part 164.308\(a\)\(6\)](#)

PROCEDURES

Creation of Response Team, Contingency Planning and Drills

- 1) **Incident Response Team.** The HIPAA Security Officer is responsible for managing security incident response and reporting. As part of a pro-active management process, he or she may recommend to the Superintendent assignment of individuals for an Incident Response Team. The mandate to this group would be to coordinate the Board's response to security incidents. This would include mitigation strategy, communications with law enforcement, the Individuals receiving services from the Board and the media.
- 2) **Contingency Plans.** The Incident Response Team may meet on a periodic basis to develop contingency plans, such as identification of a security consulting firm, public relations firm, or legal counsel who can be contacted in the event of a serious incident.
- 3) **Security Incident Drills.** The Incident Response Team may conduct security incident drills to develop skills and improve performance in the event of a serious security incident.

Security Incident Reporting and Response Procedure

- 1) **Reporting Security Incidents.** Any employee who becomes aware of a potential security incident must immediately contact the HIPAA Security Officer to report the incident.
- 2) **Response Procedure.** The HIPAA Security Officer and/or Incident Response Team will respond to all security incidents in an expedited manner to mitigate the potential harmful effects of the security incident. Procedures specified in [Policy 3035 Breach Reporting](#) and [Policy 1080 Duty to Report Violations and Security Incidents](#), [Policy 3065 Mitigation](#) will be followed as appropriate. The superintendent of the Board will be notified and any contingency plans will be activated.
- 3) **Documenting Security Incidents.** In conjunction with the HIPAA Security Officer, a written report must be filed within seventy-two hours (or as soon as practically possible) of becoming aware of the incident. The report should include
 - A) Date and time of report
 - B) Date and time of incident
 - C) Description of circumstances
 - D) Corrective action taken
 - E) Mitigating action takenDocumentation will be kept for 6 years.
- 4) **Post-Incident Analysis.** The HIPAA Security Officer and/or Incident Response Team will conduct a post-incident analysis to evaluate the organization's safeguards and the effectiveness of response, and recommend to management any changes they believe appropriate.

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APPENDICES

Appendix A: Identifying Business Associates

Identifying your Business Associates

Boards are obligated to identify and place any “Business Associate” under a contract that meets the specifications of the HIPAA regulations. Further, these Business Associates, as of January 25, 2013, are directly regulated by the HIPAA regulations and for the first time are subject to the same civil and criminal penalties for any failures to comply with the portions of the HIPAA regulations that apply to them.

An abbreviated definition of “Business Associate” is a person or entity, other than a member of the workforce, that performs certain functions, activities or provides services that involve the use or disclosure of PHI on behalf of a DD Board.

More specifically, the functions and activities that create a Business Associate relationship are:

- claims processing or administration,
- data analysis, processing or administration,
- utilization review,
- quality assurance,
- patient safety activities listed at 42 CFR 3.20,
- billing,
- benefit management,
- practice management,
- repricing,
- legal,
- actuarial,
- accounting,
- consulting,
- data aggregation,
- management,
- administrative,
- accreditation or
- financial services.

Subcontractors of Business Associates are Business Associates. A significant change in the January 25, 2013 HIPAA Rule changes is that subcontractors of your business associates, who have access to PHI, are now Business Associates. For example, suppose you contract with your COG to handle all of your MUI investigations. The COG subcontracts with an independent agency XYZ to do this work. Agency XYZ is a Business Associate. However, it is the COGs responsibility, not yours, to place XYZ under the Business Associate contract.

Common examples of Business Associates for DD Boards include

- A consultant that performs utilization reviews, compliance audits, financial services or billing support.
- A software vendor who provides customer support involving access to PHI.
- A computer contractor that provides support for Board software and/or its computer network and has access to PHI as part of its support and service capacity.
- An contractor who carries out MUI investigations.
- A COG which manages IO waiver contracts for member DD Boards (or any other function involving PHI)
- An accreditation organization (such as CARF or JCAHO) that reviews PHI as part of the accreditation process.
- An attorney whose legal services involve access to protected health information.
- A CPA firm whose accounting services involve access to protected health information.

Examples of relationships which are NOT Business Associates

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- 1) A Provider contracted by the Board to provide services, billed to Medicaid under its own Provider number, such as a provider of psychological, speech, OT or PT services.
- 2) A Provider with a contract subject to ORC § 5126.035, such as a Provider of waiver or supported living services which bills Medicaid under its own Provider number.
- 3) Ohio Department of Developmental Disabilities. There are numerous interactions with DODD. DODD is a health oversight agency and a payer.
- 4) Cleaning services. However, since these organizations may be able to easily and inappropriately access PHI, it is appropriate to include a confidentiality clause in their agreement that expressly prohibits such behavior.
- 5) Contractors such as electricians, plumbers, exterminators who perform services in Board facilities.
- 6) Contractors who perform construction or remodeling of an individual's house for accessibility or other adaptive living.

Full Definition of Business Associate from the HIPAA Rules (1/25/2013 Revision):

- 1) Except as provided in paragraph (4) of this definition, business associate means, with respect to a covered entity, a person who:
 - A) On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or
 - B) Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.
- 2) A covered entity may be a business associate of another covered entity.
- 3) Business associate includes:
 - A) A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information.
 - B) A person that offers a personal health record to one or more individuals on behalf of a covered entity.
 - C) A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.
- 4) Business associate does not include:
 - A) A health care provider, with respect to disclosures by a covered entity to the health care provider concerning the treatment of the individual.
 - B) A plan sponsor, with respect to disclosures by a group health plan (or by a health insurance issuer or HMO with respect to a group health plan) to the plan sponsor, to the extent that the requirements of § 164.504(f) of this subchapter apply and are met.
 - C) A government agency, with respect to determining eligibility for, or enrollment in, a government health plan that provides public benefits and is administered by another government agency, or collecting protected health information for such purposes, to the extent such activities are authorized by law.
 - D) A covered entity participating in an organized health care arrangement that performs a function or activity as described by paragraph (1)(i) of this definition for or on behalf of such organized health care arrangement, or that provides a service as described in paragraph (1)(ii) of this definition to or for such organized health care arrangement by virtue of such activities or services.

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Appendix B: Sample HIPAA Business Associate Agreement

County Boards are obligated to place Business Associates under a contract that meets detailed specifications that were updated on 1/25/2013. Below is a contract that meets these specifications. Note that it must be customized in Appendix A with a brief clause which defines the “allowed uses and disclosures”. Several example clauses are included.

Any new contracts must comply with the new specifications.

Limited Grandfathering of Existing Contracts. BA Contracts compliant with earlier specifications that existed prior to 1/25/2013 and were renewed no later than 3/26/2013 will be deemed compliant until 9/22/2014. However, if the agreement is renewed on or after 9/23/2013, it must be updated to the new specifications.

HIPAA BUSINESS ASSOCIATE AGREEMENT

This BUSINESS ASSOCIATE Agreement (“Agreement”) is entered into by and between _____ (“BUSINESS ASSOCIATE”) and _____ (the “COVERED ENTITY”).

RECITALS

- 1) The purpose of this Agreement is to comply with the HIPAA Privacy and Security regulations found at 45 C.F.R. Part 160 and Part 164. This agreement is written to comply with the revisions enacted in the HITECH statute in February 2009, the regulation changes published in August 2009 and further updates published January 25, 2013.
- 2) Terms used in this agreement, including but not limited to “covered entity”, “business associate”, “Protected Health Information (PHI)”, “unsecured protected health information”, “use”, “disclose”, “breach”, and “security incident”, shall have the same meaning as defined in most current versions of the above referenced regulations.
- 3) COVERED ENTITY is a covered entity and regulated by the HIPAA regulations.
- 4) Per the January 25, 2013 HIPAA Regulation changes, BUSINESS ASSOCIATE is also regulated by the HIPAA regulations, and further agrees to comply with the unique requirements of this agreement.

NOW, THEREFORE, in consideration of the foregoing, the parties agree as follows:

- 1) **Allowed Uses and Disclosures of Protected Health Information.** The BUSINESS ASSOCIATE provides services for the COVERED ENTITY. The BUSINESS ASSOCIATE may use and disclose protected health information only as follows:
 - A) BUSINESS ASSOCIATE may use and disclose protected health information for the purposes specifically provided in Attachment A. In performance of the tasks specified in Attachment A, BUSINESS ASSOCIATE may disclose PHI to its employees, subcontractors and agents, in accordance with the provisions of this agreement.
 - B) BUSINESS ASSOCIATE may further use and disclose PHI, if necessary:
 - i) for the proper management and administration of the BUSINESS ASSOCIATE’s business, and/or
 - ii) to carry out the legal responsibilities of the BUSINESS ASSOCIATE if the disclosure is either
 - a) required by law, or
 - b) BUSINESS ASSOCIATE obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person

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notifies the BUSINESS ASSOCIATE of any instances of which it is aware in which the confidentiality of the information has been breached.

- 2) **Responsibilities of BUSINESS ASSOCIATE.** With regard to its use and disclosure of protected health information, BUSINESS ASSOCIATE agrees to do the following:
 - A) Use and/or disclose the protected health information only as permitted by this Agreement or as otherwise required by law; no further use or disclosure is permitted.
 - B) Use appropriate physical, technical and administrative safeguards to protect electronic PHI, and comply with the requirements of the HIPAA Security Regulations (45 CFR Part 164 Subpart C) which are applicable to business associates.
 - C) Report to the COVERED ENTITY any security incident, and any use or disclosure not provided by this contract, including breaches of unsecured protected health information as required by 45 CFR 164.410.
 - D) Require that subcontractors who create, receive, maintain or transmit ePHI on behalf of Business Associate comply with applicable HIPAA Security regulations by entering into a Business Associate contract with these subcontractors. The Business Associate contract shall meet the specifications of 45 CFR 164.314.
 - E) Make available to the individual any requested protected health information, in accordance with procedures specified by COVERED ENTITY and in compliance with 45 CFR 164.524, "Access of individuals to protected health information".
 - F) Make available for amendment, and incorporate any amendments to protected health information in accordance with the requirements of 45 CFR 164.526, "Amendment of protected health information".
 - G) Make available the information required to provide an accounting of disclosures in accordance with 45 CFR 164.528.
 - H) To the extent that BUSINESS ASSOCIATE is to carry out COVERED ENTITY's obligations under the HIPAA Privacy Regulations, 45 CFR 164 Part E, comply with the requirements of the Privacy Regulations in the performance of those obligations.
 - I) Make available all records, books, agreements, policies and procedures relating to the use and/or disclosure of protected health information to the Secretary of HHS for purposes of determining the COVERED ENTITY's compliance with the HIPAA regulations, subject to attorney-client and other applicable legal privileges.
 - J) Return to the COVERED ENTITY or destroy, as requested by the COVERED ENTITY, within 30 days of the termination of this Agreement, the protected health information in BUSINESS ASSOCIATE's possession and retain no copies or electronic back-up copies. If this is not feasible, BUSINESS ASSOCIATE will limit further uses and disclosures to the reason that return/destruction is not feasible, and to extend the protections in this agreement for as long as the protected health information is in its possession.
- 3) **Mutual Representation and Warranty.** Each party represents and warrants to the other party that all of its employees, agents, representatives and members of its work force, who services may be used to fulfill obligations under this Agreement, are or shall be appropriately informed of the terms of this Agreement and are under legal obligation to fully comply with all provisions of this Agreement.
- 4) **Term and Termination.**
 - A) **Term.** This Agreement shall become effective on the Effective Date and shall continue in effect until all obligations of the parties have been met, unless terminated as provided herein or by mutual agreement of the parties.
 - B) **Termination.** As provided for under 45 C.F.R. §164.504, the COVERED ENTITY may immediately terminate this Agreement and any related agreement if it determines that the BUSINESS ASSOCIATE has breached a material provision of this Agreement. Alternatively, the COVERED ENTITY may choose to:
 - (i) provide the BUSINESS ASSOCIATE with 30 days written notice of the existence of an alleged material breach; and
 - (ii) afford the BUSINESS ASSOCIATE an opportunity to cure said alleged material breach upon mutually agreeable terms. Failure to cure in the manner set forth in this paragraph is grounds for the immediate termination of the Agreement.

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- 5) **Survival.** The respective rights and obligations of BUSINESS ASSOCIATE and COVERED ENTITY under the provisions of paragraph 2J above, detailing BUSINESS ASSOCIATE’s return and/or ongoing protections of protected health information, shall survive the termination of this Agreement.
- 6) **Amendment.** This Agreement supersedes any previously negotiated HIPAA Business Associate agreements. Further, it may be modified or amended only in writing as agreed to by each party.
- 7) **Notices.** Any notices to be given hereunder shall be made via U.S. mail or express courier, or hand delivery to the other party’s address given below as follows:

If to BUSINESS ASSOCIATE _____

If to COVERED ENTITY: _____

IN WITNESS WHEREOF, the parties hereto hereby set their hands and seals as of _____.

BUSINESS ASSOCIATE

COVERED ENTITY

By: _____
 Name: _____
 Title: _____
 Date: _____

By: _____
 Name: _____
 Title: _____
 Date: _____

Attachment A – Permitted Uses and Disclosures

BUSINESS ASSOCIATE is authorized to use protected health information for the purposes of

[INSERT A CLAUSE THAT DESCRIBES BUSINESS ASSOCIATE’S ALLOWED USES AND DISCLOSURES. THIS WILL VARY DEPENDING ON THE NATURE OF THE RELATIONSHIP. THE FOLLOWING IS AN EXAMPLE OF A CLAUSE FOR A BILLING SERVICE.]

Example Clauses:

MUI Investigator: Business Associate is authorized to use and disclose protected health information for the purposes of conducting MUI investigations.

Fiscal Services Consultant: Business is authorized to use protected health information for the purposes of providing fiscal consulting services.

Computer Software Vendor: Business Associate is authorized to use and disclose protected health information for the purposes of providing software training, support and troubleshooting.

Computer Network Support Consultant: Business Associate is authorized to use and disclose protected health information for the purposes of providing computer network support services.

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Appendix C: Sample Privacy & Security Officer Job Descriptions HIPAA Privacy Officer Job Description

REPORTS TO: Superintendent

General Purpose:

The privacy officer oversees all ongoing activities related to the development, implementation, maintenance of, and adherence to the CCBDD's policies and procedures covering the privacy of, and access to, individual health information in compliance with federal and state laws and the CCBDD's information privacy practices.

Responsibilities:

- Provides development guidance and assists in the identification, implementation, and maintenance of CCBDD information privacy policies and procedures in coordination with CCBDD management and administration, the HIPAA Committee, and legal counsel.
- Works with CCBDD senior management to establish an CCBDD-wide HIPAA Committee.
- Serves in a leadership role for all HIPAA activities.
- Performs initial and periodic information privacy risk assessments and conducts related ongoing compliance monitoring activities in coordination with the entity's other compliance and operational assessment functions.
- Works with legal counsel and the HIPAA committee to ensure the CCBDD has and maintains appropriate privacy and confidentiality consent, authorization forms, and information notices and materials reflecting current CCBDD and legal practices and requirements.
- Oversees, directs, delivers, or ensures delivery of privacy training and orientation to all employees, volunteers, medical and professional staff, contractors, alliances, business associates, and other appropriate third parties.
- Participates in the development, implementation, and ongoing compliance monitoring of all business associate agreements, to ensure all privacy concerns, requirements, and responsibilities are addressed.
- Assists HIPAA Security Officer with handling of any security incidents and/or security rule violations.
- Establishes with management and operations a mechanism to track access to protected health information, within the purview of the CCBDD and as required by law and to allow qualified individuals to review or receive a report on such activity.
- Works cooperatively with the applicable CCBDD units in overseeing individual rights to inspect, amend, and restrict access to protected health information when appropriate.
- Establishes and administers a process for receiving, documenting, tracking, investigating, and taking action on all complaints concerning the CCBDD's privacy policies and procedures and, when necessary, legal counsel.
- Ensures compliance with privacy practices and consistent application of sanctions for failure to comply with privacy policies for all individuals in the CCBDD's workforce, extended workforce, and for all business associates, in cooperation with administration, and legal counsel as applicable.
- Initiates, facilitates and promotes activities to foster information privacy awareness within the CCBDD and related entities.
- Assists HIPAA Security officer by reviewing all system-related information security plans throughout the CCBDD's network to ensure alignment between security and privacy practices, and acts as a liaison to the information systems department.
- Works with all CCBDD personnel involved with any aspect of release of protected health information, to ensure full coordination and cooperation under the CCBDD's policies and procedures and legal requirements
- Maintains current knowledge of federal privacy laws, specifically HIPAA and FERPA, as well as state privacy laws, accreditation standards, and monitors advancements in information privacy technologies to ensure CCBDD adaptation and compliance.
- Serves as information privacy consultant to the CCBDD for all departments and appropriate entities.
- Cooperates with the Office of Civil Rights and other legal entities in any compliance reviews or investigations.

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- Works with CCBDD administration, legal counsel, and other related parties to represent the CCBDD's information privacy interests with external parties (state or local government bodies) who undertake to adopt or amend privacy legislation, regulation, or standard.

Qualifications of Privacy Officer:

- Knowledge and experience in information privacy laws, access, release of information, and release control technologies.
- Knowledge in and the ability to apply the principles of health information management, project management, and change management.
- Demonstrated organization, facilitation, communication, and presentation skills.

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HIPAA Security Officer Job Description

REPORTS TO: Superintendent

GENERAL PURPOSE:

The information security manager serves as the process owner for all ongoing activities that serve to provide appropriate access to and protect the confidentiality and integrity of patient, provider, employee, and business information in compliance with organization policies and standards.

DUTIES:

- 1) Document security policies and procedures created by the information security committee/council.
- 2) Provide direct training and oversight to all employees, contractors, alliance, or other third parties with information security clearance on the information security policies and procedures.
- 3) Initiate activities to create information security awareness within the organization.
- 4) Perform information security risk assessments and act as an internal auditor.
- 5) Serve as the security liaison to clinical administrative and behavioral systems as they integrate with their data users,
- 6) Implement information security policies and procedures.
- 7) Review all system-related security planning throughout the network and act as a liaison to information systems.
- 8) Monitor compliance with information security policies and procedures, referring problems to the appropriate department manager.
- 9) Coordinate the activities of the information security committee.
- 10) Advise the organization with current information about information security technologies and issues.
- 11) Monitor the access control systems to assure appropriate access levels are maintained.
- 12) Prepare the disaster prevention and recovery plan.

QUALIFICATIONS:

Information security certification, such as the CISSP, is preferred.

Source: <http://www.hipaadvisory.com/>

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Appendix D: Minimum Necessary – Workforce, Disclosures, and Requests.

Workforce Access to PHI and Safeguards

<i>Person, Classes of Persons, or Business Associates</i>	<i>Categories of PHI Needed</i>	<i>Additional Safeguards(*)</i>
<u>Administration</u>		
Superintendent	All	
Business Manager	All	
Fiscal Clerk	Admin / Admin Fax / Admin Scans / Public	
Nurse	Public / Nurse	
Administrative Assistant	Admin / Admin Fax / Admin Scans / Public	
Administrative Secretary	Admin / Admin Fax / Admin Scans / Public	
<u>Service & Support</u>		
Service & Support Director	Leadership / Public / RACI / SSA / SSA Filing Cabinet / SSA Management / SSA Scans	
Administrative Secretary	Public / SSA / SSA Scans / SSA Filing Cabinet	
Service & Support Administrator	Public / SSA / SSA Scans / SSA Filing Cabinet	
<u>Operations</u>		
Operations Manager / HIPAA Officer	All Files – Except HR specific	
<u>Early Intervention</u>		
Educational Services Administrator	Central Coordination / Early Intervention / EI Service Coordinator / EI Contract Management / EI Fax / EI Scans / Employment First / HMG Scans / Leadership / Public / T&C Management	
Administrative Secretary	Central Coordination / Early Intervention / EI Service Coordinator /	

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	EI Fax / EI Scans / HMG Scans / Public	
Service Coordinator	Central Coordination / Early Intervention / EI Service Coordinator / EI Fax / EI Scans / HMG Scans / Public	
Employment Coordinator	Employment First / Public / EI Fax / EI Scans	
Integrations Coordinator	Special Olympics / Public / EI Fax / EI Scans	
Contracted Therapists	Public / EI Fax / EI Scans	

*Safeguards: All employees will receive training on board confidentiality policies and will be subject to sanctions for violations. The table above lists additional safeguards that will be employed.

Procedures for Routine Disclosures of PHI

Note: Disclosures to medical, vocational, residential and other providers, and service coordination with other agencies are “treatment” and not part of Minimum Necessary procedures.

- 1) **Software & Network Providers** – Information in the computer system is incidentally available during system support activities.
 - A) **XYZ Support.** Network support vendor XYZ Support is under contract to provide 24/7 network support. Access is provided at all times.
 - B) **Gatekeeper and other Support.** Primary Solutions and other support vendors will be granted access rights on an as needed basis. Technical solutions for implementing this authorization will be deployed by the board.
- 2) **Job and Family Services** – For services rendered, which are reimbursed by ODJFS, submit requested information to JFS.
- 3) **Health Department** – Contents of the early intervention file may be shared with the Health Department, upon their request, if the initial referral for services came through the Help Me Grow network.
- 4) **Prosecutor’s Office.** When a warrant or subpoena is presented, any file may be released to the Prosecutor’s Office. In addition, if the Board is seeking legal counsel, file contents to be revealed will be reviewed by the Privacy Officer to ensure that minimum necessary standards are being followed.
- 5) **Auditor’s Office** – When authorizing payment of bills, fiscal files may be reviewed by the Auditor’s office prior to authorization of payment.
- 6) **DODD** – Information will be shared routinely with Ohio DODD in order to ensure continuity of services for individuals. Specific to MUI case files, the Investigative Agent and internal UI staff will utilize the State’s secure website to input required information.
- 7) **Surveyors** – Upon confirmation of surveyors credentials, the superintendent or his/her designee may authorize review of any files requested by the surveyor with the exception of MUI State Files.
- 8) **Transportation Providers** – To ensure quality of care for individuals, medical needs and guardian/family contact information will be shared with contracted providers.
- 9) **County School Districts** – Individual information will be shared, upon written request on School District letterhead, if the request for services originated in the school district.
- 10) **Bureau of Disability Determination** – Using the Bureau’s forms, assessment information will be shared in order to determine individual’s eligibility for benefits.
- 11) **Attorneys** – When a subpoena is presented, the protocol in [Policy 1090 Disclosures that do Not Require an Authorization](#) will be carefully followed to determine, with legal counsel assistance, if the subpoena should be

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honored.

- 12) **Other Outside Agencies** – In order to ensure continuity of services to individuals, the Director of SSA or the Director of Adult Services will share IP, medical limitation and incident reports with authorized contacts from Family Services.
- 13) **Law Enforcement** – As identified by the Director of Services & Supports, guardianship, family contact information and behavior support plans will be shared with law enforcement agencies. In addition, upon presentation of a warrant and verification of credentials if presented in person, other file information may be shared with law enforcement agencies. See [Policy 1090 Disclosures that do not Require an Authorization](#).

Procedures for Routine Requests of PHI

- 1) **Eligibility Inquiry** – Individual insurance eligibility will be verified by using procedures provided by the Ohio Dept of DD.

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**Clinton County Board of Developmental Disabilities (CCBDD) –
Authorization Form**

Clinton County Board of DD
4425 State Route 730
Wilmington, OH 45177
Administrative Office 937-382-7519
Service and Support Administration 937-382-7889

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Name of Individual Served _____ Date of Birth _____

I authorize CCBDD to:

Release to: _____
The following information:
 Assessment and diagnosis (MFE)
 Treatment and progress
 Social History
 Psychological Test results
 Other _____

Obtain from: _____
The following information:
 Assessment and diagnosis (MFE) (F.E.D.)
 Treatment and progress
 Most current IP (ISP, IEP, IHP)
 Psychological Test results
 Results of recent physical examination
 Other _____

The purpose of this disclosure is

- Coordination of care
- Requested by Individual Receiving Services, or guardian/parent
- Other _____

- 1) I understand that I may revoke this authorization at any time by submitting a written request, unless the records have already been released.
- 2) I understand that the party receiving my information might not be subject to HIPAA, FERPA or Ohio confidentiality laws and might be allowed to disclose this information.
- 3) The CCBDD does not require that I sign this authorization in order to receive services.

Expiration Date:

- 90 days from date signed
- other date: _____

Approved by: _____ Date: _____

If signed by someone other than the Individual being served:

Print Name _____
Authority to sign: Parent or Guardian
 Appointed by Individual as HIPAA Personal Representative
 Other _____

For staff use (complete the following steps and indicate by a check. Name of Staff Person _____)

- Copy of signed authorization given to Individual / Parent / Guardian
- Copy of records released given to individual / Parent / Guardian (if requested)
- Disclosure logged on Disclosure Log
- Revocation received on _____ and acted upon.

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Notice of Privacy Practices

FOR YOUR
PROTECTION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

YOUR RECORDS
ARE PRIVATE

We understand that information we collect about you or your child and records of the services and supports we provide, are personal. Keeping these records private is one of our most important responsibilities. The Board must follow many laws to protect your privacy. For adult services, and certain services for children, we follow the federal HIPAA laws. In addition, we follow many laws specific to Ohio Developmental Disability Boards. For this notice, we will use the term "records" to mean the paper or electronic records we maintain about you.

Your records may be used and disclosed by the employees and volunteers at the Board who serve you, as well as persons or agencies who work for us and sign strict confidentiality contracts.

In general, we use and disclose your information:

WHO USES AND
DISCLOSES MY
RECORDS?

- For teaching, behavioral and medical support, transportation and school administration. For example, a school administrator will review progress data created by teachers.
- To provide the full range of services we provide: early intervention, habilitation, supported employment, and other services. For example, your service and support coordinator will review your records to create an ISP, which may be shared with you, your guardian, a vocational specialist, and other individuals involved with providing services and supports to you.
- To get payment for services provided: for example, the billing clerk uses service records of services provided to submit bills to the Ohio Department of Developmental Disabilities, and
- For other operations to operate and manage the Board: these include improving quality of care, training staff, managing costs, and conducting other business duties. For example, a quality assurance reviewer may audit your records to determine whether appropriate services were provided,
- To remind you or a guardian of an appointment for services,
- The Board or an affiliated foundation may contact you to raise funds. You have the right to opt out of any fundraising communications.

There are limited situations when we are permitted or required to disclose your records, or parts of them, without your signed permission. These situations include:

COULD MY
RECORDS BE
RELEASED
WITHOUT MY
PERMISSION?

- Record transfers to other schools your child enrolls in,
- Reports to public health authorities to prevent or control disease or other public health activities,
- To protect victims of abuse, neglect, or domestic violence,
- For oversight including investigations, audits, accreditation and inspections, such as are conducted by the Ohio Department of Developmental Disabilities, Ohio Department of Education and federal agencies,
- When a court order, subpoena or other legal process compels us to release information,
- Reports to law enforcement agencies when reporting suspected crimes, when responding to an emergency, or in other situations when we are legally required to cooperate,
- In connection with an emergency, or to reduce or prevent serious threat to public health and safety, or the safety of an individual,
- To coroners, medical examiners and funeral directors,
- To victims of alleged violence or sex offenses,
- For workers' compensation programs,
- For specialized government functions including national security, protecting the president, operating government benefit programs, and caring for prisoners,
- In connection with "whistleblowing" by an employee of the Board.

All other uses not described above require that we obtain your signed permission.

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For any purpose not described above, we will release your information only with your explicit written authorization. Federal law requires that we notify you that any healthcare provider must obtain your explicit permission to release your information for any of the following:

WHAT IF MY RECORDS NEED TO GO SOMEWHERE ELSE

1. Psychotherapy Notes will only be released with your signed authorization;
2. For marketing purposes;
3. To sell information about you.

It has never been the Board's practice to release information for marketing purposes or to sell your information. Your written authorization tells us what, where, why and to whom the information must be sent. Your signed authorization is good until the expiration date you specify. You can cancel your permission at any time by letting us know in writing.

You have legal rights concerning your privacy, access to your records, and the accuracy of your records. You have the following rights:

1. To see your records, or to get a copy, including an electronic copy;
2. To request a correction to your records if you believe they are incorrect;
3. To receive all communications at a confidential address or phone number;
4. To receive an "accounting of disclosures", that is, a list of any place we sent your record without your authorization;
5. To request additional limits on how we use or disclose your information, although we are not obliged to honor these requests except that if you choose to personally pay for services delivered, we will not bill Medicaid.
6. You may receive a paper copy of this notice.

WHAT ARE MY RIGHTS REGARDING PRIVACY, ACCESS TO MY RECORDS, AND THE ACCURACY OF MY RECORDS?

To exercise any of these rights, or if you have any questions or complaints regarding our privacy practices, call, deliver, mail or email your request to:

Kyle Lewis, HIPAA Privacy Officer
Clinton County Board of DD
4425 State Route 730
Wilmington OH 45177
(937) 382-7519
klewis@nikecenter.org

Ask any employee if you need help in putting your request in writing.

OUR DUTIES

We are obligated by law to maintain the privacy of your information and to provide this notice. In the event of a breach, that is, an improper disclosure of your information, we are required to notify you. We are required by law to abide by the terms of this notice. From time to time we may make changes to our policies, and if and when we do, your records will be protected by our new, changed policies. Our current notice will always be available on our website.

If you have any questions or complaints about our privacy practices, please contact us:

QUESTIONS OR COMPLAINTS?

Kyle Lewis, HIPAA Security Officer, Clinton CBDD
4425 State Route 730
Wilmington OH 45177
(937) 382-7519
klewis@nikecenter.org

We will never retaliate against you for filing a complaint. Further, if you are not satisfied with the results, you may also complain to the federal government:

Secretary of Health and Human Services 200 Independence
Avenue, SW Washington, D.C. 20201
www.hhs.gov/ocr/privacy/hipaa/complaints/index.html Original Notice effective

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ADDENDUM TO NOTICE OF PRIVACY PRACTICES

The Section of your Notice of Privacy Practices which addresses Sharing your Personal Information without authorization is amended to add the following language

Disability Rights Ohio (DRO) filed a state-wide class action captioned Ball v. Kasich Case No. 2:16-cv-282 in the U.S. District Court for the Southern District of Ohio. The suit was filed on March 31, 2016 against the Governor, Department of Developmental Disabilities, Department of Medicaid and Opportunities for Ohioans with Disabilities. The Ohio Association of County Boards Serving People with Developmental Disabilities may become a defendant in the lawsuit. The Plaintiffs are represented by DRO and other lawyers from Massachusetts, Illinois, Michigan and Washington D.C.

The action potentially affects all adults with DD. The parties to the lawsuit, through their lawyers, have sought and will continue to seek documentation, including Protected Health Information, on individuals who are or who may be a part of this lawsuit, or who may have information relevant to this lawsuit or who are simply receiving services from DD Boards. The DD Board will comply with requests for information and may provide Protected Health Information on any person served by the DD Board to the lawyers for any of the parties. All information provided in connection with this lawsuit is covered by a protective order issued by the court which complies with HIPAA and other privacy regulations and which ensures that the information about any individual cannot be disclosed outside of the lawsuit without their permission. At the conclusion of the lawsuit, all protected health information which was disclosed or retained by any party in the course of the lawsuit will be destroyed.

For further information on the lawsuit or the Protective Order, contact OACBDD.

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Acknowledgement of Privacy Practices

Date: _____

I have been given a copy of the Clinton County Board of DD Notice of Privacy Practices.

Individual/Guardian Signature: _____

Co. Bd. Representative: _____

The Clinton County Board of DD Privacy Practices is distributed initially at the time of enrollment and/or during intake. The acknowledgment form is maintained on file and a copy is provided to the Individual/Guardian.

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Appendix E: Miscellaneous

POLICY 1330 HIPAA Assignments and Documentation

HIPAA Privacy Officer: Operations Manager

HIPAA Security Officer: Operations Manager

Staff person to receive HIPAA Complaints: Operations Manager

Staff person to provide access to Individual records: Operations Manager and Superintendent

Staff person to receive requests for amendment of Individual records: Operations Manager and Superintendent

Staff person to answer questions about HIPAA policies and procedures: Operations Manager

Hybrid entity designation, if any: _____

Designated Record Set:

All information in Gatekeeper software

All information relating to Individual served in Intellivue imaging software

Agency-Owned Mobile Device Agreement

I, _____, have read, understand, and agree to abide by the requirements of [Policy 3085 Portable Computing Devices](#) (and any updates to the Policy). I agree to the following:

- I agree to complete all necessary training regarding implementing the security features of my agency-owned mobile device(s).
- I agree to report the loss of a device containing PHI within 24 hours in accordance with [Policy 3090 Security Incident Response and Reporting](#).
- I understand that I may be subject to disciplinary action if I access the agency's network with my agency-owned mobile device(s) without following all requirements specified in [Policy 3085 Portable Computing Devices](#).
- I understand that I may be subject to disciplinary action if I allow others unauthorized access to my agency-owned mobile device.
- I understand that I may be subject to disciplinary action if I dispose of or intentionally or recklessly damage an agency-owned mobile device.
- I understand that I may be subject to disciplinary action if I exceed acceptable personal use of an agency-owned mobile device.
- Upon termination of employment, I agree to return my agency-owned mobile device(s) to the IT department.

Employee Name (please print)

Employee signature

Date

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Appendix F: Facility Security and Access Plan

POLICY

The agency will limit physical access to its information systems that contain PHI by implementing reasonable and appropriate measures to allow only authorized persons to access the facilities in which those information systems are housed.

AUDIENCE

All Staff

AUTHORITY

HIPAA Privacy and Security Rules

PROCEDURES

- 1) **Access Control and Validation.** The agency will implement the following procedures to limit access to facilities or areas within a facility.
 - A) **Facility Access Control Management** – The Operations Manager will serve as or delegate responsibility for granting access to facility areas through the use of key cards, fobs, and physical keys, as well as maintaining digital access control systems for public events.

The Operations Manager will document facility access requests and approvals, and execution of access control methods (i.e., distribution of keys, passcodes) and will retain documentation for a period of at least six years after the documented actions are no longer in effect.
- 2) **Facility Access Rights.** The Operations Manager will grant access to equipment rooms and other facilities only to those persons (i.e., workforce members, business associates, visitors) that have a legitimate need to access the facility because of their roles or job functions. Facility access rights will be revoked or modified upon termination or change in access needs.
 - A) **Facility Access Validation.** The Operations Manager will establish, in accordance with the Facility Security Plan, control methods and/or authentication procedures to validate a person's identity and authority to access facilities based on current facility access rights. Visitors and workforce members whose roles do not require access to facilities or areas covered by this policy will be prohibited access unless they are authorized temporarily and accompanied by an appropriately authorized person.
- 3) **Contingency Operations – Emergency Access.** In the event of an emergency or disaster, the agency will modify facility access to support execution of contingency plans and emergency mode operations for information systems maintained in the facility, and Emergency Operations Center as applicable.
 - A) The agency will identify for each facility the authority in charge and the persons or classes of persons (e.g., workforce members, business associates, visitors) that may need facility access based on the nature and severity of an emergency or disaster.
 - B) In the event of an emergency or disaster, a manual authentication process through the use of hard-copy keys will be implemented in the event that electronic means cannot be used.
- 4) **Security Plan Locations Outline.** The agency will maintain a Facility Security Plan for information systems containing PHI, including:
 - A) Paper file storage areas that include cold storage building, employee file cabinets, and other storage areas for paper PHI.
 - B) Peripheral equipment locations (i.e., locations outside of data centers housing network switches and routers, and similar types of devices);
 - C) Offices that contain technical data that could be used to compromise the security of information systems that maintain or are used to access PHI.

