NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES

GUIDANCE DOCUMENT

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Pursuant to
Neb. Rev. Stat. § 84-901.03

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

EFFECTIVE DATE: March 18, 2022

Lifespan Respite Services Program

Legal Basis:

The Nebraska Department of Health and Human Services, Central Office, is responsible for administering the Respite Subsidy Program (RSP) based on Neb.Rev.Stat. § 68-1520 through 1528 and 71-7611.04.

Based on available funds, the Nebraska Department of Health and Human Services (Department) has the authority to:

1. Determine the maximum monthly subsidy amount to be paid to each eligible person or family; and
2. Determine the number of persons and/or families to be served through the RSP, based on available funding for the Lifespan.

Lifespan Respite Subsidy Definitions:

- Client means an individual who has been referred to, has applied for, or has been authorized to receive Respite Services through the RSP.
- Nebraska Respite Network means a statewide network responsible for the creation of a statewide system for the coordination of respite resources through six offices located in HHS Service Area offices.
- Nebraska Respite Network Coordinator means one of six coordinators across Nebraska responsible for the coordination of respite resources within a multiple-county area. This shall also mean the Nebraska Lifespan Respite Services Program.
- Ongoing Care means continuous, full-time supervision/care for a person with special needs.
- Provider means an individual or agency selected by a family or caregiver to provide
- Special Needs means a special need requiring ongoing care without regard to age, type of special needs, or other status.
    - Such conditions include but are not limited to a) developmental disabilities; b) physical disabilities; c) chronic illness; d) physical, mental or emotional conditions that require supervision; e) special health care needs; f) cognitive impairments, and g) situations in which a high risk of abuse or neglect exists.

- For clients aged 60 or older, this can be determined by what is on the application, but if they have not indicated a special need, verification of special need will be requested.
- For clients age 16-59 with a disability determined through Social Security Administration, that documentation will be utilized for verification of a special need. However, if that information is not available, then verification of special needs will be requested.
- For the client's age birth to 15, verification of special need will be requested from the caregiver. A statement signed and dated from a child's health professional (ex. Physician, licensed/registered nurse, or physician assistant) or an IEP from the school district qualifies as verification of the special need for program eligibility.

- Vulnerable means an individual who is susceptible to physical injury due to a substantial mental or functional impairment.
- Waiting list means a list of applications for individuals who cannot receive benefits due to limited funding availability.

Department Responsibilities:

Central Office staff will:

1. Make a determination regarding the eligibility of each applicant;
2. Process billings; and
3. Provide notification to the client regarding eligibility, changes of eligibility, and the need for annual reviews.

Application Process:

Title 464 NAC 1.008

APPLICATION PROCESS: Anyone may submit an application on a Department approved form. Anyone may submit a completed, dated, and signed program application electronically, by mail, fax, or in person.

APPLICATION FORM: The applicant must complete a current application form:

1. Name, address, and telephone number of the person with special needs;
2. Social Security number and date of birth of a person with special needs;
3. The total number of people who live in the household:
    a. Including parents, brothers and sisters ages 0 through 18 years of age;
4. A description of the person's special needs;

5. An explanation of the caregiver's need for respite;
6. Whether the client or caregiver are receiving other financial assistance for respite and a description of that assistance;
7. Health insurance coverage;
8. The source, frequency, and amount of all gross earned and unearned income;
9. Disability-related expenses, the cost and the frequency of the expenses;
10. Resources:
    a. Only liquid resources with no significant penalty for withdrawal;
11. The name, Social Security number, and relationship of the caregiver; and
12. Signature and the date signed by the client or his/her representative.

Maximum Monthly Expenditure:

Monthly expenditures can be adjusted for each recipient based on need and available funds in the recipient's authorized eligibility period. These funds cannot exceed the yearly total of $1,500 approved when eligibility is determined upon initial eligibility approval or renewal. A form will need to be completed by the caregiver and submitted for review and approval by the Department.

