

Wyoming Administrative Rules

Health, Department of

Wyoming Life Resource Center

Chapter 4: Visions Program for People with Acquired Brain Injuries

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CHAPTER 4

Rules and Regulations for the Wyoming Life Resource Center

Visions Program for People with Acquired Brain Injuries

Section 1. Authority. This Chapter is promulgated by the Department of Health pursuant to the Life Resource Center Act at W.S. § 25-5-103(ii), and the Wyoming Administrative Procedure Act at W.S. § 16-3-101, *et seq.*

Section 2. Purpose. This Chapter is being adopted to:

- (a) Provide admission and discharge processes;
- (b) Establish eligibility criteria for Acquired Brain Injury applicants to the Center;
- (c) Prescribe the Individual Program Plan process; and
- (d) Define rehabilitation services.

Section 3. Eligibility and Application Process for Services.

(a) An applicant for residential services in the Visions Program shall first make application to the Division for services per the Wyoming Medicaid Rules for Acquired Brain Injury Waiver. An applicant already determined eligible for this waiver service shall present documentation of qualification.

(b) The Division shall provide applicants and their families or legally authorized representatives a written resource guide regarding services for individuals with acquired brain injuries in the state of Wyoming.

(c) Eligibility under this Chapter is limited to persons who have completed the Division application process or who meet the following requirements:

(i) Medical determination. In order to meet the medical determination criteria for admission, an applicant shall meet the acquired brain injury criteria as determined by the medical team.

(ii) Neuropsychological or other evaluations confirmation. The neuropsychological or other evaluations confirm that the applicant meets the following criteria by attaining:

(A) A score of forty-two (42) or more on the Mayo Portland Adaptability Inventory;

(B) A score of forty (40) or less on the California Verbal Learning Test II Trials 1-5 T;

(C) A score of four (4) or more on the Supervision Rating Scale; or

(D) An Inventory for Client and Agency Planning services scores equal to or less than seventy (70).

(d) If the applicant is clinically eligible for Acquired Brain Injury Waiver services, the applicant may:

(i) Be funded for services for a home and community based waiver;

(ii) Pursue admission to the Center;

(iii) Pursue emergency services through Medicaid Rules for Acquired Brain Injury, Home and Community Based Waiver; or

(iv) Be placed on the Division's waiting list for services.

Section 4. Admission to the Center.

(a) When an applicant notifies the Division that she chooses residential services from the Center, an admission request form may be obtained from the Center or Division. The admission request form will be completed by the applicant or legally authorized representative and submitted to the Center.

(b) If a current waiver participant chooses to request services at the Center, an admission request form for Center services will be completed by the applicant or legally authorized representative and submitted to the Center. The Center staff will forward the request to the appropriate waiver representative.

(c) The Center staff shall receive the admission request form and coordinate with the applicant and other appropriate sources to obtain information requests, appropriate medical, demographic, and programmatic information pertinent to care and services required by the applicant. The applicant or his legally authorized representative shall be responsible for submitting the admission request form and all required documentation to the Center staff.

(d) An admission request form is valid for six (6) months from the date of submission. After that time, if necessary documentation has not been received, the applicant must reapply.

(e) When all of the required documentation has been received, Center staff shall notify the applicant that the formal thirty (30) day review period will begin and forward the completed application packet to the Administrator and the screening team.

(f) Membership of the screening team is determined by the Director. The preadmission screening and assessment shall be completed within thirty (30) days of receipt of completed application.

(i) The screening team shall review the applicant's information.

(ii) The screening team may assign a preliminary interdisciplinary team to include Division waiver staff for the purpose of conducting further assessments and evaluations. The preliminary interdisciplinary team may visit the applicant to complete preliminary assessments, including an assessment regarding the least restrictive, most appropriate, and most integrated placement, and submit the report to the screening team.

(iii) The screening team shall conduct a final review of the applicant's information, including any report(s) submitted by a preliminary interdisciplinary team.

(iv) A recommendation shall be made to the Administrator in writing.

(g) The Administrator shall review the screening team's recommendations and make a determination regarding the request for placement. The Administrator shall notify the applicant, legally authorized representative, and referring agency representative (if applicable) in writing, regarding placement within ten (10) days after receiving the screening team's recommendation.

(i) If the applicant is denied admission, notice of denial will be consistent with Wyoming Life Resource Center Rules, Chapter 2, Administrative Hearings.

(j) If the applicant is approved for admission, a Center interdisciplinary team will be assigned.

(k) A transition meeting will be scheduled by Center staff with the applicant, the applicant's legally authorized representative, and a representative of the Division waiver staff and current provider, if applicable, to coordinate transition to the Center.

(l) The Center Program Manager or designee will provide the client or legally authorized representative a copy of his rights after arriving at the Center.

Section 5. Initial Individual Program Plan Development.

(a) Each client admitted to the Center shall have on file at the Center an individual program plan. The individual program plan shall be prepared by an interdisciplinary team within thirty (30) days of admission for residential services under

the supervision of the program manager. The plan shall be reviewed by the interdisciplinary team for appropriateness and feasibility of discharge or transition to another level of service thirty days (30) days after implementation of the plan, at the end of each quarter for the first year, and annually thereafter.