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- 5) **Facility Security Plan Contents.** Each Facility Security Plan will address:
 - a) **Exterior Safeguards.** Methods and procedures for safeguarding exterior of premises and buildings (i.e., installation of locks, fire doors, alarms or other access control devices, access control authorization and validation, visitor registration procedures), including both public and non-public entrances and exits;
 - b) **Interior Safeguards.** Methods and procedures for safeguarding the interior of premises and buildings (i.e., installation of locks, alarms, or other access control devices for interior doors, intrusion detection devices, access control authorization and validation);
 - c) **Equipment Safeguards.** Procedures for safeguarding equipment contained within facilities and on premises (i.e., isolation of equipment, controls to guard against theft, power surges and outages, fire and other types of damage);
 - d) **Access Monitoring.** Methods and procedures for collecting, retaining, and reviewing facility access records (i.e., facility access logs, and records of issue for access cards, fobs, and hard-copy keys); and
- 8) **Facility Security Plans Review.** Upon request, the Operations Manager, may review the Facility Security Plan. The Operations Manager will review the Plan at least on an annual basis or when material modifications are made to the Plan.
- 9) **Documentation Retention.** The Facility Security Plan will be retained for a minimum of six years from the date when it was last in effect.
- 10) **Access Records – Access records will be used in secure areas (i.e., locked cages, safes, and peripheral rooms). These records will include digital logs of accesses granted at electronically controlled doors, and written records in non-electronically monitored areas (i.e., safes and server areas) so that an accurate record can be maintained.**

ACCESSIBILITY

- A. The Clinton County Board of Developmental Disabilities shall follow all Federal and State laws regarding accessibility of services and programs whether physical or other.
- B. The Board, within its available resources, will not allow barriers of any type to prevent individuals from gaining services and benefiting from programs offered. These include but are not limited to architectural, attitudinal, environmental, financial, communicative, transportation, and any other barrier.
- C. The Board shall maintain an annual plan of accessibility addressing barriers, solutions for corrections, if needed, cost, funding resources, persons responsible and target completion dates.

Revised: 11/17/15

TECHNOLOGY FIRST

A. Purpose

1. This policy implements the technology first rule in accordance with section 5123.025 of the Ohio Revised Code and 5123-2-01 of the Ohio Administrative Code.

B. Scope

1. Per OAC 5123-2-01, the Clinton County Board of Developmental Disabilities (CCBDD) must develop and implement a written local policy to enact the technology first rule, 5123-2-01.

C. Definitions

1. "Department" means the Ohio department of developmental disabilities (DODD)
2. "Home and community-based services" has the same meaning as in section 5123.01 of the Ohio Revised Code.
3. "Individual" means a person with a developmental disability or for purposes of giving, refusing to give, or withdrawing consent for services, the person's guardian in accordance with section 5126.043 of the Revised Code or other person authorized to give consent.
4. "Individual service plan" means the written description of services, supports, and activities to be provided to an individual and includes an "individual program plan" as that term is used in 42 C.F.R. 483.440 as in effect on the effective date of this rule.
5. "Technology first policy" means the state of Ohio policy, established in section 5123.025 of the Ohio Revised Code, that individuals with developmental disabilities have access to technology solutions.
6. "Technology solution" means any product, device, equipment, or service used to maintain, increase, or improve the functional capabilities of an individual with developmental disabilities and that is deployed in accordance with applicable federal, state, and local rules and regulations. The efficacy of a technology solution is subject to review and approval by the department.

D. Implementation

1. The CCBDD Technology Solutions are to be:
 - a. Explored and documented throughout the initial and ongoing person-centered assessment and planning process; and
 - b. Used to the greatest extent possible to support the outcomes in an individual service plan.
2. The CCBDD will increase capacity for use of technology solutions and outline specific steps, as applicable, to be taken including, when applicable, establishment of benchmarks for increasing the number of individuals who benefit from the use of technology solutions in the Technology First Procedures 3.08.1, the CCBDD strategic plan, and the CCBDD annual goals.
3. The CCBDD will identify strategies for increasing the level of knowledge, skill, and comfort of staff related to: assessing how technology may help meet needs, or achieve outcomes, and the use of technology solutions.
4. The CCBDD will annually review and update, as applicable, its goals and objectives identified in the CCBDD strategic plan or annual plan related to increasing the use

- of technology solutions by individuals served.
5. The CCBDD will actively collaborate with individuals served and their families, providers of services, DODD, and community partners (i.e. local schools, mental health agencies, area agencies on aging, county departments of job and family services, public transit authorities, local vocational rehabilitation centers, and employers) to expand awareness and use of technology solutions by individuals served.
 6. Each intermediate care facility for individuals with intellectual disabilities will actively collaborate with residents served and their families, persons or entities under contract to provide services to residents, DODD, and community partners (e.g., county boards, local schools, mental health agencies, local vocational rehabilitation centers, and employers) to expand awareness and use of technology solutions by residents served.
 7. Each individual served by the CCBDD will participate in a person-centered assessment and planning process in accordance with rule 5123-3-03 or 5123-4-02 of the Ohio Administrative Code, as applicable, which identifies the individual's unique strengths, interests, abilities, preferences, and resources and explores how technology solutions might support the individual's desired outcomes.
 8. Through the person-centered planning process (refer to CCBDD Procedures 3.08.1 and 5.05.2) the individual and the individual's team will discuss any technology solution previously or currently used by the individual and the effectiveness of the technology solution.

Reference: ORC 5123.025, ORC 5123.01, OAC 5123-2-01, OAC 5123-3-03, and OAC 5123-4-02

Board Approved: 5/17/2022

TECHNOLOGY FIRST

A. Purpose

The CCBDD will promote the utilization of technology to support all individuals served.

B. Scope

1. The CCBDD will establish guidelines according to 5123-2-01 of the OAC and CCBDD Policy 3.08 for increasing the use of supportive technology to meet the assessed needs of individuals served.
2. The CCBDD will include the benchmarks and strategies for increasing the number of individuals that access supportive technology in the CCBDD's strategic plan and annual goals
3. The CCBDD will ensure that supportive technology solutions are addressed in each person-centered assessment and individual service plan for individuals served.

C. Implementation Strategies

1. The CCBDD will participate in the Telehealth Pilot Project, with Station MD and DODD to promote the use of technology to deliver medical services through a virtual platform.
2. The CCBDD will designate a staff person for the purpose of leading the agency in increasing the technology solutions utilized by individuals served. The designated staff person will be responsible for the following:
 - a. Attending ongoing trainings pertaining to technology solutions,
 - b. Being a resource to other staff within the agency,
 - c. Meeting with technology providers on an ongoing basis,
 - d. Disseminating information and resources to individuals, guardians/families, and providers on the types of technology solutions available and the potential benefits,
 - e. Coordinating one or two technology informational sessions a year,
 - f. Share success stories a minimum of bi-annually with individuals, guardians/families, and providers where technology solutions have been beneficial to individuals served (i.e. social media, website, newsletter, etc.).

D. Person-Centered Assessment and Planning Process

1. Technology Solutions identified should be: a more effective use of staff time, be proactive around health and safety, assist in the workforce crisis, empower independence, be less intrusive, and promote natural supports.
2. The individual and the individual's team will ensure that the person-centered assessment and planning process addresses technology solutions that could be utilized to support the individual.
3. The individual and the individual's team will discuss the individual's needs, explore information regarding available technology solutions, and consider how each technology solution might:
 - a. Enhance the individual's personal freedom;
 - b. Increase the individual's ability to communicate effectively with others;
 - c. Expand opportunities for the individual to access and pursue available activities and establish meaningful relationships with people who are important to the individual;

- d. Enable the individual to perform tasks that support the individual's efforts to obtain or maintain employment; or
 - e. Help the individual increase and/or maintain independence with daily tasks and activities.
 4. After discussing whether or not technology solutions may be appropriate, the individual and the individual's team:
 - a. Will discuss how available technology solutions may advance what is important to or important for the individual;
 - b. May make referrals for assessments by technology subject matter experts to identify technology solutions; and
 - c. May identify additional evaluations needed to determine whether other available technology solutions meet the individual's assessed needs.
 5. When available technology solutions have been determined by the individual and the individual's team to meet the individual's assessed needs, they will be included in the individual service plan.
 - a. The individual and the individual's team will identify in the individual service plan the outcome to be achieved through the use of the technology solution.
 - b. Technology solutions included for the duration of the individual service plan may be reviewed and modified at any time based on a request by the individual or the individual's team.
 - c. Technology solutions included on a trial basis are to be reviewed by the individual and the individual's team at the conclusion of the trial period.
 6. When reviewing a technology solution to determine whether the technology solution is effective and should continue, the individual and the individual's team are to consider:
 - a. The individual's experience in terms of achieving outcomes described in paragraph (C) (2) of this procedure;
 - b. Whether the technology solution enhanced the individual's health or safety;
 - c. Whether additional support is needed to facilitate use of the technology solution (e.g., scheduled battery replacements or more frequent communication with the technology solution vendor);
 - d. Whether the technology solution reduced dependence on staff by increasing the individual's independence and without having the effect of isolating the individual from the individual's community or preventing the individual from interacting with people with or without disabilities; and
 - e. Whether the individual has a desire to continue to use the technology solution.
 7. The results of the person-centered planning process, including, as applicable, the individual's desired outcomes as they relate to technology solutions and the activities that will occur to expand the individual's exploration, awareness, and use of technology solutions, will be integrated into the individual service plan. The individual service plan will be amended if the individual's service needs change.

Reference: ORC 5123.025, ORC 5123.01, OAC 5123-2-01, OAC 5123-3-03, and OAC 5123-4-02

Superintendent Approved: 5/17/2022

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HEALTH AND SAFETY

- A. The Clinton County Board of Development Disabilities shall establish policies and procedures to ensure and protect the health and safety of individuals.
- B. The design and maintenance of the Agency program facilities and equipment shall be in conformance with all applicable laws, including the Americans with Disabilities Act and Section 504 – Rehabilitation Act of 1973 and any reauthorization of these acts by the federal government.
- C. Each program facility owned, leased, or operated by the Agency shall be inspected, as required by code, by the local fire marshal or designee to ensure compliance with fire safety practices.
- D. The Agency shall develop written building emergency plans in accordance with OAC 5123:2-1-02, and shall include procedures for fire, tornado, and other emergencies. These building emergency plans shall be available to and communicated in writing to all members of the staff, including volunteers.
- E. The Agency is committed to protecting the health of employees and individuals as well as ensuring the right of individuals who may be infected with either a short-term or a life-threatening communicable disease.
- F. The Agency shall cooperate with local and state health officials in regards to infection control standards and reporting of communicable diseases.
- G. The Superintendent shall develop procedures for communicable diseases including but not limited to the following:
 - 1. Education of staff, including initial orientation and ongoing education, to understand their role in the prevention of communicable diseases and how to work with an individual who has a communicable disease. The education program shall include recognizing signs and symptoms of illness, injury or discomfort.
 - 2. Infection control and reporting.
 - 3. Management of communicable diseases.
- H. The Superintendent shall establish a program wide Safety Committee to be responsible for the oversight of the Agency's health and safety policies, plan and procedures.

Revised: 10/15/19

HEALTH AND SAFETY PROCEDURE

The goal of the Individual Health and Safety Training program is to increase the awareness of individuals and staff regarding health and safety issues affecting the individuals we serve and to ensure that they are well protected.

A. Infection Control:

1. All new employees will be given infection control education during orientation.
2. All employees will be retrained annually to reinforce healthy and safe habits.
3. The Agency Nurse will ensure that the following training occurs and will submit documentation of staff training to the Human Resource Department to be maintained with personnel records:
4. Initial orientation and continuing education will be scheduled for employees concerning epidemiology, modes of transmission, and prevention of common and uncommon communicable diseases to which they may be exposed during their employment (i.e. Hepatitis B, CIV, Aids, lice, various pandemics/viruses, etc.).
5. Education will be scheduled to review current knowledge of laws, practices and policies regarding communicable disease contact.
6. Periodic training will be done for all staff on the need for routine use of precautions to control the spread of communicable diseases.
7. Provision of equipment and supplies (and appropriate training to use same) necessary to minimize the risk of infection will be available for employees use.

B. Communication Regarding Hazardous Materials:

1. Based upon activities/job duties, any individual who handles chemicals, such as cleaning products, will be informed of safe handling directions, prior to assignment to the activity/job.
2. Information will be given on proper storage and what to do if an emergency exposure occurs.
3. Material Data Safety Sheets will be maintained.
4. Cleaning supplies and chemicals will be kept in a locked cabinet.

C. Emergency Procedures Training:

1. All new employees will receive information regarding emergency plan and procedures during orientation covering fire/tornado/illness/injury.
2. Information presented during the initial and/or annual health and safety training may need to be reinforced on an ongoing basis.
3. The Agency Nurse will maintain AED certification and AED Instructor certification renewed as required through the American Red Cross or equivalent.

D. Documentation of Health and Safety Training:

1. Documentation will be maintained in personnel office of all trainings.
2. The Nurse may assist staff in implementing the Individual Health and Safety program and may make recommendations to improve the program.

E. Health and Safety

1. The Nurse may provide health education information to consumers, parents and other caregivers.
2. The Nurse may assist the family in addressing an individual's health problems through use of community resources and referral to appropriate specialists.
3. An individual's planning team may request a physical examination when an individual's condition appears to warrant such examination

4. Individuals will be excluded from board sponsored programs for health reasons if required by the local health department for specific diseases.

F. Communicable Diseases

1. When incidences of communicable diseases occur, the Superintendent or designee will notify, when appropriate, staff who may have been exposed to infections. Notifications are given for incidences of chicken pox, measles, mumps, scarlet fever, certain viruses, and diseases such as lice and scabies. Staff are required to notify the Superintendent of known exposure or diagnosis of communicable diseases. The Clinton County Health Department will be notified as appropriate.
2. Options for exposed staff will be discussed, which may include use of leave or working from home during the period of contagion. When the period of contagion has expired, staff will be required to submit a doctor's statement that he or she can safely return to work.
3. Upon diagnosis of a communicable disease, staff will use leave during the period of illness. While on leave, staff are not to perform any work on behalf of the Board. Upon full recovery, staff will be required to submit a doctor's statement that he or she can safely return to work.

G. Pandemic

The Clinton County Board of DD (CCBDD) is committed to working cooperatively with the Clinton County Health Department (CCHD) to ensure public safety during any public crisis. The CCBDD understands that the CCHD is the ultimate authority responsible for declaring a public emergency. The CCBDD also understands that the Nike Center facilities may be used, upon request from the CCHD, as a site for surge capacity of healthcare and other services to meet the needs of the greater community during a crisis.

1. Action Steps During a Pandemic:

A. Level 1: (Mitigation/Prevention/Precautions)

- a. Communication via email to staff
- b. Educate staff regarding Health & Safety Procedure
- c. Educate staff regarding current signs and symptoms
- d. Update the plan as needed
- e. Ensure all necessary supplies are available (hand sanitizer, soap, disinfectant, etc.)
- f. Follow precautionary measures
- g. Stay at home if you're ill
- h. Institute rigorous cleaning practices

B. Level 2: (Surveillance and Heightened Awareness)

- a. Maintain contact with CCHD
- b. Continue to review the Health & Safety Procedure with all staff
- c. Communicate via email to staff
- d. Continue to educate staff
- e. Ensure all staff contact information is updated
- f. Reinforce to staff the necessity of adhering to precautionary measures
- g. Limit or temporarily eliminate staff travel for trainings, etc.
- h. Continue rigorous cleaning practices

C. Level 3: (Possible Implementation of Remote Work/Closure of Buildings)

- a. Maintain contact with CCHD
- b. Make preparations for all staff to work remotely
- c. Cancel all staff travel plans
- d. Continue with rigorous cleaning practices

D. Level 4: (Implementation of Remote Work/Closure of Buildings)

- a. Maintain contact with CCHD

- b. Implement remote work practices for all staff
 - c. Service & Support and Early Intervention staff to maintain contact with individuals, as needed and possible, in order to ensure health and safety and continuity of services
 - d. Secure premises
 - e. Post notices of closure on entry points and main buildings
- E. Level 5: (Recovery)
- a. Maintain contact with CCHD
 - b. Notify staff via telecommunication of facility reopening
 - c. Continue with rigorous cleaning practices prior to reopening
 - d. Assess the effectiveness of this plan and adjust, in coordination with CCHD, as appropriate
 - e. Prepare for any second waves and re-implement this plan at Level 1

2. Prevention Steps

1. Wash hands often with soap and water for at least 20 seconds, dry hands with a clean towel or air dry
2. Use alcohol-based hand sanitizer when soap and water is not available
3. Cover your mouth and nose with a tissue when sneezing or coughing, wash hands immediately after discarding
4. Avoid touching your eyes, nose or mouth with unwashed hands
5. Stay at home if you are sick
6. Avoid contact with people if they are sick
7. Do not share personal items with others
8. Encourage staff with symptoms of acute respiratory illness to stay home
9. Send staff home immediately for acute respiratory symptoms
10. Inform staff that some people may be at higher risk for severe illness, such as older people and those with chronic medical conditions
11. Emphasize respiratory etiquette and hand hygiene by all employees at all times:
12. Place posters that encourage staying home when sick, cough sneeze etiquette and hand hygiene at the entrance to the workplace and other areas where likely to be seen.
13. Provide tissues and no-touch disposal receptacles, if possible
14. Maintain adequate supplies of soap and water and alcohol-based hand rubs, if possible
15. Routinely clean all frequently touched surfaces, such as desks, countertops and doorknobs. Use cleaning agents that are effective against viruses and follow the directions on the label.
16. Limit non-essential travel plans, if possible
17. Prepare to consider cancelling large work-related meetings or events

H. Good sanitation is the obligation of ALL employees. Attention will be given to facilities, grounds, and surroundings for environmental factors that may affect health. Maintenance and or custodial staff will give buildings close scrutiny, including equipment, floors, walls, ceilings. Routine housekeeping procedures will incorporate the use of disinfectants. The water supply waste disposal system toilets will be periodically checked. Problems will be brought to the attention of the facility director for resolution.

EMERGENCY PLAN AND PROCEDURES

- A. An emergency plan and related procedures shall be developed by the superintendent, pursuant to OAC 5123:2-1-02. The plan and procedures shall address emergencies at the Nike Center, and may be adapted to the specific environment of each building. The plan and related procedures shall be used as a guide in the event of emergency situations.

- B. Emergency procedures shall contain detailed responses to be implemented and should be used as a step by step guide in most cases. It is acknowledged that procedures will not address every aspect of every emergency situation. Accordingly, persons in charge during emergency situations are encouraged to use common sense and their own initiative when they judge that the situation warrants it. All board employees are to familiarize themselves with the plan and procedures and be prepared to implement procedures immediately in the event of an emergency. Emergency telephone numbers are posted on or near all telephones on site.

- C. The emergency plan shall:
 - 1. Include procedures for fire, tornado, emergency closing of all programs, bomb threats, power failure, medical emergencies, natural disasters, security procedures, terrorists threat, hazardous material spills, and the reporting of all accidents and injuries.
 - 2. Be available to and communicated in writing to all members of the staff, including volunteers.
 - 3. Provide for the training of at least one staff member in each building in the techniques of fire suppression.
 - 4. Include procedures for reporting all accidents or injuries within twenty-four hours of the occurrence. The report shall include recommendations for prevention at a future time. Information concerning health and special job considerations shall be communicated to appropriate supervisory personnel.
 - 5. Assure all of the following:
 - a. Emergency fire drills shall be conducted not less than once a month in each building and shall be recorded.
 - b. Tornado drills shall be conducted monthly for program in session, during the tornado season of April, May, June and July.
 - c. Lock down drills shall be conducted by December 1 of each year and shall be recorded.
 - d. A written analysis of the conduct and effectiveness of each fire, tornado, and lock down drill shall be prepared by a designated staff member and reviewed by the superintendent or designee.
 - e. The evacuation plan for fire and tornado drills and other emergencies shall be posted in each room or special area of the facility.
 - f. Fire extinguishers, fire gongs, and alarms shall be properly located, identified, and kept in good working order.
 - g. Storage areas for combustible or flammable materials shall be effectively separated from all rooms and work areas in such a way as to minimize and inhibit the spread of a fire.
 - h. All hallways, entrances, ramps and corridors shall be kept clear and unobstructed at all times.

- i. Power equipment, fixed or portable, should include operating safeguards as required by the division of safety and hygiene, Bureau of Workers' Compensation.
 - j. The Agency shall be staffed with at least one employee trained in techniques of fire suppression, first aid and CPR.
 - k. Swimming programs sponsored by the board shall have present a person who has a current water safety instructor certificate or a senior lifeguard certificate, or an adapted aquatics certificate.
 - l. The board's maintenance department shall make regular inspections of all facilities including playgrounds to ensure safety.
 - m. Electrical outlets in facilities housing children's programs shall have appropriate coverings when not in use.
 - n. Staff in all board facilities shall have immediate access to a telephone for the purposes of work and/or safety.
 - o. All facilities and grounds of the board shall be maintained with clear and unobstructed sidewalks, entrances, ramps, hallways and corridors at all times.
- D. In the event of an emergency, board employees should refer all media inquiries to the superintendent. The superintendent may designate additional personnel to serve as spokesperson for the board when such action is necessary and appropriate.

Addressing Major Unusual Incidents (MUI's) and Unusual Incidents (UI's) to Ensure Health, Welfare, and Continuous Quality Improvement

- A. The CCBDD will follow the Ohio Administrative Code (OAC) 5123-17-02 regarding Major Unusual Incidents (MUI's) and Unusual Incidents (UI's) and implement a continuous quality improvement process to prevent or reduce the risk of harm to Individuals.
- B. All certified providers providing services to Individuals with developmental disabilities will follow this policy.
- C. Any person providing services to an Individual is required to report alleged, suspected, or actual occurrences of abuse or neglect to the statutorily responsible agent.
- D. Failure to report suspected abuse or neglect is a Major Unusual Incident (MUI) and may result in penalties under law, and/or appropriate action as defined in personnel policy.
- E. Per 5123.52 of the Ohio Revised Code (ORC), the "Registry" consists of DD employees who have been found to have committed abuse, neglect, misappropriation, a failure to report, or that have engaged in prohibited sexual relations.
- F. Per ORC 5123:61(K), any person including witnesses that report an incident will be immune from any civil or criminal liability that might otherwise be incurred or imposed as a result of such actions, except liability for perjury, unless the person or governmental entity has acted in bad faith or with malicious purpose.

G. Definitions:

- 1. "Administrative investigation" means the gathering and analysis of information related to a Major Unusual Incident (MUI), so that appropriate action can be taken to address any harm or risk of harm and prevent recurrence. There are three administrative investigation procedures (category A, category B, and category C) that correspond to the three categories of major unusual incidents.
- 2. "At-risk Individual" means an Individual whose health or welfare is adversely affected or whose health or welfare may reasonably be considered to be in danger of being adversely affected.
- 3. "Incident report" means documentation that contains details about a Major Unusual Incident (MUI) or an Unusual Incident (UI) and will include, but is not limited to:
 - a) Individual's name;
 - b) Individual's address;
 - c) Date of incident;
 - d) Location of incident;
 - e) Description of Incident

- f) Type and location of injuries
 - g) Immediate actions taken to ensure health and welfare of Individual involved and any at-risk Individuals;
 - h) Name of primary person involved (PPI) and his or her relationship to the Individual;
 - i) Names of witnesses;
 - j) Statements completed by persons who witnessed or have personal knowledge of the incident;
 - k) Notifications with name, title, and time and date of notice;
 - l) Further medical follow-up; and
 - m) Name and signature of person completing the incident report.
4. "Investigative agent" means an employee of CCBDD or a person under contract with CCBDD who is certified by the Ohio Department of Developmental Disabilities (DODD) to conduct administrative investigations of Major Unusual Incidents.
 5. "Major Unusual Incident" (MUI) means the alleged, suspected, or actual occurrence of an incident described in section H (1), H (2), H (3) of this policy, when there is reason to believe the incident has occurred.
 6. "Physical harm" means any injury, illness, or other physiological impairment, regardless of its gravity or duration.
 7. "Primary person involved" (PPI) means the person alleged to have committed or to have been responsible for the accidental or suspicious death, exploitation, failure to report, misappropriation, neglect, physical abuse, prohibited sexual relations, rights code violation, sexual abuse, or verbal abuse.
 8. "Program Implementation Incident" means an Unusual Incident (UI) involving the failure to carry out a person-centered plan when such failure causes minimal risk or no risk. Examples include, but are not limited to failing to provide supervision for short periods of time, automobile accidents without harm, and self-reported incidents with minimal risk.
 9. "Specialized services" means any program or service designed and operated to serve primarily Individuals, including a program or service provided by an entity licensed or certified by the DODD.
 10. "Systems issue" means a substantiated Major Unusual Incident (MUI) attributed to multiple variables.
 11. "Unusual Incident" means an event or occurrence involving an Individual that is not consistent with routine operations, policies and procedures, or the Individual's care or Individual Service Plan (ISP), but is not a Major Unusual Incident. Unusual Incidents may include, but are not limited to: dental injuries; falls; an injury that is not a significant injury; medication errors without a likely risk to health and welfare;

overnight relocation of an Individual due to a fire, natural disaster, or mechanical failure; an incident involving two Individuals served that is not a peer-to-peer act major unusual incident; rights code violations or unapproved behavioral supports without a likely risk to health and welfare; emergency room or urgent care treatment center visits; and program implementation incidents (i.e. failing to provide supervision for short periods of time, automobile accidents without harm and self-reported incidents with minimal risk).

12. "Working day" means Monday, Tuesday, Wednesday, Thursday, or Friday except when that day is a holiday as defined in section 1.14 of the Ohio Revised Code (ORC).

H. Major Unusual Incident (MUI) Categories:

1. Category A:

- a) "Accidental or suspicious death" means the death of an Individual resulting from an accident or suspicious circumstances.
- b) "Exploitation" means the unlawful or improper act of using an Individual or an Individual's resources for monetary or personal benefit, profit, or gain.
- c) "Failure to report" means that a person, who is required to report pursuant to section 5123.61 of the Ohio Revised Code (ORC), has reason to believe that an Individual has suffered or faces a substantial risk of suffering any wound, injury, disability, or condition of such a nature as to reasonably indicate abuse, neglect, misappropriation, or exploitation that results in a risk to health and welfare of that Individual, and such person does not immediately report such information to a law enforcement agency, CCBDD, or in the case of an Individual living in a developmental center, either to law enforcement or the DODD. Pursuant to division (C) (1) of section 5123.61 of the Ohio Revised Code (ORC), such report will be made to the DODD and the CCBDD when the incident involves an act or omission of an employee of CCBDD.
- d) "Misappropriation" means depriving, defrauding, or otherwise obtaining the real or personal property of an Individual by any means prohibited by the Ohio Revised Code (ORC), including ORC Chapters 2911 and 2913.
- e) "Neglect" means when there is a duty to do so, failing to provide an Individual with medical care, personal care, or other support that consequently results in serious injury or places an Individual or another person at risk of serious injury. Serious injury means an injury that results in treatment by a physician, physician assistant, or nurse practitioner.
- f) "Physical abuse" means the use of physical force that can reasonably be expected to result in physical harm to an Individual. Such physical force may include, but is not limited to, hitting, slapping, pushing, or throwing objects at an Individual.
- g) "Prohibited sexual relations," means a CCBDD or developmental disabilities employee engaging in consensual sexual conduct or having consensual sexual contact with an Individual who is not the employee's spouse, and for whom the developmental disabilities employee was employed or under contract to provide care or supervise the provision of care at the time of the incident.

- h) "Rights code violation" means any violation of the rights enumerated in section 5123.62 of the Ohio Revised Code (ORC) that creates a likely risk of harm to the health or welfare of an Individual.
 - i) "Sexual abuse" means unlawful sexual conduct or sexual contact as those terms are defined in section 2907.01 of the Ohio Revised Code (ORC) and the commission of any act prohibited by Chapter 2907 of the Ohio Revised Code (i.e. public indecency, importuning, and voyeurism) when the sexual conduct, sexual contact, or act involves an Individual.
 - j) "Verbal abuse" means the use of words, gestures, or other communicative means to purposefully threaten, coerce, intimidate, harass, or humiliate an Individual.
- 2. Category B:**
- a) "Attempted suicide" means a physical attempt by an Individual that results in emergency room treatment, in-patient observation, or hospital admission.
 - b) "Death other than accidental or suspicious death" means the death of an Individual by natural cause without suspicious circumstances.
 - c) "Medical emergency" means an incident where emergency medical intervention is required to save an Individual's life (i.e. choking relief techniques such as back blows or cardiopulmonary resuscitation, use of an automated external defibrillator, or use of an epinephrine auto injector).
 - d) "Missing Individual," means an incident that is not considered neglect and an Individual's whereabouts, after immediate measures taken, are unknown and the Individual is believed to be at or pose an imminent risk of harm to self or others. An incident when an Individual's whereabouts are unknown for longer than the period of time specified in the Individual Service Plan (ISP) that does not result in imminent risk of harm to self or others will be investigated as an unusual incident.
 - e) "Peer-to-peer act" means any of the following incidents involving two Individuals:
 - (i.) "Exploitation" which means the unlawful or improper act of using another Individual or another Individual's resources for monetary or personal benefit, profit, or gain.
 - (ii.) "Theft" which means intentionally depriving another Individual of real or personal property valued at **twenty dollars or more** or property of significant personal value to the Individual.
 - (iii.) "Physical Act" which means a physical altercation that:
 - (a.) Results in examination or treatment by a physician, physician assistant, or nurse practitioner; or
 - (b.) Involves strangulation, a bloody nose, a bloody lip, a black eye, a concussion, or biting which causes breaking of the skin; or
 - (c.) Results in an Individual being arrested, incarcerated, or the subject of criminal charges.
 - (iv.) "Sexual act" which means sexual conduct and/or contact for the purposes of sexual gratification without the consent of the other Individual.

- (v.) "Verbal act" which means the use of words, gestures, or other communicative means to purposefully threaten, coerce, or intimidate the other Individual when there is the opportunity and ability to carry out the threat.
- f) "Significant injury" means an injury to an Individual of known or unknown cause that is not considered abuse or neglect and that results in concussion, broken bone, dislocation, second or third degree burns or that requires immobilization, casting, or five or more sutures.
 - (i.) Significant injuries will be designated in the DODD incident tracking system as either known or unknown cause.

3. Category C:

- a) "Law enforcement" means any incident that results in the Individual served being tased, arrested, charged, or incarcerated.
- b) "Unanticipated hospitalization" means any hospital admission or hospital stay over twenty-four hours that is not pre-scheduled or planned. A hospital admission associated with a planned treatment or pre-existing condition that is specified in the Individual Service Plan (ISP) indicating the specific symptoms and criteria that require hospitalization need not be reported.
- c) "Unapproved behavioral support" means the use of a prohibited measure as defined in rule 5123:2-2-06 of the Ohio Administrative Code (OAC), or the use of a restrictive measure implemented without approval of the human rights committee or without informed consent of the Individual or the Individual's guardian in accordance with rule 5123:2-2-06 of the Administrative Code; when use of the prohibited measure or restrictive measure results in risk to the Individual's health or welfare. When use of the prohibited measure or restrictive measure does not result in risk to the Individual's health or welfare, the incident will be investigated as an Unusual Incident.

I. Reporting Requirements for Major Unusual Incidents (MUI's):

1. The CCBDD will have a system that is available twenty-four hours a day, seven days a week, to receive and respond to all reports required by this policy. The CCBDD will communicate this system in writing to all Individuals receiving services in the county or their guardians as applicable, providers in the county, and to the DODD.

J. Abuser Registry:

1. If there is a reasonable basis for believing that a DD employee has committed a "registry offense"; or an act as set forth in division (c)(3)(a) of 5123.51 of the Ohio Revised Code (ORC), the DODD will provide notification to the DD employee of the charges against the DD employee and the DD employee's right to a hearing if timely requested.
2. Any person or governmental entity seeking to hire, contract with, or employ a person as an employee of the DODD, or the CCBDD, or in a position that provides specialized services to an Individual will make an inquiry to the DODD regarding

- whether the person's name is on the registry. If the subject of the inquiry is on the registry, the inquiring party will not hire, contract with, or employ the person in any of these capacities.
3. Information contained in the registry is a public record for the purposes of section 149.43 of the Ohio Revised Code (ORC).

K. General Administrative Investigation Requirements:

1. The CCBDD will ensure that all reported Major Unusual Incidents (MUI's) occurring in Clinton County are investigated by an investigative agent that is certified by the Ohio Department of DD (DODD). The CCBDD may contract with the Southern Ohio Council of Governments (SOCOG) to complete investigations per the Ohio Administrative Code (OAC) 5123-17-02.
2. All CCBDD or developmental disabilities employees will cooperate with administrative investigations conducted by entities authorized to conduct investigations. All CCBDD employees and Providers will respond to requests for information within the time frame requested. The time frames identified will be reasonable.

L. DODD-Directed Administrative Investigations of Major Unusual Incidents (MUI's):

1. The DODD will conduct the administrative investigation when the Major Unusual Incident (MUI) includes an allegation against:
 - a) The Superintendent of a county board or developmental center;
 - b) The executive director or equivalent of a regional council of governments;
 - c) A management employee who reports directly to the Superintendent of the county board, the Superintendent of a developmental center, or executive director or equivalent of a regional council of governments;
 - d) An investigative agent;
 - e) A service and support administrator;
 - f) A Major Unusual Incident (MUI) contact or designee employed by a county board;
 - g) A current member of a county board;
 - h) A person having any known relationship with any of the persons specified in paragraphs (L)(1)(a) to (L)(1)(g) of this policy when such relationship may present a conflict of interest or the appearance of a conflict of interest; or
 - i) An employee of a county board or a developmental center when it is alleged that the employee is responsible for an Individual's death, has committed sexual abuse, engaged in prohibited sexual activity, or committed physical abuse or neglect resulting in emergency room treatment or hospitalization.
2. A DODD directed administrative investigation or administrative investigation review may be conducted following the receipt of a request from CCBDD, a developmental center, provider, Individual, or guardian if the DODD determines that there is a reasonable basis for the request.

3. The DODD may conduct a review or administrative investigation of any Major Unusual Incident (MUI), or may request that a review or administrative investigation be conducted by another county board, a regional council of governments, or any other governmental entity authorized to conduct an investigation.

M. Disputes:

1. An Individual, an Individual's guardian, other person whom the Individual has identified, or provider; may dispute the findings of a Major Unusual Incident (MUI) investigation by submitting a letter of dispute and supporting documentation to the CCBDD Superintendent, or to the Director of the DODD; if the DODD conducted the administrative investigation, within **fifteen (15) calendar days** following receipt of the findings. An Individual may receive assistance from any person selected by the Individual to prepare a letter of dispute and provide supporting documentation.
2. The CCBDD Superintendent or his or her designee, the Director of the DODD or his or her designee, as applicable, will consider the letter of dispute, the supporting documentation, and any other relevant information and issue a determination within **thirty (30) calendar days** of such submission and take action consistent with such determination, including confirming or modifying the findings or directing that more information be gathered and the findings be reconsidered.
3. In cases where the letter of dispute has been filed with the CCBDD, the disputant may dispute the final findings made by the CCBDD by filing those findings and any documentation contesting such findings as are disputed with the Director of the DODD within **fifteen (15) calendar days** of the CCBDD determination. The Director of the DODD will issue a decision within **thirty (30) calendar days**.

N. Review, Prevention, and Closure of Major Unusual Incidents (MUI's):

1. The DODD may review reports submitted by the CCBDD. The DODD may obtain additional information necessary to consider the report, including copies of all administrative investigation reports that have been prepared. Such additional information will be provided within the time period specified by the DODD.
2. The DODD may review any case to ensure it has been properly closed and will conduct sample reviews to ensure proper closure by the CCBDD. The DODD may reopen any administrative investigation that does not meet the requirements of the Ohio Administrative Code (OAC) 5123-17-02. The CCBDD will provide any information deemed necessary by the DODD to close the case.

O. Requirements for Unusual Incidents (UI's):

1. The Unusual Incident (UI) reports, documentation of identified trends and patterns, and corrective action will be made available to the CCBDD and the DODD upon request.
2. The CCBDD, each Agency Provider, and Independent Provider will maintain a log of all Unusual Incidents. The log will contain only Unusual Incidents (UI's) as defined in paragraph (G)(11) of this policy and will include, but is not limited to: the name of the Individual, a brief description of the Unusual Incident (UI), any injuries, time, date, location, cause and contributing factors, and preventive measures.
3. All Providers upon request will provide any and all information and documentation regarding an Unusual Incident (UI) and investigation of the Unusual Incident (UI) to the DODD or the CCBDD.

