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## Public Assistance

**Secs. 17-2-1—17-2-3.**

Repealed, December 21, 1990.

**Sec. 17-2-4.**

Repealed, May 26, 1970.

**Sec. 17-2-4a.**

Repealed, December 21, 1990.

**Sec. 17-2-5.**

Repealed, May 26, 1970.

**Secs. 17-2-5a—17-2-6.**

Repealed, December 21, 1990.

**Sec. 17-2-7.**

Repealed, March 31, 1970.

**Secs. 17-2-7a—17-2-25.**

Repealed, December 21, 1990.

**Sec. 17-2-26.**

Repealed, April 2, 1985.

**Secs. 17-2-26a—17-2-26b.**

Repealed, December 21, 1990.

**Sec. 17-2-27.**

Repealed, February 17, 1982.

**Secs. 17-2-28—17-2-65.**

Repealed, December 21, 1990.

**Secs. 17-2-66—17-2-68.**

Repealed, August 26, 1988.

**Sec. 17-2-69.**

Repealed, February 8, 1999.

**Secs. 17-2-70—17-2-76.**

Repealed, December 21, 1990.

**Sec. 17-2-77. State department of social services policy**

A. Services Covered by Medicare. For services covered by Medicare, the Provider must complete the Form SSA-1490, Request for Medicare Payment, or Form SSA-1491, Request for Medicare Payment—Ambulance, and submit the Medicare Claim Form directly to Connecticut General, Medicare Claim Office, 200 Pratt Street, Meriden, Connecticut 06450. Please provide the recipient's health insurance claim number, current Social Services case number and signature.

B. Acceptance of Assignment. An assignment for each bill must be accepted since the Social Services recipient has no other resources to meet medical expenses.

The Department of Social Services will not be liable for any balance between the amount billed to Medicare and the total amount allowed by Medicare.

C. Prior Authorization. There are services which ordinarily require a Prior Authorization by the Department of Social Services.

If the provider sends a Medicare claim for these services to the Connecticut General Medicare Claim Office and the claim is rejected because the individual is not covered under Medicare Part B, a prior authorization will not be required by this Department. However, these bills will be reviewed by the State Department of Social Services, Division of Health Services, for necessity of services provided and the charge for same.

D. Services Definitely Not Covered by Medicare. Claims for payment for those services which Medicare definitely does not cover, must be submitted directly to the State Department of Social Services on the Social Services Bill Form with the notation on the bill "SERVICE NOT COVERED BY MEDICARE." (For example, flu shots, hearing aids (cords, batteries), et cetera). In order to bill in this manner, it must be clearly evident to the provider that the service is definitely not covered by Medicare.

If these non-covered services require a Prior Authorization, the Provider must submit a prior authorization to the Department of Social Services prior to the submission of the Social Services Bill. The provider must note on the prior authorization form "SERVICE NOT COVERED BY MEDICARE." This will alert the Department of Social Services that it is the intent of the provider to bill the Department directly.

**IMPORTANT:** If the Provider is aware that the services are definitely not covered by Medicare and continues to bill Medicare directly for these particular services, the Department of Social Services will not honor the bill(s) for payment.

(Effective September 29, 1977)

### **Sec. 17-2-78. Billing procedures effective October 30, 1976**

A. Connecticut General Medicare Claim Office—Claim and Payment Form. Connecticut General Medicare Claim Office will supply the provider with a three-part Form SSA-1490, Request for Medicare Payment, or a two-part Form SSA-1491, Request for Medicare Payment—Ambulance.

The Provider will complete the Form SSA-1490 or Form SSA-1491, and submit the original copy to Connecticut General Medicare Claim Office. The Provider should retain the copies for his files.

Connecticut General will process the original copy and send the provider a two-part Form MC-131, Medicare Payment Report, which lists payment information for each individual, including the deductible and coinsurance amounts, and remarks codes for claims partially or totally rejected. (Explanation of remarks codes are listed on the reverse side of Form MC-131, Medicare Payment Report.)

B. Department of Social Services—Payment for Deductible and Coinsurance or Claims Partially or Totally Rejected. 1. The provider must complete a Social Services bill form for each date of service, for each Social Services recipient listed on the Medicare Payment Report.

NOTE: If the Medicare Payment Report shows a rejection code and a deductible and/or coinsurance amount for the same date of service for the same recipient, two separate invoices must be completed.

2. The provider must submit the following to the Department of Social Services:
  - a. Duplicate copy of MC-131, Medicare Payment Report,

b. Copy of SSA-1490 or SSA-1491 (for signature purposes) for only those Social Services recipients listed on the MC-131, Medicare Payment Report,

c. The completed Social Services bill forms for each date of service and for each Social Services recipient listed on the Medicare Payment Report.