Exceptional Circumstances is classified as:

- An unplanned event that jeopardizes the health and safety of the Client;
- An unplanned event that jeopardizes the health and safety of the Family Caregiver;
- Immediate and unavoidable absence of the Family Caregiver for more than 4 hours when a qualified caregiver is not available;
- Family Caregiver health crisis;
- Physical;
- Mental;
- Emotional;
- The client has exceptionally high care needs requiring supervision;
- Medical / Physical Health;
- Behavioral and/or Emotional Needs; and
- Personal Safety of:
    - Self: or
    - Others

Circumstances not listed above can be reviewed by the Department on a case by case basis in determining authorized funds to meet recipient needs.

Saving of Exceptional Circumstances funds (Banking):

Funds from exceptional circumstances or crises needed within the respite subsidy can be saved for an extended period with Department staff making special arrangements in advance. These are to allow for extended periods of crisis or exceptional need with approval from DHHS staff to bank or adjust how the funds are divided each month to best support the caregiver or care recipient.

Payment to the Provider:

Title 464 NAC 1.016.02

Providers receiving direct payment must complete a Department approved billing document. Incomplete or inaccurate billing documents will be rejected and not paid.

1. Describes the service provided;
2. Includes the dates and hours of service;
3. Is signed by the client or caregiver; and
4. Includes the provider's Social Security number or Federal Tax I.D. number.

Provider Approval:

The providers must meet any applicable local, state, and federal laws and regulations. It is the responsibility of the caregiver to make this determination.

Per the Department of Labor: Minors must be at least 14 years of age to be employed in the State of Nebraska. There are a few exceptions, including minors working for their parent's business and minors working in agriculture. Minors under 16 years of age must obtain an Employment Certificate from the school district in which they reside. Homeschooled children may obtain an Employment Certificate by providing proof of age and grade level to their City Superintendent of School's Office or the Nebraska Department of Labor. The minor must be present in order for a certificate to be issued.

Under Nebraska law, minors 14-15 years of age are not permitted to work more than 8 hours a day or 48 hours per week, and not before 6 a.m. or after 10 p.m. Federal Child Labor rules are stricter. They can be viewed online at www.dol.gov. When both laws apply, the more stringent standard must be observed.

Provider Network Screening:

Network screening completed by the Lifespan Respite Network must be completed before all new providers provide care to a care recipient. The network screening process will be completed with the assistance of the Respite Coordinator and CCFL.

- Providers must be Nebraska Lifespan Respite Network screened Title 464 NAC 1.019.
    - Effective on October 3rd, 2021, any potential provider applicants will be required to complete the Nebraska Lifespan Respite Network (NLRN) network screening process.
    - Additionally, the applicant will be required to complete an NLRN provider application and meet minimum state background check requirements.
    - Any current providers that are not Network screened will have a provision of being able to continue to provide respite care

and submit billing for care provided without being Network screened for no more than 6 months. If the provider elects to continue to provide respite care, they will be required to have all steps of the Network screening completed by April 3, 2022. In the event the provider elects to not complete the above-listed steps to become NLRN screened, the provider will no longer be able to provide respite care or submit billing under the Respite Subsidy program until the completion of their screening.

Network screening must be completed by any provider over the age of 14 that will be providing direct supervision and care to a care recipient or client. This includes any community agency or community-based organization that has applied to be a respite provider. If staff is going to be under supervision or present with someone from the agency or organization that has completed Network screening, then they will not have to complete the screening. However, if the provider is not going to be under the supervision of a provider that has completed the Network screening, then they will have to complete the Network screening before providing any respite care.

Network screening consists of the following:

1. Online orientation and training must be completed. This includes a 2-hour training and orientation provided by CCFL with a certificate of completion to be issued to the provider after training has concluded.
    a. The provider must notify the Respite Coordinator of the completion of training by downloading the certificate of completion and emailing it to the Respite Coordinator.
2. BOTH APS/CPS Central Registry Check form and APS/CPS Central Registry Check form must be completed. The APS/CPS Central Registry Check form provides the information needed to enter the applicant into the Central Registry Portal and Portal Identity Verification form is the notary form needed to upload into Central Registry Portal. The Portal Identity Verification form MUST be notarized.