P. Oversight:

1. The DODD will conduct reviews of CCBDD and Providers as necessary to ensure the health and welfare of Individuals and compliance with this policy and Ohio Administrative Code (OAC) 5123-17-02 Failure to comply may be considered by the DODD in any regulatory capacity, including certification, licensure, and accreditation.
2. The DODD will review and take any action appropriate when a complaint is received about how an administrative investigation is conducted.

Q. Access to Records:

1. Reports and investigations of all Major Unusual Incidents (MUI's) will be kept confidential.
2. Reports made under section 5123.61 of the Ohio Revised Code (ORC), 5123-17-02 of the Ohio Administrative Code (OAC) and this policy are not public records as defined in section 149.43 of the Ohio Revised Code (ORC). Records may be provided to parties authorized to receive them in accordance with sections 5123.613 and 5126.044 of the Ohio Revised Code (ORC); to any governmental entity authorized to investigate the circumstances of the alleged abuse, neglect, misappropriation, or exploitation and to any party to the extent that release of a record is necessary for the health or welfare of an Individual.
 - a) CCBDD or the DODD will not review, copy, or include in any report required by Ohio Administrative Code (OAC) 5123-17-02, or this policy a Provider's personnel records that are confidential under state or federal statutes or rules, including medical and insurance records, workers' compensation records, employment eligibility verification (I-9) forms, and social security numbers.

- b) The Provider will redact any confidential information contained in a record before copies are provided to the CCBDD or the DODD.
- c) A Provider will make all other records available upon request by the CCBDD or the DODD.
- d) A Provider will provide confidential information, including the date of birth and social security number, when requested by the DODD as part of the abuser registry process in accordance with rule 5123-17-03 of the Administrative Code.
- e) Any party entitled to receive a report required by this policy, or the Ohio Administrative Code (OAC) 5123-17-02, may waive receipt of the report. Any waiver of receipt of a report will be made in writing.

R. Training:

1. The CCBDD and all Agency Providers will ensure staff employed in direct services positions are trained on the requirements of the Ohio Administrative Code (OAC) 5123-17-02 prior to direct contact with any Individual. Thereafter, staff employed in direct services positions will receive annual training on the requirements including a review of health and welfare alerts issued by the DODD since the previous year's training.
2. The CCBDD and all Agency Providers will ensure staff employed in positions other than direct services positions are trained on the requirements of the Ohio Administrative Code (OAC) 5123-17-02 no later than ninety calendar days from date of hire. Thereafter, staff employed in positions other than direct services positions will receive annual training on the requirements including a review of health and welfare alerts issued by the DODD since the previous year's training.
3. Independent Providers will be trained on the requirements of the Ohio Administrative Code (OAC) 5123-17-02 prior to application for initial certification in accordance with rule 5123:2-2-01 of the Ohio Administrative Code (OAC) and will receive annual training on the requirements including a review of health and welfare alerts issued by the DODD since the previous year's training.

Reference: ORC Chapters 2911 and 2913, ORC 2907.01, ORC 149.43, ORC 5123.51, 5123.52, 5123:61, 5123.62, 5123.613, & 5126.044

OAC 5123-17-02, 5123:2-2-06, 5123:2-2-01 & 5123-17-03

Addressing Major Unusual Incidents (MUI’s) and Unusual Incidents (UI’s) to Ensure Health, Welfare, and Continuous Quality Improvement

- A. All Clinton County Board of Developmental Disabilities (CCBDD) employees and Providers serving Individuals must report Major Unusual incidents (MUI’s) and Unusual Incidents (UI’s) in accordance with these procedures and with 5123-17-02 of the Ohio Administrative Code (OAC).
- B. The CCBDD has a contractual agreement with the Southern Ohio Council of Governments (SOCOG) to provide an Investigative Agent who will investigate all Major Unusual Incidents (MUI’s) per the requirements set forth in 5123-17-02 of the Ohio Administrative Code (OAC). This agreement is available at the CCBDD Administrative Office and the SOCOG Administrative Office, with renewals as indicated via terms specified in the contractual agreement.

C. Reporting Requirements for Major Unusual Incidents (MUI’s):

- 1. All Providers will contact the Service and Support Office to report all Major Unusual Incidents (MUI’s) as follows:
 - a) During the CCBDD’s business hours, reports of Major Unusual Incidents (MUI’s) may be made by:
 - (i.) Phone: (937) 382-7889
 - (ii.) Emailing the report to: irsubmissions@nikecenter.org
 - (iii.) Faxing the report to: (937) 382-0350
 - b) After Hours: (937) 725-5074
- 2. The after-hours on-call SSA, upon receiving the initial verbal Major Unusual Incident (MUI) notification, will document all applicable information on the On-Call Report, including the date and time the initial call was received and forward to the SSA Manager/MUI Contact/Designee by 9:00am the following work day.
- 3. Reports regarding all Major Unusual Incidents (MUI’s) involving an Individual who resides in an intermediate care facility or who receives around-the-clock waiver services will be filed and the requirements of OAC 5123-17-02 followed regardless of where the incident occurred:
 - a) Accidental or suspicious death;
 - b) Attempted suicide;
 - c) Death other than accidental or suspicious death;
 - d) Exploitation;
 - e) Failure to report;
 - f) Law enforcement;
 - g) Misappropriation;
 - h) Missing Individual;
 - i) Neglect;

- j) Peer-to-peer act;
 - k) Physical abuse;
 - l) Prohibited sexual relations;
 - m) Sexual abuse; and
 - n) Verbal abuse.
4. Reports regarding the following Major Unusual Incidents (MUI's) will be filed and the requirements of OAC 5123-17-02 followed only when the incident occurs in a program operated by the CCBDD or when the Individual is being served by a licensed or certified provider:
 - a) Medical emergency;
 - b) Rights code violation;
 - c) Significant injury;
 - d) Unanticipated hospitalization; and
 - e) Unapproved behavioral support.
 5. Immediately upon identification or notification of a Major Unusual Incident (MUI), the CCBDD and/or the Provider will take all reasonable measures to ensure the health and welfare of at-risk Individuals.
 6. The CCBDD and the Provider will discuss any disagreements regarding reasonable measures in order to resolve them. If the CCBDD and the Provider are unable to agree on reasonable measures to ensure the health and welfare of at-risk Individuals, the DODD will make the determination. Such measures will include:
 - a) Immediate and ongoing medical attention, as appropriate;
 - b) Removal of an employee from direct contact with any Individual when the employee is alleged to have been involved in physical abuse or sexual abuse until such time as the provider has reasonably determined that such removal is no longer necessary; and
 - c) Other necessary measures to protect the health and welfare of at-risk Individuals.
 7. Immediately upon receipt of a report or notification of an allegation of a Major Unusual Incident (MUI), the CCBDD will:
 - a) Ensure that all reasonable measures necessary to protect the health and welfare of at-risk Individuals have been taken;
 - b) Determine if additional measures are needed; and
 - c) Notify the DODD if the circumstances require a department-directed administrative investigation. Such notification will take place on the first working day the CCBDD becomes aware of the incident.
 8. The CCBDD employees and/or the provider will immediately, **but no later than four hours after discovery** of the Major Unusual Incident (MUI), notify the SSA Manager/MUI Contact/Designee for the following Major Unusual Incidents (MUI's):
 - a) Accidental or suspicious death;

- b) Exploitation;
 - c) Misappropriation;
 - d) Neglect;
 - e) Peer-to-peer act;
 - f) Physical abuse;
 - g) Prohibited sexual relations;
 - h) Sexual abuse;
 - i) Verbal abuse; and
 - j) When the CCBDD and/or the provider have received an inquiry from the media regarding a Major Unusual Incident (MUI).
9. For all Major Unusual Incidents (MUI's), CCBDD employees and/or the provider will submit a written/electronic incident report to the CCBDD SSA Manager/MUI Contact/Designee **by three p.m. on the first working day** following the day the CCBDD employee and/or provider becomes aware of a potential or determined Major Unusual Incident (MUI). The report will be submitted in a format prescribed by the DODD.
 10. The CCBDD will enter preliminary information regarding the Major Unusual Incident (MUI) in the Incident Tracking and Monitoring System (ITMS) and in the manner prescribed by the DODD **by five p.m. on the first working day** following the day the CCBDD receives notification from a CCBDD employee, a provider and/or otherwise becomes aware of the Major Unusual Incident (MUI).
 11. When a provider has placed an employee on leave or otherwise taken protective action pending the outcome of the administrative investigation, the CCBDD SSA Manager/MUI Contact/Designee or the DODD, as applicable, will keep the provider apprised of the status of the administrative investigation so that the provider can resume normal operations as soon as possible consistent with the health and welfare of at-risk Individuals. The provider will notify the CCBDD or the DODD, as applicable, of any changes regarding the protective action.
 12. If the provider is a developmental center, all reports required by OAC 5123-17-02 will be made directly to the DODD.

D. Reporting of Alleged Criminal Acts:

1. The CCBDD or the provider will immediately report to the law enforcement entity having jurisdiction of the location where the incident occurred, any allegation of a criminal act.
2. The CCBDD or the provider will document the time, date, and name of person notified of the alleged criminal act.
3. The CCBDD will ensure that the notification has been made.

4. The DODD will immediately report to the Ohio state highway patrol, any allegation of a criminal act occurring at a developmental center. The DODD will document the time, date, and name of person notified of the alleged criminal act.

E. Abused or Neglected Children:

1. All allegations of abuse or neglect as defined in sections 2151.03 and 2151.031 of the Ohio Revised Code of an Individual **under the age of twenty-one (21) years** will be immediately reported to the local public children's services agency. The CCBDD or the provider may make the notification.
2. The CCBDD will ensure that the notification has been made.

F. Notification Requirements for Major Unusual Incidents (MUI's):

1. The CCBDD SSA Manager/MUI Contact/Designee, or the Provider will make the following notifications, as applicable, when the Major Unusual Incident (MUI) or discovery of the Major Unusual Incident (MUI) occurs when such provider has responsibility for the Individual.
2. The notification will be made on the **same day** the Major Unusual Incident (MUI) or discovery of the Major Unusual Incident (MUI) occurs and include immediate actions taken.
3. Notifications will be made to following persons:
 - a) Guardian or other person whom the Individual has identified.
 - b) The SSA serving the Individual.
 - c) Other providers of services as necessary to ensure continuity of care and support for the Individual.
 - d) Staff or family living at the Individual's residence who have responsibility for the Individual's care.
4. All notifications or efforts to notify will be documented. The CCBDD will ensure that all required notifications have been made.
5. Notification will not be made:
 - a) If the person to be notified is the primary person involved, the spouse of the primary person involved, or the significant other of the primary person involved; or
 - b) When such notification could jeopardize the health and welfare of an Individual involved.
6. Notification to a person is not required when the report comes from such person or in the case of a death when the family is already aware of the death.

7. In any case, where law enforcement has been notified of an alleged criminal act, the DODD may provide notification of the Major Unusual Incident (MUI) to any other provider, developmental center, or county board for whom the primary person involved works, for the purpose of ensuring the health and welfare of any at-risk Individual. The notified provider or county board will take such steps necessary to address the health and welfare needs of any at risk Individual and may consult the DODD in this regard.
8. The DODD will inform any notified entity as to whether the Major Unusual Incident (MUI) is substantiated. Providers, developmental centers, or county boards employing a primary person involved will notify the DODD when they are aware that the primary person involved works for another provider.

G. General Administrative Investigation Requirements:

1. Upon receipt of an Incident Report, the Service and Support Manager/MUI Contact/Designee will review the information to determine if the incident meets the criteria of a Major Unusual Incident (MUI).
2. If the incident does not meet the criteria of a Major Unusual Incident (MUI), the agency or provider staff reporting the incident will be notified that the incident was classified as an Unusual Incident (UI).
3. All Major Unusual Incidents (MUI's) require an administrative investigation meeting the applicable administrative investigation procedure in Appendix A, Appendix B, or Appendix C to OAC 5123-17-02 and per the CCBDD's policy 4.02, unless it is not possible or relevant to the administrative investigation to meet a requirement under OAC 5123-17-02, in which case the reason will be documented.
4. Administrative investigations will be conducted and reviewed by investigative agents.
5. The DODD or the CCBDD may elect to follow the administrative investigation procedure for Category A (MUI's) for any MUI.
6. Based on the facts discovered during administrative investigation of the MUI, the category may change or additional categories may be added to the record. If a MUI changes category, the reason for the change will be documented and the new applicable category administrative investigation procedure will be followed to investigate the MUI.
7. MUI's that involve an active criminal investigation may be closed as soon as the CCBDD ensures that the MUI is properly coded, the history of the primary person involved has been reviewed, cause and contributing factors are determined, a

finding is made, and prevention measures implemented. Information needed for closure of the MUI may be obtained from the criminal investigation.

8. The CCBDD SSA Manager/MUI Contact/Designee may assist the investigative agent by gathering documents, entering information into the incident tracking system, fulfilling category C administrative investigation requirements, or performing other administrative or clerical duties that are not specific to the investigative agent role.
9. Except when law enforcement or the public children's services agency is conducting the investigation, the SOCOG investigative agent will conduct all interviews for MUI's unless the investigative agent determines the need for assistance with interviewing an Individual.
10. For a MUI occurring at an intermediate care facility the investigative agent may utilize interviews conducted by the intermediate care facility or conduct his or her own interviews. If the investigative agent determines the information is reliable, the investigative agent may utilize other information received from law enforcement, the public children's services agency, or providers in order to meet the requirements of OAC 5123-17-02.
11. Except when law enforcement or the public children's services agency has been notified and is considering conducting an investigation, the CCBDD SSA Manager/MUI Contact/Designee will notify the SOCOG investigative agent to commence an administrative investigation.
12. If law enforcement or the public children's services agency notifies the CCBDD that it has declined to investigate; the CCBDD SSA Manager/MUI Contact/Designee will notify the SOCOG investigative agent to commence the administrative investigation within a reasonable amount of time based on the initial information received or obtained and consistent with the health and welfare of all at-risk Individuals, but **no later than twenty-four hours for a MUI in category A or no later than three working days for a MUI in category B or category C.**
13. An intermediate care facility will conduct an investigation that complies with applicable federal regulations, including 42 C.F.R. 483.420 as in effect on the effective date of OAC 5123-17-02, for any UI or MUI involving a resident of the facility, regardless of where the UI or MUI occurs.
14. The intermediate care facility will provide a copy of its full report of an administrative investigation of a MUI to the CCBDD.
15. The investigative agent may utilize information from the administrative investigation conducted by the intermediate care facility to meet the requirements of OAC 5123-17-02, or conduct a separate administrative investigation.

16. The CCBDD will provide a copy of its full report of the administrative investigation to the intermediate care facility.
17. The DODD will resolve any conflicts that arise.
18. When an agency provider; excluding an intermediate care facility, conducts an internal review of an incident for which a MUI has been filed, the agency provider will submit the results of its internal review of the incident, including statements and documents, to the CCBDD within **fourteen (14) calendar days** of the agency provider becoming aware of the incident.
19. Except when law enforcement or the public children's service agency is conducting an investigation, the investigative agent will endeavor to reach a preliminary finding regarding allegations of physical abuse or sexual abuse and notify the CCBDD SSA Manager/MUI Contact/Designee, the Individual or Individual's guardian and provider of the preliminary finding within **fourteen (14) working days**. When it is not possible for the investigative agent to reach a preliminary finding within **fourteen (14) working days**, he or she will instead notify the CCBDD SSA Manager/MUI Contact/Designee, the Individual or Individual's guardian and provider of the status of the investigation.
20. The investigative agent will complete a report of the administrative investigation and submit it for closure in the DODD incident tracking system within **thirty (30) working days** unless the CCBDD SSA Manager/MUI Contact/Designee, or the SOCOG investigative agent requests and the DODD grants an extension for good cause. If an extension is granted, the DODD may require submission of interim reports and may identify alternative actions to assist with the timely conclusion of the report.
21. The investigative report will follow the format prescribed by the DODD. The investigative agent will include the initial allegation, a list of persons interviewed and documents reviewed, a summary of each interview and document reviewed, and a findings and conclusions section, which will include the cause and contributing factors to the incident and the facts that support the findings and conclusions.

H. Written Summaries of MUI's:

1. No later than **five (5) working days** following the CCBDD's, developmental center's, or the DODD's recommendation for closure via the incident tracking system, the CCBDD SSA Manager/MUI Contact/Designee, the SOCOG investigative agent, developmental center, or the DODD will provide a written summary of the administrative investigation of each Category A or Category B MUI, including the allegations, the facts and findings, including as applicable,

whether the case was substantiated or unsubstantiated, and preventive measures implemented in response to the MUI to:

- a) The Individual, Individual's guardian, or other person whom the Individual has identified, as applicable; in the case of a peer-to-peer act, both Individuals, Individuals' guardians, or other persons whom the Individuals have identified, as applicable, will receive the written summary;
 - b) The licensed or certified provider and provider at the time of the MUI; and
 - c) The Individual's SSA and support broker, as applicable.
2. In the case of an Individual's death, the written summary will be provided to the Individual's family only upon request by the Individual's family.
 3. The written summary will not be provided to the primary person involved, the spouse of the primary person involved, or the significant other of the primary person involved.
 4. When the primary person involved is a developmental disabilities employee or a guardian, the SOCOG Investigative Agent/Designee will, no later than **five (5) working days** following the recommended closure of a case, make a reasonable attempt to provide written notice to the primary person involved as to whether the MUI has been substantiated, unsubstantiated/insufficient evidence, or unsubstantiated/unfounded.
 5. If an SSA is not assigned, the CCBDD SSA Manager/MUI Contact/Designee will be responsible for ensuring the preventive measures are implemented based upon the written summary.

I. Review, Prevention, and Closure of MUI's:

1. All Agency providers will implement a written procedure for the internal review of all MUI's and will be responsible for taking all reasonable steps necessary to prevent the recurrence of MUI's.
2. Senior management of the County Board (i.e., Superintendent, SSA Director, SSA Manager and/or the Educational Services Manager) will be **informed within two (2) working days** following the day staff become aware of a potential or determined MUI involving misappropriation, neglect, physical abuse, or sexual abuse.
 - a) For any potential or determined MUI, CCBDD employees will notify their designated supervisor immediately and submit an incident report to their supervisor.
 - b) The designated supervisor will then notify the CCBDD MUI Contact or the SSA Manager.
 - c) For incidents not reported by SSA: The designated supervisor will review the incident report and submit the report to the irsubmissions@nikecenter.org

- email address immediately for any potential or determined MUI's and within 24 hours for UI's.
- d) The SSA MUI Contact or the SSA Manager will enter the incident report into the incident log in Gatekeeper.
 - e) If an incident occurs after hours, CCBDD employees will call the on-call cell phone at (937) 725-5074.
 - f) All incident reports sent to the irsubmissions email address will be received and reviewed the same day by the SSA Secretary, CCBDD MUI Contact, and /or the SSA Manager.
 - g) SSA's who witness or become aware of an incident will enter the incident information into the incident log in Gatekeeper and submit the incident report to the SSA "Signed Forms for Supervisor's" folder for review.
 - h) SSA's will notify the SSA Manager and the CCBDD MUI Contact immediately for any suspected or potential MUI.
 - i) All incidents received from Providers or witnessed by CCBDD employees regardless of type will be entered into the incident log in Gatekeeper
 - j) The CCBDD Superintendent, SSA Director, and SSA Manager will receive an alert when an incident has been entered into Gatekeeper
 - k) The CCBDD Superintendent, SSA Director, and SSA Manager will review all incidents in Gatekeeper to ensure reporting requirements have been met and that immediate action has been taken.
3. Members of an Individual's team will ensure that risks associated with MUI's are addressed in the Individual Service Plan of each Individual affected and collaborate on the development of preventive measures to address the causes and contributing factors to the MUI.
 4. The team members will jointly determine what constitutes reasonable steps necessary to prevent the recurrence of MUI's. If there is no SSA assigned; a team, qualified intellectual disability professional, or agency provider involved with the Individual; the CCBDD SSA Manger/MUI Contact/Designee will ensure that reasonably possible preventive measures are fully implemented.
 5. The CCBDD SSA Manager/MUI Contact/Designee will receive the final MUI report from the SOCOG Investigative Agent for review and approval.
 - a) The CCBDD SSA Manager/MUI Contact/Designee will send an email to the SOCOG Investigative Agent/Designee as to whether or not the report and any recommendations made by the SOCOG investigative agent are being accepted.
 - b) If the CCBDD accepts the report, the SOCOG will add/upload the report to the DODD's Incident Tracking and Monitoring System (ITMS)
 - c) If the CCBDD does not accept the initial report, the SSA Manager/MUI Contact/Designee will notify the SOCOG Investigative Agent why the report has not been accepted and collaborate with the Investigative Agent on any changes that need to be made.

- d) Once the final investigative report is accepted; the CCBDD SSA Manager/MUI Contact/Designee will obtain the final prevention plan from the team, add it to the DODD's Incident Tracking and Monitoring System (ITMS) under the prevention plan tab and then close or recommend the MUI for closure to the DODD.
6. The DODD will review and close reports regarding the following Major Unusual Incidents (MUI's):
 - a) Accidental or suspicious death;
 - b) Death other than accidental or suspicious death;
 - c) Exploitation;
 - d) Medical emergency;
 - e) Misappropriation;
 - f) Neglect;
 - g) Peer-to-peer act;
 - h) Physical abuse;
 - i) Prohibited sexual relations;
 - j) Sexual abuse;
 - k) Significant injury when cause is unknown;
 - l) Verbal abuse;
 - m) Any MUI that is the subject of a director's alert; and
 - n) Any MUI investigated by the DODD.
 7. The CCBDD SSA Manager/MUI Contact/Designee will review and close reports regarding the following Major Unusual Incidents (MUI's):
 - a) Attempted suicide;
 - b) Failure to report;
 - c) Law enforcement;
 - d) Missing Individual;
 - e) Rights code violation;
 - f) Significant injury when cause is known;
 - g) Unanticipated hospitalization; and
 - h) Unapproved behavioral support.
 8. The DODD and the CCBDD SSA Manager/MUI Contact/Designee will consider the following criteria when determining whether to close a case:
 - a) Whether sufficient reasonable measures have been taken to ensure the health and welfare of any at-risk Individual;
 - b) Whether a thorough administrative investigation has been conducted consistent with the standards set forth in this OAC 5123-17-02 and the CCBDD Policy 4.02;
 - c) Whether the team, including the CCBDD and provider, collaborated on developing preventive measures to address the causes and contributing factors;
 - d) Whether the CCBDD and the provider has ensured that preventive measures have been implemented to prevent recurrence;

- e) Whether the incident is part of a pattern or trend as flagged through the incident tracking system requiring some additional action; and
- f) Whether all requirements set forth in statute or OAC 5123-17-02 have been satisfied.

J. Analysis of Major Unusual Incident (MUI) Trends and/or Patterns:

1. By **January thirty-first of each year**, the CCBDD and all providers will conduct an in-depth review and analysis of trends and patterns of MUI's occurring during the preceding calendar year and compile an annual report which contains:
 - a) Date of review;
 - b) Name of person completing review;
 - c) Time period of review;
 - d) Comparison of data for previous three years;
 - e) Explanation of data;
 - f) Data for review by MUI category type;
 - g) Specific Individuals involved in established trends and patterns (i.e., **five (5) MUI's of any kind within six months, ten (10) MUI's of any kind within a year**, or other pattern identified by the Individual's team);
 - h) Specific trends by residence, region, or program;
 - i) Previously identified trends and patterns; and
 - j) Action plans and preventive measures implemented to address noted trends and patterns.

2. All providers will send the annual report to the CCBDD for all programs operated in the county by **February twenty-eighth of each year**. The CCBDD will review the annual report to ensure that all issues have been reasonably addressed to prevent the recurrence of MUI's.
 - a) The CCBDD will keep the annual report on file and make it available to the DODD upon request.

3. The CCBDD will send an annual report to the DODD for all MUI's reported in Clinton County including any MUI's that occur in programs operated by the CCBDD by **February twenty-eighth of each year**.
 - a) The DODD will review the annual report to ensure that all issues have been reasonably addressed to prevent the recurrence of MUI's.

4. The CCBDD will have a committee that reviews trends and patterns of Major Unusual Incidents (MUI's).
 - a) The committee will be made up of a reasonable representation of providers, Individuals who receive services and their families, and other stakeholders deemed appropriate by the committee.
 - b) The role of the committee will be to review and share aggregate data prepared by the CCBDD SSA Manager/MUI Contact, the CCBDD SSA Director, and the SOCOG to identify trends, patterns, or areas for improving the quality of life for Individuals served in the county or counties.

- c) The committee will meet **each March** to review and analyze data for the preceding calendar year.
- d) The CCBDD SSA Manager/MUI Contact or the SSA Director will send the aggregate data prepared for the meeting to all participants at least **ten (10) calendar days** in advance of the meeting.
- e) The CCBDD SSA Manager/MUI Contact or the SSA Director will record and maintain minutes of each meeting, distribute the minutes to members of the committee, and make the minutes available to any person upon request.
- f) The CCBDD SSA Manager/MUI Contact and the SSA Director will ensure follow-up actions identified by the committee have been implemented.

K. Requirements for Unusual Incidents (UI's):

1. Unusual Incidents (UI's) may include, but are not limited to: dental injuries; falls; an injury that is not a significant injury; medication errors without a likely risk to health and welfare; overnight relocation of an Individual due to a fire, natural disaster, or mechanical failure; an incident involving two Individuals served that is not a peer-to-peer act major unusual incident; rights code violations or unapproved behavioral supports without a likely risk to health and welfare; emergency room or urgent care treatment center visits; and program implementation incidents (i.e. failing to provide supervision for short periods of time, automobile accidents without harm, and self-reported incidents with minimal risk).
2. Unusual Incidents (UI's) will be reported and investigated by the CCBDD and all providers.
3. All CCBDD employees and all Providers will report Unusual Incidents (UI's) to the CCBDD Service and Support Division.
4. Both Agency and Independent Providers will forward all Unusual Incidents (UI's) to the CCBDD Service and Support Division:
 - a) All Providers will complete an UI report, notify the Individual's guardian or other person whom the Individual has identified, and/or other providers of services as necessary to ensure continuity of care and support for the Individual, as applicable, and forward the UI report to CCBDD on the **first working day following the day the Unusual Incident (UI) is discovered by:**
 - (i.) Delivering the report to the SSA office, or
 - (ii.) Emailing the report to: irsubmissions@nikecenter.org, or
 - (iii.) Faxing the report to: (937) 382-0350
5. All incident reports received by the Service and Support Division via paper or electronic means will be entered into an incident log in Gatekeeper regardless of the type of incident. All incidents received via paper or electronic means will be filed electronically in Intellivue in the UI or MUI file for the individual served.

6. The Service and Support Division will ensure that all Unusual Incident (UI) reports are sent to the assigned SSA for review upon receipt via paper or electronic means.
 - a) For incident reports that are faxed or dropped off to the SSA office, the SSA Secretary will date and time stamp the report prior to routing. For incidents submitted via the irsubmissions email or via fax the date and time stamp of receipt is noted in the email/fax upon receipt.
 - b) The assigned SSA will review the UI Report, investigate/gather any additional information needed, ensure immediate action has been taken, ensure applicable notifications have been made, identify/address the cause and contributing factors when applicable, and ensure preventive measures have been implemented to protect the health and welfare of any at-risk Individuals.
 - c) After addressing any concerns/follow-up on the UI report, the SSA will ensure the UI has been entered into the Incident Tracking System/UI log in Gatekeeper ~~and~~ within **three (3) business days** following the receipt of the UI.
 - d) When a report is received for an individual who does not have an assigned SSA; the SSA Manager or the CCBDD MUI Contact will enter the incident into the Incident Tracking System/UI Log in Gatekeeper within **three (3) business days** following the receipt of the UI.
 - (i.) The UI log will contain all of the information required for UI's per the CCBDD policy 4.02 and OAC 5123-17-02.
 - (ii.) The UI log will be maintained for all UI's reported by CCBDD employees, Independent, and Agency providers.
 - (iii.) The log will be made available to the DODD upon request.
 - e) The SSA Manager/MUI Contact will review the Unusual Incident (UI) report in Gatekeeper, note any additional concerns or follow-up that is needed, ensure the Unusual Incident (UI) is properly coded, ensure that the incident does not meet the criteria of a Major Unusual Incident (MUI),
 - f) The SSA Director and the Superintendent will review the Unusual Incident (UI) report in Gatekeeper, note any additional concerns or follow-up that is needed. After all parties have reviewed the Unusual Incident (UI) report internally, the assigned SSA will address any additional administrative concerns noted on the electronic Unusual Incident (UI) report in Gatekeeper.
 - g) Any follow-up notes/reports will be attached to the original Unusual Incident (UI) report. If an incident becomes, or is related to a Major Unusual Incident (MUI), it will be filed with the applicable Major Unusual Incident (MUI).
7. The multi-level process noted above for reviewing incidents will be conducted for all reports received by the SSA Division.
8. Each agency provider is responsible for developing and implementing a written Unusual Incident (UI) policy and procedure that:
 - a) Identifies what is to be reported as an Unusual Incident (UI), which will include Unusual Incidents (UI's) as defined in OAC 5123-17-02 and in the CCBDD's policy 4.02 (G) (11);
 - b) Requires an employee who becomes aware of an Unusual Incident (UI) to report it to the person designated by the agency provider who can initiate proper action;

- c) Requires the report to be made **no later than twenty-four hours** after the occurrence of the Unusual Incident (UI); and
 - d) Requires the agency provider to investigate Unusual Incidents (UI's), identify the cause and contributing factors when applicable, and develop preventive measures to protect the health and welfare of any at-risk Individuals.
9. Each agency provider will ensure that all staff are trained and knowledgeable regarding the agencies Unusual Incident (UI) policies and procedures.
 10. The provider providing services when an Unusual Incident (UI) occurs will notify other providers of services as necessary to ensure continuity of care and support for the Individual.
 11. The CCBDD, each agency provider, and independent provider will review all Unusual Incidents (UI's) as necessary, but **no less than monthly**, to ensure appropriate preventive measures have been implemented and to ensure any trends and/or patterns are identified and addressed as appropriate.
 12. The CCBDD Unusual Incident (UI) Log review will be a review of each Unusual Incident (UI) reported by the CCBDD employees, Independent, and Agency Providers.
 13. In addition to reviewing each Unusual Incident (UI) report the following will occur:
 - a) The SSA Manager/MUI Contact will run a report from the Incident Tracking System in Gatekeeper at the beginning of each month that will include all of the Unusual Incidents (UI's) reported by the CCBDD employees and Unusual Incidents (UI's) reported by both Independent and Agency providers during the previous month.
 - b) The SSA Manager/MUI Contact will route the report to the SSA's and the SSA Director by the 15th of following month for review.
 - c) The assigned SSA will review the report and identify if there are any trends and/or patterns specific to an Individual (**i.e., three (3) similar UI's in one week, five (5) similar UI's within one month**), or other pattern identified by the Individual's team.
 - d) If trends and/or patterns are identified for an Individual, the SSA will follow up with the team and note in the Gatekeeper Incident Tracking System any additional preventive measures that have been implemented to address the trends and/or patterns.
 - e) The SSA will ensure that if any trends and/or patterns are identified for an Individual that an Individual Service Plan addendum is completed within **thirty (30) calendar days** to add the trends and/or patterns discovered and the preventive measures implemented to address the incidents and/or to prevent recurrence.
 - f) The CCBDD Unusual Incident (UI) log/report maintained in the Gatekeeper Incident Tracking System will be made available to the DODD for review upon request.

14. All members of an Individual's team are responsible for ensuring that risks associated with Unusual Incidents (UI's) are addressed in the Individual Service Plan of each Individual affected.

L. Oversight:

1. The CCBDD will review, on at least a quarterly basis, a representative sample of provider Unusual Incident (UI) logs, including logs where the CCBDD is a provider, to ensure that Major Unusual Incidents (MUI's) have been reported, preventive measures have been implemented, and that trends and/or patterns have been identified and addressed in accordance with OAC 5123-17-02 and per the CCBDD procedures 4.02.1.
2. The sample will be made available to the DODD for review upon request.
3. The DODD will review, on a monthly basis, a representative sample of the CCBDD Unusual Incident (UI) logs to ensure that Major Unusual Incidents (MUI's) have been reported, preventive measures have been implemented, and that trends and/or patterns have been identified and addressed in accordance with OAC 5123-17-02.
4. The CCBDD will submit the specified Unusual Incident (UI) logs to the DODD upon request.

Reference: ORC Chapters 2911 and 2913, ORC 2907.01, ORC 149.43, ORC 5123.51, 5123.52, 5123:61, 5123.62, 5123.613, & 5126.044
OAC 5123-17-02, 5123:2-2-06, 5123:2-2-01 & 5123-17-03

Revised: 01/04/2024

DEVELOPMENT AND IMPLEMENTATION OF BEHAVIORAL SUPPORT STRATEGIES

A. Purpose

The Clinton County Board of Developmental Disabilities (CCBDD) has set forth requirements for the development and implementation of behavioral support strategies in this policy as required by OAC 5123-2-06 that include both positive measures and restrictive measures for the purpose of ensuring that:

1. Individuals with developmental disabilities are supported in a caring and responsive manner that promotes dignity, respect, and trust and with recognition that they are equal citizens with the same rights and personal freedoms granted to Ohioans without developmental disabilities;
2. Services and supports are based on an understanding of the individual and the reasons for his or her actions;
3. Effort is directed at creating opportunities for individuals to exercise choice in matters affecting their everyday lives and supporting individuals to make choices that yield positive outcomes; and
4. Restrictive measures are used only when necessary to keep people safe and always in conjunction with positive measures

B. Scope

This policy applies to persons and entities that provide specialized services regardless of source of payment, including but not limited to:

1. The CCBDD and entities under contract with the CCBDD;
2. Residential facilities licensed pursuant to section 5123.19 of the Revised Code, including intermediate care facilities;
3. Providers of supported living certified pursuant to section 5123.161 of the Revised Code; and
4. Providers of services funded by Medicaid home and community- based services waivers administered by DODD pursuant to section 5166.21 of the Revised Code.
5. Individuals receiving services in a setting governed by the Ohio Department of Education will be supported in accordance with rule 3301-35-15 of the Administrative Code.

C. Definitions

1. “Chemical restraint” means the use of medication in accordance with scheduled

dosing or pro re nata ("PRN" or as needed) for the purpose of causing a general or non-specific blunt suppression of behavior (i.e., the effect of the medication results in a noticeable or discernible difference in the individual's ability to complete activities of daily living), or for the purpose of treating sexual offending behavior.

- a) A behavioral support strategy may include chemical restraint only when an individual's actions pose risk of harm or an individual engages in a precisely-defined pattern of behavior that is very likely to result in risk of harm.
 - b) A medication prescribed for the treatment of a physical or psychiatric condition in accordance with the standards of treatment for that condition and not for the purpose of causing a general or non-specific blunt suppression of behavior, is presumed to not be a chemical restraint.
 - c) "Chemical restraint" does not include a medication that is routinely prescribed in conjunction with a medical procedure for patients without developmental disabilities.
2. "County Board" means a county board of developmental disabilities.
 3. "Department" means the Ohio department of developmental disabilities.
 4. "Director" means the director of the Ohio department of developmental disabilities.
 5. "Emergency" means an individual's behavior presents an immediate danger of physical harm to the individual or another person or the individual being the subject of a legal sanction and all available positive measures have proved ineffective or infeasible.
 6. "Human rights committee" means a standing committee formed by a county board or an intermediate care facility for individuals with intellectual disabilities to safeguard individuals' rights and protect individuals from physical, emotional, and psychological harm. At an intermediate care facility for individuals with intellectual disabilities, the human rights committee may also be referred to as a "specially constituted committee" as that term is used in 42 C.F.R. 483.440.
 7. "Individual" means a person with a developmental disability.
 8. "Individual Service Plan" means the written description of services, supports, and activities to be provided to an individual and includes an "individual program plan" as that term is used in 42 C.F.R. 483.440.
 9. "Informed Consent" means a documented written agreement to allow a proposed action, treatment, or service after full disclosure provided in a manner the individual or his or her guardian understands, of the relevant facts necessary to make the decision. Relevant facts include the risks and benefits of the action, treatment, or service; the risks and benefits of the alternatives to the action, treatment, or service; and the right to refuse the action, treatment, or service. The individual or his or her guardian, as applicable, may withdraw informed consent at any time.