3. Please staple corresponding material and mail directly to:

**MEDICARE SECTION**

Division of Fiscal Services

Department of Social Services

110 Bartholomew Avenue

Hartford, Connecticut 06115

**IMPORTANT:** Only Medicare/Medicaid related billing is to be mailed to the Medicare Section. All other bills should be directed to the Division of Medical Disbursements.

(Effective September 29, 1977)

**Sec. 17-2-79. Reserved**

**Sec. 17-2-80.**

Repealed, August 22, 2000.

**Sec. 17-2-81. Criteria for determining length of need**

1. **Long term** - medical need may be for life, permanent or the need for a sufficient number of months which would justify purchase;

2. **Intermediate term** - medical need which cannot be classified as short or long term due to an inadequate prognosis;

3. **Short term** - medical need for a number of months but not long enough to justify purchase.

To insure proper evaluation and control by the Department it will be necessary to include the following items on a prior authorization:

1. Item number. (If item is not covered under contract, describe the item).

2. New or replacement. (If replacement, explain.)

3. Original request or extension. (If extension, date of original request.)

4. Period of use. (Enter in the number of months according to the prognosis. If for life, state.)

Items under \$50.00 will be purchased and no prior authorization is required. This will not eliminate the need for proper medical diagnosis and/or a prescription to substantiate need for same.

Note: The Department's Medical Consultant's authorization of services on durable medical equipment does not establish financial eligibility. The Medical Consultant is approving the medical need, not the price of the item. The price is determined by a fee schedule and any variance of the price must have additional justification. Authorization for the item is valid only if the recipient presents his current medical identification card on the date the item is delivered to the recipient.

All prior authorizations are submitted to the Department of Social Services, Health Services, 110 Bartholomew Avenue, Hartford, Connecticut 06115.

In an emergency situation, verbal approval may be secured. The formal request on Form W-604 must follow as soon as possible and no later than 48 hours, with the notation that verbal approval had been given and by whom.

(Effective October 11, 1977)

**Sec. 17-2-82. Form W-614, bill for medical and surgical supplies**

When billing for equipment, Form W-614, “Bill for Medical and Surgical Supplies” is used.

When billing for items requiring prior authorization, Form W-614 must be accompanied by the yellow copy of the authorization, Form W-604.

When billing for part of the items covered by the authorization, the authorization number should be inserted on Form W-614 in the designated area, “Authorization Number.” The yellow copy of the authorization should be attached to the bill for the last items covered by the authorization.

The vendor is responsible for having Form W-544, “Medicaid Durable Equipment Agreement” signed by the recipient. The form is attached to all bills for items over \$50.00. This is required for payment to the provider.

(Effective October 11, 1977)

**Sec. 17-2-83. Fee schedule for commercial ambulance services**

Revised Ambulance Rates to be Reimbursed by the Department of Social Services to Ambulance Companies for Services Rendered to Title XIX (Medicaid) Recipients.

	Base Rate	\$49.00	Note a
	Mileage	\$ 1.75	Note b
	Procedure	Not Specified	Note f
17001	Oxygen & Mask	\$10.00	
17003	Resuscitator	\$10.00	
17004	Suction Machine	\$10.00	
17005	Female Attendant	\$18.50	
17006	Waiting Time	\$25.00 per hour	Note c
17007	Waiting Time (Additional)	\$ 6.25 per one quarter hour	
17008	Cancelled Call	\$25.00	Note d
17009	Multiple Patients	Note e	By Report

Note a. Base rate shall be applicable where both the origin and destination are within one town.

Note b. Mileage to be applied from point of origin of movement to any final destination outside town in which pick-up is made. Mileage to be determined from the P.U.C.A.’s Official Mileage Docket No. 6770.

Note c. Waiting time charges apply per hour. Additional waiting time beyond the first hour will be assessed in multiples of 15 minutes at the rate of \$6.25 per quarter hour.

Note d. A charge for cancelled ambulance call will be assessed whenever such ambulance call is cancelled after an ambulance has been called for and dispatched to a home, hospital, or scene of accident.

Note e. Whenever multiple patients are carried in any one given ambulance, the base rate will be charged for each patient requiring medical attention. The other charges to be equally assessed against all patients transported are mileage, waiting time, and where applicable, female attendant.

Note f. Charges for loss of equipment used in transporting patients shall be assessed at actual cost, subject to proof of connection between loss of equipment and the transportation of patient.