(b) A client shall be determined no longer eligible when she:

- (i) Does not meet eligibility when re-tested; or
- (ii) Changes residence to another state.

Section 6. Development of the Annual Individual Program Plan by an Interdisciplinary Team.

(a) The purpose of the interdisciplinary team process is to provide team members with the opportunity to review and discuss information and recommendations relevant to the client's needs and to reach decisions as a team, rather than individually, on how best to address those needs, including transfer or discharge to another service.

(b) The interdisciplinary team is comprised of the client, or legally authorized representative and those individuals, professionals, and paraprofessionals who possess the knowledge, skills, and expertise necessary to accurately identify the comprehensive array of the client's needs and design a program that is responsive to those needs. The number of individuals who comprise the interdisciplinary team is based upon each client's individual needs and may vary.

(c) To ensure informed choice, placement options are reviewed annually, or anytime by request, with the client and/or legally authorized representative. The plan developed by the interdisciplinary team will include documentation of appropriateness of placement at the Center or at any other placement recommended.

(d) For a school-aged client, the home school district develops the individual education plan and the Center will coordinate the individual program plan process.

Section 7. Individualized Rehabilitation Services. Each client must receive a continuous rehabilitation treatment program, which includes aggressive and consistent implementation of a program of specialized and generic training, treatment, health services, and related services to acquire the behaviors necessary for the client to function with as much self determination and independence as possible.

The rehabilitation treatment program is pervasive, systematic, and sufficient in scope to assure that individuals are appropriately served by assessing each individual client's needs in the following areas:

(a) **Physical History and Health:** The client's pre-morbid and post-injury history, results of the neuropsychological evaluation conducted by a licensed

neuropsychologist, results of the physical examination conducted by a licensed physician, physician assistant, or nurse practitioner, health assessment data (including a medication and immunization history), which may be compiled by a nurse, and skills normally associated with the monitoring and supervision of the client's own health status, and administration and or scheduling of the client's own medical treatments.

(b) Nutritional Status: The determination of appropriateness of diet, adequacy of total food intake, and the skills associated with eating.

(c) Sensorimotor: The retraining of perceptual skills that are involved in observing the environment and making sense of it. Motor skills include those behaviors that primarily involve: muscular, neuromuscular, or physical skills and varying degrees of physical dexterity. Assessment data identifies the extent to which corrective, orthotic, prosthetic, or support devices would impact the functional status.

(d) Affective (Emotional) Rehabilitation: The restoration of behaviors that relate to his or her interests, attitudes, values, and emotional expressions.

(e) Speech and Language: The restoration of both verbal and nonverbal and receptive and expressive communication skills. Assessment data identifies the appropriate intervention strategy to be applied, and which, if any, augmentative or assistive devices will improve communication and functional status.

(f) Auditory Functioning: The extent to which a person can hear and to the maximum use of residual hearing, if a hearing loss exists, and whether or not the client will benefit from the use of amplification, including a hearing aid or a program of amplification. Assessment may include teaching techniques for conducting the assessment or the use of electrophysiologic techniques.

(g) Cognitive Rehabilitation: The restoration of those processes by which information received by the senses is stored, recovered, and used. It includes the retraining of the processes and abilities involved in memory, reasoning, and problem solving.

(h) Social Rehabilitation: The restoration of self-help, recreation and leisure, and interpersonal skills that enable a client to establish and maintain appropriate roles and fulfilling relationships with others.

(i) Adaptive Behaviors or Independent Living Skills: The effectiveness or degree with which clients meet the standards of personal independence and social responsibility expected of their age and cultural group. Independent living skills include, but are not limited to, such things as meal preparation, doing laundry, bed making and budgeting.

(j) Vocational (Prevocational) Retraining, as applicable: The work interests, work skills, work attitudes, work-related behaviors, and present and future employment options.

Section 8. Discharge.

(a) Transfer or discharge occurs only when:

(i) The Center cannot meet the individual's needs;

(ii) The individual or her legally authorized representative chooses for her to reside elsewhere; or

(iii) A determination is made, by testing or review, that another level of service or living situation, either internal or external, would be more beneficial.

(b) The Center will provide a reasonable time to prepare the client and his legally authorized representative for the transfer or discharge (except in emergencies).

(c) At the time of discharge, the Center must:

(i) Develop a final summary of the client's behavioral, social, health, and nutritional status, and with the consent of the client or legally authorized representative, provide a copy to authorized persons and agencies; and

(ii) Provide a post-discharge plan of care that will assist the client to adjust to the new living environment.

(d) The Administrator shall formally discharge the client with written notification to the client and legally authorized representative and the court, if necessary.

(e) If a client or legally authorized representative chooses to change to another Division service provider, he shall inform Center staff of the decision. Center staff shall then contact the Division waiver staff and begin the process outlined in Wyoming Medicaid Rules for home and community based waiver services.