10. "Intermediate care facility for individuals with intellectual disabilities" has the same meaning as in section 5124.01 of the Revised Code.
11. "Manual restraint" means use of a hands-on method, but never in a prone restraint, to control an identified action by restricting the movement or function of an individual's head, neck, torso, one or more limbs, or entire body, using sufficient force to cause the possibility of injury and includes holding or disabling an individual's wheelchair or other mobility device.
 - a) A behavioral support strategy may include manual restraint only when an individual's actions pose risk of harm.
 - b) An individual in a manual restraint will be under constant visual supervision by staff.
 - c) Manual restraint will cease immediately once risk of harm has passed.
 - d) "Manual restraint" does not include a method that is routinely used during a medical procedure for patients without developmental disabilities.
12. "Mechanical restraint" means use of a device, but never in a prone restraint, to control an identified action by restricting an individual's movement or function.
 - a) A behavioral support strategy may include mechanical restraint only when an individual's actions pose risk of harm.
 - b) Mechanical restraint will cease immediately once risk of harm has passed.
 - c) "Mechanical restraint" does not include:
 - 1) A seatbelt of a type found in an ordinary passenger vehicle or an age appropriate child safety seat;
 - 2) A medically-necessary device (such as a wheelchair seatbelt or a gait belt) used for supporting or positioning an individual's body; or
 - 3) A device that is routinely used during a medical procedure for patients without developmental disabilities.
13. "Precisely-defined pattern of behavior" means a documented and predictable sequence of actions that if left uninterrupted, will very likely result in physical harm to self or others.
14. "Prohibited Measure" means a method that will not be used by persons or entities providing specialized services. "Prohibited measures" include:
 - a) Prone Restraint.
 - b) Use of a Manual Restraint or Mechanical Restraint that has the potential to inhibit or restrict an individual's ability to breathe or that is medically contraindicated.
 - c) Use of a manual restraint or mechanical restraint that causes pain or harm to an individual.
 - d) Disabling an individual's communication device.
 - e) Denial of breakfast, lunch, dinner, snacks, or beverages (excluding denial of snacks or beverages for an individual with primary polydipsia or a compulsive eating disorder attributed to a diagnosed condition such as "Prader-Willi Syndrome," and denial is based on specific medical treatment of the diagnosed condition and approved by the human rights committee).
 - f) Placing an individual in a room with no light.
 - g) Subjecting an individual to damaging or painful sound.

- h) Application of electric shock to an individual's body (excluding electroconvulsive therapy prescribed and administered by a physician as a clinical intervention to treat a diagnosed medical condition and administered by a physician or a credentialed advanced practice registered nurse).
 - i) Subjecting an individual to any humiliating or derogatory treatment.
 - j) Squirting an individual with any substance as an inducement or consequence for behavior.
 - k) Using any restrictive measure for punishment, retaliation, convenience of providers, or as a substitute for specialized services.
15. "Prone restraint" means a method of intervention where an individual's face and/or frontal part of an individual's body is placed in a downward position touching any surface for any amount of time.
16. "Provider" means any person or entity that provides specialized services.
17. "Qualified intellectual disability professional" has the same meaning as in 42 C.F.R. 483.430.
18. "Restrictive Measure" means a method of last resort that may be used by persons or entities providing specialized services only when necessary to keep people safe and with prior approval by the human rights committee in accordance with paragraph (G) this policy. "Restrictive measures" include:
- a) Chemical Restraint;
 - b) Manual Restraint;
 - c) Mechanical restraint
 - d) Rights restriction; and
 - e) Time-out.
19. "Rights restriction" means restriction of an individual's rights as enumerated in section 5123.62 of the Revised Code.
- a) A behavioral support strategy may include a rights restriction only when an individual's actions pose risk of harm or are very likely to result in the individual being the subject of a legal sanction such as eviction, arrest, or incarceration.
 - b) Absent risk of harm or likelihood of legal sanction, an individual's rights will not be restricted (e.g., by imposition of arbitrary schedules or limitation on consumption of tobacco products).
20. "Risk of harm" means there exists a direct and serious risk of physical harm to an individual or another person. For risk of harm:
- a) An individual must be capable of causing physical harm to self or others; and
 - b) The individual must be causing physical harm to self or others or very likely to begin doing so.
21. "Service and Support Administrator" means a person, regardless of title, employed by or under contract with a county board to perform the functions of service and support administration and who holds the appropriate certification in accordance with rule 5123:2-5-02 of the Administrative Code.

22. "Specialized services" means any program or service designed and operated to serve primarily individuals with developmental disabilities, including a program or service provided by an entity licensed or certified by the department. If there is a question as to whether a provider or entity under contract with a provider is providing specialized services, the provider or contract entity may request that the director make a determination. The director's determination is not subject to appeal.
23. "Team," as applicable, has the same meaning as in rule 5123-4-02 of the Administrative Code or means an "interdisciplinary team" as that term is used in 42 C.F.R. 483.440.
24. "Time-out" means confining an individual in a room or area and preventing the individual from leaving the room or area by applying physical force or by closing a door or constructing another barrier, including placement in such a room or area when a staff person remains in the room or area.
- a) A behavioral support strategy may include time-out only when an individual's actions pose risk of harm.
 - b) Time-out will not exceed thirty minutes for any one incident nor one hour in any twenty-four hour period.
 - c) A time-out room or area will not be key-locked, but the door may be held shut by a staff person or by a mechanism that requires constant physical pressure from a staff person to keep the mechanism engaged.
 - d) A time-out room or area will be adequately lighted and ventilated and provide a safe environment for the individual.
 - e) An individual in a time-out room or area will be protected from hazardous conditions including but not limited to, sharp corners and objects, uncovered light fixtures, or unprotected electrical outlets.
 - f) An individual in a time-out room or area will be under constant visual supervision by staff.
 - g) Time-out will cease immediately once risk of harm has passed or if the individual engages in self-abuse, becomes incontinent, or shows other signs of illness.
 - h) Time-out does not include periods when an individual, for a limited and specified time, is separated from others in an unlocked room or area for the purpose of self-regulation of behavior and is not physically restrained or prevented from leaving the room or area by physical barriers.

D. Development of a behavioral support strategy

1. The focus of a behavioral support strategy is the proactive creation of supportive environments that enhance an individual's quality of life by understanding and respecting the individual's needs and expanding opportunities for the individual to exercise choice, voice, and control through identification and implementation of positive measures such as:
 - a) Emphasizing alternative ways for the individual to communicate needs and to have needs met;
 - b) Adjusting the physical or social environment;
 - c) Addressing sensory stimulus;
 - d) Adjusting schedules; and

- e) Establishing trusting relationships.
2. A behavioral support strategy that includes restrictive measures requires:
 - a) Documentation that demonstrates that positive measures have been employed and have been determined ineffective.
 - b) An assessment conducted within the past twelve months that clearly describes:
 - 1) The behavior that poses risk of harm or likelihood of legal sanction or the individual's engagement in a precisely-defined pattern of behavior that is very likely to result in risk of harm;
 - 2) The level of harm or type of legal sanction that could reasonably be expected to occur with the behavior;
 - 3) When the behavior is likely to occur;
 - 4) The individual's interpersonal, environmental, medical, mental health, communication, sensory, and emotional needs; diagnosis; and life history including traumatic experiences as a means to gain insight into origins and patterns of the individual's actions; and
 - 5) The nature and degree of risk to the individual if the restrictive measure is implemented.
 - c) A description of actions to be taken to:
 - 1) Mitigate risk of harm or likelihood of legal sanction;
 - 2) Reduce and ultimately eliminate the need for restrictive measures; and
 - 3) Ensure environments where the individual has access to preferred activities and is less likely to engage in unsafe actions due to boredom, frustration, lack of effective communication, or unrecognized health problems.
 3. A behavioral support strategy will never include prohibited measures.
 4. Persons who conduct assessments and develop behavioral support strategies that include restrictive measures will:
 - a) Hold a valid license issued by the Ohio board of psychology;
 - b) Hold a valid license issued by the Ohio counselor, social worker and marriage and family therapist board;
 - c) Hold a valid physician license issued by the state medical board of Ohio; or
 - d) Hold a bachelor's or graduate-level degree from an accredited college or university and have at least three years of paid, full-time (or equivalent part-time) experience in developing and/or implementing behavioral support and/or risk reduction strategies or plans.
 5. A behavioral support strategy that includes restrictive measures will:
 - a) Be designed in a manner that promotes healing, recovery, and resilience;
 - b) Have the goal of helping the individual to achieve outcomes and pursue interests without the need for restrictive measures to ensure safety;
 - c) Describe tangible outcome and goals and how progress toward achievement of outcomes and goals will be identified;
 - d) Recognize the role environment has on behavior;
 - e) Capitalize on the individual's strengths to meet challenges and needs;
 - f) Delineate measures to be implemented and identify those who are responsible for implementation;
 - g) Specify steps to be taken to ensure the safety of the individual and others;

- h) As applicable, identify needed services and supports to assist the individual in meeting court-ordered community controls such as mandated sex offender registration, drug-testing, or participation in mental health treatment; and
 - i) As applicable, outline necessary coordination with other entities (e.g., courts, prisons, hospitals, and law enforcement) charged with the individual's care, confinement, or reentry to the community.
6. A behavioral support strategy that includes chemical restraint, manual restraint, or time-out will specify when and how the provider will notify the individual's guardian when such restraint is used.
7. When a behavioral support strategy that includes restrictive measures is proposed by an individual and the individual's team, the qualified intellectual disability professional or the service and support administrator, as applicable, will:
- a) Ensure the strategy is developed in accordance with the principles of person-centered planning and trauma informed care and is incorporated as an integral part of the individual service plan.
 - b) When indicated, seek input from persons with specialized expertise to address an individual's specific support needs.
 - c) Secure informed consent of the individual or the individual's guardian, as applicable.
 - d) Submit to the human rights committee the strategy and documentation, including the record of restrictive measures described in paragraph (F) (4) of this policy, based upon an assessment that clearly indicates:
 - 1) The justification for the proposed restrictive measure, that is:
 - (a) When manual restraint, mechanical restraint, or time-out is proposed -- risk of harm;
 - (b) When chemical restraint is proposed -- risk of harm or how the individual's engagement in a precisely-defined pattern of behavior is very likely to result in risk of harm; or
 - (c) When rights restriction is proposed -- risk of harm or how the individual's actions are very likely to result in the individual being the subject of a legal sanction.
 - 2) The nature and degree of risk to the individual if the restrictive measure is implemented.
 - e) Ensure the strategy is reviewed and approved in accordance with paragraph (G) of this policy prior to implementation and whenever the behavioral support strategy is revised to add restrictive measures.
 - f) Ensure the strategy is reviewed by the individual and the individual's team at least every ninety calendar days or more frequently when specified by the human rights committee to determine and document the effectiveness of the strategy and whether the strategy should be continued, discontinued, or revised.
 - 1) The review will consider:
 - (a) Numeric data on changes in the severity or frequency of behaviors that had been targeted for reduction due to a threat to safety or wellbeing;
 - (b) New skills that have been developed which have eliminated or mitigated threats to safety or wellbeing;
 - (c) The individual's self-report of overall satisfaction in achieving desired outcomes and pursuing interests; and

- (d) Observations by paid staff and/or natural supports as they relate to safety or wellbeing and the individual's achievement of desired outcomes and pursuit of interests.
- 2) When a manual restraint has been used in the past ninety calendar days, the review will include seeking the perspective of the individual and at least one direct support professional involved in use of the manual restraint regarding why the manual restraint occurred and what could be done differently in the future to avoid manual restraint.
- 3) A decision to continue the strategy will be based upon review of up-to-date information justifying the continuation of the strategy.

E. Reconsideration of a medication initially presumed to not be a chemical restraint

1. When administration of a medication initially presumed to not be a chemical restraint in accordance actually results in a general or non-specific blunt suppression of behavior, the provider is to alert the individual's qualified intellectual disability professional or service and support administrator, as applicable. The qualified intellectual disability professional or the service and support administrator is to ensure the prescriber of the medication and the individual's team are notified.
 - a) The prescriber of the medication may adjust the medication (type or dose) in an effort to abate the general or non-specific blunt suppression of behavior.
 - b) When the prescriber of the medication is not inclined to adjust the medication, the individual's team is to meet to consider what actions may be necessary (e.g., seeking an opinion from a different prescriber or introducing activities that may mitigate the impact of the medication on the individual's ability to complete activities of daily living).
2. When a medication (as originally administered or as adjusted) continues to cause a general or non-specific blunt suppression of behavior beyond thirty calendar days, the medication is to be regarded as a chemical restraint and submitted to the human rights committee.

F. Implementation of behavioral support strategies with restrictive measures

1. Restrictive measures will be implemented with sufficient safeguards and supervision to ensure the health, welfare, and rights of individuals receiving specialized services.
2. Each person providing specialized services to an individual with a behavioral support strategy that includes restrictive measures will successfully complete training in the strategy prior to serving the individual.
3. After each incidence of manual restraint, a provider will take any measures necessary to ensure the safety and wellbeing of the individual who was restrained, individuals who witnessed the manual restraint, and staff and minimize traumas for all involved.
4. Each provider will maintain a record of the date, time, and antecedent factors regarding each event of a restrictive measure other than a restrictive measure that is

not based on antecedent factors (e.g., bed alarm or locked cabinet). The record for each event of a manual restraint or a mechanical restraint will include the duration. The provider will share the record with the individual or the individual's guardian, as applicable, and the individual's team whenever the individual's behavioral support strategy is being reviewed or reconsidered.

G. Establishment of Human Rights Committees

1. The Clinton County Board of Developmental Disabilities (CCBDD) and each intermediate care facility for individuals with intellectual disabilities will actively participate in an established human rights committee. A human rights committee may be established by the CCBDD or an intermediate care facility for individuals with intellectual disabilities acting independently or jointly in collaboration with one or more other county boards and/or intermediate care facilities for individuals with intellectual disabilities.

The human rights committee will:

- a) Be comprised of at least four persons;
 - b) Include at least one individual who receives or is eligible to receive specialized services;
 - c) Include qualified persons who have either experience or training in contemporary practices for behavioral support; and
 - d) Reflect a balance of representatives from each of the following two groups:
 - 1) Individuals who receive or are eligible to receive specialized services or family members or guardians of individuals who receive or are eligible to receive specialized services; and
 - 2) County boards, intermediate care facilities for individuals with intellectual disabilities, or other providers, or other professionals.
2. All information and documents provided to the human rights committee and all discussions of the committee are confidential and will not be shared or discussed with anyone other than the individual, the individual's guardian, and the individual's team.
 3. Members of the human rights committee will receive department-approved training within three months of appointment to the committee in:
 - a) Rights of individuals as enumerated in section 5123.62 of the Revised Code;
 - b) Person-centered planning;
 - c) Informed consent;
 - d) Confidentiality; and
 - e) The requirements of this policy.
 4. Members of the human rights committee will annually receive department approved training in relevant topics which may include but are not limited to:
 - a) Self-advocacy and self-determination;
 - b) Role of guardians and section 5126.043 of the Revised Code;
 - c) Effect of traumatic experiences on behavior; and
 - d) Court-ordered community controls and the role of the court, the county board or intermediate care facility for individuals with intellectual disabilities, and the human rights committee.

H. Review of behavioral support strategies that include restrictive measures

There are two distinct processes for review of behavioral support strategies that include restrictive measures based on the nature of the request:

1. Emergency request
 - a) An emergency request for a behavioral support strategy that includes restrictive measures will consist of:
 - 1) A description of the restrictive measures to be implemented;
 - 2) Documentation of risk of harm or legal sanction which demonstrates the situation is an emergency;
 - 3) A description of positive measures that have been implemented and proved ineffective or infeasible;
 - 4) Any medical contraindications; and
 - 5) Informed consent by the individual or the individual's guardian, as applicable.
 - b) Prior to implementation of a behavioral support strategy submitted via the emergency request process, the strategy must be approved by:
 - 1) A quorum of members of the human rights committee in accordance with 42 C.F.R. 483.440 for an individual who resides in an intermediate care facility for individuals with intellectual disabilities; or
 - 2) The Superintendent of the CCBDD or the Superintendent's designee for an individual who does not reside in an intermediate care facility for individuals with intellectual disabilities.
 - c) A behavioral support strategy approved via the emergency request process may be in place for a period not to exceed forty-five calendar days. Continuation of the strategy beyond the initial forty-five calendar days requires approval by the human rights committee in accordance with the process for a routine request described in paragraph (H)(2) of this policy.
2. Routine request
 - a) Absent an emergency, a human rights committee will review a request to implement a behavioral support strategy that includes restrictive measures
 - b) An individual or the individual's guardian, as applicable, is to be notified at least seventy-two hours in advance of the date, time, and location of the human rights committee meeting at which the individual's behavioral support strategy will be reviewed. The individual or guardian has the right to attend to present related information in advance of the human right committee commencing its review.
 - c) In its review of an individual's behavioral support strategy, the human rights committee is to:
 - 1) Ensure that the planning process outlined in this policy has been followed and that the individual or the individual's guardian, as applicable, has provided informed consent.
 - 2) Ensure that the proposed restrictive measures are necessary to reduce risk of harm or likelihood of legal sanction.
 - 3) When indicated, seek input from persons with specialized expertise to address an individual's specific support needs.

- 4) Ensure that the overall outcome of the behavioral support strategy promotes the physical, emotional, and psychological wellbeing of the individual while reducing risk of harm or likelihood of legal sanction.
 - 5) Ensure that a restrictive measure is temporary in nature and occurs only in specifically-defined situations based on:
 - (a) Risk of harm for manual restraint, mechanical restraint, or timeout;
 - (b) Risk of harm or an individual's engagement in a precisely defined pattern of behavior that is very likely to result in risk of harm for chemical restraint; or
 - (c) Risk of harm or likelihood of legal sanction for a rights restriction.
 - 6) Verify that any behavioral support strategy that includes restrictive measures also incorporates positive measures designed to enable the individual to feel safe, respected, and valued while emphasizing choice, self-determination, and an improved quality of life.
 - 7) Determine the period of time for which a restrictive measure is appropriate and may approve a strategy that includes restrictive measures for any number of days not to exceed three hundred sixty-five.
 - 8) Approve in whole or in part, reject in whole or in part, monitor, and when indicated, reauthorize behavioral support strategies that include restrictive measures.
 - 9) Communicate the committee's determination including an explanation of its rejection of a strategy in writing to the qualified intellectual disability professional or service and support administrator that submitted the request for approval.
- d) The qualified intellectual disability professional or service and support administrator will communicate in writing to the individual or individual's guardian, as applicable, the determination of the human rights committee including an explanation of rejection of a strategy as well as the individual's or guardian's right to seek reconsideration when the human rights committee rejects a strategy.
- e) An individual or the individual's guardian, as applicable, may seek reconsideration of rejection by the human rights committee of a strategy that includes restrictive measures by submitting the request for reconsideration with additional information provided as rationale for the request to the qualified intellectual disability professional or service and support administrator, as applicable, in writing within fourteen calendar days of being informed of the rejection. The qualified intellectual disability professional or service and support administrator is to forward the request to the human rights committee within seventy-two hours. The human rights committee will consider the request for reconsideration and respond in writing to the individual or guardian within fourteen calendar days of receiving the request.
- f) An individual who resides in an intermediate care facility for individuals with intellectual disabilities or the individual's guardian, as applicable, may appeal to the facility's specially constituted committee in accordance with the facility's procedure if the individual or guardian, as applicable, is dissatisfied with the strategy or the process used for development of the strategy.

- g) An individual who does not reside in an intermediate care facility for individuals with intellectual disabilities or the individual's guardian, as applicable, may seek administrative resolution in accordance with rule 5123-4-04 of the Administrative Code if the individual or guardian is dissatisfied with the strategy or the process used for development of the strategy.

I. Use of a restrictive measure without prior approval

1. Nothing in this policy will be construed to prohibit or prevent any person from intervening in a crisis situation as necessary to ensure a person's immediate health and safety.
2. Use of a restrictive measure, including use of a restrictive measure in a crisis situation (e.g., to prevent an individual from running into traffic), without prior approval in accordance with paragraph (G) of this policy will be reported as "unapproved behavioral support" in accordance with rule 5123-17-02 of the Administrative Code.

J. Reporting of behavioral support strategies that include restrictive measures

The CCBDD will enter information regarding behavioral support strategies that include restrictive measures in the department's restrictive measures notification system. Corresponding entries are to be made:

1. After securing approval in accordance with paragraph (G) of this policy and prior to implementation of a behavioral support strategy that includes restrictive measures; and
2. When a restrictive measure is discontinued.

K. Analysis of behavioral support strategies that include restrictive measures

1. The CCBDD will annually compile and analyze aggregate data regarding behavioral support strategies that include restrictive measures and furnish the data and analyses to the human rights committee by **March fifteenth** of each year for the preceding calendar year. Data compiled and analyzed will include, but are not limited to:
 - a) Nature and frequency of risk of harm or likelihood of legal sanction that triggered development of strategies that include restrictive measures;
 - b) Number of strategies that include restrictive measures by type of restrictive measure (i.e., chemical restraint, manual restraint, mechanical restraint, rights restriction, and time-out) reviewed, approved, rejected, and reauthorized in accordance with this policy;
 - c) Number of restrictive measures by type of restrictive measure (i.e., chemical restraint, manual restraint, mechanical restraint, rights restriction, and time-out) implemented;
 - d) Number of strategies that include restrictive measures that have been discontinued and the reasons for discontinuing the strategies; and
 - e) An in-depth review and analysis of either:
 - 1) Trends and patterns regarding strategies that include restrictive measures for purposes of determining methods for enhancing risk reduction efforts and

outcomes, reducing the frequency of restrictive measures, and identifying technical assistance and training needs; or

- 2) A sample of implemented strategies that include restrictive measures for purposes of ensuring that strategies are developed, implemented, documented, and monitored in accordance with this policy.
2. The CCBDD will make the data and analyses available to the department upon request.

L. Department oversight

1. The department will take immediate action as necessary to protect the health and welfare of individuals which may include, but is not limited to:
 - a) Suspension of a behavioral support strategy not developed, implemented, documented, or monitored in accordance with rule 5123-2-06 or where trends and patterns of data suggest the need for further review;
 - b) Provision of technical assistance in development or redevelopment of a behavioral support strategy; and
 - c) Referral to other state agencies or licensing bodies, as indicated.
2. The department will compile and analyze data regarding behavioral support strategies for purposes of determining methods for enhancing risk reduction efforts and outcomes, reducing the frequency of restrictive measures, and identifying technical assistance and training needs. The department will make the data and analyses available.
3. The department may periodically select a sample of behavioral support strategies for review to ensure that strategies are developed, implemented, documented, and monitored in accordance with rule 5123-2-06.
4. The department will conduct reviews of county boards and providers as necessary to ensure the health and welfare of individuals and compliance with rule 5123-2-06. Failure to comply with rule 5123-2-06 may be considered by the department in any regulatory capacity, including certification, licensure, and accreditation.

M. Waiving provisions of rule 5123-2-06 and this policy

1. For good cause, the director of the Ohio Department of Developmental Disabilities may waive a condition or specific requirement of rule 5123-2-06 except that the director will not permit use of a prohibited measure. The director's decision to waive a condition or specific requirement of rule 5123-2-06 will not be contrary to the rights, health, or safety of individuals receiving services. The director's decision to grant or deny a request is not subject to appeal.

DEVELOPMENT AND IMPLEMENTATION OF BEHAVIORAL SUPPORT STRATEGIES

A. Contractual agreement for behavioral support services

1. The Clinton County Board of Developmental Disabilities (CCBDD) has a contractual agreement with the Southwestern Ohio Council of Government (SWOCOG) to provide Behavioral Support services to individuals served. The Behavioral Specialists through this agreement may complete the following on behalf of the CCBDD:
 - a) Observations of individuals served for the purpose of developing behavioral strategies;
 - b) Complete behavioral assessments and other applicable assessments initially, annually, or as needed;
 - c) Develop behavioral support strategies including restrictive measures;
 - d) Develop outcomes for the individual service plan related to the behavioral support strategies;
 - e) Attend and participate in the Human Rights Committee (HRC) meetings; and
 - f) Provide training to CCBDD employees and Providers of service prior to strategies being implemented.
2. The CCBDD through the SWOCOG contractual agreement will utilize the Human Rights Committee established and maintained by the Warren County Board of DD to review, approve, or reject all plans with restrictive measures prior to implementation.
3. The contractual agreement is available at the CCBDD Administrative Office and through the SWOCOG, with renewals being completed annually, or as specified in the agreement.
4. The CCBDD is responsible for ensuring that services provided through the contractual agreement are in accordance with Administrative Rule 5123-2-06.

B. Implementation of behavioral support strategies including those with restrictive measures

1. If /when an individual and/or their team requests behavioral supports services, the assigned Service and Support Administrator (SSA) will complete the SWOCOG behavior support referral form.
2. If the SWOCOG agrees to providing services, the case will be assigned to a Behavioral Specialist.

3. The Behavioral Specialist and the SSA will coordinate the completion of observations and applicable assessments with the individual or the individual's guardian.
4. After the observations and assessments are complete, the Behavioral Specialist will submit all recommendations including but not limited to: behavioral support strategies, restrictive measures, and outcomes, in writing to the assigned SSA.
5. The SSA will present the recommendations made by the Behavioral Specialist to the individual and the individual's team for review and approval.
6. The SSA will incorporate the agreed upon behavioral support strategies, restrictive measures, and outcomes into the Individual Service Plan (ISP).
7. If the team agrees to any restrictive measures recommended by the Behavioral Specialist; the Behavioral Specialist and the SSA will present the behavioral strategies that have been incorporated into the ISP, to the Human Rights Committee (HRC) for review and approval through the contractual agreement with the SWOCOG as indicated in paragraph A of this procedure.

C. Individual service plan timelines

Behavioral support strategies including those with restrictive measures must be incorporated as an integral part of an ISP. The timeline for development of the ISP is as follows:

1. **120 days prior to the effective date:** The behavior assessment will be initiated by the SWOCOG Behavior Specialist.
2. **60- 90 days prior to the effective date:** The individual's team meeting will be scheduled.
3. **45-60 days prior to the effective date:** The behavior assessment will be finalized by the SWOCOG Behavior Specialist. The Behavioral Specialist will submit recommendations in writing to the SSA.
4. **A minimum of 45 days prior to the effective date:** If the ISP contains restrictive measures, the SSA and the SWOCOG Behavior Specialist will present the ISP to the HRC for approval prior to implementation.
5. **30 days prior to the effective date:** The SSA will coordinate a date and time for all direct care staff responsible for implementation to be trained on the ISP with the SWOCOG Behavior Specialist and the provider(s). Documentation of the training

including but not limited to: the date and time of the training and the names of those in attendance will be attached to the ISP and maintained on file with the CCBDD.

6. **15 - 30 days prior to the effective date:** The ISP will be forwarded to all team members.
7. **5 days prior to the effective date:** The assigned SSA will complete the Restrictive Measure Notification (RMN) form through the Ohio Department of Developmental Disabilities website. The RMN form will be maintained on file with the CCBDD.
8. The ISP will be implemented on the effective span date by all service providers.
9. The SSA will coordinate a meeting with the individual, the individual's team, and the Behavioral Specialist, every ninety days to review ISP's that include restrictive measures. Documentation from the team meeting including but not limited to, those in attendance and meeting minutes will be maintained on file at the CCBDD.
10. The SSA and the Behavioral Specialist will provide a summary every ninety days to the HRC regarding the progress made, implementation concerns, recommendations for revisions, and/or recommendations for fading strategies/restrictive measures.

Reference: OAC 5123: 2-2-06; OAC 5123:2-17-02

Revised: 06/21/2022

COMPLIANCE AND QUALITY ASSESSMENT REVIEWS

- A. To ensure that individuals receive high quality services, the county board is committed to implementing an effective quality assessment and continuous improvement process that consists of both formal and informal activities.
- B. The county board may contract with the Southern Ohio Council of Governments (SOCOG) for the provision of Provider Compliance reviews and Quality Assessment reviews.
- C. A Provider Compliance review is a review of a certified provider conducted by DODD, or a county board or contracted entity for the purpose of determining provider compliance with applicable requirements in order to ensure the health, safety, and welfare of individuals served per OAC 5123:2-2-04.
- D. The county board may contract with the SOCOG for a registered nurse, a registered nurse instructor, or a registered nurse trainer who will serve as a quality assessment registered nurse to assist with completing Quality Assessment reviews, for consultation and oversight.
- E. In accordance with OAC 5123:2-6-07, quality assessment reviews will be conducted when certified developmental disabilities personnel perform health-related activities, administer oral prescribed medication, administer topical prescribed medication, administer topical over-the-counter musculoskeletal medication, administer oxygen, or administer metered dose inhaled medication.
- F. Quality assessment reviews and reports will be completed in a format prescribed by DODD.
- G. The registered nurse will evaluate for patterns of failure to comply or maintain compliance with OAC 5123:2-6-07.
- H. The registered nurse will act as a resource for the county board and providers of services concerning health management issues and may assist in expanding health care services in the community.
- I. When a registered nurse receives a complaint or identifies concerns based on a quality assessment review; the registered nurse will conduct an initial investigation which will include a discussion with developmental disabilities personnel and his or her employer. After completing the initial investigation, the registered nurse will contact and work with the department's designee to ensure that cases are handled in a consistent manner statewide.

- J. The county board will cooperate fully with reviewers from local, state, and federal entities.

COMPLIANCE AND QUALITY ASSESSMENT REVIEWS

- A. The purpose of this procedure is to outline guidelines followed for Provider Compliance (OAC 5123:2-2-04) and Quality Assessment reviews (OAC 5123:2-6-07).
- B. Provider Compliance reviews can be conducted by DODD, the CCBDD, or a contracted entity. Provider Compliance reviews may include: routine, special and abbreviated reviews.
 - 1. The outcomes from a Provider Compliance review are shared with the Provider in accordance with OAC 5123: 2-2-04.
 - 2. If a Provider Compliance review requires a Plan of Improvement, the Provider will be notified by DODD, the CCBDD, or a contracted entity per OAC 5123: 2-2-04
 - 3. The Provider is responsible for submitting the Plan of Improvement to DODD, the CCBDD or the contracted entity per the timelines outlined in OAC 5123: 2-2-04.
- C. Quality assessment reviews will be conducted by a CCBDD registered nurse or a contracted registered nurse when certified developmental disabilities personnel perform health-related activities, administer oral prescribed medication, administer topical prescribed medication, administer topical over-the-counter musculoskeletal medication, administer oxygen, or administer metered dose inhaled medication for individuals who:
 - 1. Receive services from certified supported living providers;
 - 2. Receive residential support services from certified HCBS providers, if the services are received in a community living arrangement that includes four (4) or fewer individuals;
 - 3. Receive adult services in a setting where sixteen (16) or fewer individuals receive services; and
 - 4. Reside in residential facilities of five (5) or fewer beds, excluding intermediate care facilities for individuals with intellectual disabilities.
- D. The registered nurse will complete quality assessment reviews at least once every three (3) years for each provider location in the county where certified developmental disabilities personnel perform: health-related activities, administer oral prescribed medication, administer topical prescribed medication, administer topical over-the-counter musculoskeletal medication, administer oxygen, or administer metered dose inhaled medication.
- E. The registered nurse may conduct more frequent reviews if the registered nurse, CCBDD, provider, or DODD determines there are issues to warrant such.
- F. Quality assessment reviews and reports will include, but are not limited to:
 - 1. Observation of performance of health-related activities and administration of prescribed medication;
 - 2. Review of the system of communication and supports related to performance of health-related activities and administration of prescribed medication to ensure complete and accurate administration of health care directives given by health care professionals;
 - 3. Review of documentation of performance of health-related activities and administration of prescribed medication for completeness and for documentation of appropriate actions taken based on rule 5123:2-6-06 of the OAC;

4. Review of all medication/treatment errors from the past twelve months; and
5. Review of the processes and procedures used by the agency or independent provider to monitor and document completeness and correct techniques used when performing health-related activities, administering oral prescribed medication, and administering topical prescribed medication.

G. Requirements for reporting medication/treatment errors:

1. Any medication/treatment error in the performance of health-related activities, administration of oral prescribed medication, or administration of topical prescribed medication that results in physical harm will be immediately reported to an appropriate licensed health care professional. The requirement to immediately report medication/treatment errors applies to errors involving prescribed medication, treatments, over-the-counter medication, and health-related activities.
2. Any medication/treatment error by developmental disabilities personnel will be reported in accordance with rule 5123:2-17-02 of the OAC when the medication/treatment error meets the definition of major unusual incident or unusual incident.
3. All medication/treatment errors will be documented in an unusual incident report in accordance with OAC 5123:2-17-02.

H. The registered nurse will provide the quality assessment report to the CCBDD and the provider of services within ten (10) business days of the review.

1. The report will identify findings specific to section F (1-5) above, and the registered nurse may recommend to the CCBDD and the provider of services steps to take to improve the systems and procedures used by the provider for improving tasks related to the performance of health-related activities and the administration of prescribed medication to maintain compliance with OAC 5123:2-6-07.
2. The registered nurse will coordinate with the CCBDD, the agency or independent provider to ensure that safety concerns are immediately addressed.
3. The CCBDD, the agency or the independent provider will submit a written Plan of Improvement to the registered nurse that addresses specific rule violations identified in the quality assessment review within thirty (30) calendar days of receipt of the report:
 - a. If/when a Plan of Improvement is required; the SSA will list the areas requiring a Plan of Improvement on the MAQA Plan of Improvement form. The SSA will send the form to the Provider requesting that a Plan of Improvement be completed and returned to the SSA.
 - b. The Provider must complete their Plan of Improvement within fifteen (15) calendar days after receipt of the MAQA Report. Upon completion, the Provider will return the Plan of Improvement form along with any supporting documentation to the SSA for review.
 - c. The SSA will complete the MAQA follow-up report for all MAQA's within thirty (30) calendar days after receipt of the MAQA.
 - d. If applicable, the SSA and the Provider will ensure that the Plan of Improvement has been submitted to the registered nurse within thirty (30) calendar days of receipt of the MAQA Report.
4. Upon receipt of a MAQA report that does not require a Plan of Improvement the SSA will:

- a. Complete the Co. Bd. Follow-up Report within thirty (30) calendar days of receipt.
 - b. Identify any recommendations based upon best practices, and how those recommendations will be addressed.
 5. The MAQA Report, the Provider's Plan of Improvement if applicable, the Co. Bd. Follow-up Report, and any applicable documentation will be forwarded to the SSA Manager/SSD for final review.
 6. The SSA Manager/SSD will then forward the completed MAQA and all applicable documentation to the SSA Secretary for filing/scanning into the Individual's file.
- I. The registered nurse will notify the CCBDD and the department when the agency or the independent provider fails to:
1. Submit a written Plan of Improvement within sixty (60) calendar days of receipt of the report; or
 2. Successfully implement the written Plan of Improvement within sixty (60) calendar days of submission of the plan to the registered nurse.
- J. Prohibition on performance of health-related activities and administration of prescribed medication:
1. If an agency provider is notified by the CCBDD, the department, a delegating nurse, or the quality assessment registered nurse that an employee has not or will not safely perform health-related activities or administer prescribed medication, the agency provider will prohibit the action from continuing or commencing. Employees of an agency provider will not engage in the action or actions subject to an employer's prohibition.
 2. When the agency provider prohibits the action from continuing or commencing, the agency will:
 - a. Notify the employee of the prohibition and immediately make other staffing arrangements so that the needs of individuals served are met in a manner that ensures compliance with OAC 5123:2-6-07;
 - b. Immediately notify DODD by making a notation regarding the prohibition of the employee in the medication administration information system database;
 - c. If applicable, immediately notify the CCBDD via the major unusual incident reporting system in accordance with OAC 5123:2-17-02; the CCBDD, as applicable, will notify the registered nurse; and
 - d. If applicable, immediately notify the delegating nurse.
 3. The agency provider will ensure corrective action is taken prior to allowing an employee to resume the performance of health-related activities or the administration of prescribed medication.
 4. The agency provider will notify the department by making an entry regarding the corrective action and end of prohibition for the employee in the medication administration information system database and, as applicable, notify the CCBDD, the registered nurse, and/or the delegating nurse of the corrective action taken.