Note g. There shall be no charges assessed for the transportation of non-patients as riders accompanying patients requiring ambulance service.

(Effective March 1, 1978)

**Secs. 17-2-84—17-2-85.**

Repealed, December 21, 1990.

**Sec. 17-2-86. Ambulance and chaircar services**

A. **Eligibility.** Transportation services by ambulance and chaircar for the purpose of securing medical services are available to individuals eligible for Medical Assistance (Title XIX) with the following limitations:

1. Transportation is for treatment which is medically necessary.
2. Transportation by taxi with medical assist and by taxi is medically not feasible.

3. Eligibility under medicare is first explored for individuals 65 years of age and over.

4. Prior authorization is required except in the following situations: a. Emergency Situation. A policeman or physician orders an ambulance in an emergency situation. An ambulance is called by someone other than a policeman or a physician in a situation which can later be verified by the Department as an emergency.

Note: An emergency situation is one in which it would be detrimental to the patient to be transported by means other than ambulance or chaircar for medical conditions, such as accidents, heart attacks, hemorrhage, stroke, coma, etc., which require immediate medical or surgical therapy.

(Effective October 27, 1977)

### **Sec. 17-2-87. Conditions which usually require transportation by ambulance**

A. **Medical.** 1. Dependent on oxygen (continually).

2. Continually confined to bed (individually judged-stretcher service could be utilized).

3. Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency or of the anginal syndrome may be present even at rest. If any physical activity is undertaken discomfort is increased.

4. On IV.

5. After cardiac catheterization.

6. Having uncontrolled seizure disorders.

B. **Orthopedic.** 1. Total body cast.

2. Hip spica and other casts, which prevent flexion at the hip (individually judged in some cases, stretcher service could be utilized).

C. **Pediatric.** 1. In isolette (incubator).

2. Tracheostomy cases, requiring suction.

D. **Psychiatric.** 1. Needing restraints (possibly harmful to self or others).

2. Heavily sedated.

E. **Neuro-Surgical.** 1. Continually confined to bed (severe brain damage, for example).

2. Comatose.

3. After pneumonencephalogram.

F. The following do not necessarily require ambulance transport:

Routine hospital discharges and admissions.

Emergency room releases.

Persons categorized as quadriplegic, epileptic, or mentally retarded.

Patients unable to ambulate.

Patients undergoing medical procedures such as hemodialysis, chemotherapy, or brain scans, on an outpatient basis.

These persons may be safely transported by taxi or chaircar unless the seriousness of their condition renders it hazardous. In those special cases, an ambulance will be required.

(Effective October 27, 1977)

### **Sec. 17-2-88. Procedures**

A. **Ambulance and Chaircar.** 1. Prior authorization. For ambulance and chaircar, prior authorization must indicate the name of the physician requesting the service. When verbal approval is given, the formal request must follow as soon as possible and no later than 5 days, with the notation that verbal approval has been given and by whom.

Ambulance and chaircar requests for prior authorization must be signed by a physician or other medically responsible person. If the appropriate signature does not appear on the request for prior authorization, said request will be returned unauthorized.

2. **Billing.** A bill for Medical Transportation must be accompanied by a copy of the prior authorization. A billing not accompanied by a copy of the prior authorization because the service was given on an emergency basis, will be forwarded to the Division of Health Services for review and decision regarding the emergency need for the ambulance service or the need to request additional information from the ambulance company substantiating the bill.

3. **Return Trip from Hospital - Emergency Room.** Transportation by taxicab should be used unless medically contra-indicated.

4. **Over-utilization.** Patients who over-utilize ambulance services will be identified and a medical social worker from the Bureau of Health Services will visit the patient.

(Effective October 27, 1977)

**Secs. 17-2-89—17-2-94. Reserved**

**Policy and Procedures Governing the Billing and  
Payment for Prescription Drugs on behalf of  
Title XIX (Medicaid) Recipients**

**Sec. 17-2-95. Definition**

1. **A.W.P. or Average Wholesale Price** means the published wholesale price listed in the “Red Book” and its subsequent monthly supplements, except that, in those cases where the current wholesale price in Connecticut is greater than the “Red Book” wholesale price, the Connecticut current wholesale price shall apply.

2. **E.A.C. (Estimated Acquisition Cost)** means the Department of Social Services’ closest estimate of the price generally and currently paid by providers for a prescribed drug.

3. **Nonlegend drugs** mean those drugs which do not require a prescription to be purchased and which are commonly referred to as over the counter drugs (OTC drugs).

