Frequently Asked Questions Regarding the OPWDD FSS Family Reimbursement ADM 2022-02R

Responses as of June 10, 2024

	Question	Response
1.	Do new applications need to be submitted for applications/pre-authorized goods/services already approved in before the ADM is effective 7/1/22?	No. As long as what was previously approved meets the requirements outlined in the ADM, the previously approved application can remain.
2.	Are providers required to accept receipts/requests for reimbursements 90 days after the contract year ends?	No. Providers aren't required to accept receipts/requests for reimbursement 90 days after the end of the year. They can choose to restrict it to less than 90 days. The 90 days was suggested to give providers enough time to close out everything from the previous year.
3.	Does the committee need to meet for an emergency reimbursement or can that just be done at the provider level?	Yes. The committee is required to meet for all types of reimbursements, including emergency reimbursement.
4.	How should providers handle the spending cap changing halfway through the contract year?	It's going to depend on the available resources of the provider to determine if they can reimburse for over $3,000 in this contract year. The provider must adhere to the priority tiers and will have to balance how much they can reimburse for with the number of people they are expected to serve within their contract work plan.
5.	Can providers set a cap lower than the statewide cap for a specific good/service? For example, $750 per individual for respite only.	Yes. The ADM does not prevent providers from setting a cap *lower* than the statewide cap for a specific good/service.
6.	Do applications and respite verification forms require original signatures or are digital/electronic signatures allowable?	Electronic/digital signatures are allowable. Please note that OPWDD has removed references to "original signatures" from the ADM and all attachments.
7.	Under Section B: Eligibility, it indicates that the individual must reside with a non-paid family member. What does that mean? We have parents that access CDPAP, does this mean they are disqualified?	Paid Caregivers are not eligible for Family Reimbursement. The CDPAP program allows family/caregivers to be paid as CDPAP staff while living with the person they provide CDPAP to. CDPAP also allows for someone who lives outside of the home to provide CDPAP services. Family/caregivers who provide CDPAP to a person they live with are ineligible for FSS family reimbursement. When a person receives CDPAP only from one or more staff who live outside of their home, their family is eligible to apply for FSS family reimbursement.

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8.	Can an individual receive FSS reimbursement if they have a self-direction budget and have exhausted OTPS, IDGS and/or FRR?	No. Individuals can consider accessing FSS family reimbursement if they have explored those self-direction specific funding mechanisms (i.e., OTPS, IDGS, FRR) and have been denied or as an emergency reimbursement.
9.	Does an individual need to have a care manager or be enrolled in care coordination to receive FSS family reimbursement?	No, care management is not a requirement to request FSS family reimbursement.
10.	How often are emergency reimbursement requests allowed per individual?	Emergency requests may be allowed only onetime per each type of emergency listed in the ADM.
11.	How should goods/services be treated that aren't specifically listed as allowable or non-allowable in the ADM?	Providers can continue to reimburse for goods/services they have already pre-approved if they meet the criteria outlined in the ADM. Providers must send any items that are not covered on the list in the ADM to their Regional Field Office (RFO) to Central Office for consideration before the individual is reimbursed to ensure consistency statewide.
12.	What are the requirements of the family reimbursement committee?	As noted on pg. 5 of the ADM: FSS providers must have a Family Reimbursement Committee (the "Committee") to review reimbursement requests. Committees must contain at least four (4) members, and must include: i. Individual(s) with developmental disabilities; or ii. Family members or advocates of individuals with developmental disabilities; and iii. At least two (2) people not employed by the FSS provider agency. The Committee must meet as needed to review applications. The Committee can only approve applications for reimbursements through FSS where the application establishes that the: i. Individual has established eligibility for OPWDD services; ii. Individual/family meets FSS eligibility criteria; iii. Reimbursement request cannot be funded by any other funding mechanism; iv. Reimbursement request does not exceed contractual limits and/or individual spending cap; v. Requested item or service: a. Is related to the individual's intellectual or developmental disability; b. Supports a quality of life comparable, to the extent practicable, to that of similarly situated

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		families without a family member having a developmental disability; c. Maximizes the potential of the individual; and d. Supports the individual to remain at home with their family.
13.	Can an individual enrolled in Self-Direction, but still in the start-up phase receive family reimbursement?	The person is only eligible for family reimbursement prior to approval of the person's initial Self-Direction budget or in circumstances as described in question 8.
14.	What are the requirements for an allowable clothing reimbursement request?	Clinical justification would be needed if the clothing request is based on behaviors or incontinence directly connected to the individual's I/DD diagnosis and needs to be included in the Life Plan if someone is enrolled in a Care Coordination Organization (CCO.) When clothing is requested as a necessity (see #21 for more information), a clinical justification would not be required.
15.	What is specifically needed for a proper clinical justification?	The family must provide the FSS provider with a clinical justification that indicates a significant, definable, positive impact on the individual/family directly relating to health, safety and emotional well-being, normalization of life, accessibility to needed services, personal growth and/or development of the individual. The clinical justification must be clinically indicated and substantiate the need for the item or service that is being requested. The clinical justification must be supported by a clinician and demonstrate a clear connection to the individual's developmental and/or intellectual disability. Clinical justification from clinician(s) working within their scope of practice including but not limited to physical therapist, occupational therapist, speech therapist, physician, registered nurse, is acceptable. The clinician must provide a signed letter dated within a year of request (on formal letterhead) that demonstrates the need based on the criteria listed above in this paragraph.
16.	When are clinical justifications required?	Clinical justifications are not required when the basis of the request is for a necessity, respite, recreations programs, camps and other items/services that are not driven by a specific clinical need. FSS providers need to obtain clinical justifications and/or physicians orders where the need for the item/service was identified as part a physician or clinician service (see the FSS ADM, Section N for more details). Clinical justification is also required for FSS reimbursement of electronic devices, as detailed in the FSS ADM, Section J., Electronic Devices. Please see question (#15) for specific information that needs to be included in the clinical