Reference: OAC 5123:2-6-07; 5123:2-6-06; OAC 5123:2-17-02; OAC 5123:2-2-04
 Revised: 05/02/2022

**PRE-ADMISSION SCREENING AND RESIDENT REVIEW
FOR NURSING FACILITY APPLICANTS AND NURSING FACILITY RESIDENTS
WITH DEVELOPMENTAL DISABILITIES**

In accordance with the Ohio Administrative Code 5123:2-14-01, the SSA Department of the Clinton County Board of DD (CCBDD) will participate in the PASRR (Preadmission Screening and Resident Review) evaluation process for individuals seeking admission to a nursing facility (NF) who have indications of developmental disabilities (DD), residents of a NF who have indications of DD, and persons acting on behalf of these applicants or residents.

The PASRR is a federal requirement to help ensure that individuals are not inappropriately placed in a Medicaid Certified nursing facility for long term care unless it is the “least restrictive setting” possible. The purpose of the PASRR evaluation is to determine whether an individual is eligible for admission to a NF or eligible to continue to receive services in a NF.

If determined necessary, specialized services will be provided or arranged for by the CCBDD to ensure continuous active treatment. No one who has indications of DD will move into a NF in Ohio until the PASRR determinations have been made by DODD.

- A. Adverse Determination means a determination made in accordance with rules 5160-3-15.1, 5160-3-15.2, 5122-21-03 and 5123:2-14-01 of the Administrative Code, that an individual does not require the level of services provided by a NF. An adverse determination that an individual does not require NF services will include:
1. A face-to-face assessment of the individual performed by a Service and Support Administrator or other professional as outlined in 5123:2-14-01.
 2. Authorized personnel from DODD and/or the Ohio Department of Mental Health and Addiction Services (MHAS), other than the personnel identified above who conducted the face-to-face assessment, will review the assessment and make the final determination regarding the need for NF services and specialized services for DD.
- B. Preadmission Screening means the preadmission portion of the PASRR requirements mandated by section 1919(e) (7) of the Social Security Act, which must be implemented in accordance rule 5123:2-14-01 and rules 5160-3-15.1 and 5122-21-03 of the Administrative Code.
1. The Preadmission screening for developmental disabilities (PAS-DD), also known as a level two screen means the process by which DODD determines:
 - a. Whether, due to the individual’s physical and mental condition, an individual who has developmental disabilities requires the level of services provided by a NF or another type of setting; and

- b. When the level of services provided a NF is needed, whether the individual requires specialized services for DD.

- C. Categorical Determination (completed by DODD) means a preadmission screening for developmental disabilities (PAS-DD) determination, which may be made for an individual with DD without first completing a full PASRR evaluation when the individual's circumstances fall within one of the following two categories:
 - 1. The individual requires an 'emergency nursing facility stay', as defined in the Ohio Administrative Code (OAC) 5160-3-15, or
 - 2. The individual is seeking admission to a NF for a 'respite nursing facility stay' as defined in the OAC 5160-3-15.

- D. Resident Review (RR) means the resident review portion of the PASRR requirements mandated by section 1919 (e) (7) of the Social Security Act, which must be implemented in accordance with rule 5123:2-14-01 and rules 5160-3-15.2 and 5122-21-03 of the Administrative Code.
 - 1. The Resident Review (RR) for developmental disabilities (DD) means the process as set forth in rule 5123:2-14-01, by which DODD determines whether, due to the individual's physical and mental condition, an individual who is subject to resident review, and who has DD, requires the level of services provided by a NF, or another type of setting and whether the individual requires specialized services.

- E. Ruled out means that the individual has been determined not to be subject to further review by DODD or MHAS. An individual may be ruled out for further PASRR review at any point in the PASRR process. When DODD or MHAS finds at any time during the evaluation that the individual being evaluated:
 - 1. Does not have a developmental disability or serious mental illness; or
 - 2. Has a primary diagnosis of dementia (including Alzheimer's disease or a related disorder) which is not acute or due to another medical condition; or
 - 3. Has a non-primary diagnosis of dementia without a primary diagnosis that is serious mental illness and does not have a diagnosis of developmental disabilities or a related condition.

- F. Specialized services for DD means the services or supports identified through the level two screen component of the PASRR. Specialized services will be provided or arranged by the county board. Individuals determined through the processes set forth in rule 5123: 2-14-01 to require specialized services for DD will not be placed on a waiting list for such services. Specialized services for DD will be:
 - 1. Individualized;

2. Based on a person-centered assessment, rather than determined categorically based on disability or diagnosis;
 3. Made available at the frequency and intensity required to address the individual's specific needs in each of the areas of major life activity (i.e., self-care, understanding and use of language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency) for which functional limitations have been identified; and
 4. Unique services; not otherwise available through the routine, rehabilitative services provided by a NF; examples may include non-medical supports, such as habilitation or long-term daily living supports.
- G. Referral for PAS-DD
1. Referral requests will be forwarded to the county board of the county in which the request is initiated. When the county in which the request is initiated is not the county in which the individual resides and/or the county where the NF is located, notification will also be made to the county board of the county in which the individual resides and the county board of the county where the NF is located. The county board, in which the request is initiated, will be responsible for completing the review and collaborating with the other county boards to agree on a recommendation.
 - a. The PAS-DD must be completed by the county board:
 - (i) Within seven business days of receipt of the referral by the Ohio Department of Medicaid or its designee of an individual for PASRR, the county board will gather data, complete an evaluation, and submit its recommendations in the form of a written evaluative report to DODD regarding whether the individual has DD and whether NF services and specialized services for DD are required.
 - (ii) The county board will be responsible for requesting any information necessary to make the PAS-DD evaluation and recommendations. The evaluation will be based on relevant data that are valid, accurate, and reflect the current functional status of the individual.
 - (iii) Persons completing the PAS-DD evaluations will not have a direct or indirect affiliation with a NF.
 - (iv) PAS-DD evaluations will involve the individual being evaluated, the individual's guardian, and the individual's family if available and if the individual or guardian agrees to family participation.
 - (v) PAS-DD evaluations will be adapted to the cultural background, language, ethnic origin, and means of communication used by the individual.
 5. The PAS-DD evaluation has three components:
 - a. A DD assessment that is based on the following documentation: Intellectual functioning as measured by a psychologist or other related condition(s) as

identified by a physician, and a determination of whether the individual meets DD eligibility criteria pursuant to section 5123.01 of the Revised Code.

- b. A NF needs assessment that is based upon an evaluation of written documentation which includes the following:
 - (i) The history and physical examination performed by a registered nurse, a clinical nurse specialist, a certified nurse practitioner, a person registered by the state medical board as a physician assistant under Chapter 4730 of the Revised Code, or a physician. If someone other than a physician performs the history and physical examination, a physician will review and concur with the conclusions. If a clinical nurse specialist performs the history and physical examination or a certified nurse practitioner who has entered into a standard care arrangement with a collaborative physician in accordance with section 4723.431 of the Revised Code, physician review is only required as indicated in the standard care arrangement.
 - (ii) Current nursing care needs.
 - (iii) Current medications
 - (iv) Current functional status including any therapy assessments and reports (i.e. physical therapy, speech therapy, occupational therapy, or respiratory therapy).
 - (v) Current social history, including current living arrangement prior to admission and any medical problems, including their impact on the individual's independent functioning.
 - c. The county board will complete a specialized DD needs assessment and recommend whether the individual currently has a need for specialized services for DD. The county board will document, in a format prescribed by DODD, the recommendation, the type of specialized services for DD to be provided, and who will provide the specialized services. When a determination is made to admit, or to allow an individual who requires specialized services to remain in a NF, the determination will be supported by assurances that the specialized services will be provided while the individual resides in the NF.
- H. If the individual does not meet DD eligibility criteria, no further review by the county board is required; the county board will submit documentation and a recommendation to DODD that the individual be ruled out (refer to paragraph E above).
- I. The county board will submit its recommendations in the form of a written evaluative report to DODD regarding whether the individual has DD and whether NF services and specialized services for DD are required. The report will:
1. Identify the name and professional title of the persons who performed the evaluations and the dates upon which the evaluations were performed;
 2. Provide a summary of the evaluated individual's medical and social history;

3. If NF services are recommended, identify the services which are required to meet the evaluated individual's needs;
 4. Identify whether specialized services for DD are needed;
 5. Include the basis for the report's conclusions; and
 6. Include copies of the documentation gathered and reviewed in accordance with sections (G)(2) of this policy.
- J. DODD may request additional information when necessary to make a determination.
- K. Within two business days of receipt of the county board's recommendations and documentation, DODD will determine:
1. Whether the individual has DD.
 2. Whether the individual requires the level of services provided by a NF based on a comprehensive analysis of all data and consideration of the most appropriate placement such that the individual's needs for treatment do not exceed the level of services that can be delivered in the NF.
 3. Whether the individual requires specialized services for DD.
- L. DODD will issue a determination in the form of a written report in accordance with rule 5123:2-14-01.
- M. One of two outcomes of the PAS-DD review is possible:
1. The individual requires the level of services provided by a NF and therefore may be admitted to a NF.
 2. The individual does not require the level of services provided by a NF, and therefore will not be admitted. The county board will assist the individual and/or his or her guardian with alternative placement options, services, and resources as necessary to ensure the health and welfare of the individual.
- N. PAS-DD for individuals being directly admitted to a NF from a Psychiatric Hospital
1. DODD or its designee will complete a written evaluative report regarding:
 - a. Whether the individual has DD;
 - b. Whether the individual requires the level of services provided by a NF based on a comprehensive analysis of all data and consideration of the most appropriate placement such that the individuals needs for treatment do not exceed the level of services that can be delivered in a NF; and

- c. Whether the individual requires specialized services for DD.
- 2. DODD will issue a determination in the form of a written report in accordance with rule 5123:2-14-01.

O. Resident Review (RR) for DD

- 1. The NF will submit the RR identification to DODD in accordance with 5160-3-15.2 of the Administrative Code.
- 2. Upon receipt of the RR, DODD will notify the county board.
- 3. Within seven business days of notification by DODD, the county board will gather data, complete an evaluation, and submit its recommendations and documentation to DODD in accordance with rule 5123:2-14-01.
- 4. Within two business days of receipt of the county board's recommendations and documentation, DODD will determine whether the individual has DD, whether the individual requires the level of services provided by a NF, and whether the individual requires specialized services for DD in accordance with rule 5123:2-14-01.
- 5. Possible outcomes of the RR for DD include:
 - a. A NF resident with DD who is determined to require the level of services provided by a NF may continue to reside in the NF.
 - b. A NF resident with DD who is resided in a NF for thirty months or longer who is determined not to require the level of services provided by a NF, but does require specialized services for DD, may choose to continue to reside in the NF or receive covered services in an alternative setting. DODD will inform the resident of the institutional and non-institutional alternatives covered in the state plan for medical assistance. If the resident chooses to leave the NF, DODD will clarify the effect on eligibility for services under the state plan for medical assistance, including its effect on readmission to the NF. Wherever the resident chooses to reside, the county board will meet the resident's specialized services for DD needs as identified in the individual's service plan.
 - c. A NF resident with DD who has resided in a NF for less than thirty months who is determined not to require the level of services provided by a NF, but does require specialized services for DD will be discharged to an appropriate setting where the county board will meet the residents specialized services for DD needs as identified in the individual service plan. The county board, in conjunction with the NF, will arrange for a safe and orderly discharge to an appropriate setting.

- d. A NF resident with DD who has resided in a NF for less than thirty months who is determined not to require the level of services provided by a NF will be discharged. The county board, in conjunction with the NF, will arrange for a safe and orderly discharge to an appropriate setting.

P. Notification of determination of PAS-DD or RR

- 1. DODD will prepare a report which will include:
 - a. The determination as to whether the individual has DD;
 - b. The determination as to whether the individual requires the level of services provided by a NF;
 - c. The determination as to whether the individual requires specialized services for DD that will be provided or arranged for by the county board resulting in continuous active treatment to address needs in each of the life areas for which functional limitations are identified by the county board;
 - d. The placement and/or service options that are available to the individual consistent with the determinations;
 - e. Discharge arrangements, if applicable; and
 - f. The right to appeal as outlined in rule 5123:2-14-01
- 2. DODD will provide a copy of its written report to:
 - a. The evaluated individual and when applicable, his or her guardian;
 - b. The individual's attending physician;
 - c. The admitting or retaining NF for inclusion in the individual's medical record;
 - d. The discharging hospital if the individual is seeking NF admission from a hospital;
 - e. The county board where the individual resides and when applicable, the county board where the NF is located; and
 - f. In the case of an adverse resident review determination, the Ohio Department of Medicaid.

Q. Appeals

1. The individual or the individual's guardian may appeal adverse determinations made by DODD within ninety calendar days of the date of determination by filing an appeal with the Ohio Department of Medicaid in accordance with 5101:6 of the Administrative Code.
2. DODD will conduct an informal reconsideration of the case when notified of appeal or at the request of the individual or guardian.
3. If the individual is subject to both preadmission screening and resident review for DD, the informal reconsideration and appeal will be conducted jointly by DODD and MHAS.

Reference: ORC 4730; ORC 4723.431; ORC 5123.01; OAC 5122-21-03; OAC 5123:2-14-01; 5160-3-15; 5160-3-15.1; 5160-3-15.2; 5101:6

Revised 02/20/2018

**PRE-ADMISSION SCREENING AND RESIDENT REVIEW
FOR NURSING FACILITY APPLICANTS AND NURSING FACILITY RESIDENTS
WITH DEVELOPMENTAL DISABILITIES**

The purpose of the PASRR evaluation is to determine whether an individual is eligible for admission to a Nursing Facility (NF) or eligible to continue to receive services in a NF.

- A. Preadmission screening for developmental disabilities (PAS-DD), also known as a level two screen, means the process by which DODD determines:
1. Whether, due to the individual's physical and mental condition, an individual who has a developmental disability requires the level of services provided by a nursing facility or another type of setting; and
 2. When the level of services provided by a nursing facility is needed, whether the individual requires specialized services for a developmental disability.
- B. Resident review for developmental disabilities (RR-DD) means the process, set forth in rule 5123:2-14-01 of the Administrative Code, by which DODD determines whether, due to the individual's physical and mental condition, an individual who is subject to resident review, and who has a developmental disability requires the level of services provided by a nursing facility or another type of setting; and, whether the individual requires specialized services for a developmental disability.
- C. The CCBDD will be notified by DODD when a PASRR evaluation is required.
- D. The CCBDD will gather data and complete the PASRR Evaluation within seven (7) business days after receiving notification from DODD.
1. The individual, the guardian, and the family (if appropriate) are to be involved in the assessment process. Therefore, the CCBDD evaluator will complete the resident review assessment face-to-face in the setting where the individual is located.
- E. As part of the PASRR Evaluation, the CCBDD will review and submit the following to DODD:
1. PASRR Evaluation Summary Form
 2. Patient Care & Plan of Treatment (ODJFS 3697) or MDS (as reviewed & dated by a professional per rule)
 3. Social History (include current situation)
 4. Disability Assessment (psychological or medical report)
 5. County Board eligibility verification (FED form)
 6. Current Medical Information & List of Medications
 7. Current Physician's Orders
 8. Current Therapy Evaluations & Current Progress Reports
- F. The CCBDD will recommend to DODD whether or not Specialized Services are needed:
1. If Specialized Services are recommended, the services will be provided or arranged for by the CCBDD in conjunction with DODD.

2. If Specialized Services are not recommended, the CCBDD will provide a detailed explanation as to why the individual would not benefit from receiving Specialized Services (habilitation services for improvement or maintenance of functional skills).
3. If applicable, Specialized Services will be delivered to the individual in the chosen setting (i.e. adult day program, community, etc.).
4. If Specialized Services are recommended, an Individual Service Plan must be developed and include services and outcomes that are person centered, identify the provider of service, and identify the frequency and duration of the services and outcomes to be achieved.
5. All staff will be trained on the Individual Service Plan prior to the Specialized Services being implemented and prior to the Individual Service Plan effective date.
6. Specialized Services will be monitored while the individual remains in a NF.

G. Request for an “Unspecified Period of Time” or a “Specified Period of Time” for the NF placement:

1. The CCBDD Evaluator will recommend an “Unspecified Period of Time” or a “Specified Period of Time” for the NF placement.
2. The CCBDD Evaluator should first consider if a “Specified Period of Time” is warranted for the case based upon the individual’s medical condition and need for NF placement.
3. The CCBDD Evaluator will discuss with the NF personnel how long the “Specified Period of time” will last (not to exceed a period of up to 180 days).
4. The CCBDD will summarize the “Specified Period of Time” recommendations on the PASRR Evaluation Summary to justify the NF placement.

H. DODD will review the CCBDD’s documentation and recommendations submitted for approval and send a determination to all parties within two (2) business days of receipt.

I. Refusal to Receive Specialized Services:

1. An individual has the right to refuse Specialized Services at any given time.
2. If an individual refuses Specialized Services, the provider of service will document the refusal and notify the CCBDD.
3. If an individual refuses the Specialized Services recommended, CCBDD will notify DODD to determine if the Specialized Services should be discontinued or if another assessment is warranted.

Revised: 2/20/2018

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PROGRAM PHILOSOPHIES

Early Intervention

The Early Intervention Program is for children from birth through age two and their families. It helps the parents of young children who are showing delays to understand why the child is behind and what can be done to stimulate his or her development. The Clinton County Board's early intervention program is part of a comprehensive, collaborative, coordinated, and family centered system. Parents are given the opportunity to design a program with the services they have chosen reflective of their cultural beliefs, values, and family structures. They may enter and exit the program as they wish. In some cases, early intervention can lessen delays. Some children attain developmental age level and are no longer in need of special services.

Without early intervention, children may continue to fall behind. Research indicates that children learn and grow most quickly from birth to five years. Special help during this time for children who are delayed can make the difference between special or regular classroom education when the child is school age.

The Early Intervention program serves the child with supportive services in the home. An attempt is made to address the complete needs of the family of a child who has delays or a disability. Other components of the program include: child find, program evaluation, family-support, follow along, and transition. The following outline explains guidelines which are followed to ensure a successful program.

The purpose of the early intervention program is to meet the identified needs of infants and toddlers birth through age two and to meet the needs of the family related to promoting the child's development.

Preschool

Preschool supervisory services are provided through the Clinton County Board of Developmental Disabilities to support the school districts in Clinton County.

Adult Services

Persons with developmental disabilities have the right to receive the full range of supports and services they need to be participating members of their communities. Services will be available to individuals dependent upon their choices, desires and preferences. Regardless of the individual's choice of a work site, adults should have access to the supports necessary to be successful and should receive the benefits provided to other workers in the same setting.

Individuals should have supports as needed to have access to retirement, recreational, social and employment activities. Services may be provided in an individual's home if appropriate. Individuals for whom work is not a priority have the right to spend their days involved in activities of interest and personal benefit in integrated, community-based settings.

The central purpose of adult services is to assist each adult to (1) grow into the fullness of their individual capabilities and (2) to help equip them for becoming a member of society.

The primary indicators that such processes are serving their central purpose are these:

- Individual differences among individuals are understood so keenly by the staff that each person acquires indispensable basic skills and knowledge.
- Each person is able to communicate.
- Each person is able to live in satisfactory relationships with others. Each person is able to use time in meaningful and rewarding ways.
- Each person can understand and accept himself or herself.
- Each person can accept responsibilities for him/herself.

The instructional program offers training in:

- The ability to communicate
- Managing one's body
- Understanding self and others
- Home and work responsibilities
- The ability to travel

Services are designed to assist individuals with disabilities in achieving their highest level of independent functioning and to aid them in being productive and active members of society. In doing so, the adult program emphasizes the teaching of self-care skills, independent travel, use of recreational and leisure time and, whenever appropriate, movement toward job training and placement in community employment. Of utmost importance is the effort to teach the concepts of self-worth and independence in order to maximize the process of becoming fully integrated into society, as well informed and active participants.

Service and Support Administration

The Clinton County Board of DD believes that service and support administration should be a person centered process that assists with:

- Supporting people in determining and pursuing life goals,
- Working with families, guardians and natural supports to access, provide and/or enlist whatever support is needed in any life area, including protective intervention and
- Maintaining the person as the focus while coordinating services across multiple systems.

Residential Alternatives, Waiver, and Support Living Services

The Clinton County Board of DD supports the premise that it is the right of all individuals with a developmental disability to live within the community. A selection of quality residential alternatives should be planned and developed reflecting the needs and choices of the individuals

to be served. We recognize the uniqueness of teaching individuals and the need to individualize all services to best meet unique needs. We believe that every individual must be given the maximum opportunity to determine his/her own destiny. We, therefore, encourage the development of a continuum of alternatives from which persons with disabilities, their families, guardians and/or those responsible for their care may choose.

We perceive the family as being the primary residential resource. Essential to family maintenance and stability is the provision of an adequate network of community support services. However, should the time come when it is in the best interest of the individual and/or his/her family to reside away from the natural home setting, a community based residential option should be available.

A functional model will serve as the basis for all residential programming. This model generates an optimistic orientation toward all individuals, regardless of type or degree of handicap. It assumes that given a supportive environment each individual is capable of growth, development and learning, and has the potential to progress through training to live in the least restrictive environment.

We support the philosophy of normalization. Stated simply, normalization means a normal environment will nurture and encourage more normalized behavior.

The county board believes and adheres to the human, civil, and legal rights of persons with developmental disabilities.

Revised: 10/21/14

EMPLOYMENT FIRST

The Clinton County Board of Developmental Disabilities supports the Employment First Initiative instituted by Executive Order 2012-05K. The Executive Order established statewide collaboration and coordination by creating the Employment First Taskforce and Advisory Committee and made competitive integrated employment the preferred outcome for individuals with developmental disabilities.

The purpose of the Employment First Policy is to:

- A. Expand competitive integrated employment opportunities by reducing barriers and aligning state policy.
- B. Enhance lives by creating greater opportunities for all people to advance their careers.
- C. Provide diversity and enrichment to the community, promote equal opportunity within the community, and decrease dependency on public funding.
- D. Provide employers and their businesses with more value because of access to dependable and qualified employees.
- E. Encourage, provide, create, and reward competitive integrated employment in the workforce as the first and preferred option of all students and adults with disabilities who are served by the Board.
- F. For students, Board staff will work with school district personnel, students, families, and other applicable entities to draft Individualized Education Programs (IEP's) and Transition Plans that consider the ultimate outcome of competitive integrated employment as the preferred option and shall work cooperatively to attain career goals. In support of this, the Board shall develop and maintain a "Local Interagency Agreement for Transition of Students with Disabilities to the Workforce". Any decision by the student and/or family to not pursue career planning activities as part of a Transition Plan OR to not consider employment in the community upon graduation from a school program shall be documented, with reasons and rationale provided.
- G. For adults, Individual Service Plans (ISP's) shall consider competitive integrated employment as the preferred option for each person served and the team shall work cooperatively with persons served to attain that career goal. Any decision to not consider employment in the community for specific individuals is to be re-evaluated on a regular basis, with the reasons and rationale for these decisions fully documented and addressed in service plans.

For purposes of the policy, the Board shall:

- A. Engage in the person-centered planning process. The purpose of a person-centered planning process is to identify an individual's unique strengths, interests, abilities, preferences, resources, and desired outcomes as they relate to competitive integrated employment.
- B. Incorporate Employment First principles in its strategic plan.
- C. Collect data and submit it to the Ohio Department of Developmental Disabilities regarding individuals who received employment services, as well as individuals who do not receive employment services but who are engaged in competitive or community employment.
- D. Develop and monitor on-going benchmarks for increasing the number of individuals of working-age who are engaged in competitive integrated employment services.
- E. Work collaboratively with local school districts in the county to ensure a framework exists for individuals approaching completion of a school program that supports competitive integrated employment and reduces or eliminates duplication of efforts.
- F. Disseminate information to individuals served, families, and community partners that promote and facilitate competitive integrated employment.
- G. Adopt procedures that align with this policy that outline appropriate roles, tasks, and coordination activities.

EMPLOYMENT FIRST

Mission: To inspire people of all abilities to embrace the pursuit of self-advocacy, choice, and integration.

A. Description of Services

Employment First ensures that people live, work, and recreate in their community and are seen as full, engaged partners with other members of the community. Employment First is about removing barriers and identifying supports needed to help people make more money and contribute to the community and society overall. Ultimately, competitive integrated employment is the preferred option for individuals.

The initiative of the Clinton County Board of Developmental Disabilities (CCBDD) and the State of Ohio is to encourage all individuals with developmental disabilities to work and engage in their community and to receive the needed supports to do so. The initiative encourages the exploration and growth of skills, interests, and job goals with the individual so that they will be successful in their pursuit.

An Employment Coordinator (EC) and Transition Coordinator (TC) has been hired through the CCBDD for the purpose of meeting the criteria through the Ohio Department of Developmental Disabilities' role in the state and federal requirements for employment services for school age youth with disabilities and adults with disabilities served by the Board.

The EC and TC coordinate referrals to other agencies for the purpose of employment training, skill development and overall supportive services designed to enhance an individual's quality of life. The TC coordinates other services such as in school and summer work experiences for Clinton county school students and other programs such as Wilmington College Immersion program, JOBCOM, Project S.T.I.R. (Steps Toward Independence and Responsibility) in the schools, etc. The TC attends student Individual Education Program (IEP) meetings, coordinates School to Adult Life Transition (S.A.L.T.) sessions for students and their families to gain information regarding employment and adult living.

B. Definitions

1. Employment First: Ensures that people live, work, and recreate in their community and are seen as fully engaged partners with other members of the community. Employment First is about removing barriers and identifying supports needed to help people to earn at or above the minimum wage and not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by persons who do not have disabilities. Ultimately, competitive integrated employment is the preferred option for individuals.
2. Community First: The initiative of the Clinton County Board and the State of Ohio is to encourage all individuals with developmental disabilities to work and engage in their community and to receive the needed supports to do so. The initiative encourages the

- exploration and growth of skills, interests, and job goals with the individual so that they will be successful in their pursuit.
3. Least Restrictive: When a person receives only the services and supports needed to participate in activities and become full partner and participant and to receive services and support in the most typical environment.
 4. Individual: A student or adult with a developmental disability.
 5. IEP: The IEP is the Individualized Education Program for each student that is developed by the local school district and governed by the Ohio Department of Education.
 6. ISP: The ISP is the Individual Service Plan for each adult that is authorized by the County Board of Developmental Disabilities.
 7. Person-Centered Planning Process: The purpose of the person-centered planning process is to identify an individual's unique strengths, interests, abilities, preferences, resources, and desired outcomes as they relate to community employment.
 8. Team: The individual's supports and advocates that include but not limited to a Service and Support Administrator, a personal advocate, family, direct support staff, providers, licensed or certified professionals, school personnel and other persons chosen by the individual to help the individual think through possibilities and decisions. The purpose of the team is to provide written and/or verbal information relevant to the development of the IEP or ISP for the individual. Team members may be invited by the individual to actively participate in the development of the IEP or ISP.
 9. Community Employment: Competitive employment that takes place in an integrated setting.
 10. Competitive Employment: Full-time or part-time work in the competitive labor market in which payment is at or above the minimum wage and not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by persons who do not have disabilities.
 11. Supported Employment Services: Intensive, ongoing supports provided in the community that enable participants, for whom competitive employment at or above minimum wage is unlikely, due to their disability, absent the provision of supports.
 12. Vocational Habilitation: Services designed to teach and reinforce habilitation concepts related to work including responsibility, attendance, task completion, problem solving, social interaction, motor skill development, and safety.
 13. Benefits Analysis: Information provided to individuals about the impact of work on public assistance programs, including but not limited to, social security disability insurance, supplemental security income, Medicaid/Medicare coverage, Medicaid buy-in for workers with disabilities, veteran's benefits, housing assistance, and food stamps.
 14. Natural Support: A support that is not paid. Natural supports can include but are not limited to family members, significant others, and community members who share interests with the person they are supporting. Natural supports should be documented in the IEP or ISP.
 15. OOD/BVR: Opportunities for Ohioans with Disabilities (OOD)/the Ohio Bureau of Vocational Rehabilitation (BVR) provides direct, personalized services to help individuals with disabilities obtain or retain employment. The Vocational Rehabilitation counselor works with individuals one-on-one to plan an individualized program leading to gainful employment.

16. Provider: An agency provider or an independent provider that is certified or licensed by The Ohio Department of Developmental Disabilities.
17. Transition: Refers to the time period before the individual exits high school and enters work or college. Effective transition services and supports shall be in place in sufficient time to discover the services and supports needed to ensure success.
18. Community Employment Skills Assessment: An instrument that is used to gather information and data regarding a student's preferences, abilities, job readiness, etc.
19. Working Age means at least 18 years of age.

C. Transition Plan for Students

1. Individuals with developmental disabilities have the right to make informed decisions about where they work, and to have opportunities to obtain community jobs that may result in greater earnings, better benefits, improved health and increased quality of life. Individuals with developmental disabilities should be encouraged to take part in the workforce and to bring their individual strengths and talents to participate in business and industry.
2. The County Board of DD Transition Coordinator will collaborate with local school districts, as well as workforce development, vocational rehabilitation, mental health, and other applicable agencies, to facilitate the transition from school to work for students. The Transition Coordinator will serve as a key resource regarding employment skill assessments, career planning, job training, and employment options. The Transition Coordinator will establish an effective link between all interested stakeholders leading to a successful transition for each student.
3. All students are expected to engage in activities that will prepare them for competitive integrated employment as supported by the State of Ohio Employment First Initiative. Students at age 14 will develop a transition plan through the student's IEP. Their plan will include a specific statement of their perceived future as well as goals that lead to the development of job readiness skills.
4. When a student reaches working age, or approaches the completion of program or service, they will participate in person-centered planning process which shall include identification and documentation of:
 - a. The individual's place on the path to competitive integrated employment, that is:
 - i) The individual is already engaged in competitive integrated employment and needs support for job stabilization, job improvement, or career advancement;
 - ii) The individual expresses a desire to obtain competitive integrated employment but is not currently employed and needs support to obtain employment or identify career options and employment opportunities;
 - iii) The individual is unsure about competitive integrated employment and needs support to identify career options and employment opportunities and the economic impact for the individual of the decision to work; or
 - iv) The individual does not express a desire to work and needs support to learn more about careers and employment opportunities and the economic impact for the individual of the decision not to work.
 - b. The individual's desired competitive integrated employment outcome.

- c. Clearly defined activities, services, and supports necessary for the individual to achieve or maintain competitive integrated employment, job improvement, or career advancement.
5. The results of the person-centered planning process, including the individual's desired outcomes as they relate to competitive integrated employment, shall be integrated into the individual plan or individual service plan, as applicable.
6. Competitive integrated employment is the preferred option for each person served and the team shall work cooperatively with persons served to obtain that career goal. Any decision to not consider employment in the community for specific individuals is to be re-evaluated on a regular basis with the reasons and rationale for these decisions fully documented and addressed in service plans.
7. The results of the person-centered planning process shall be reviewed at least once every twelve months and whenever a significant change in employment, training, continuing education, services, or supports occurs or is proposed.
8. At age 14, a referral to Bureau of Vocational Rehabilitation (BVR/OOD) can be made by the local school district, Transition Coordinator, or family.
9. As appropriate, students will be encouraged to begin the eligibility process with the CCBDD's Eligibility and Investigations Coordinator.
10. Students who do not follow through with the intake/eligibility process, but are suspected of a qualifying disability by the County Board of DD staff, may receive services provided by the Transition Coordinator until graduation or exit from high school.
11. In addition referrals will be made to appropriate agencies or providers on their behalf.

D. Plan for Adults

1. Individuals with developmental disabilities have the right to make informed decisions about where they work, and to have opportunities to obtain community jobs that may result in greater earnings, better benefits, improved health and increased quality of life. Individuals with developmental disabilities should be encouraged to take part in the workforce and to bring their individual strengths and talents to participate in their communities.
2. Adults who are currently interested in adult service programs shall go through eligibility and intake through CCBDD.
3. A Service and Support Administrator will be assigned to each eligible adult. An Individual Service Plan (ISP) will be developed using the person centered planning approach. The person-centered planning process shall include identification and documentation of:
 - a. The individual's place on the path to community employment, that is:
 - i) The individual is already engaged in competitive integrated employment and needs support for job stabilization, job improvement, or career advancement;
 - ii) The individual expresses a desire to obtain competitive integrated employment but is not currently employed and needs support to obtain employment or identify career options and employment opportunities;
 - iii) The individual is unsure about competitive integrated employment and needs support to identify career options and employment opportunities and the economic impact for the individual of the decision to work; or

- iv) The individual does not express a desire to work and needs support to learn more about careers and employment opportunities and the economic impact for the individual of the decision not to work.
 - b. The individual's desired competitive integrated employment outcome.
 - c. Clearly defined activities, services, and supports necessary for the individual to achieve or maintain competitive integrated employment, job improvement, or career advancement.
- 4. The results of the person-centered planning process, including the individual's desired outcomes as they relate to competitive integrated employment, shall be integrated into the individual plan or individual service plan, as applicable.
- 5. The results of the person-centered planning process shall be reviewed at least once every twelve months and whenever a significant change in employment, training, continuing education, services, or supports occurs or is proposed.
- 6. As part of the ISP process individuals will choose their provider of services. The ISP shall consider integrated employment as the preferred option for each person served and the team shall work cooperatively with persons served to obtain that career goal. Any decision to not consider employment in the community for specific individuals is to be re-evaluated on a regular basis with the reasons and rationale for these decisions fully documented and addressed in service plans.
- 7. A referral, and all communication regarding adults, will be made by the Service and Support Administrator or Employment Coordinator to the Bureau of Vocational Rehabilitation (OOD) as appropriate.
- 8. The Service and Support Administrator or Employment Coordinator will facilitate a referral for a Benefits Analysis consultation with the individual as needed.

E. Data Collection

- 1. The Transition Coordinator (for students) and Service and Support Administrators or Employment Coordinator (for adults) will facilitate the development of ongoing benchmarks for increasing the number of individuals of working-age who are engaged in Competitive Employment services.
- 2. The Transition Coordinator (for students) and Service and Support Administrators or Employment Coordinator (for adults) will be responsible for the collection of data regarding individuals who currently receive employment services as well as individuals who do not receive employment services but who are engaged in competitive or community employment.

F. Additional Tasks

- 1. The Transition Coordinator and Employment Coordinator will use collected data to assist with the development of the County Board's strategic plan.
- 2. The Transition Coordinator and Employment Coordinator will disseminate information to individuals served, families and community partners that promote and facilitate competitive integrated employment.
- 3. The Transition Coordinator and Educational Services Administrator will maintain the "Local Interagency Agreement for Transition of Students with Disabilities to the Workforce".

4. The Transition Coordinator and Employment Coordinator will successfully complete the online Employment First training, Ohio's Orientation to Supported Employment, which is provided by Employment First of Ohio.
5. The Employment Coordinator will notify the Service and Support Department (Waiver Coordinator) of providers who are active employment service vendors for the county so that outreach efforts can be made to provide them with basic provider training.
6. The Service and Support Administrators or Employment Coordinator will be responsible for submitting data to the Ohio Department of Developmental Disabilities as well as to community partners.

Approved 5/17/23

EARLY INTERVENTION SERVICES

The Ohio Department of Developmental Disabilities is the lead agency for the Early Intervention program. Central Coordination (CC) duties and Home Visiting Services (HV) are overseen through the Ohio Department of Health Help Me Grow.

- A. The Clinton County Board of Developmental Disabilities shall provide year round early intervention services to parents of infants and toddlers with delays or disabilities birth through two years of age as part of a comprehensive, coordinated, multidisciplinary, interagency early intervention system in accordance with Ohio Administrative Code 5123-10-02 (Part C Early Intervention) and all other applicable local, state, and federal laws, rules and regulations.
- B. The CCBDD shall provide choices and options to families that enhance quality outcomes for children and their families. The CCBDD shall communicate this information to families, county agency partners and regulatory bodies for the purpose of clarifying the county board's role for the Early Intervention Program.