4. **Usual and Customary Charge to the “General Public”** means the charge which will be made for the particular prescription by the provider to the patient group accounting for the largest number of Non-Medicaid prescriptions. In determining such charge, all charges made to third party payors and special discounts offered to an individual such as a senior citizen will be excluded.

(Effective September 26, 1978)

**Sec. 17-2-96. Generic prescribing of drugs and quantities thereof**

The department may pay for accepted methods of diagnosis and treatments, but will not pay for anything of an unproven, experimental or research nature.

(Effective September 26, 1978)

**Sec. 17-2-97. Charge**

1. When the more commonly used generic drugs are prescribed, average prices of such generic drugs as determined by the department will apply as to the charge to the state—not prices applicable to trade names. This will apply to the more commonly prescribed drugs such as: chloral hydrate, penicillin—G, penicillin—VK, tetracycline, ampicillin, meprobamate, reserpine, prednisone, propoxyphene and its compounds, hydrochlorothiazide, etc.

2. Except as provided in sec. 17-2-99A, the charge for prescriptions shall be based on the average wholesale price per 100, pint or package, as indicated in the Red Book, plus the applicable professional fee, or the E.A.C. plus the applicable professional fee, or the usual and customary charge to the general public whichever is lower; the use of the foregoing price determination methods shall be as follows:

A. For the most frequently proscribed legend drugs, reimbursement shall be made on the basis of an estimated acquisition cost or AWP which shall be the price generally and currently paid by providers and which shall be determined by the department of social services, plus the applicable professional fee, or the usual and customary charge to the general public by the provider, whichever is lower.

Following final determination of the E.A.C. prices for the most frequently prescribed drugs, a list shall be compiled by the department showing the name of the drug, the procedure code for the drug and its E.A.C. price. Such lists shall be distributed to all pharmacy providers.

B. For all legend drugs for which an E.A.C. price has not been determined, reimbursement shall be made on the basis of the average wholesale price per 100, pint or package as indicated in the Red Book or their respective continuing supplements plus the applicable professional fee, or the usual and customary charge to the general public by the provider whichever is lower. In those cases where the current wholesale price in Connecticut is greater than the Red Book or AWP (e.g. controlled drugs) the Connecticut current wholesale price shall apply.

C. For nonlegend drugs (OTC drugs) reimbursement shall be based on the usual and customary over the counter price. For any nonlegend drug prescribed in less than the standard package, reimbursement shall be made for the full standard package size closest to the quantity ordered. The list of items in sec. 17-2-98 represents by category, those products which are reimbursable.

(Effective September 26, 1978)

**Sec. 17-2-98.**

Repealed, March 3, 1981.

**Secs. 17-2-98a—17-2-101.**

Repealed, January 31, 1991.

**Sec. 17-2-102. Reserved**

**Sec. 17-2-103.**

Repealed, February 17, 1982.

**Secs. 17-2-104—17-2-113.**

Repealed, April 2, 1985.

**Secs. 17-2-114—17-2-117.**

Repealed, May 2, 1983.

**Sec. 17-2-118.**

Repealed, December 21, 1990.

**Sec. 17-2-119. Services requiring prior authorization**

a. **Contact Lenses.** When such lenses provide better management of a visual or ocular condition that can be achieved with spectacle lenses — for unilateral aphakia, (after second eye is operated a spectacle, lenticular “regular” cataract Rx will be supplied instead of additional contact lenses), keratoconus, corneal transplant, and anisometropia.

Soft lenses will not be provided unless necessary for treatment of corneal disease.  
(Effective November 28, 1977)

**Secs. 17-2-120—17-2-122.**

Repealed, May 2, 1983.

**Establishment of a Pilot Program of Shelter Services  
for Victims of Household Abuse**

**Secs. 17-2-123—17-2-128.**

Repealed, August 28, 1981.

**Sec. 17-2-129. Reserved**

**Sec. 17-2-130.**

Repealed, May 11, 1998.

**Secs. 17-2-131—17-2-139.**

Repealed, December 21, 1990.

**Title XIX (Medicaid) Recipient's Personal Allowance in a nursing facility,  
intermediate care facility for the mentally retarded (ICF/MR),  
Chronic Disease Facility or Mental Health Facility**

**Sec. 17-2-140. Definitions**

**A. Patient's Personal Allowance.** The Patient's Personal Allowance (PPA) is the amount of money that patients who are recipients of Medical Assistance in Long-Term Care Facilities have accumulated from the amount allowed each month from his or her income for personal needs, as determined by section 17b-272 of the Connecticut General Statutes.