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		justification. For more information about clothing requests, please see question #14.
17.	Is partial reimbursement of a good or service allowable?	Per the ADM, as a state paid service, any goods or services must be cost effective meaning whenever a comparable item is available at a lesser cost, the lesser cost item must be purchased or utilized. Partial reimbursement for goods and services is at the discretion of the provider.
18.	How should individuals requesting respite reimbursement be prioritized in terms of Waiver enrollment?	Individuals enrolled in any Waiver Service must explore Waiver respite prior to accessing FSS family reimbursed respite. The individual/family with their Care Manager (CM) if applicable must explore if Waiver respite opportunities are available. If staffing is not available from any Waiver respite providers, individuals/families can then apply for FSS family reimbursed respite.
19.	How should FSS family reimbursement be documented in an individual's Life Plan?	Per the ADM, for those that have a (CM) FSS should be listed in Section V of the Life Plan. In addition, reference to the requested goods or services must be included in Section I of the Life Plan. This is needed to provide a better understanding of why the good or service is being considered for family reimbursement.
20.	Is respite allowable during the hours a parent/caregiver is working?	Routine expenses one would incur in caring for a loved one without a disability or raising a child remains the (fiscal) responsibility of the caregiver. FSS funded respite, and respite by definition, is not intended to offer ongoing, long-term coverage for care but to allow the caregiver an occasional break in routine caregiving needs. Both the regularity of this service and how frequently it is provided should be assessed by the FSS provider in terms of appropriateness and need. Respite funding should never overlap with Medicaid paid/Waiver services or educational programming (and occur outside of the regularly scheduled academic day).
21.	What does clothing as a necessity mean?	Clothing as a necessity can include specially designed garments for individuals with physical disabilities or medically prescribed clothing/articles for which other funding is not available. Per the ADM, clothing may be funded if there are specific needs related to the intellectual/developmental disability (I/DD) (e.g., excessive chewing, destruction due to behavior or incontinence) where clothing needs replacement more frequently than would otherwise be normally expected. Clothing related to the intellectual/developmental disability (I/DD) needs to be clinically indicated (i.e., included in the Life Plan or with supporting documentation). Clothing as a necessity can also include articles related to health/safety,

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		functional, or environmental needs. Unless sufficiently justified, it remains the responsibility of the caregiver to provide clothing and daily wardrobe needs to children and adults in their care as an out-of-pocket expense not otherwise covered.
22.	Can more than one FSS provider be listed in a Self-Direction budget?	Yes, multiple providers can be listed. There is only one field on the OPWDD Self-Direction Budget template for FSS Providers on the Direct Provider Purchased tab. Brokers can and should input all the provider names into this field. Individuals who self-direct and are applying for FSS reimbursement must include total FSS expenses in their Self-Direction budget. All FSS funded services (if received through multiple FSS providers) should be included in the budget even if they cannot be itemized. Any FSS reimbursement is counted towards their total Personal Resource Account (PRA). The Total Annual Cost for FSS on the Self-Direction budget needs to be the aggregate amount across all providers. The Life Plan, as a corresponding document which supports SDS budgeted services, should list any/all FSS providers in the required Life Plan sections.
23.	Can families apply for multiple FSS reimbursements via multiple FSS providers in the same year?	Ideally, one provider per service should be used to avoid duplication and/or overpayments. For example, an individual should not be enrolled in multiple FSS Family Reimbursed Respite programs (situationally and only with pre-approval from the DDRO). However, OPWDD recognizes that there may be occasions where an individual/family may benefit from receiving separate and distinct FSS services from multiple agencies (e.g.: sibling support group, FSS Family reimbursement for goods, FSS camp...). In these cases, accessing multiple providers-- as justifiable and approved-- may occur. It is the responsibility of the CM (as applicable) to alert FSS Providers to changes in individual's status, need, or eligibility. All needs and services should all be current and appropriately documented by CM in the Life Plan. It is the responsibility of FSS Providers, with oversight provided by their RFO, to collaborate and coordinate with partnering FSS providers who may also offer FSS Family Reimbursement services to avoid duplication as well as over-utilization of funds beyond the $3,000 allowable annual cap. Throughout the contract year, FSS Providers should routinely review their FSS program enrollments in CHOICES to ensure that rosters are current and accurately reflect enrollments/terminations and to monitor any service conflicts/overlaps which may disallow funding.

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24.	Can a non-family member who resides within the individual's home provide respite?	No. Respite providers, whether they are related to the individual or not, must reside outside of the individual's home.
25.	Can an individual access FSS during the redetermination process (during the period between Provisional and Full eligibility status)?	Eligibility for children who are first determined *provisionally* eligible for services must be reviewed again by the (RFO) prior to the child's eighth birthday. The eligibility department will notify the family, and if applicable, CCO, of the need for updated documentation for this review prior to the child's eighth birthday to ensure continuity of services and eligibility. To avoid any lapse in needed or beneficial supports throughout this period of eligibility reassessment, FSS services can continue until the time a final determination of eligibility is issued by the RFO (for example, this timeframe may extend beyond the person's 8th birthday until the final determination is issued). This allowance extends to both existing FSS programs and services the individual/families may receive/be enrolled in (such as family reimbursement). Newly requested FSS services cannot be supported for individuals eight years or older who have not had their provisional eligibility reassessed.