The CCBDD's Early Intervention services shall include the provision of the following components:

- a. outreach/child find;
- b. assurance of parents' rights and procedural safeguards to families;
- c. mandated service coordination activities which include the individualized family service plan development and transition activities for the child and family prior to the age of three as outlined in OAC 5123-10-02;
- d. family support services as defined in OAC 5123:2-1-02 and in CCBDD board policy 5.06;
- e. evaluation and child/family assessment from qualified personnel to determine Part C eligibility and need;
- f. qualified personnel to participate in the development, implementation, review, and monitoring of the IFSP and its timelines;
- g. early intervention service provision in everyday routines, activities, and in natural environments as developed through the individual family service plan development process. Services shall be delivered in the family's native language, and culturally sensitive to the diversity in beliefs, values, and family configurations;
- h. specialized instruction, physical, occupational, and speech therapy by qualified personnel as available;
- i. nursing services, behavioral specialist services, and mental health services as a consultative resource as appropriate and available;
- j. facilitated in collaboration with other agencies, play and social opportunities in the community for children and families receiving services as well as typically developing children and families;
- k. support to children in the Early Intervention program with specific communication and sensory needs through an Autism P.L.A.Y. Project (Play and Language for Autistic Youngsters). This project utilizes a research-driven curriculum that is

designed to provide intensive relationship-based interventions to children driven by the IFSP process.

- C. The Agency shall assure employees of the county board or contracting entities who are hired to work shall hold applicable registration or certification in accordance with rule OAC 5123-10-04 for Service Coordinators and Supervisors of Service Coordinators and OAC 5123:2-5-05 for Developmental Specialists and Supervisors of Developmental Specialists.
- D. The Agency shall maintain caseloads in a manner that ensures the Agency will be able to provide services and supports to families as outlined on the IFSP. Caseloads shall be reviewed as needed (at least annually) and variables considered which may affect the family-to-primary service provider ratio.
- E. Job and Family Services shall contract with CCBDD to provide all service coordination activities. The CCBDD may also use additional board revenue for operating costs not covered by grant/contract funds.
- F. The provision of and payment for early intervention services shall be in accordance with OAC 5123-10-03. This includes but is not limited to the early intervention service coordinators' responsibility to explain this rule in determining a parent's ability to pay for early intervention services.

Approved 6/18/19

EARLY INTERVENTION PERSONNEL QUALIFICATIONS

- A. Employees of the Agency who are hired to work as Early Intervention personnel shall hold applicable certification in accordance with OAC Rule 5123-10-5 or OAC Rule 5123-10-04(D) and state accredited licensing boards.

Revised 3/17/2023

**EARLY INTERVENTION ONGOING CHILD AND FAMILY EVALUATION
AND ASSESSMENT PROCEDURE**

- A. Two qualified Early Intervention (EI) team members shall conduct the evaluation with the child and family to determine eligibility for EI services (per parental informed consent). In the case that Informed Clinical Opinion is used to determine eligibility the team shall conduct the evaluation prior to the annual re-determination of eligibility for ongoing EI services.

- B. Child and family assessments to determine need for services and program planning shall be completed by two qualified team members (personnel) and shall be summarized, documented, and provide detailed strength-oriented information on the child's abilities and recommended approaches for future interventions. This information shall be provided to parents and other team members as parental consent allows. The family shall be provided every opportunity to take an active role in the assessment process.

(In accordance with Federal Rule IDEA Part C and State Rule 5123-10)

Revised 3/17/2023

EARLY INTERVENTION INTAKE AND REFERRAL PROCEDURE

- A. Upon receipt of a referral from the family or other source, the county board shall immediately refer the family to the centralized intake and referral system through Help Me Grow. Communication to the centralized intake and referral system shall include the child and caregiver information as well as confirmation the parent has concerns about their child's development.

(In accordance with Rule 5123-10-02)

Revised 3/17/2023

EARLY INTERVENTION CHILD RECORDS PROCEDURE

For each child birth through two years of age receiving early intervention services and supports or service coordination from the Clinton County Board of Developmental Disabilities (CCBDD), the following information, in accordance with the records retention schedule, may be compiled and kept on file:

1. Documentation verifying the date of request for or referral to services in Early Intervention (EI) program and the date of initial contact with the CCBDD if the county board is assisting in the initial evaluation/assessment process.
2. Documents used to determine eligibility, which may include the written report of the developmental evaluation or the written medical report.
3. Signed written consents and releases including, but not limited to, a developmental evaluation from EI; parents' rights and procedural safeguards; photo and video consent for publication, educational materials, and for coaching purposes; and ongoing services.
4. A health record that contains pertinent health information, which may include a record of current immunizations and a list of medications and any allergies.
5. Current IFSP, subsequent reviews, written notices regarding meetings, and other related correspondence with the family.
6. Documentation (case summary notes) by each primary service provider that includes date, duration, frequency, intensity and specific type of service provided, and outcomes in accordance with the IFSP. A summary of this data shall be used to measure progress on the outcomes identified on the IFSP.
7. Any ongoing assessments of the child and family.
8. Documentation of an unusual incident and major unusual incidents (forms completed and on file with Service and Support department).
9. Documentation that a request for a copy of any required information was made, but the information was not available.
10. Parent and child play group attendance, home and other community-based visitation records (Family Fun Days and Parent trainings), and ongoing, systematic program data shall be kept on file at the CCBDD office.
11. All Early Intervention records of specialized services provided by the county board will be retained for 10 years from last date of service. EI Service Coordination records will be retained until the child's 9th birthday

(In accordance with Rule 5123-10-01)

Revised 3/17/2023

**EARLY INTERVENTION INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP)
PROCEDURE**

- A. The IFSP is a functional document resulting from an ongoing process that begins at first contact and continues throughout the family's involvement with early intervention services.
- B. The child's Early Intervention (EI) Service Coordinator is responsible to ensure the development, implementation, review, and monitoring of the IFSP, its timelines, and funding sources for needed services.
- C. The Agency's Early Intervention Personnel shall conduct evaluations and assessments.
- D. The Agency team shall:
 - 1. Use the statewide IFSP form made available through the Ohio Department of Developmental Disabilities.
 - 2. Develop a written plan (IFSP) with the parent to record parent's priorities and concerns about their child's development in everyday activities and routines. The child's team will also review the written plan (IFSP) every six months or sooner if needed.
 - 3. Participate in transition planning no less than 90 calendar days and no greater than nine (9) months prior to the child's third birthday or when the child exits the system at any other time.

(In accordance with Rule 5123-10)

Revised 3/17/2023

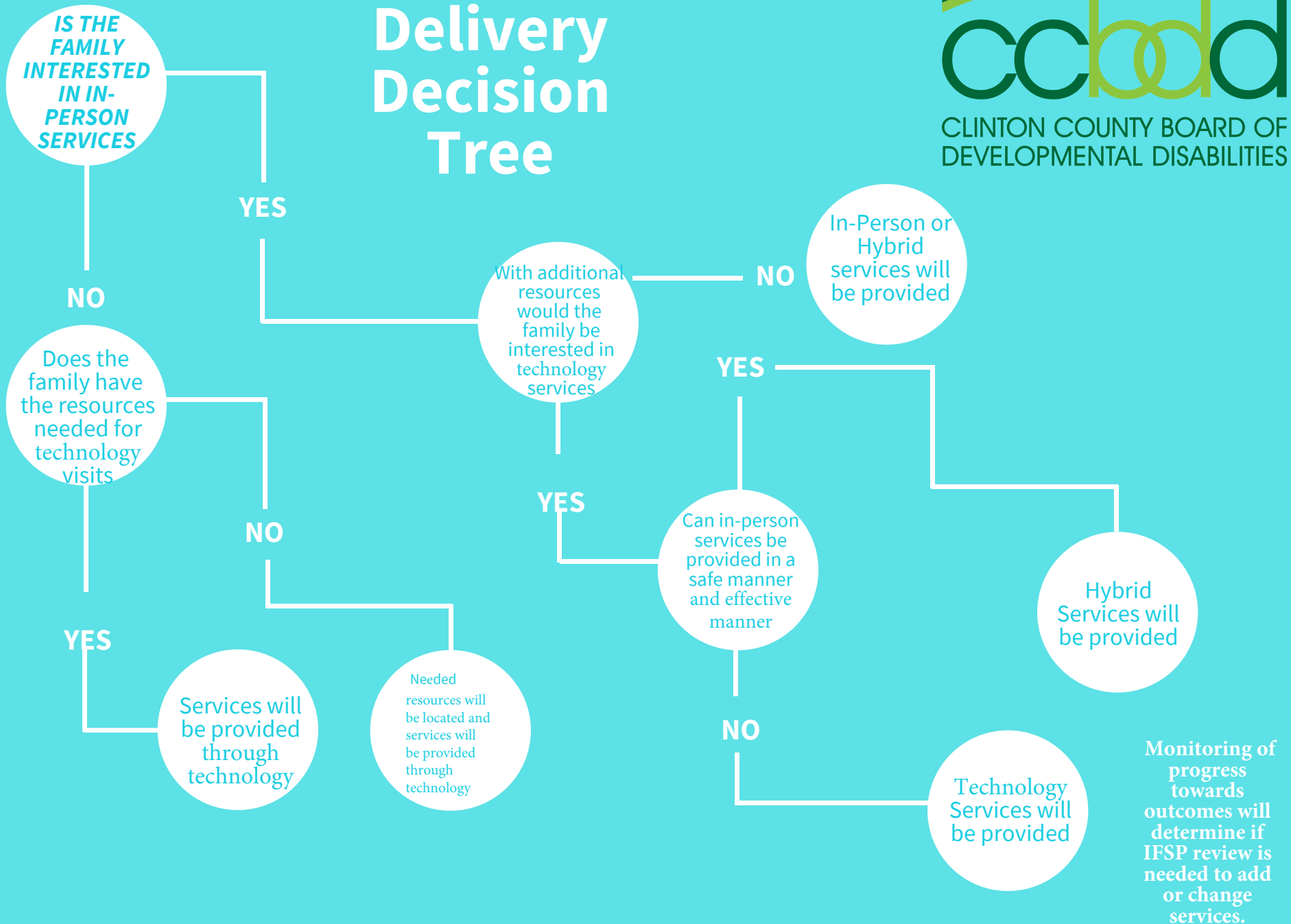
**EARLY INTERVENTION PARENTS' RIGHTS AND PROCEDURAL SAFEGUARDS
PROCEDURE**

For infants and toddlers in the Early Intervention program, the Agency has established parents' rights and procedural safeguards that protect the rights of parents and their eligible children.

- A. For all Part C eligible infants and toddlers served by the Agency, the Agency shall:
1. Comply with the Ohio Department of Developmental Disabilities Parents Rights and Procedural Safeguards (in accordance with 5123-10-01 and Resolution of Complaints in the Ohio Administrative Code 5123:2-1-12. In addition, the 5123.62 of the Ohio Revised Code Rights for Persons with Developmental Disabilities). The Procedural Safeguards and Resolution of Complaints are outlined in the Clinton County Board of Developmental Disabilities Early Intervention Handbook and Early Intervention Parents Rights brochure, and documented that the parent has received a copy.
 2. Ensure that parents are informed of these procedural safeguards afforded under the lead agency, provide a copy upon receipt of a complaint and upon request, and ensure that families are aware that they may file a complaint with the lead agency at any time.
 3. Ensure that if the parent is unable to read the list of rights, the Agency shall communicate the contents to the parent to the extent practicable in a manner the parent understands.
 4. Ensure that the parent shall sign an acknowledgement of receipt of a copy of the Parents Rights and Procedural Safeguards and a copy of the signed acknowledgement shall be placed in the child's file.

Revised 3/17/2023

Service Delivery Decision Tree



EARLY INTERVENTION STAFFING RATIOS PROCEDURE

- A. Each year as part of the Annual Action Plan process, the Superintendent and the Early Intervention Personnel will review the EI caseloads to determine that services and supports to families and children can be supplied as determined by the IFSP teams.

- B. Variables that may affect the ratio and be incorporated into planning include:
 - 1. The extent and intensity of the family supports provided;
 - 2. The extent and intensity of the child's needs;
 - 3. Location of services and supports including travel time for home-based services;
 - 4. The extent and time required to ensure completion of service coordination responsibilities; if applicable
 - 5. The involvement and assistance of other services, supports, and agencies;
 - 6. The resources and support from the EI team available within the Agency, DODD and the community.

Revised: 3/17/2023

**EARLY INTERVENTION REPORTING AND MONITORING REQUIREMENTS
PROCEDURE**

- A. To establish and maintain standards for Early Intervention Services offered by the Agency, the Agency shall:
 - 1. Participate in the department's monitoring system through the accreditation process established pursuant to section 5126.081 of the Revised Code and rule 5123:2-4-01 of the Administrative Code; and
 - 2. Provide information requested by the lead agency for the purpose of monitoring for compliance with Ohio Department of Developmental Disabilities policies or Part C federal regulations.

Revised: 3/17/2023

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PROCEDURE**

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 - 2. Provide information requested by the lead agency for the purpose of monitoring for compliance with Ohio Department of Developmental Disabilities policies or Part C federal regulations.

Revised: 3/17/2023

EDUCATION OF CHILDREN WITH DISABILITIES

The Agency may provide pre-school special education and related services to eligible students in Clinton County, in accordance with procedures, standards, and guidelines adopted by the state board of education. At this time the children in Clinton County are receiving their special education preschool services by their Local Education Agency (LEA). The Clinton County Board of Developmental Disabilities provides Preschool supervisory services to LEA's in Clinton County.

DESCRIPTION OF SERVICES FOR SCHOOL AGE INDIVIDUALS

The Educational Services Administrator (ESA) assists preschool programs with transition plan conferences, evaluations and meetings as requested by the school districts. In addition the ESA coordinates a leadership team that meets regularly in efforts to collaborate with districts regarding preschool services and also maintains an Interagency Agreement for Early Intervention and Preschool Services with all stakeholders involved.

During the school age years the ESA serves as a consultant for school district staff and families regarding special education services. The support may include answering questions, making referrals to the Clinton County Board of Developmental Disabilities for eligibility of services, attendance at students' meetings, sharing information about resources and/or activities in the community for families, etc. The ESA also oversees the duties of the Employment First Coordinator who coordinates transition activities for high school youth. The ESA may assist with referrals to the Clinton County Board of Developmental Disabilities at any time for an individual.

Approved: 11-2-16

ADULT SERVICES

- A. The Agency shall ensure, within planning and priorities set forth in annual and strategic plans, that Adult Services Programs are available to eligible individuals with disabilities as defined under the Eligibility Determination Policy.
- B. Adult Services Programs will provide programs to eligible individuals based upon choice, including but not limited to employment, vocational habilitation, adult day supports, continuing education, transportation, technological supports and therapeutic services.

Revised: 10/21/14

SERVICE AND SUPPORT ADMINISTRATION

- A. The Clinton County Board of Developmental Disabilities (CCBDD) will provide Service and Support Administration (SSA) in accordance with ORC 5126.15.
- B. Decision-making responsibility
1. Each individual, including an individual who has been adjudicated incompetent pursuant to Chapter 2111. of the Revised Code, has the right to participate in decisions that affect the individual's life and to have what is important to the individual and what is important for the individual supported.
 2. An individual for whom a guardian has not been appointed will make decisions regarding receipt of a service or support or participation in a program provided for or funded under Chapter 5123., 5124., or 5126. of the Revised Code. The individual may obtain support and guidance from another person; doing so does not affect the right of the individual to make decisions.
 3. An individual for whom a guardian has not been appointed may, in accordance with section 5126.043 of the Revised Code, authorize an adult (who may be referred to as a "chosen representative") to make a decision described in paragraph (B)(2) of this policy on behalf of the individual as long as the adult does not have a financial interest in the decision. The authorization will be made in writing.
 4. When a guardian has been appointed for an individual, the guardian will make a decision described in paragraph (B)(2) of this policy on behalf of the individual within the scope of the guardian's authority. This paragraph will not be construed to compel appointment of a guardian.
 5. An adult or guardian who makes a decision pursuant to paragraph (B)(3) or (B)(4) of this policy will make a decision that is in the best interest of the individual on whose behalf the decision is made and that is consistent with what is important to the individual, what is important for the individual, and the individual's desired outcomes.
- C. The CCBDD will provide service and support administration in accordance with the requirements of section 5126.15 of the Revised Code to the following:
1. An individual regardless of age or eligibility for county board services, who is applying for or is enrolled in a home and community-based services waiver.
 2. An individual three years of age or older who is eligible for county board services and requests service and support administration, or has services requested on their behalf by a guardian or person designated pursuant to section B above.
 3. An individual residing in an ICF/DD who requests, or a person on their behalf requests pursuant to rule 5123-4-02 (C) assistance to move from the ICF/DD facility to a community setting.
 4. An individual who is eligible for service and support administration in accordance with paragraph (D)(1) of rule 5123-4-02 and requests, or a person on the individual's behalf requests pursuant to paragraph (C) of rule 5123-4-02, service and support administration will receive service and support administration and will not be placed on a waiting list for service and support administration.

- D. Determination of eligibility for county board services
1. SSA's will, in accordance with rules adopted by the Ohio Department of Developmental Disabilities (DODD), determine individuals' eligibility for county board services. The CCBDD may assign responsibility for eligibility determination to a Service and Support Administrator who does not perform other service and support administration functions; in such a case, results of the eligibility determination will be shared with the SSA who is the primary point of coordination for the individual in order to ensure coordination of services and supports. Results of the eligibility determination will be shared in a timely manner with the individual and the individual's guardian, and/or the adult whom the individual has identified, as applicable.
- E. The CCBDD will identify a Service and Support Administrator for each individual receiving service and support administration who will be the primary point of coordination for the individual. An individual will be given the opportunity to request a different SSA from the CCBDD.
- F. With the active participation of the individual and members of the team, the SSA will perform the following duties:
1. Initially, and at least every twelve months thereafter, coordinate assessment of the individual.
 2. Using person centered planning and the web-based Ohio Individual Service Plan approved by DODD; develop, review, and revise the Ohio Individual Service Plan as indicated in rule 5123-4-02.
 - a. "Ohio individual service plan" means the web-based information technology platform created and maintained by the department used to carry out the person-centered process for assessing and planning with Ohioans with developmental disabilities and includes an information technology platform maintained by a county board or an intermediate care facility for individuals with intellectual disabilities to manage, store, and electronically exchange information with the department's web-based information technology platform.
 3. Establish a recommendation for and obtain approval of the budget for services based on the individual's assessed needs and preferred ways of meeting those needs.
 4. Through objective facilitation, assist the individual in choosing providers by:
 - a. Ensuring that the individual is given the opportunity to select providers from all willing and qualified providers in accordance with applicable federal and state laws and regulations including rule 5123-9-11_of the Administrative Code; and
 - b. Assisting the individual as necessary to work with providers to resolve concerns involving a provider or direct support professionals who are assigned to work with the individual.
 5. Secure commitments from providers to support the individual in achievement of the individual's desired outcomes.
 6. Verify by signature and date that prior to implementation each Ohio Individual Service Plan:
 - a. Indicates the provider, frequency, and funding source for each service and support; and
 - b. Specifies which provider will deliver each service or support across all settings.

5. Establish and maintain contact with providers as frequently as necessary to ensure that each provider is trained on the Ohio Individual Service Plan and has a clear understanding of the expectations and desired outcomes of the supports being provided.
6. Establish and maintain contact with natural supports as frequently as necessary to ensure that natural supports are available and meeting desired outcomes as indicated in the Ohio Individual Service Plan.
7. Facilitate effective communication and coordination among the individual and members of the team by ensuring that the individual and each member of the team has a copy of the current Ohio Individual Service Plan unless otherwise directed by the individual, the individual's guardian, or the adult whom the individual has identified, as applicable. The individual and individual's providers will receive a copy of the Ohio Individual Service Plan at least fifteen calendar days in advance of implementation unless extenuating circumstances make fifteen-day advance copy impractical and with agreement by the individual and individual's providers.
8. Provide ongoing Ohio Individual Service Plan coordination to ensure services and supports are provided in accordance with the Ohio Individual Service Plan and to the benefit and satisfaction of the individual.
9. Review and revise the Ohio Individual Service Plan at least every twelve months and as needed per rule 5123-4-02.
10. Explain to the individual, in conjunction with the process of recommending eligibility and/or assisting the individual in making application for enrollment in a home and community-based services waiver or any other Medicaid service, and in accordance with rules adopted by the department:
 - a. Alternative services available to the individual;
 - b. The individual's due process and appeal rights; and
 - c. The individual's right to choose any qualified and willing provider.
11. Explain to the individual, at the time the individual is being recommended for enrollment in a home and community-based services waiver:
 - a. Choice of enrollment in a home and community-based services waiver as an alternative to residing in an intermediate care facility for individuals with intellectual disabilities; and
 - b. Services and supports funded by a home and community-based services waiver.
12. Provide an individual with written notification and explanation of the individual's right to a Medicaid state hearing if the Ohio Individual Service Plan process results in a recommendation for the approval, reduction, denial, or termination of services funded by a home and community-based services waiver. Notice will be provided in accordance with section 5101.35 of the Revised Code.
13. Make a recommendation to DODD, in accordance with rule 5123-8-01 of the Administrative Code, as to whether the individual meets the criteria for a developmental disabilities level of care.
14. Explain to an individual whose Ohio Individual Service Plan includes services funded by a home and community-based services waiver or other Medicaid services that the services are subject to approval by DODD and the Ohio Department of Medicaid. If DODD or the Ohio Department of Medicaid approves, reduces, denies, or terminates services funded by a home and community-based services waiver or other Medicaid

services included in an Ohio Individual Service Plan, the SSA will communicate with the individual about this action.

15. Provide an individual with written notification and explanation of the individual's right to use the administrative resolution of complaint process set forth in rule 5123-4-04 of the Administrative Code if the Ohio Individual Service Plan process results in the reduction, denial, or termination of a service other than a service funded by a home and community-based services waiver or targeted case management services. Such written notice and explanation will also be provided to an individual if the Ohio Individual Service Plan process results in an approved service that the individual does not want to receive, but is necessary to ensure the individual's health, safety, and welfare. Notice will be provided in accordance with rule 5123-4-04 of the Administrative Code.
 16. Advise members of the team of their right to file a complaint in accordance with rule 5123-4-04 of the Administrative Code.
 17. Retain responsibility for all decision-making regarding service and support administration functions and the communication of any such decisions to the individual.
 18. Take actions necessary to remediate any immediate concerns regarding the individual's health and welfare.
 19. Implement a continuous review process to ensure that Ohio Individual Service Plans are developed and implemented in accordance with rule 5123-4-02.
- G. The CCBDD will establish an on-call emergency response system that is available twenty-four hours per day, seven days per week to provide immediate response to an unanticipated event that requires an immediate change in an individual's existing situation and/or Ohio Individual Service Plan to ensure health and safety.
- H. The CCBDD will establish procedures for the following functions of SSA:
1. Primary Point of Coordination
 2. Ohio Individual Service Plan
 3. Individual Budgets
 4. Continuous Review Process for Monitoring
 5. On-Call Emergency Response
 6. Overtime for Independent Providers
- I. Case management records will be maintained on individuals receiving service and support administration in accordance with OAC 5123:4-02, OAC 5123:2-17-02, and the CCBDD's records retention schedule and will include the following if applicable:
1. Identifying data;
 2. Information identifying guardianship, other adult whom the Individual has identified, trusteeship, or protectorship;
 3. Date of request for services from the county board;
 4. Evidence of eligibility for county board services;
 5. Assessment information relevant for services and the Ohio Individual Service Plan process for supports and services;
 6. Current Ohio Individual Service Plan;
 7. Current budget for services;

8. Documentation that the Individual exercised freedom of choice in the provider selection process;
 9. Documentation of unusual incidents
 10. Major unusual incident investigation summary reports;
 11. The name of the Service and Support Administrator;
 12. Emergency Information;
 13. Personal financial information, when appropriate;
 14. Release of information and consent forms;
 15. Case notes which include coordination or services and supports and continuous review process activities; and
 16. Documentation that the Individual was afforded due process in accordance with paragraph (I) of OAC 5123:4-02, including but not limited to, appropriate prior notice of any action to deny, reduce, or terminate services and an opportunity for a hearing.
- J. SSA's will ensure that information about individuals served, including an individual's living arrangements and address, guardianship status, and guardian's address and contact information is updated in DODD's information systems within fifteen (15) calendar days of any change.
- K. Due process will be afforded to each individual receiving service and support administration pursuant to section 5101.35 of the Revised Code for services funded by a home and community-based services waiver and targeted case management services or pursuant to rule 5123-4-04 of the Administrative Code for services other than services funded by a home and community-based services waiver and targeted case management services.
- L. DODD will monitor compliance with rule 5123-4-02. Technical assistance, as determined necessary by the department, will be provided upon request and through regional and statewide trainings.
- M. The Ohio Department of Medicaid retains final authority to monitor the provision of targeted case management services in accordance with rule 5160-48-01 of the Administrative Code.
- N. Transition to Ohio Individual Service Plan
1. The use of Ohio individual service plan to capture assessments and individual service plans by June 30, 2024 is required only for individuals enrolled in home and community-based services waivers. The CCBDD, however, will use the Ohio individual Service plan for all individuals served regardless of the funding type.

Reference: ORC 5126.15, OAC 5123-4-02; OAC 5123-4-01; OAC 5123-4-04
Revised: 04/18/2023

PRIMARY POINT OF COORDINATION

- A. The CCBDD will identify a service and support administrator (SSA) for each individual receiving service and support administration who will be the primary point of coordination for the individual.
- B. An individual will be given the opportunity to request a different SSA from the CCBDD.
- C. As the Primary Point of Coordination, the identified SSA will be responsible to an individual for the effective development, implementation, and coordination of the Individual Service Plan.
- D. With the active participation of the individual and members of the team, the SSA, as the primary point of coordination, will perform all SSA duties as outlined in Policy 5.05.

OHIO INDIVIDUAL SERVICE PLAN

- A. SSA's employed by or under subcontract with the CCBDD to provide service and support administration will develop Ohio Individual Service Plans (OISP's) with the active participation of the individual and members of the team.
- B. The "Ohio Individual Service Plan" means the web-based information technology platform created and maintained by the DODD that is used to carry out the person-centered process for assessing and planning with Ohioans with developmental disabilities and includes an information technology platform maintained by a county board or an intermediate care facility for individuals with intellectual disabilities to manage, store, and electronically exchange information with the DODD's web-based information technology platform.
- C. Initially, and at least every twelve months thereafter, SSA will coordinate assessment of each individual, as part of the OISP process.
 1. The assessment will take into consideration:
 - a. What is important to the individual to promote satisfaction and achievement of desired outcomes;
 - b. What is important for the individual to maintain health and welfare;
 - c. Known and likely risks;
 - d. The individual's place on the path to community employment; and
 - e. The individual's skills and abilities
 2. The assessment will identify supports that promote the individual's:
 - a. Communication (expressing oneself and understanding others);
 - b. Advocacy and engagement (valued roles and making choices; responsibility and leadership);
 - c. Safety and security (safety and emergency skills; behavioral well-being; emotional well-being; supervision considerations);
 - d. Social and spirituality (personal networks, activities, and faith; friends and relationships);
 - e. Daily life and employment (school and education; employment; finance);
 - f. Community living (life at home; getting around); and
 - g. Healthy living (medical and dental care; nutrition; wellness)
- D. Using person-centered planning, SSA will develop, review, and revise the OISP at least every twelve months and ensure the OISP:
 1. Reflects results of the assessment
 2. Includes services and supports that:
 - a. Ensure health and welfare;
 - b. Assist the individual to engage in meaningful and productive activities;
 - c. Support community connections and networking with persons or groups including persons with disabilities and others;
 - d. Assist the individual to improve self-advocacy skills and increase the individual's opportunities to participate in advocacy activities, to the extent desired by the individual;

- e. Ensure achievement of outcomes that are important to the individual and outcomes that are important for the individual and address the balance of and any conflicts between what is important to the individual and what is important for the individual;
 - f. Address identified risks and include supports to prevent or minimize risks;
 - 3. Integrates all sources of services and supports, including natural supports and alternative services, available to meet the individual's needs and desired outcomes;
 - 4. Reflects services and supports that are consistent with efficiency, economy, and quality of care;
 - 5. Includes an approved individual budget that is based on the individual's assessed needs and preferred ways of meeting those needs, per CCBDD Procedure 5.05.2;
 - 6. Includes service providers chosen by the individual per OAC 5123-9-11, CCBDD Policy 3.04 and CCBDD Procedure 3.04.1.
 - 7. Has been verified by signature and date; prior to implementation, and includes:
 - a. The provider, frequency, and funding source for each service and support; and
 - b. Specifies which provider will deliver each service or support across all settings
- E. With the active participation of the individual and members of the team, SSA will:
- 1. Establish and maintain contact with providers as frequently as necessary to ensure that each provider is trained on the OISP and has a clear understanding of the expectations and desired outcomes of the supports being provided,
 - 2. Establish and maintain contact with natural supports as frequently as necessary to ensure that natural supports are available and meeting desired outcomes as indicated in the OISP,
 - 3. Facilitate effective communication and coordination among the individual and members of the team by:
 - a. Ensuring that the individual and each team member has a copy of the current OISP, unless otherwise directed by the individual, the individual's guardian, or the adult whom the individual has identified, as applicable;
 - b. Ensuring that the individual and his or her providers receive a copy of the OISP at least fifteen calendar days in advance of implementation, unless extenuating circumstances make the fifteen-day advance copy impractical, and with agreement by the individual and his or her providers;
 - c. Requesting that team members notify the SSA when a team member becomes aware that revisions to the OISP are needed;
 - d. Reminding team members that they may disagree with any provision in the OISP at any time
 - e. Ensuring that all dissenting opinions are specifically noted in writing and attached to the OISP.
- F. SSA will provide ongoing OISP coordination to ensure services and supports are provided in accordance with the OISP and to the benefit and satisfaction of the individual. Ongoing OISP coordination will:
- 1. Occur with the active participation of the individual and members of the team,
 - 2. Focus on achievement of the desired outcomes of the individual;
 - 3. Balance what is important to the individual and what is important for the individual;

4. Examine service satisfaction (i.e., what is working for the individual and what is not working); and
5. Use the Ohio individual service plan as the fundamental tool to ensure the health and welfare of the individual.

G. SSA will revise the OISP within thirty calendar days under the following circumstances:

1. At the request of the individual or a member of the team
2. Whenever the individual's assessed needs, situation, circumstances, or status changes;
3. If the individual chooses a new provider or type of service or support;
4. As a result of reviews conducted in accordance with CCBDD Procedure 5.05.4;
5. When trends and patterns of unusual incidents or major unusual incidents are identified; and
6. When services are reduced, denied, or terminated by the department or the Ohio department of Medicaid.

H. Due Process and Complaints:

1. SSA will provide an individual with written notification of the individual's right to a Medicaid state hearing if /when there is an approval, reduction, denial, or termination of services funded by a home and community-based services (HCBS) waiver. Notice will be provided in accordance with section 5101.35 of the ORC.
2. SSA will explain to an individual whose OISP includes services funded by a HCBS waiver or other Medicaid services that the services are subject to approval by DODD and the Ohio Department of Medicaid. If DODD or the Ohio Department of Medicaid approves, reduces, denies, or terminates services included in the OISP, the SSA will communicate with the individual about this action.
3. SSA will provide an individual with written notification of the individual's right to use the administrative resolution of complaint process set forth in OAC 5123-4-04 if the OISP process results in the reduction, denial, or termination of a service **other than** a service funded by a HCBS waiver or targeted case management services. Such written notice will also be provided to an individual if the OISP process results in an approved service that the individual does not want to receive, but that is necessary to ensure the individual's health, safety, and welfare. Notice will be provided in accordance with OAC 5123-4-04.
4. SSA will advise members of the team of their right to file a complaint in accordance with rule 5123-4-04 of the OAC.
5. Written notifications for the above are provided to the individual and the individual's team members for the following if applicable:
 1. Annual OISP
 2. OISP Addendums/Revisions
 3. Waiting List Assessments and
 4. Eligibility Assessments

Reference: ORC: 5126.15 and 5101.35; OAC: 5123-4-02, 5123-4-01, 5123-4-04, and 5123-9-11
 Revised: 04/18/2023

INDIVIDUAL BUDGETS

- A. The SSA will establish a recommendation for and obtain approval of the budget for services based on the individual's assessed needs and preferred ways of meeting those needs.
- B. The SSA will obtain a waiver utilization report if applicable, staffing schedule if applicable, and current cost summary from the Waiver Coordinator (WC) to review at the team meeting.
- C. The team will review the waiver utilization report if applicable, staffing schedule if applicable, current cost summary, and the services listed in the ISP to determine if changes are warranted.
- D. After the team meeting the SSA will:
 - 1. Finalize the individual budget form, and staffing schedule if applicable
 - 2. Enter the individual budget form and staffing schedule into MSS (DODD application), or submit the individual budget form and final staffing schedule to the WC to enter into MSS.
 - 3. SSA/WC will attach a completed individual budget to the ISP in Gatekeeper (GK)
 - 4. The Service and Support Manager (SSM) or the Service and Support Director (SSD) will review and approve the individual budget form /total costs by signing/authorizing the ISP.
 - 5. SSM/SSD will delete the individual budget form from the ISP in GK.
 - 6. SSM/SSD will note approval of the ISP on the ISP tracking spreadsheet
 - 7. WC will finalize the costs in MSS
 - 8. WC will authorize the costs in MSS by completing the SPA (Service Payment Authorization)
 - 9. WC will download the Cost Projection Report Tool (CPR/CPT) from MSS and attach the CPT, or the PAS (Payment Authorization for Services) to the ISP in GK
 - 10. WC will note completion of CPT/PAS on the ISP tracking spreadsheet
- E. The Individual Budget, or CPT/PAS may include the following where applicable (i.e. depending on whether services are funded via waiver or local dollars)
 - 1. Site Name
 - 2. Individual
 - 3. Waiver Span (effective begin and end date)
 - 4. Is Authorized (Yes or No)
 - 5. Waiver Type or Funding Source
 - 6. DDP Funding Level
 - 7. AAI Group
 - 8. Service Type/PAWS Roll-Up Code
 - 9. Provider Name
 - 10. Total Authorized Units
 - 11. Total Authorized Costs

- F. When a request is made to the SSA for additional services, resulting in a cost increase the following will occur:
1. SSA will ask that the individual, guardian/primary caregiver, and/or provider submit a request in writing outlining the services to be increased and the reason for the request
 2. If the reason for the request is due to a change in the individual's needs, the SSA will review the Ohio Developmental Disabilities Profile (ODDP) to determine if updates are needed
 3. If the team determines that the request in services is warranted, the SSA will complete an individual budget form and submit to the WC (refer to procedures above)
 4. SSA will complete a Prior Authorization (PA) through the Ohio Department of Developmental Disabilities if the increase in costs exceeds the budget limitations (only applicable for waiver services)
 5. SSA will complete an ISP addendum and submit for review and approval
- G. Individual budgets for Home and Community Based Waiver Services are subject to the Waiver Reimbursement Methodology outlined in 5123:2-9-06 of the Ohio Administrative Code.