**B. Long-Term Care Facility.** Long-Term Care Facilities include licensed nursing facilities, ICF/MR, Chronic Disease Facilities and Mental Health Facilities.

(Effective June 30, 1978; amended October 1, 2001)

**Sec. 17-2-141. Purpose of patient's personal allowance policy**

The purpose of the Patient's Personal Allowance (PPA) Policy is to establish standards and accounting controls for PPA when the Long-Term Care Facility acts as trustee for publicly-aided patients who are residents of the Long-Term Care Facility. In terms of this section, publicly-aided patients are those recipients who participate in the Medical Assistance Program through residence in a licensed nursing facility, ICF/MR, Chronic Disease Facility or Mental Health Facility. Items and services that may be charged to the patient's personal allowance are described in 42 CFR 483.10(c)(8)(ii), as amended from time to time.

(Effective June 30, 1978; amended October 1, 2001)

**Sec. 17-2-142. Patient's authorization for facility to manage funds**

When a facility assumes responsibility for funds for a patient receiving Medical Assistance, there must be a statement on file signed by the patient, his guardian, conservator or legally liable relative authorizing the facility to manage the personal funds. No nursing home shall use or cause to be used for any purpose the personal funds of any patient admitted to a Long-Term Care Facility unless written consent has been obtained from the patient or from a legally liable relative, conservator or guardian.

Consent by a patient shall not be effective unless co-signed by a legally liable relative or guardian if the patient has been determined by a physician to be mentally incapable of understanding and no conservator has been appointed.

A facility may request written authorization from a competent patient of an alternative plan of control of his personal funds if he should become incompetent. A Power-of-Attorney designating a relative or other responsible person may be an acceptable plan for assuming responsibility for the funds. The "other responsible person" shall not be an employee of the facility or in any way related to an employee of the facility.

(Effective June 30, 1978)

### **Sec. 17-2-143. The PPA accounting system-responsibilities of facility**

**A. Relative, Guardian or Conservator Handles the PPA.** 1. If a relative, guardian or conservator receives the patient's resource or Supplemental Security Income (SSI) check and keeps the PPA to manage for the patient, the facility is not required to keep any records.

2. If the facility receives the resource or SSI check and remits the PPA to a relative, guardian or conservator, the facility shall obtain a signature from the person receiving funds and record the dates and amounts received. This must be done in the Disbursements Register. If the facility mails checks to the relative, guardian, or conservator, the cancelled checks are acceptable in lieu of a signature. A signed receipt is also acceptable in lieu of a signature. Records must be kept of all these transactions.

**B. Patient Handles His/Her Own Money.** When a Long-Term Care Facility delivers the entire \$25.00 PPA lump-sum amount to the patient, the facility must obtain a signature from the patient for receipt of the money, along with the date and amount received. This must be done in the Disbursements Register or a petty cash receipt slip, or via a check endorsed by the patient. The facility need keep no additional records since it is the patient who is managing his/her own funds.

**C. Facility as Trustee for Funds.** When the facility acts as trustee of the PPA, the facility shall follow the accounting procedures listed below.

1. **The Banking System.** The facility may elect to have individual bank accounts for patients, utilizing bank books, or it may establish a single aggregate trust account or it may have a combination of these two types of accounts. If an aggregate trust account is used, the account shall be clearly entitled as such and the facility owner or administrator shall be at least one of the designated trustees. The trustee account shall be entirely separate at all times from any facility business account. The trustee account need not be interest bearing, but if it is, interest shall accrue for the patients in an equitable manner.

Additional Stipulation: a. Designated trustee updated for sale of facility or change of personnel. b. Interest division in an equitable manner should be spelled out in detail; i.e., mathematical method. c. Survivorship accounts are prohibited.

2. **The Accounting System.** a. Regardless of whether or not a patient's personal allowance is deposited into an individual bank account, or an aggregate PPA trustee account, or some combination, there must be an accounting system maintained which reflects the activity into and out of the bank account. The accounting system, at a minimum, should consist of the following:

1. Receipts Register or acceptable equivalent
2. Patient's Ledger - control card with subsidiary ledger cards (individual patient accounts)
3. Disbursement Vouchers

b. The bank account statements and the patient’s ledger shall be in agreement and reconcilable at any point in time. All bank statements and cancelled checks of the trust account shall be kept in the facility for at least three years.

c. All of the personal fund portion of checks or cash received on behalf of the patient shall be deposited into the trustee or bank book account in a timely manner which shall be no later than two weeks after the receipt of the money by the facility.

d. Each patient for whom the facility manages funds shall have an individual recording in the Receipts Register or its acceptable equivalent and all disbursements (cash or check) shall be charged directly to the patient’s account.

e. All disbursements made on the patient’s behalf (check or cash) shall have an accompanying voucher. All vouchers shall be maintained on file for a period of at least three years to allow for audits of individual patient accounts. These invoices should be kept in individual envelopes or folders with the patient’s name on the outside. If cash or a check is disbursed for a number of patients at once, such as an aggregate amount for a hairdresser, barber or newspapers, the invoices submitted by these service people may be kept in an “aggregate” folder in lieu of filing into each individual patient’s folder.