CONTINUOUS REVIEW PROCESS FOR MONITORING

- A. CCBDD will implement the following continuous review process to ensure that Individual Service Plans (ISP's) are developed and implemented in accordance with rule 5123-4-02.
- B. The continuous review process will be tailored to the individual and based on information provided by the individual and the team.
- C. The scope, type, and frequency of reviews will be specified in the ISP and will include, but are not limited to:
 - 1. Face-to-face visits, occurring at a time and place convenient for the individual, at least annually or more frequently as needed by the individual; and
 - 2. Contact via phone, email, or other appropriate means as needed
- D. Areas that to be monitored, as applicable to each individual, may include but is not limited to:
 - 1. Services and Outcomes identified in the ISP
 - 2. Behavioral Support Strategies identified in the ISP
 - 3. Unusual and Major Unusual Incidents and Prevention
 - 4. Results of Provider Compliance and Quality Assessment Reviews (MAQA's)
 - 5. Emergency situations resulting in loss of caregiver, loss of residence, etc.
 - 6. Other individual needs as determined by the team
- E. The frequency of reviews may be increased when:
 - 1. The individual has intensive behavioral or medical needs;
 - 2. The individual has an interruption of services of more than thirty-calendar days;
 - 3. The individual encounters a crisis or multiple less serious but destabilizing events within a three-month period;
 - 4. The individual has transitioned from an intermediate carefacility for individuals with intellectual disabilities to a community setting within the past twelve months;
 - 5. The individual has transitioned to a new provider of homemaker/personal care or participant-directed homemaker/personal care within the past twelve months;
 - 6. The individual receives services from a provider that has been notified of the department's intent to suspend or revoke the provider's certification or license; or
 - 7. Requested by the individual, the individual's guardian, or the adult whom the individual has identified, as applicable.
- F. The SSA will share results of reviews in a timely manner with the individual, the individual's guardian, and/or the adult whom the individual has identified, as applicable, and the individual's providers, as appropriate.
 - 1. The results of the reviews may be shared by the SSA through follow up phone calls, email, special team meetings, etc.
 - 2. All reviews/monitoring will be documented in Targeted Case Management (TCM)
- G. If the continuous review process as indicated above indicates areas of non-compliance for providers of services funded by a home and community-based services waiver, the CCBDD

will conduct a provider compliance review in accordance with rule 5123-2-04 of the Ohio Administrative Code

1. The CCBDD may contract with an outside entity such as the Southern Ohio Council of Governments (SOCOG) to complete Provider Compliance Reviews and/or Special Provider Compliance Reviews.

Reference: ORC 5126.15, OAC 5123-4-02, OAC 5123-9-06, 5123-2-03, 5123-2-04, and OAC 5123-4-01

Revised: 10/27/2021

ON-CALL EMERGENCY RESPONSE

- A. The CCBDD has an On-Call Emergency Response system available twenty-four hours per day, seven days per week.
- B. The SSA on-call can be reached after hours via the on-call cell phone at (937) 725-5074.
- C. SSA's that are assigned to the on-call emergency response system will:
 - 1. Provide emergency response directly or through immediate linkage with the SSA who is the primary point of coordination for the individual or with the primary provider;
 - 2. Be trained and have the skills to identify the problem, determine what immediate response is needed to alleviate the emergency and ensure health and welfare, and identify and contact persons to take the needed action;
 - 3. Notify the providers and the SSA who is the primary-point of coordination for the individual to ensure adequate follow-up;
 - 4. Notify the county board's investigative agent as determined necessary by the nature of the emergency; and
 - 5. Ensure documentation of the call received, as indicated in paragraph E below.
- D. On-Call Schedule:
 - 1. The SSM/SSD will create an On-Call Schedule prior to the beginning of each calendar year.
 - 2. The on-call period will run Monday to the following Monday
 - 3. The on-call SSA may carry the agency's on-call cell phone, or forward the calls from the on-call cell phone to their assigned agency cell phone.
 - 4. If a holiday falls on a Monday or if the on-call SSA is absent from work; the change in the assigned on-call SSA will take place the next business day per the On-Call Schedule.
 - 5. If an SSA is unable to be on-call during an assigned week, it is the responsibility of the SSA to switch weeks with another SSA, to notify the SSM/SSD of the change, and to update the Master On-Call Schedule
- E. The SSA On-Call will:
 - 1. Be available to respond immediately to a call that is received
 - 2. Arrive at the location when an on-site response is needed, as soon as feasible
 - 3. Provide emergency intervention directly or through immediate linkage to other CCBDD personnel, or other agencies as applicable
 - 4. Notify the SSM or the SSD of any suspected Major Unusual Incident (MUI).
 - 5. The SSM, SSA, or the SSD will notify the Investigative Agent through the SOCOG and ensure all other applicable MUI notifications have been made (i.e. Law Enforcement, CSB, guardian, provider, etc.)
 - 6. Complete an on-call report documenting the date and time the call was received, a summary of the incident, all persons notified, and whether or not an incident is a potential MUI. The on-call SSA will electronically sign the report once completed.
 - 7. Route the on-call report to the assigned SSA the next business day via email for review

and follow-up

8. Document all on-call time in Targeted Case Management, ensuring the entries match the in and out time documented on the on-call report and timesheet

F. Additional Follow-Up:

1. The assigned SSA will review the report, document any follow up completed, and electronically sign the report.
2. The assigned SSA will save the on-call report to the folder on the server, titled "Signed Forms for Supervisors"
3. The SSM and the SSD will review the on-call report, document any follow-up, and electronically sign.
4. The on-call report will be uploaded to the individual's file in Intellivue

G. On-Call Timesheet and Compensation:

1. The on-call SSA will be compensated for all time spent working, which may include: responding by telephone, traveling to and from any applicable location, and time spent at each location
2. The on-call SSA is required to document start and end times on the on-call timesheet for any time spent working
3. The on-call SSA will complete and electronically sign the on-call timesheet and place it in the folder on the server, titled "Signed Forms for Supervisors", by 8:30am on the day the on-call period ends
4. If an SSA is absent from work or not scheduled; the day the on-call period has ended, the on-call SSA will report the total on-call time to the SSM or the SSD by 8:15am.
5. The SSM or SSD will review and approve the on-call timesheet and save it in the "Signed Forms for Superintendent" folder on the server.
6. Each SSA is required to complete a timecard in infallible in accordance with 4.03 of the personnel policy to document scheduled time worked and paid time off.
7. Administration will add the total on-call time to the SSA's timecard in infallible (time will be rounded up to the next highest quarter hour for pay calculation purposes)
8. Administration will calculate the amount of time owed for a given work week by totaling the accumulated credited time on the timecard in infallible and the on-call timesheet, in accordance with personnel policy 11.04 [Overtime].

OVERTIME PROCEDURE FOR INDEPENDENT PROVIDERS

- A. Overtime is defined as hours worked in excess of forty (40) in a work week. This procedure establishes a process and the circumstances under which overtime for an independent provider will be approved.
1. Although OAC 5123:2-9-03, states that prior approval is only needed for an independent provider to exceed the limit of sixty (60) hours a week; if an independent provider currently works over forty (40) hours a week; the independent provider is responsible for notifying all County Boards where services are provided.
 2. The SSA and the individual's team must work collaboratively to develop a plan to reduce the number of hours worked, to efficiently use available resources, and to the extent possible reduce the need for overtime.
 3. An independent provider will inform the SSA of the number of persons for whom he/she provides any Medicaid-funded services in the state of Ohio, and the number of hours he/she provides in a work week when:
 - a. Selected by an individual to provide services;
 - b. An emergency occurs (an unanticipated and sudden absence of an individual's provider, or natural supports due to illness, incapacity or other cause) that makes it necessary to exceed the limit of sixty (60) hours per OAC 5123:2-9-03; and
 - c. At other times upon request of the SSA.
 4. An independent provider will submit a request for additional services and/or supports in writing to the SSA and include an explanation as to why the services are needed.
 5. The SSA will coordinate with the team the need for the overtime hours to be approved.
 6. The SSA will complete a revision to the ISP and Individual Budget if applicable
- B. Limit on providing services in a work week:**
1. After an independent provider has worked sixty (60) hours in a work week he/she may provide additional units of services under a HCBS waiver in that work week only when authorized by the SSA.
 2. The SSA and the individual's team will take all measures necessary to achieve compliance with the limit of sixty (60) hours per week as noted in OAC 5123:2-9-03.
 3. As part of the ISP process the team will identify known or anticipated events or circumstances that will require an independent provider to exceed the limit of sixty (60) hours established in OAC 5123:2-9-03.
 4. The SSA will address known circumstances that will require an independent provider to exceed the limit. Examples of known circumstances may include
 - a. Scheduled travel or surgery of the individual, the individual's family member, or the individual's provider;
 - b. Holidays or scheduled breaks from school;
 - c. When the individual has a compromised immune system and may be put at risk by having additional providers;
 - d. When the independent provider is the only provider that has been trained by a nurse on delegated tasks or trained by a behavioral specialist to implement behavioral support strategies; and/or
 - e. When there is a shortage of other available providers.
 5. When an individual requests that an independent provider be authorized to routinely

exceed the limit of sixty (60) hours due to a shortage of other available providers, the SSA and the team will seek additional providers.

6. The SSA may authorize an independent provider to exceed the limit as specified in the ISP for the duration of the individual's waiver span, when additional providers cannot be found.
7. The SSA will work with the team to develop a plan to eliminate the need for the independent provider to exceed the limit of sixty (60) hours for the following:
 1. The independent provider is the only provider that has been trained by a nurse on delegated tasks or trained by a behavioral specialist to implement behavioral support strategies; and/or
 2. If there is a shortage of other available providers

C. For Emergencies that necessitate an independent provider to exceed sixty (60) hours, the independent provider will:

1. Notify the SSA in accordance with this procedure and within seventy- two (72) hours of the emergency, and
2. Report the hours worked that exceeded the limit.

D. The CCBDD will notify all independent providers serving in Clinton County, at least thirty (30) calendar days prior to revising these procedures.

E. Violations of this procedure and rule 5123:2-9-03:

1. An independent provider who violates the requirements of this procedure and OAC 5123:2-9-03 may be subject to denial, suspension, or revocation of their certification per OAC 5123:2-2-01.

F. Complaints, Due Process Rights and Responsibilities:

1. The CCBDD will process any complaints received by an individual regarding the implementation of this procedure by responding to the individual within thirty (30) calendar days and provide DODD with a copy of the complaint and the CCBDD's response.
2. For appeals, individuals will be directed to follow the process outlined in ORC 5160.31; providers cannot file an appeal under this section of the ORC.
3. Individuals will be directed to follow the process outlined in ORC 5160.31 for any appeal/complaint related to the type, amount, level, or scope, or duration of services included in or excluded from an ISP.
4. The CCBDD's denial for an independent provider to exceed sixty (60) hours per 5123:2-9-03 will not necessarily result in a change in the level of services received by an individual.

COMPLIANCE REVIEWS OF CERTIFIED PROVIDERS

- A.** Compliance review is defined as a review of a certified provider conducted by DODD or a county board for the purpose of determining provider compliance with applicable requirements in order to ensure the health, safety, and welfare of individuals served. This procedure establishes a process and the circumstances under which a compliance review will be conducted for certified providers.
1. There are three types of compliance reviews:
 - a. **Routine compliance reviews.** Established by DODD in the protocol for compliance, DODD will coordinate with CCBDD's Provider Support Coordinator to ensure that each certified provider receives a routine compliance review within one year of the certified provider's initial billing for provision of services. Thereafter, routine compliance reviews of certified providers will be conducted so that each certified provider that has billed for provision of services within the past twenty-four months is reviewed once during the term of certification.
 - b. **Special compliance reviews.** DODD or CCBDD's Provider Support Coordinator may conduct special compliance reviews as necessary:
 - i. Pertaining to the health, safety, or welfare of an individual;
 - ii. Based on a complaint or allegation; or
 - iii. Based on a major unusual incident that may indicate the certified provider's failure to comply with applicable requirements.
 - c. **Abbreviated compliance reviews.** An abbreviated review may only be conducted by DODD Office of Compliance. An abbreviated review may be available upon request to providers who are accredited by a national accrediting entity. Providers who wish to request an abbreviated review should submit a written request to the DODD that includes a copy of the most recent survey/review of the certified provider by the national accrediting entity to DODD's Office of Compliance.
- B.** Only DODD may conduct compliance reviews of residential facilities licensed in accordance with section 5123.19 of the Revised Code.
- C.** CCBDD will implement the protocol maintained by DODD for compliance reviews and will not change or augment the protocol for compliance reviews.
1. The protocol for compliance reviews will include, but is not limited to:
 - a. The method for selecting certified providers to be reviewed;
 - b. The types and scope of reviews that may be conducted;
 - c. The process and procedures for notifying certified providers of upcoming reviews;
 - d. The elements of provider compliance which will be based on the applicable requirements;
 - e. The elements of a written compliance review summary to a certified provider that will include an explanation of any citations, the process to develop and implement a plan of correction, and an explanation of the due process afforded to a certified provider;

- f. The criteria for conducting announced and unannounced reviews; and
 - g. Any forms or methods of documentation approved by DODD.
2. The protocol for compliance reviews can be found on DODD's website.

D. Compliance review summary and plan of correction

1. DODD or CCBDD will issue to the certified provider, a written compliance review summary or a written explanation of the reason for delay in issuance of the written compliance review summary within ten days after the compliance review.
 - a. A written compliance review summary will adhere to the protocol's format, objectively observing and citing standards, and relying on documentation that address the standards reviewed.
 - b. The DODD or CCBDD will issue a written compliance review summary within twenty calendar days after the compliance review, stating the reason for the delay.
2. The certified provider must submit to DODD or CCBDD a written appeal or correction plan for each citation within fourteen days of receiving the compliance review summary. The compliance review summary is final and non-appealable if the certified provider does not submit a written appeal within fourteen calendar days.
 - a. The appeal for a citation will include the certified provider's basis with supporting documentation for challenging the citation. DODD or CCBDD will allow or disallow the appeal within ten calendar days of receipt.
 - i. If the compliance review was conducted by DODD and the appeal is disallowed, the certified provider will submit a written plan of correction for the citation to the department within fourteen calendar days.
 - ii. If the compliance review was conducted by CCBDD and the appeal is disallowed, the certified provider will either:
 - a) Submit a written plan of correction for the citation to CCBDD within fourteen calendar days; or
 - b) If the certified provider objects to the county board's decision to disallow the appeal, submit to the department a written appeal within fourteen calendar days of CCBDD's decision. DODD will notify the certified provider and CCBDD of its decision to allow or disallow the appeal within ten calendar days of receipt. If DODD disallows the appeal, the certified provider will submit a written plan of correction for the citation to the county board within fourteen calendar days.
 - b. The written plan of correction for a citation will include action steps and timelines for remediation. The DODD or CCBDD will approve or disapprove the plan of correction within twenty calendar days of receipt. When DODD or CCBDD disapproves a plan of correction, the certified provider will work with DODD or CCBDD to develop an acceptable plan of correction.

E. Qualifications for persons conducting compliance reviews

1. A person conducting compliance reviews will either:
 - a. Hold a bachelor's degree or graduate-level degree from an accredited college or university and have at least two years of full-time (or

- equivalent part-time) paid work experience working directly with individuals; or
 - b. Have been, without interruption, employed by or under contract with the DODD or a county board to conduct compliance reviews since June 30, 2019.
2. The person conducting compliance reviews will complete training in accordance with paragraph (F) of this procedure.
 3. The person conducting compliance reviews will not be an investigative agent or an SSA.

F. Training

1. DODD will provide or arrange for initial training to county boards and certified providers regarding the requirements and procedures outlined in rule 5123-2-04 and in the protocol for compliance reviews.
2. Any employees or agents of DODD or CCBDD whose responsibilities include conducting compliance reviews will successfully complete the initial training in the requirements and procedures prior to being authorized by DODD to conduct compliance reviews.
3. DODD will provide documentation of a person's successful completion of the initial training to the county board. CCBDD will maintain a list of the persons in its county that have successfully completed the initial training and are authorized by the department to conduct compliance reviews in accordance with this rule.
4. The department may require persons who have received the initial training to receive continuing training in the implementation of this rule in a manner prescribed by the department.

G. Certification suspension and certification revocation

1. DODD may initiate certification suspension or certification revocation proceedings if DODD finds:
 - a. Substantial violation of applicable requirements which present a risk to an individual's health and welfare; or
 - b. A pattern of non-compliance with plans of correction approved in accordance with this rule; or
 - c. A pattern of continuing non-compliance with applicable requirements; or
 - d. A licensed provider has had its license revoked by the licensing authority; or
 - e. Failure to cooperate with the compliance review process set forth in this rule; or
 - f. Other good cause, including misfeasance, malfeasance, nonfeasance, substantiated abuse or neglect, financial irresponsibility, or other conduct DODD determines is injurious to individuals being served. DODD may gather and evaluate information from a variety of sources, including CCBDD and the provider, in making such a determination.
2. Certification suspension and certification revocation proceedings will be conducted in accordance with Chapter 119 of the Revised Code.
3. When DODD issues a notice of its intent to suspend or revoke a certified provider's certification, the department will give written notice to the Ohio Department of Medicaid and to the county board of each county in which the proposed suspension or revocation is proposed to be effective.

4. Each county board that is notified in writing by DODD of their intent to suspend or revoke a certified provider's certification will so notify in writing each individual in the county who is receiving services for which the provider's certification is proposed to be suspended or revoked (or as applicable, the individual's parent or guardian).
5. DODD may suspend or revoke a certified provider's certification regardless of whether some or all of the deficiencies enumerated in accordance with this rule that prompted the department's intent to suspend or revoke the certification have been corrected at the time of the hearing.
6. When DODD suspends or revokes a certified provider's certification, the certified provider will comply with the DODD's adjudication order within thirty calendar days of the date of the mailing of the order.
7. DODD will give written notice of the certified provider's suspension or revocation to the Ohio Department of Medicaid and to the county board of each county in which the suspension or revocation is effective.
8. CCBDD will be notified in writing by DODD of suspension or revocation of a certified provider's certification as well as each individual in the county who is receiving services for which the provider's certification is suspended or revoked (or as applicable, the individual's parent or guardian).

Reference: 42 C.F.R 431.51, ORC: Chapter 119, 5123.044, 5126.046, 5160.31, 5101.35, 5126.055, 5123.19

OAC: 5123:4-02, 5123:2-9, 5123-9-01, 5123-2-04

Created: 10/2/2023; Effective: 11/09/2023

FAMILY SUPPORT SERVICES

- A. Family Support Services (FSS) is a program per Ohio Administrative Code (OAC) 5123:2-1-02, that provides support, services, and assistance to eligible families for the purpose of:
- enabling a family to care for their family member with developmental disabilities at home by assisting with specific expenses.
 - enhancing the quality of life for the family, including the individual with developmental disabilities.
- B. A family is eligible for FSS if their household includes a child or adult with a disability who has been determined eligible by the Clinton County Board of DD. The family's income is not considered in determining eligibility for the FSS program.
- C. A Board approved FSS Plan that outlines program guidelines shall be developed and maintained by the FSS Coordinator.

Approved by Board: 9/18/18

RESIDENTIAL AND SUPPORTED LIVING

- A. Within available resources and pursuant to sections 5126.051, 5126.40 through 5126.457 of the ORC, the Agency will provide for or arrange residential services and supported living services to eligible individuals residing in Clinton County in a manner that empowers them to exercise choice and enhance the quality of their lives.
 - 1. The Agency may acquire, convey, lease, or sell property for residential services and supported living and enter into loan agreements, including mortgages, for the acquisition of such property.
 - 2. Supported Living services provides support to individuals in adult foster care, development of independent living skills, transportation services, payee services, and other needed and requested services based on the availability of funds. Services are not limited to the above-mentioned areas, but rather are provided on the basis of individual choice.

- B. In accordance with Rule 5126.43 of the ORC, the Agency shall arrange for Supported Living in one or more of the following ways:
 - 1. By contracting under section 5126.45 of the Revised Code with providers selected by the individual to be served;
 - 2. By entering into shared funding agreements with state agencies, local public agencies, or political subdivision at rates negotiated by the Agency;
 - 3. By providing direct payment or vouchers to be used to purchase supported living services, pursuant to a written contract in an amount determined by the Agency, to the individual *or* a person providing the individual with protective services as defined in section 5123.55 of the Revised Code.

- C. The Individual Service Plan (ISP) shall be developed by the individual with the support of a certified Service and Support Administrator (SSA) and other persons of the individual's choice. The plan shall be based upon the individual's choices and shall document the services that are needed to support the choices of and meet the needs of the individual. The Agency shall promote conditions that will provide a valued lifestyle for the individuals served.

- D. The Agency shall develop and implement a provider selection system. Each system shall enable an individual to choose to continue receiving supported living from the same providers, to select additional providers, or to choose alternative providers.

- E. All providers must be certified by the director of developmental disabilities to provide supported living services.

- F. The Agency will have a written contract with the provider of supported living in accordance with ORC 5126.45. The contract is based on the individual service plan. The plan may be submitted as an addendum to the contract. An individual receiving service pursuant to a contract shall be considered a third-party beneficiary to the contract.

Revised: 6/16/15

SUPPORTED LIVING CONTRACTS PROCEDURE

- A. The contract is negotiated between the provider and the Agency. The terms of the contract shall include at least the following:
 - 1. The contract period and conditions for renewal;
 - 2. The services to be provided pursuant to the individual service plan;
 - 3. The rights and responsibilities of all parties to the contract;
 - 4. The methods that will be used to evaluate the services delivered by the provider;
 - 5. Procedures for contract modification that ensure all parties affected by the modification are involved and agree;
 - 6. A process for resolving conflicts between individuals receiving services, the Agency, and the provider, as applicable;
 - 7. Procedures for the retention of applicable records;
 - 8. Provisions for contract termination by any party involved that include requirements for an appropriate notice of intent to terminate the contract;
 - 9. Methods to be used to document services provided;
 - 10. Procedures for submitting reports required by the Agency as a condition of receiving payment under the contract;
 - 11. The method and schedule the Agency will use to make payments to the provider and whether periodic payment adjustments will be made to the provider;
 - 12. Provisions for conducting fiscal reconciliations for payments made through methods other than a fee-for-service arrangement.

- B. Payments to the provider under a supported living contract will be determined by the Agency to be reasonable in accordance with Agency policies and procedures. Goods or services provided without charge to the provider is not included as expenditures of the provider.

**RENT SUBSIDY
SUPPORTED LIVING AND
HOME AND COMMUNITY BASED WAIVER SERVICES**

A. OBJECTIVE

The objective of this document is to provide a set of standardized procedures and guidelines for individuals receiving supported living services/Home and Community Based Waiver Services (HCBS) as they and their teams complete their subsidy application and calculations. The procedures and guidelines are designed to assist the individuals and the team in completing fiscally prudent subsidy programs that utilizes individual, family and community resources and only uses County Board funds as a last resort. Granting of County Board funds will be based on availability of said funds and at the discretion of the County Board.

B. ELIGIBILITY REQUIREMENTS FOR RENT SUBSIDY

1. The individual must have been a resident for at least a year, or if they were a previous resident; moved back to the county for at least a year.
2. Individuals receiving subsidy must be working/volunteering or participating in day activities at least 15 hours or more per week unless they have a medical or psychiatric exemption, or are 60 years of age or older and choose to retire. Documentation of exemptions may be requested by the Board.
3. Individuals must verify they have applied for available public assistance and are willing to accept assistance when available. This includes application for Section 8 subsidy from Clinton County Metropolitan Housing and their waiting lists if applicable.

C. RENT SUBSIDY GUIDELINES

This procedure applies to “Community Residential” homes. When an individual enters the Supported Living/HCBS Program they may apply for rent subsidy from the Board. The rent subsidy program follows the guidelines and payment standards of the Clinton Metropolitan Housing Authority and local Housing and Urban Development Programs.

NOT COVERED

1. Any residential setting costs that qualifies for an ICF/IID or would otherwise be considered a nursing home.
2. Insurance premiums including but not limited to: homeowners, health, life, vehicle, renters, etc.
3. Household furnishings: Individuals are responsible for obtaining individual and household items.
4. Individual Vacation expenses, lodging and transportation of providers, subsidized individual income, phones/phone service, or any non-essential services.
5. Household expenses related to non-eligible family members and/or roommates in the home including dependent children. This includes respite and memberships for non-eligible family members and roommates.

6. Individual insurance premiums or expenses related to medical or dental care including but not limited to prescribed medications, hospital stays, surgery, inpatient treatment, etc.
7. Rent will not be subsidized for individuals living in property owned by a family member.
8. Rent will not be subsidized for individuals living in property owned by a trust/foundation, or like entity.
9. Items and activities such as alcohol, tobacco, firearms, gambling, pornography, drugs or other illegal articles/activities.

D. INDIVIDUAL RESPONSIBILITIES

1. The individual/guardian/family/provider will contact the County Board Service and Support Division, and make application for subsidy via the individual service plan.
2. All documentation of income (earned and unearned), assets, and resources will be provided.
3. The individual shall pay 30% of all income toward rent and utilities.
4. Total individual subsidy consideration cannot exceed \$400.00; the tenant will pay any costs over this amount.
5. The individual shall maintain employment/day activity/volunteer work for a minimum of 15 hours weekly, or provide documentation for exemption (as listed previously above).
6. The individual shall maintain the upkeep of the rental property including inside cleanliness and outside trash and grounds when the lease requires.
7. The individual shall follow tenant and landlord rights and responsibilities according to the Ohio Revised Code and the lease agreement.
8. The individual shall be responsible for reporting any maintenance needs to the landlord.
9. The individual will pay their portion of the rent by the 5th of the month.
10. The individual should explore alternative forms of rental subsidy programs and provide documentation of such before applying for the County Board's rent subsidy program, i.e. HUD, Clinton Metropolitan Housing.
11. The individual must report changes in financial status to the County Board immediately so the rent subsidy can be re-determined. Failure to report may cause ineligibility.
12. Subsidy will be re-determined annually.
13. Payment will only be made to the landlord. Therefore, a landlord must be processed as a vendor through the County Board prior to the subsidy becoming effective.
14. The individual service plan will be revised by the individual's team and will identify if/when an individual has been determined eligible to receive rent subsidy through the County Board.

E. PROCESS FOR NEW APPLICATIONS

1. Application/request will be made to the SSA by the individual, guardian, payee, provider, etc.
2. The SSA will complete the County Board referral form.
3. The SSA will request and attach to the referral; supporting documentation of monthly utility expenses along with documentation of unearned and earned income.
4. The SSA will include in the referral packet documentation: the rent amount, the name, address, and contact information of the landlord.
5. The SSA will submit the referral along with the supporting documentation to the SSD.
6. The SSD will forward the referral packet to the Administrative Secretary for processing.
7. The Administrative Secretary will review the application packet and complete the spreadsheet calculations to determine eligibility.
8. The Administrative Secretary will ensure the landlord has been set up as a vendor once eligibility for the rent subsidy program has been determined.
9. The Administrative Secretary will complete a form letter to notify the Fiscal Clerk, the Business Manager, the SSM and the SSD as to whether or not an individual is eligible for the rent subsidy program. The form letter will include the effective date of the subsidy, the subsidy amount, and when the next redetermination is due. A copy of the subsidy spreadsheet will be attached to the form letter that is sent to the SSM and SSD.
10. The SSM or the SSD will then ensure that a copy of the form letter is shared with applicable parties (SSA, individual/guardian/family member, payee, provider, and landlord).
11. The form letter identifying an individual's eligibility or ineligibility must be sent to the Fiscal Clerk and Business Manager by the 25th day of the month (two months prior to the effective date), so payment is issued by the first of the month (i.e. form letter should be submitted on or before the 25th of November for rent subsidies effective January 1st).
12. The SSA will complete an ISP addendum if applicable; forward a copy of the form letter, and the spreadsheet to the individual's file.

F. PROCESS FOR ANNUAL REDETERMINATIONS

1. The Administrative Secretary will request (via email or in writing), documentation of earned and unearned income and the cost of monthly utilities from the SSA in October of each year.
2. The SSA will submit documentation requested by November 1st of each year.
3. If there is change in landlord the SSA will include in the referral packet documentation: the rent amount, the name, address, and contact information of the landlord.
4. The Administrative Secretary will complete the application packet and eligibility worksheet.
5. If there is a change in landlord: the Administrative Secretary will ensure the landlord has been set up as a vendor.
6. The Administrative Secretary will complete a form letter to notify the Fiscal Clerk, the Business Manager, the SSM, and the SSD as to whether or not an individual is eligible for the rent subsidy program. The form letter will include the effective date of the subsidy, the subsidy amount, and when the next redetermination is due. A copy of the

subsidy spreadsheet will be attached to the form letter that is sent to the SSM and the SSD.

7. The SSM or the SSD will then ensure that a copy of the form letter is shared with applicable parties (SSA, individual/guardian/family member, payee, provider, and landlord).
8. The form letter identifying an individual's eligibility or ineligibility must be sent to the Fiscal Clerk or Business Manager by the 25th day of the month (two months prior to the effective date), so payment is issued by the first of the month (i.e. form letter should be submitted on or before the 25th of November for rent subsidies effective January 1st).
9. The SSA will forward a copy of the form letter and the spreadsheet to the individual's file.

G. EXAMPLES OF SUPPORTING DOCUMENTATION:

Unearned and Earned Income:

- ~Last social security award letter, AND
- ~Copies of the last months paystubs (i.e. four paystubs if paid weekly), OR
- ~Most recent checking/savings account statement showing both unearned and an average of earned income for a month

Expenses

- ~Most recent checking account statement with an average cost of monthly utilities (electric/heat/gas, water, sewage and trash), OR
- ~Utility bills for the past two months to obtain an average

Revised: 12/21/2017

RESIDENTIAL PROGRAMS FOR CHILDREN PROCEDURE

- A. In accordance to section 5126.04 the Agency plans and set priorities based on available resources for the provision of facilities, programs, and other services to meet the needs of county residents who are individuals with developmental disabilities, former residents of the county residing in state institutions or placed under purchase of service agreements under section 5123.18 of the Revised Code, and children subject to a determination made pursuant to section 121.38 of the Revised Code.

- B. Except as required in section 5126.04(B) and section 121.38 of the Revised Code, residential services to children are not planned by the Board as a priority, except for Medicaid eligible individuals receiving wavier services. Residential programs for children will only be considered after all the residential needs of adults are met. Children may receive waivers through the waiting list process.

- C. The Service and Support Manager may assist in applying for any funds available from other sources (see section 5.05 of this manual).

- D. The Agency's assistance with residential placement of children is determined by:
 - 1. A court order; or
 - 2. A recommendation by the case review team. The Agency must agree with the recommendation.
 - 3. Funding is agreed upon and shared by the member Agencies on the case review team.

RESIDENTIAL SERVICES EMERGENCY DETERMINATION PROCEDURE

PURPOSE/GOAL: To establish consistent methods for assessing and providing services in emergency situations.

- A. As defined in ORC Section 5126.042 “emergency” means any situation that creates for an individual with developmental disabilities a risk of substantial self-harm or substantial harm to others if action is not taken within thirty days. An “emergency” may include one or more of the following situations.
 - 1. Loss of present residence for any reason, including legal action;
 - 2. Loss of present caretaker for any reason, including serious illness of the caretaker, change in the caretaker’s status or inability of the caretaker to perform effectively for the individual;
 - 3. Abuse, neglect or exploitation of the individual;
 - 4. Health and safety conditions that pose a serious risk to the individual or others of immediate harm or death;
 - 5. Change in the emotional or physical condition of the individual that necessitates substantial accommodation that cannot be reasonably provided by the individual’s existing caretaker.

- B. When notification is made to the Service and Support Administration Division that one or more of the above defined conditions exist, the division shall make every effort to document the following:
 - 1. Gather facts regarding the nature of the emergency (making written follow-up-notification via unusual incident reporting, case notes, etc).
 - a. If medical in nature – emergency hospital service may be indicated, a MUI/IA investigation may be needed/filed using the criteria already established by the Quality Assurance Division based upon MUI/IA protocol
 - b. Make arrangements for prompt first aid or medical intervention. Contact guardian or next of kin if possible. (Police/Sheriff Dept. can exist in getting word to guardian if phone contact is not possible.)
 - c. If safety is a factor, police intervention may be necessary. Contact Police/Sheriff Dept. again following criteria of the MUI/IA protocol.
 - d. Initiate eligibility determination if not already determined.

 - 2. Assessment of immediate needs
 - a. If there is a loss of caretaker or provider it is necessary to contact the next of kin or guardian. Make arrangements for another family member or significant other to provide temporary arrangements.
 - b. If there is no next of kin/guardian then the Service and Support Administration Division will attempt to develop a temporary emergency shelter/residential situation which may include in home supports, placement in a licensed facility, placement in an existing supported living home, placement in an emergency respite home or other contracted residential service, depending on the needs of the individual, and may include contact with the Residential Advisory Council Inc. for assistance.
 - c. Establish timeline for the intervention – within 24 hrs, 2 weeks or 30 days.

- d. All emergencies will be assessed and documented utilizing the *Service Assessment Protocol*. Additional assessments that reflect the emergency (Safety Assessment, Behavioral Assessment, Risk Assessments) can be attached. A memo to the SSA Director summarizing nature of emergency and recommendations for addressing emergency. Assessment (s) will be submitted to the Service and Support Director for review/signature prior to approval of emergency services/funds.
3. Plan for assistance
- a. Emergencies normally revolve around finding funds or alternative placements. If this is the situation then explore funding options of:
 - i. Natural supports such as family members, etc.
 - ii. Family Supports program
 - iii. Donations from various organizations.
 - iv. Board approved funds
 - v. Request waiver from the department if emergency criteria is met and approved by Superintendent as part of emergency plan.
 - vi. Supported Living funds are only a short-term option until a waiver would become available.
 - b. Housing alternatives related to supervision and personal care needs.
 - i. Check the vacancy registry with the department online
 - ii. Do a statewide search of all 88 county boards
 - iii. Pursue local housing options – licensed facilities, and other programs such as mental health, foster care, etc.
 - iv. Pursue placements with other Individuals in a supported living/waiver program.
 - c. Assistance with other needs – complete ISP addendum.
 - i. Resources – Application to SS/SSI, Medicaid, food stamps, etc.
 - ii. Utilities – HEAP, community services, churches
 - iii. Adaptive Equipment – pursue Medicaid for payment first; if not funded, pursue Family Supports
 - iv. Other – use any of the above and/or contact social groups (ie. Lions), churches, etc. for donations or funds.

C. Emergency Services with existing ISP

When an Individual is in need of emergency services or an increase/change of services and has an existing ISP, complete the following:

1. Have an emergency meeting for an ISP addendum.
2. Identify the services that need to be established or developed. These are services with the existing provider or work program. Examples may be change of work assignments, behavior plans, adaptive equipment, etc.
3. Contact SSA Director to determine funding availability. Submit any cost information and estimates for preliminary cost approval.
4. Authorize funds via existing budget – Family Supports, Supported Living, and/or waivers.
5. Assign the current provider to develop or complete services.

6. Complete ISP addendum form, PAWS, or other funding forms (SL contract-SSA Director and Provider) where applicable.

D. Emergency Services for Starting a New Service Provider (Residential Alternatives)

1. Hold an emergency meeting or consultation documenting the emergency; check all natural supports; and/or agencies for benefit payment of needed services.
2. Identify the services, which need to be established or developed.
3. Contact the SSA Director to determine funding availability. Submit any cost information; initial assessment of needs report; and estimates for preliminary cost approval.
4. Start provider selection process. A true emergency indicates that services need to start within 24 hours to 2 weeks, or at the longest 30 days if given prior notice of upcoming changes.
5. Complete application process gathering all required data. If waiver, complete all necessary forms for emergency approval including the *Service Assessment Protocol* and checklists.
6. Hold ISP meeting. Complete ISP addendum or new annual ISP.
7. Start services and monitor that health and safety needs are met.

TRANSPORTATION

- A. The Agency shall ensure, within planning and priorities set forth in the Agency's strategic plan, an array of transportation services are available to eligible individuals with disabilities as defined under the Eligibility Determination Policy. The Agency shall provide transportation services through collaborative arrangements with other entities.
- B. Transportation services shall be provided in accordance with an individual's Individual Service Plan, as applicable, and shall incorporate within the ISP any specific transportation services and supports.
- C. Providers of non-medical transportation services shall follow Ohio Administrative Code Chapter 5123:2-9 Home and Community-Based Services Waiver rules as well as all other applicable federal, state and local transportation rules.
- D. Local funded specialized transportation shall be provided in compliance with OAC 5123:2-1-03. Providers shall provide services in accordance with their contracts with the Agency and the individual's ISP.
 - 1. Each contract shall specify the terms and conditions for the delivery of training, services, and supports to individuals served and shall be in compliance with applicable law.
 - 2. The Agency shall ensure that the contract meets such requirements and that contracting entities are trained in and have access to applicable rules in the Administrative Code.
 - 3. The Agency shall ensure the development and provision of appropriate annual safety instruction to all individuals who use specialized transportation and/or annually communicate safety information to appropriate family members, as applicable, and caregivers.
- E. Each provider shall annually document that all relevant rules and regulations are being followed. This documentation will also show that these contractors have been trained and have access to the appropriate rules and regulations including those federal and state regulations governing Medicaid.

Revised: 6/16/15

TRANSPORTATION

- A. The Clinton CBDDD employees may provide transportation services to individuals when no other collaborative arrangement can be made with family, neighbors, friends, community agencies or other providers. Employees shall provide transportation in a safe and efficient manner and in the most normalized mode possible for each individual.
- B. Drivers shall be responsible for compliance with all regulations contained in:
1. Transportation Policy 5.08
 2. Ohio Department of Public Safety Motor Vehicles Laws
 3. Personnel Policies:
 - 3.05 – Background Checks
 - 3.10 – Medical Examinations
 - 6.01 – Training
 - 8.05 – Drug-Free Workplace
 - 8.06 – Drugs & Alcohol
 - 8.07 – Drugs & Alcohol Testing
 - 9.01 – Vehicles
 - 9.05 – Cellular Telephones
 - 10.01 – Safety & Health
 - 10.02 – Accidents & Incidences
 - 10.04 – Building & Employee Security
 - 10.05 – Smoking
 - 11.06 – Expense Reimbursement
 4. In addition, the Agency shall adhere to any restrictions placed upon the Agency by vehicle insurance carriers including but not limited to age requirements, driving experience, and driving record.
- C. Drivers are required to attend the Agency's annual in-service training as well as complete additional specialized transportation training. The training will include but not be limited to the following topics:
1. Rights of individuals
 2. Incidents adversely affecting health and safety
 3. Transportation policies and procedures
 4. General needs and characteristics of individuals
 5. Vehicle operation
 6. Proper use, operation, and safety inspection of adaptive equipment and securement systems (wheelchairs, vests, car seats, etc.)
 7. Safe operation of wheelchair lift systems and the safe loading and unloading of individuals
- D. Drivers will obtain from the SSAs necessary individual specific information that may affect safe transportation and medical well-being while being transported. The driver will keep the information confidential and readily accessible in the event of an emergency. This information will include but not be limited to:
1. The identity of all authorized passengers in addition to the individual (family members,

- caregivers, volunteers, etc.)
2. The interventions specified in the ISP of individuals being transported including specifics concerning how relevant restraints should properly be used during transportation as well as non-violent crisis intervention strategies identified in the ISP.
- E. Agency vehicles will be equipped with the following in a safely secured area of the vehicle:
1. Storage space for removable equipment and passenger property.
 2. Fire extinguisher
 3. Emergency first-aid kit
- F. Drivers shall carry their Agency cell phone for communications needed for transportation reasons, but must adhere to Personnel Policy 9.05.
- G. Each day prior to transporting an individual the driver will complete and document a pre-trip safety inspection including testing of lights, windshield washers/wipers, emergency equipment, mirrors, horn, tires, and brakes and at the conclusion of the trip complete and document a post-trip inspection for remaining passengers and belongings.
- H. Inclement weather: Non-essential transportation services may be cancelled during inclement weather or other emergencies.
- I. Vehicle failure: Should the vehicle fail, the driver shall:
1. Move vehicle off roadway if possible to prevent accidents with other vehicles.
 2. Notify the Superintendent or designee.
 3. Ensure the safety of the passengers.
 4. Secure vehicle and protect scene.
 5. The Superintendent or designee shall arrange for another vehicle.
- J. If the driver becomes ill or disabled while transporting, he/she shall remove the vehicle from the roadway into a parking lot or driveway. The driver shall contact the Superintendent or designee and request assistance. At all times, safety shall be the primary consideration in evaluating the situation.
- K. If a passenger is exhibiting behaviors in the vehicle that are a danger to him or to others, the driver should park the vehicle in a safe place off the road, turn off engine, and set parking brake until driver can continue transporting passengers safely. The driver shall then notify the Service and Support Administrator in writing by completing an incident report. The Service and Support Administrator will review the incident and make recommendations to support the passenger.
- L. Drivers shall use their best judgment in situations that are dangerous or threatening such as, weapons on the vehicle, assault situations, unauthorized attempted boarding, and impeding the movement of the vehicle. The driver shall immediately call 911. Notify the Superintendent or designee as soon as it's safe to do so.

ACCIDENT

1. Driver shall evaluate the need for medical assistance and notify law enforcement/medical emergency (911).
2. Driver will protect the accident scene and ensure the safety of the passengers.
3. Driver will notify the Superintendent or designee of any accident giving the following information:
 - injuries
 - location of accident
 - how many individuals in vehicle at time of accident
 - if injuries; how severe, ambulance dispatched, hospital, etc.
 - any changes in schedule due to delay
4. If the ambulance is dispatched or individuals are injured, the Superintendent or designee will notify the parent/guardian/residential provider of hospital and its location.
5. Driver will collect and record data essential to the preparation of required reports.
6. If another motorist is involved, the driver will give name, address, driver's license number and vehicle information to the other motorist and request the same information from the other driver.
7. Driver will notify the SSA Department with the above information to determine if the incident needs to be reported as a MUI and follow up with a written incident and accident report.
8. Driver will call a responsible person at the individual's residence to notify them of accident for those passengers who were not transported to hospital.

MEDICAL EMERGENCY

All Agency personnel transporting individuals shall be trained in First Aid & CPR and shall utilize this training in the event of a medical emergency.

In addition:

1. Determine if a health and safety issue exists for the individual or for other individuals on the vehicle.
2. If a health and safety issue exists then the driver will call 911.
3. Notify the SSA department who will determine if the incident needs to be reported as a MUI and follow up with a written incident and accident report.
4. The Service and Support Administrator will contact the parent, guardian or care provider and inform them that “911” has been called and the individual will be taken by ambulance to the closest medical facilities unless specified otherwise on an Emergency Medical Authorization form.

SEIZURE

This procedure should be discussed in ISP meetings with individuals, parents and guardians so they are aware.

If a seizure occurs while in route, the driver is to park the vehicle in a safe place off the road, turn off engine, set parking brake and assist the person having the seizure as per the following instructions:

1. Do not restrain the individual.
2. Put a blanket or clothing next to their head, but **NOT** under it, to protect them from injury.
3. Remove items from the area that may cause the individual harm.
4. Let the seizure run its full normal course.
5. After the seizure, roll the individual to their side with their head tilted back.
6. **DO NOT** Go anywhere near the mouth or put anything in the mouth
7. **Call 911 immediately for the following:**
 - The seizure lasts more than 5 minutes, or the person has multiple seizures in a row
 - The person was injured as a result of a seizure
 - The person is unresponsive and not breathing or only gasping after the seizure
 - The person is pregnant or diabetic
 - The person is a young child or infant and the seizure was brought on by a fever
 - The person is elderly
 - This is the person's first seizure, or the cause of the seizure is unknown
 - The seizure took place in water
8. Observe the details including duration of the seizure, and report it on Agency board seizure report for individuals with known seizure condition.
9. If potential injury from seizure, or 911 was called, also document on Agency unusual incident report.
10. When the passenger regains consciousness, he/she may be incoherent or very sleepy. Let the passenger rest if he/she desires.
11. Help the other passengers understand about seizures. Try to treat the passenger as normally as you treat others.
12. Call Superintendent **AS SOON AS POSSIBLE** with the following information:
 - Your location (street you are on and the nearest cross street)
 - Individual's name.
 - Condition of the person.
 - Contact, or have Superintendent contact Place of Residence to notify them of the seizure.
 - Complete Agency Unusual Incident Report when: seizure condition was unknown; 911 was notified, injury occurred as result of seizure.

SEIZURE REPORT

Name: _____ Date: _____ Time: _____

Location: _____ Duration of Seizure: _____

Pre-Seizure Observation: _____

Other Information (include Triggers, Auras, Emergency Medication Guideline, Medical Device Guideline):

OBSERVATIONS DURING SEIZURE

- _____ CRIED OUT
- _____ FELL
- _____ BECAME RIGID
- _____ DROP-TYPE SEIZURE
- _____ APNEA

POST SEIZURE OBSERVATIONS

- _____ CONFUSED
- _____ DROWSY
- _____ DEEP SLEEP
- _____ BIT TONGUE

HAD SINGLE REPEATED JERKING OF:

- _____ RT. ARM _____ LEFT ARM
- _____ RT. LEG _____ LEFT LEG
- _____ WHOLE BODY

- _____ DEFECATED
- _____ URINATED
- _____ ANY OTHER INJURY (DESCRIBE):

HAD RHYTHMIC JERKING OF:

- EYES TURN** _____ RT. _____ LEFT
- _____ WAS UNCONSCIOUS (HOW LONG)
 - _____ DURATION
 - _____ VOMITED

PRESENT MEDICATION AND DOSAGE:

OTHER

- _____ EYES BLINKING
- _____ MOMENTARY STARING
- _____ CHEWING MOVEMENT OF LIPS
- _____ HEAD NODDING
- _____ ANY OTHER UNUSUAL PATTERNED BEHAVIOR (describe on back of this form)

- _____ VAGAL NERVE STIMULATOR?
- _____ MAGNET USED?

OBSERVER/REPORTED BY: _____

COMMENTS: _____

Cc: SSA and Co. Bd. Nurse

REVISED 5-11-2011

TORNADO PROCEDURES

- A. If a tornado warning is received prior to the beginning of transportation, the driver shall not pick-up individual until the "**ALL CLEAR**" is announced.
- B. Protection of the passengers on the vehicle in transit is the primary responsibility of the driver. As soon as the driver visually observes a tornado, the driver shall take the following action:

In Rural Areas:

1. If possible, park vehicle off roadway away from large trees, power lines, poles or buildings;
2. Evacuate vehicle, take first aid kit.
3. Position individuals away from the side of the vehicle without crossing the highway.
4. Position individuals in the lowest area available such as a ditch, hollow, ravine, culvert or embankment.
5. After danger has passed, driver shall check individuals for shock or injury;
6. Administer necessary first aid and request assistance;
7. If assistance is not needed, proceed with transportation;
8. The driver shall contact the Superintendent if further instructions are needed;
9. An incident report must be completed within the established timelines.

In Urban Areas:

1. Park vehicle immediately;
2. Give command to evacuate vehicle, take first aid kit;
3. Send individuals into nearest building after obtaining permission of building management;
4. After danger has passed, driver shall check individuals for shock or injury;
5. Administer necessary first aid and request assistance;
6. If assistance is not needed, proceed with transportation;
7. Driver shall contact Superintendent if further instructions are needed;
8. An incident report must be completed within the established timelines;

In the event that a tornado warning is issued after the transportation starts, the driver shall:

1. Continue to listen to the radio for updates.
2. Contact the Superintendent for further instructions;
3. Make a judgment based on information available and observable weather conditions as to whether the vehicle should be evacuated.

WHEELCHAIR REQUIREMENTS

- A. Each passenger in a wheelchair must have a pelvic belt holding his/her hips to the back of the seat. This belt must be securely fastened before the passenger gets on the vehicle.
- B. Passengers who require a shoulder strap system and/or side-to-side pads should have the strap fastened securely and side-to-side pads in place before the passenger gets on the vehicle. The strap system should be fastened on the back of the seat and looped through either the pelvic belt or the additional belt, provided for many of the harness systems, in front of the passenger.
- C. Passengers who require a headrest must have the headrest in place at all times. If the headrest system is missing or if the passenger's head is not positioned in the usual manner, the corrections need to be made before the passenger gets on the vehicle.
- D. Strollers cannot be used in place of wheelchairs.
- E. There are many things that can affect the safe transportation of wheelchairs. Items which must be on the wheelchair and working properly before transportation starts are:
 - 1. **Brakes**-they must both be securely attached to the chair and both hold securely. The chair must not roll when locked.
 - 2. **Tire tread**-it must be sufficient for brakes to grip the wheel.
 - 3. **Tire inflation**-it must be sufficient to hold tire up under the brakes.
 - 4. **Wheels**-they must be secure to chair, and not crooked to frame.
 - 5. **Seat belt**-it must be attached to the frame of the chair, not with plastic clips, and no Velcro. It must have a buckle.
 - 6. **Seat/Seat back**-should not have excessive wear, or be torn.
 - 7. **Frame**-it cannot have any cracks, or be bent out of shape.
 - 8. **Bolts**-none should be missing, and all must be secure.
 - 9. **Special equipment**-must be listed on an IEP or IP form.
 - 10. **Electric chairs**-the power to the wheels must be able to be shut off and wheelchair rolled by hand. The electric is NOT to be used after the vehicle left leaves the ground.
 - 11. **Reclining seat backs**-must be upright for transport.
 - 12. **Trays**-if not needed for support, may be removed for transport.
 - 13. If chair is equipped with **tip bar**, it must be in place.
- F. These items need to be checked daily for excessive wear or breakage, and repaired before transport.

EPI-PEN/MEDICATION PROCEDURE

- A. To ensure the health and safety of all clients, an Epi-Pen or other medication will be given to the driver on the vehicle for any individual that has current physician orders.
- B. If the Epi-Pen is NOT given to the driver or is expired or damaged, the individual will not be transported. All expired Epi-Pens will be given back to individual, guardian/staff to be destroyed according to their policy and procedure. The Epi-Pen/Medications will be kept in an easily accessed, but secure location on the vehicle to ensure the health and safety of other passengers. This medication cannot be exposed to extreme hot or cold temperatures.
- C. Epi-Pens/Medication will be discussed at the annual ISP meeting.
- D. The driver will document he/she has received and returned the Epi-Pen/Medication
- E. Once the individual arrives at their destination, the Epi-Pen/Medications will be kept in a secure, but easily accessed location near that client.
- F. If the individual is unable to administer their own medication:
 - 1. **Call 911.**
 - 2. You may assist the person using an Epi-Pen when the person has a previous diagnosis of anaphylaxis and been prescribed the auto-injector.
 - 3. The person is having signs and symptoms of anaphylaxis.
 - 4. Have the person sitting in a comfortable position, or have them lie down if he/she is showing signs of shock.
 - 5. The person requests your help using an auto-injector and the State of Ohio permits this assistance.

TRANSPORTATION OF INDIVIDUALS WITH OXYGEN SUPPLIES

- A. The Agency may, at the discretion of the Superintendent transport individuals with oxygen. Medically necessary oxygen may be transported provided it is properly secured. The oxygen must be housed in portable units less than fifteen pounds total weight each.

- B. It is the responsibility of the Agency to:
 - 1. Eliminate as much as possible the risk of potential danger of injury or death due to use of oxygen and supplies on program vehicles.
 - 2. To provide all related staff with information and training on oxygen and associated supplies.
 - 3. To inform all other staff as to "awareness" of the use/presence of oxygen and what it means.
 - 4. It is further the responsibility of the Agency Employees to:
 - a. Adhere to all components of this policy.
 - b. Be aware of the regulations.
 - c. Be familiar with emergency procedures and locations of nearest means of communication in the case of an emergency.

- C. When the transportation of oxygen on Agency vehicles has been approved by the Superintendent, oxygen will only be transported when it is medically necessary. The individual's ISP must document the oxygen use requirement.
 - 1. Prior to initial transportation, administration and drivers shall be informed as to the type and size of the oxygen tank to be transported.
 - 2. Regarding an individual using oxygen only on an "as needed" basis, the decision as to what is necessary is the responsibility of trained medical personnel only. This decision is not the responsibility of the vehicle operator or aide.
 - a. A determination must be made as to who will load and unload the medical support equipment. Appropriate training will be provided for these procedures.
 - 3. Employees shall refer to the Agency's emergency plan in the event of a medical emergency or equipment failure.
 - 4. Only one medical support device per individual shall be transported unless otherwise approved by the Superintendent.
 - 5. The county board will not assume responsibility for storing any medical equipment.
 - 6. Changes in medical equipment or transportation must be so noted on the ISP.
 - 7. In the event a vehicle breaks down and oxygen must be transported without proper securement the driver the Superintendent for instructions for the transportation of the oxygen in the replacement vehicle.

- D. Oxygen must be transported in a secure container maintained in accordance with the manufacturer's instructions. The oxygen must be housed in a portable unit and should be less than 15 pounds total weight.
 - 1. Gas oxygen tanks shall have a maximum capacity of twenty-two (22) cubic feet (Medical E). Medical E tanks are usually no larger than 4 ½ inches in diameter and 31 inches in length.
 - 2. Liquid oxygen units shall have a maximum capacity of thirty-eight (38) cubic feet and be no larger than 5 inches in diameter and 13 inches in length. For transportation purposes,

- these units must not be larger than 38 cubic feet.
3. All oxygen shall have valves and regulators that are protected against breakage. Manufacturer's precautions are usually printed on a label attached to the cylinder and should be followed whenever possible.
- E. All oxygen tanks shall be securely attached to prevent movement and leakage. This securement should be located on the sidewall of the vehicle in the upright position at a rib or body support in a rack or mounting bracket capable of sustaining five (5) times the weight of the tank and contents.
1. Since they are under pressure and could accelerate a fire, all oxygen tanks (gas or liquid) must be secured away from intense heat or friction.
 2. In cases where the oxygen is attached to a wheelchair or other support equipment, the tank shall be removed and secured prior to transport.
 3. Oxygen tanks or other medical support equipment shall never be stored or secured in the head impact zone.
- G. A decal shall be placed on the vehicle indicating medical support equipment is in use to notify emergency personnel in the event of an accident.

Approved by Superintendent 1/17/17

HOME AND COMMUNITY-BASED SERVICES WAIVERS

- A. The Clinton County Board of Developmental Disabilities shall participate in the Home and Community-Based Services Waiver (HCBS) program in accordance with the OAC 5123:2-9.
- B. Requests for waivers shall be based upon the Agency's available funds for local match requirement and the staff and provider capacity to administer waiver services.
- C. Under the direction of the Superintendent, the Service and Support Administration Unit shall be responsible for the administration of the Agency's waiver program.
- D. The Agency shall use the rule referred to in para. A above as the Agency procedures for the HCBS Waiver program and services.

COMPREHENSIVE SOCIAL SERVICES BLOCK GRANT

- A. The Clinton County Board of Developmental Disabilities agrees to enter into a contract with the Ohio Department of Developmental Disabilities (herein referred to as the "Department") to participate in the Comprehensive Social Services Block Grant (CFDA 93.667) dealing with developmental disabilities services.
- B. The Social Services Block Grant program is authorized under Title XX of the Social Security Act, as amended, and is codified as 42USC 1397 through 1397e.
- C. The Agency agrees to work cooperatively with the Department to carry all grant program objectives, maximize the use of Title XX federal assistance, and ensure services listed in the Comprehensive Social Services Profile are provided to developmentally disabled residents in the community.
- D. The Agency agrees to provide to the Department all necessary monthly and quarterly reports, documentation of services, and eligibility information according to the guidelines established by the Department.
- E. The Agency agrees to provide Title XX services as defined in 5101:2-25-01 of the Ohio Administrative Code.
- F. The Agency agrees reimbursement for Title XX services will not exceed the Department authorized Title XX allocation amount.
- G. The Agency agrees to provide Title XX Services without regard to income to individuals who are determined eligible for Board services based on the Ohio Eligibility Determination Instrument (OEDI).
- H. The Agency's Title XX services will be billed in accordance with the DODD's procedures for quarterly invoicing. The Agency will use the fee schedule established by the Department for billing.
- I. The Agency will re-determine eligibility for Title XX funded services no less than annually.

TARGETED CASE MANAGEMENT SERVICES

- A. The Clinton County Board of Developmental Disabilities shall provide Targeted Case Management Services (TCM) in accordance with ORC 5126.15, OAC 5123:2-1-11 and OAC 5160-48-01 to eligible individuals with developmental disabilities (DD).
- B. Targeted Case Management is a service which will assist individuals in gaining access to needed medical, social, educational, and other services described in OAC 5160-48-01. Targeted case management is also referred to as Medicaid case management.
- C. The Board shall request Medicaid payment of TCM services provided to Medicaid eligible individuals in accordance with all Medicaid rules and regulations. Individuals eligible for Medicaid TCM services are:
1. Medicaid eligible individuals, regardless of age, who are enrolled on home and community-based service (HCBS) waivers administered by the DODD, and
 2. All other Medicaid eligible individuals, age three or above, who are determined to have a developmental disability according to ORC 5126.01.
- D. The following activities are reimbursable only if provided to or on behalf of a Medicaid eligible individual and only if provided by a Board employee certified in Service and Support Administration:
1. **Assessment.** Activities reimbursable under the assessment category are limited to the following:
 - (a) Activities performed to make arrangements to obtain from therapists and appropriately qualified persons the initial and on-going assessments of an eligible individual's need for any medical, educational, social, and other services which includes employment-related.
 - (b) Eligibility assessment activities that provide the basis for the recommendation of an eligible individual's need for HCBS waiver services administered by DODD.
 - (c) Activities related to recommending an eligible individual's initial and on-going need for services and associated costs for those individuals eligible for HCBS waiver services administered by DODD.
 2. **Care planning.** Activities reimbursable under the care planning category are limited to the following:
 - (a) Activities related to ensuring the active participation of the eligible individual and working with the eligible individual and others to develop goals and identify a course of action to respond to the assessed needs of the eligible individual. These activities result in the development, monitoring, and on-going revision of an individualized service plan (ISP).
 3. **Referral and linkage.** Activities reimbursable under the referral and linkage category are limited to the following:
 - (a) Activities that help link eligible individuals with medical, social, educational providers and/or other programs and services that are capable of providing needed services including employment-related providers and employment-related programs and services.

4. **Monitoring and follow-up.** Activities reimbursable under the monitoring and follow-up category are limited to the following:
 - (a) Activities and contacts that are necessary to ensure that the ISP is effectively implemented and adequately addresses the needs of the eligible individual.
 - (b) Reviewing the individual trends and patterns resulting from reports of investigations of unusual incidents and MUIs and integrating prevention plans into amendments of an ISP.
 - (c) Ensuring that services are provided in accordance with the ISP and ISP services are effectively coordinated through communication with service providers.
 - (d) Activities and contacts that are necessary to ensure that guardians and eligible individuals receive appropriate notification and communication related to unusual incidents and MUIs.
 5. **State hearings:** Activities reimbursable under the state hearing category are limited to the following:
 - (a) Activities performed to assist an eligible individual in preparing for a state hearing related to the reduction, termination or denial of a service on an ISP.
- E. Payment for TCM services may not duplicate payments made to the Board under other program authorities for this same purpose.
- F. The following activities are not reimbursable:
1. Activities performed on behalf of an eligible individual residing in an institution are not billable for Medicaid TCM reimbursement except for the last one hundred eighty consecutive days of residence when the activities are related to moving the eligible individual from an institution to a non-institutional community setting.
 2. Emergency response systems as described in paragraph (Q) of rule 5123:2-1-11 of the Administrative Code. This does not preclude those activities covered above when responding to an emergency and provided by a certified or registered service and support administrator.
 3. Conducting investigations of abuse, neglect, unusual incidents, or major unusual incidents.
 4. The provision of direct services (medical, educational, vocational, transportation, or social services) to which the eligible individual has been referred and with respect to the direct delivery of foster care services, including but not limited to those described in paragraph (A) (iii) of section 1915(g) of the Social Security Act (42 U.S.C. 1396n (g) (2)) as effective October 1, 2015.
 5. Services provided to individuals who have been determined to not have mental retardation or another developmental disability according to section 5126.01 of the Revised Code, except for individuals eligible for coverage of TCM services.
 6. Payment or coverage for establishing budgets for services outside of the scope of individual assessment and care planning.
 7. Activities related to the development, monitoring or implementation of an individualized education program (IEP).
 8. Services provided to groups of individuals.
 9. Habilitation management
 10. Eligibility determinations for county board of developmental disabilities services.

- G. Due process shall be afforded to each individual receiving TCM services.
- H. The Board shall establish procedures which address TCM documentation requirements, reimbursement, claims submission, cost reports, fiscal reviews, record retention, due process and designation of local matching funds.

Reference: ORC 5126.15, ORC 5126.01, OAC 5123:2-1-11, & OAC 5160-48-01

Revised: 11/12/2019

TARGETED CASE MANAGEMENT

A. Documentation Requirements

1. To receive Medicaid reimbursement for TCM activities; documentation must include, but is not limited to, the following elements:
 - a. The date that the activity was provided, including the year;
 - b. The name of the person for whom the activity was provided;
 - c. A description of the activity provided and location of the activity delivery (may be in case notes or a coded system with a corresponding key);
 - d. The duration in minutes or time in/time out of the activity provided. Duration in minutes is acceptable if the provider's schedule is maintained on file;
 - e. The identification of the activity provider by signature or initials on each entry of service delivery. Each documentation recording sheet must contain a legend that indicates the service provider's name (typed or printed), title, signature, and initials to correspond with each entries identifying signature or initials.
 - f. SSAs will document the following activities as general administrative time:
 - i. Services after the date of death. Medicaid coverage terminates on the date of an individual's death.
 - ii. Travel time and case note documentation time. These units are not reported on the annual cost report; however, the cost report instructions require a county board to track these units.

B. SSA Responsibilities

1. All SSA's will complete TCM documentation daily in Gatekeeper.
2. All SSA's with an assigned caseload will maintain a quarterly TCM productivity average of at least 50% per quarter.
3. All monthly case notes will be entered in no later than the end of the 5th day of the month.
4. All SSA's will be responsible for reviewing and correcting rejected case notes.
5. All monthly case notes that have been rejected will be corrected no later than the end of the 10th day of the month.
6. All SSA's with an assigned caseload are responsible for monitoring their productivity on a monthly basis to ensure they are meeting a quarterly productivity average of 50%.
7. The SS Manager and/or the SS Director will review TCM documentation by random spot checks for all SSA's.
8. Each month TCM productivity reports will be generated and reviewed by the SS Manager and/or the SS Director. The productivity reports will be shared with the SSA's to ensure that the minimum TCM productivity average of 50% is maintained by each SSA on a quarterly basis.

C. Productivity Expectations

1. If an SSA with an assigned caseload does not meet an average productivity of 50% in a **quarter** (Jan. – March, April – June, July – Sept., Oct. – December), the SS Manager will meet with the SSA to address the job performance issue and take disciplinary action by following the Progressive Disciplinary Levels, per Board Policy, 13.01.
 - a. The SS Manager and the SSA will develop strategies to increase his/her productivity. The strategies that are developed will be documented and placed in the SSA's personnel file.

2. If an SSA with an assigned caseload that has been previously disciplined for not meeting the 50% productivity average in a given quarter; fails to meet the expectation during any given **month** thereafter; the SS Manager will follow the Progressive Disciplinary Levels, per Board Policy, 13.01, until the SSA has met the 50% productivity for **two consecutive quarters**.
 - a. The SS Manager will meet with the SSA on a monthly basis to review the SSA's productivity rating and the strategies developed to increase his/her productivity, until the SSA has met the 50% productivity for two consecutive quarters.
3. A new SSA will have 3 months to acclimate to the SSA position. The new SSA is exempt from meeting the 50% productivity average during the first quarter of employment only. During the acclimation period, the SS Manager will monitor productivity percentages on a monthly basis and provide feedback to the new SSA.
 - a. On the fourth month of employment (beginning the second quarter of employment) and after, the new SSA must meet the 50% productivity average in each quarter.
4. Only days worked will be included in the SSA productivity percentages. There will not be a penalty for missing work.

D. Reimbursement and Claims Submission

1. The Agency shall maintain a current fee schedule of usual and customary charges. Records of fee schedules must be maintained for a period of six years. The Agency shall bill DODD its usual and customary charge for a TCM covered service. TCM services will be reimbursed the lesser of the Agency's usual and customary charge or the rate - found in Appendix A of OAC 5160-48-01. Without regard to the rate of reimbursement that may be identified in appendix A to rule 5160-48-01, no provider of TCM shall receive reimbursement at a rate in excess of the rate in the federally approved state plan amendment.
2. The Agency is responsible for instituting collection efforts against third parties liable for the payment of TCM services as required by rule 5160-1-08. The Agency must maintain sufficient documentation to substantiate collection activities and any payments received. Sufficient documentation includes a written confirmation every twelve months from any known possible third party, if applicable, which states that the TCM service is not covered under that program or policy.
3. If any of the TCM services provided by the Agency are paid or attributable to another federal program, the costs of such services should be allocated in accordance with OMB Circular A-87.
4. The Agency shall not alter or adjust usual and customary rates charged to the Medicaid Program if such adjustments will result in a direct or indirect charge for costs of uncompensated care being charged to the Medicaid program.
The Agency is required to submit claims to DODD within three hundred thirty days from the date of service in accordance with the format specified by DODD. Failure to submit claims within the specified three hundred thirty days may result in the Agency not being reimbursed for such claims. The Agency shall have no recourse to recover such non-reimbursed claims.
5. Medicaid reimbursement for TCM services shall constitute payment in full. Medicaid recipients may not be billed for Medicaid covered services.
6. Payment for TCM services must not duplicate payments made to the Agency under other programs.
7. A unit of service is equivalent to fifteen minutes. Minutes of service provided to a specific

eligible individual can be accrued over one calendar day. The number of units that may be billed during a day is equivalent to the total number of minutes of TCM provided during the day for a specific individual divided by fifteen plus one additional unit if the remaining number of minutes is eight or greater minutes.

8. Billable units of service are those tasks/contacts made with the eligible individual or on behalf of the eligible individual. Activities which are not performed on behalf of or are not specific to an eligible individual are not billable.

E. Record Requests and Retention

1. The Agency shall make available all records for review by representatives from ODM, ODM's designee, CMS, or DODD at the discretion and request of these representatives.
2. Documentation will be retained for a period of six years from the date of receipt of final payment or until such time as a lawsuit or audit finding has been resolved, whichever is longer. The records shall be provided to ODM or its designee upon request in a timely manner. Records produced electronically must be produced at the provider's expense, in the format specific by state or federal authorities.

F. Due Process

1. Medicaid eligible individuals whose TCM services either affect the provision of services or whose TCM services are affected by any decision may appeal that decision at a Medicaid state hearing. The Agency must provide notice to the individual of their right to request a state hearing.

G. Nonfederal Share

1. The Agency is responsible for payment of the nonfederal share of Medicaid expenditures in accordance with section 5126.057 of the Revised Code. The Agency shall provide this nonfederal share prior to the Agency receiving payment.

Reference: ORC 5126.15, ORC 5126.01, OAC 5160-48-01, OAC 5123:2-1-11

Revised: 11/12/2019, Effective 1/1/2020

Policy and Procedure
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6.03	Building Security

PROGRAM FACILITY, MATERIALS, AND EQUIPMENT

- A. The Agency shall ensure that sufficient facilities, materials and equipment are available to address the programmatic needs of children, individuals, and families enrolled in county board programs.
- B. Program facilities owned or leased by the Agency shall be in compliance with state and local building and mechanical codes with respect to the design, construction, and equipment applicable to the occupancy classification.
- C. Facilities shall be in compliance with the “Ohio Fire Code” as administered by the state or local fire official.
- D. Plumbing and sanitary installation shall be in compliance with the Ohio and local plumbing codes as administered by the Ohio health department or the local official having jurisdiction.
- E. Breakrooms, restrooms, and dining areas shall be maintained in an orderly and sanitary manner.
- F. Power equipment, fixed or portable, should include operating safeguards as required by the division of safety and hygiene, bureau of workers’ compensation.

Revised: 10/21/14

USE OF BUILDINGS

- A. The Agency wishes to make all county-owned Agency facilities available for community use under the provisions of the law, whenever such use does not interfere with program activities.
- B. The county-owned buildings may be used, without charge, for the following purposes: (In order of priority):
 - 1. Agency activities
 - 2. Clinton County voting location
 - 3. Agency affiliated groups as determined by the Superintendent
 - 4. Civic Organizations, e.g., Boy Scouts, Girl Scouts, etc.
- C. The Agency reserves the right to charge a commensurate rate for the use of its building.
- D. The Agency shall prohibit the use of county property by individuals or organizations when such use is primarily for profit.
- E. All facilities operated by the Agency are accessible to individuals with handicapping conditions. The Agency will be in compliance with Section 504 of the Rehabilitation Act of 1973, as amended, and the Americans with Disabilities Act of 1990.

USE OF BUILDINGS PROCEDURE

- A. Application for use of the building shall be made to the building administrator.
- B. If an application is approved, a written permit for use of a building on a specified date and time shall be issued.
- C. Checks in payment for the use of any building and related fees shall be made payable to Clinton County Board of DD and sent to the Board at the Nike Center; 4425 SR 730 Wilmington, OH 45177.
- D. The buildings shall not be open for use on Saturdays, Sundays or holidays without special permission.
- E. Individuals or organizations not affiliated with the Agency shall use the buildings no later than 10:00 P.M. unless special permission is granted.
- F. Any individual group or organization, whose activities result in damage to Agency property, shall be fully responsible for the cost of repairing the damages.
- G. No food or beverages may be sold or served unless special permission is obtained.

DEADLY WEAPONS AND DANGEROUS ORDNANCE

- A.** The Agency is committed to providing a safe and secure environment for its staff, visitors, and individuals served. Pursuant to Ohio law, the Agency is required to take certain actions and post certain notices with respect to the carrying of concealed weapons. In compliance with that law, and in accordance with the Agency's commitment to safety, it is the policy of the Agency, that no person, including staff, volunteers, individuals served by the Agency, or visitors, except law enforcement officers and security personnel acting in the scope of their official duty, shall carry, convey, or possess a deadly weapon or dangerous ordnance within any Board building. Likewise, except as specified in paragraphs B and C below for holders of a current concealed weapon license:
- no person is permitted to possess or carry a firearm or any other weapon anywhere on Board property, and
 - no employee is permitted to carry a firearm or any other weapon in a Board owned vehicle or in their own personal vehicle when traveling on Board business.
- B.** An employee, volunteer, individual served by the Agency, or visitor, who holds a current concealed carry license, may store a concealed firearm within that person's personal vehicle while parking on the Board's parking areas. Likewise, a person, with a concealed carry license, may carry a concealed weapon in that person's private vehicle when traveling on Board business. However, when exercising these concealed carry rights, this person must meet the following conditions and otherwise be in compliance with the Ohio concealed carry law and regulations.
- Each firearm and all of the ammunition must remain inside the vehicle while the person is physically present inside the vehicle, or each firearm and all of the ammunition must be locked within the trunk, glove box, or other enclosed compartment or container within or on the vehicle.
 - The vehicle is in a location where it is otherwise permitted to be.
- C.** The firearm that is authorized to be stored on the Board's parking area, or which is transported while on Board business must be the type of firearm covered and permitted for storage and transport under Ohio's concealed carry law.
- D.** Weapons that are prohibited anywhere on Board property, including parking areas and vehicles, include any weapon that is not authorized by the Ohio Concealed Carry law, such as but not limited to rifles, explosives, knives, BB guns, stun guns and other dangerous ordnances. This policy does not prohibit an employee or visitor from carrying mace on their person while working for that person's own personal protection.
- F.** No person shall have a deadly weapon or dangerous ordnance in any vehicle leased or owned by the Agency.
- G.** Failure to comply with these polices by non-staff will be subject to criminal prosecution as recommended by the Board's legal counsel. Failure to comply with these policies by a staff member will subject the employee to disciplinary action, up to and including discharge from employment, as well as subject the employee to criminal prosecution, as recommended by the Board's legal counsel.

CONCEALED WEAPONS PROCEDURE

In accordance with ORC Section 2923.1212, the following language shall be posted at the entrance all Agency-owned buildings and at the entrance to the portion of any building, which is not owned by the Agency but is leased by the Agency:

“Unless otherwise authorized by law, pursuant to Ohio Revised Code, no person shall knowingly possess, have under the person’s control, convey or attempt to convey a deadly weapon or dangerous ordnance onto these premises.”

BUILDING SECURITY

When a building is opened the intrusion alarm system is deactivated (if applicable). Before departure, the buildings are to be closed by the last person leaving, who, after securing the buildings, will activate the intrusion alarm system (if applicable).

Guests entering a building must sign-in and/or make their presence known to the office staff.