The facility may, if it elects, utilize in lieu of individual patient folders, a continuous sequence file of invoices as long as it adheres to a date or reference number from the invoice to the disbursements register.

f. All cash receipts and disbursements shall be recorded in the related registers as follows:

*Cash Receipts*

- (1) Date (of entry)
- (2) Patient
- (3) Patient A/C No.
- (4) Amount

*Cash Disbursements*

- (1) Date
- (2) Check No.
- (3) Payee
- (4) Amount
- (5) Patient A/C to be changed
- (6) Specific item

*Patient’s Ledger-Subsidiary Accounts*

- (1) Date (of entry)
- (2) Specific item (i.e., cigarette, shoes, not the words “misc.” or “personal needs”)
- (3) Amount
- (4) A copy of the patient’s signature is kept on file and all disbursements are made by check or if in cash, they are verified by a voucher signed by the patient and charged directly to the patient’s account.
- (5) Persons working with the facility receiving cash from patients for services rendered will sign a voucher for filing in the business office.
- (6) Invoice number or date

g. Patient’s ledger records shall be posted once a month.

h. Cash shall be available to patients in the form of actual cash or a check no less than ten hours a week and no less than three days a week. The patients shall be fully informed of the time when they may receive their money.

i. All money disbursed on behalf of a patient shall be within guidelines of Social Services Department guidelines and consistent with that patient’s needs and desires.

j. If money is disbursed to a patient by means of a check, or if the patient signs petty cash vouchers, these are acceptable in lieu of a signature in the register.

k. When cash is disbursed to a patient there is no need to itemize other than “cash to patient” if not in excess of \$1.00.

3. Petty Cash in the Facility. The facility may, if it chooses, maintain a petty cash fund in order to make direct cash distributions to patients. The facility must *not* keep on hand an amount which exceeds more than five dollars (\$5.00) per patient or 5 times the number of patients for whom the facility handles funds; however, two hundred and fifty dollars (\$250.00) is allowable regardless of the

number of patients. The facility is responsible to ensure the safekeeping of this money and must repay the patients for any money which cannot be accounted for accurately via the general ledger or which has been lost through theft in the facility.

4. The Distribution of Cash at a Second Point in the Facility. If the facility elects to distribute cash at a point other than the business office, and if it is not convenient that the required records be brought to that point, disbursement vouchers must be maintained at this point.

5. Availability of PPA Records to Department Personnel. All PPA records including the accompanying bank statements, cancelled checks and invoices, must be kept in the facility at all times and must be available to Department of Social Services personnel upon request. The request may be made in person, or by mail.

6. Patient Signatures. It is recognized that not all patients in Long-Term Care Facilities are capable of signing their names. If the patient absolutely cannot sign, then two signatures are needed on the voucher, that of the custodian of the fund and the manager or their designees.

7. Patients with Balances of \$275.00. Patients whose PPA balances held by the facility reach \$275.00 require the establishment of a burial reserve.

8. Specialized Accounting Situations. If the Department auditor and the owner, administrator, or comptroller of a facility or group of facilities reach agreement as to the establishment of a "specialized" accounting system designed to meet particular needs of that facility, the new system must be followed. The Department must agree to any changes in writing. In addition, any of these regulations may be waived at the option of the Department.

9. Request to See PPA Records by Patient or His Authorized Representative, Relative, Guardian, Conservator or Ombudsman. The facility shall, within a reasonable period of time, allow the following persons to see the PPA records of an individual patient: (a) The patient, or his authorized representative, or (b) a responsible relative, or (c) guardian, or (d) conservator, or (e) ombudsman, or (f) representative of the Department of Social Services.

In lieu of this, the facility may send copies of the records in the general ledger to the person making the request.

10. Items That May Not Be Charged to Personal Fund Allowance. When the facility is Trustee for the PPA, the funds must be used only for the patient's personal needs. The funds shall not be used to purchase items included in the per diem rate set by the Rate Setting Commission for the facility or allowable under the Medical Care Plan on a vendor payment basis, or includable under the Rate Setting Regulations. Therefore, patients' gowns, geri-chairs, physical therapy, speech therapy and other like items are not chargeable.

To guide you further, a partial list of items that cannot be charged to the patient's Personal Allowance Fund appears below.

This list is not intended to preclude the facility from purchasing items which are not reimbursed through the per diem or on a fee for service basis and charging them through the PPA funds.

- (a) Group activities or entertainment which occurs within the facility.
- (b) Parties organized by the facility.
- (c) Medically necessary drugs, medicines or medical supplies.
- (d) Funeral expenses, up to \$600.00.
- (e) Room and board to the facility.
- (f) Wheelchair purchase, rental or repair. (The facility is not, however, expected to provide customized, i.e., motorized wheelchairs.)

- (g) Physical restraints.
- (h) Transportation to obtain necessary medical treatment.
- (i) Gifts to relatives in excess of \$25.00.
- (j) Medically necessary treatment ordinarily paid for under the Title XIX program.

11. **Withdrawal of Personal Needs Funds.** At no time may any funds be withdrawn from the Personal Fund account for use in the business or operating expense of the facility or for the personal use of any employee, administrator, owner or relative thereof. The Personal Funds are not available for loan to anyone.

12. **Individual Unable to Use Monthly Personal Needs Allowance and His Account Accrues.** A. At the time of admission the facility should contact the District Office Resource Unit to determine if the individual has assets.

B. If the individual has no assets when his account accrues to a balance of \$275.00 the facility will apply any excess over \$250.00 to a bank account for the patient established for burial purposes only. When a burial account accrues to \$600.00 and the patient's account in the facility has a balance of \$275.00, any excess over \$250.00 must be applied to the monthly cost of care.

C. If the individual has the maximum assets allowed (\$250.00 personal funds plus \$600.00 burial reserve) the balance in the patient's account may accrue an additional \$25.00. Any amount over \$275.00 in personal funds must be applied towards the patient's monthly cost of care.

D. To serve as notice to the Department and the recipient that personal funds in excess of \$275.00 have been applied to the cost of care, the facility will complete Form W-138 "Application of Excess Personal Funds to Cost of Care" in quadruplicate and will distribute it as follows: One copy is attached to the W-291N Billing Form and submitted to the Medical Disbursements' Section in Central Office. The second copy is sent to the appropriate District Office for filing in the case record, the third copy is given to the recipient and the fourth copy is kept on file by the facility.

There have been instances where accumulated personal funds have been transferred to families. The facility will be held responsible for such transfers except upon specific approval of the Department of Social Services. Money gifts at Christmas and relative birthdates are exceptions to the above, but must be reasonable.

13. **Personal Funds of a Patient Who is Transferred to Another Long-Term Care Facility.** If a patient is transferred or released to another Long-Term Care facility, the patient shall leave retaining his or her bank book; the balance of the patient's funds shall be sent to the new facility within ten (10) days of the transfer date. This shall include any cash held in the facility plus any amount held in aggregate trustee bank account.

14. **Discharge or Release of a Patient to Community Living.** The patient who has been discharged from the facility to the community shall leave retaining his or her bank book or with a check for the balance of his PPA account. The amount shall reflect the cash held in the facility plus the bank balance.

15. **Death of a Patient While in a Long-Term Care Facility.** If a Title XIX recipient in a facility expires, funds on deposit in his account become part of his estate. Immediately upon the death of the recipient, the facility will notify the District Office Resource Supervisor. Within seven (7) days of the patient's death the Department of Social Services District Office Resource Supervisor will inform the facility as to the disposition of the patient's funds.

16. **Patient is transferred to a Hospital and Does Not Return to Facility.** If a patient is transferred to a hospital and does not return to the facility, the balance of the PPA must be sent to the patient within ten (10) days after he/she leaves the

hospital. If the patient cannot be located, the Department of Social Services should be contacted.

(Effective June 30, 1978)

**Sec. 17-2-144. Annual accounting to the department of PPA balance**

Annually, by each June 1st, an accounting must be made to the Department of Social Services reflecting the balance of the PPA for each patient for whom the facility handles the funds. If money is held in an aggregate trustee bank account, the balance for each patient must be accompanied by a bank statement. A bank statement is not necessary for individual patient bank accounts. The accounting must consist of the following:

- (a) Recipient's name
- (b) Welfare number
- (c) Welfare Service Office
- (d) Petty cash held in facility for patient
- (e) Balance held in bank book for patient
- (f) Balance held in Trustee account for patient
- (g) Any other money being held for patient for whom facility is trustee

If the facility is not trustee for any patient's money it *must so state* by each June 1st to the Department.

The accounting to the Department must be submitted by June 1st of each year on the Statement of Patient's Personal Fund Account (Form W-411) and must be dated, signed by the administrator of facility, and mailed to:

Connecticut State Department of Social Services  
Internal Audit Division  
110 Bartholomew Avenue  
Hartford, Connecticut 06115

(Effective June 30, 1978)

**Sec. 17-2-145. Accounting of personal funds upon sale of a facility**

If the facility is sold, an accounting must be made to the Department of the Personal Funds balances which are to be transferred to the new owner. This accounting must consist of the use of the "Statement of Patient's Personal Fund Account" form (the same format as the annual accounting) and must be signed and dated by both the seller and the buyer. In the case of corporations it must be signed by a person authorized on behalf of the corporation. In a partnership, one or both partners may sign; if a sole owner, he/she must sign. The accounting must be accompanied by the most current bank statement and must be reconciled accurately with the statement. The W-411 form must be mailed to the same address as in Item 17.

The Department will not enter into a contract with a new owner unless this information is submitted.

If the facility does not handle any Patient's Personal Allowance it must so state upon sale of the facility.

Should changes occur in personnel responsible for personal needs funds accountability, appropriate changes in authorized signature for checking accounts or designated Trustee for Savings Passbooks shall be made at financial institutions and documented. The supporting data is to be made available for review purposes.

(Effective June 30, 1978)

**A Reporting Law for Protection of the Elderly which  
provides for the Establishment of a Protective  
Services Program for Elderly Persons**

**Secs. 17-2-146—17-2-151.**

Repealed, March 27, 1990.

**Sec. 17-2-152. Reserved**

**Secs. 17-2-153—17-2-154.**

Repealed, May 10, 2000.

**Use of Provider Numbers by Physicians Salaried by  
General Hospitals and Public and Private  
Institutions and Clinics**

**Secs. 17-2-155—17-2-156.**

Repealed, May 11, 1998.

**Secs. 17-2-157—17-2-162.**

Repealed, October 14, 1982.

**Sec. 17-2-163. Requirements for skilled nursing, intermediate care and chronic disease facilities in taking deposits or prepayments on behalf of patients who are applicants for Title XIX (Medicaid), who are subsequently determined eligible for Title XIX (Medicaid) and the requirements for these facilities to refund such deposit or prepayment**

(a) Any prepayment or deposit made by or on behalf of an applicant for Title XIX (Medicaid), which is accepted by a facility, must be refunded to the payor when Title XIX (Medicaid) eligibility is established.

(b) Any such prepayment or deposit cannot exceed \$1,500.00 and such prepayment or deposit shall be placed in escrow as designated by the Department of Income Maintenance.

(c) Upon a determination of eligibility, the payment held in escrow shall be refunded to the payor and the Title XIX payment shall be made to the facility. Upon a determination of ineligibility, the payment held in escrow may be transferred to the facility operating account unless the applicant requests a Fair Hearing, in which case the payment shall continue to be held in escrow until final disposition of the administrative appeal.

(d) One escrow bank account is sufficient to handle the deposits. Documentation in the form of receipts and disbursements by the individual must be available to the Department of Income Maintenance showing dates, purpose and disposition. Subsidiary accounts for each person shall be maintained to provide adequate record of transactions and current balances.

(e) Where a prepayment or deposit is to be refunded, the full amount paid for services rendered during the period of Title XIX eligibility must be refunded. Example: If the Department of Income Maintenance payment was \$30.00 for a service toward which the recipient had made a \$40.00 deposit or prepayment, the facility must refund the full \$40.00 and accept the \$30.00 payment as payment in full for that service.

(f) The Department of Income Maintenance shall not pay a facility for services for which a prepayment or deposit is being held in escrow until such time as the

escrow account is refunded to the person who made such payment. Any payment for services made by the Department of Income Maintenance is subject to the criteria of existing program policy.

(Effective May 8, 1980)

**Sec. 17-2-164. Payments made on behalf of an applicant of Title XIX (Medicaid) who is a patient at a skilled nursing, intermediate care and chronic disease facility which is considered as income and not a deposit or prepayment**

Payments made to a Title XIX (Medicaid) applicant for his own use are considered as income available to him and must be counted in determining his financial eligibility for Medicaid. These payments shall not be regarded as available income until the applicant attains a personal asset account of \$250.00 and a burial reserve of \$600.00, when program policy so allows.

(Effective May 8, 1980)

**Secs. 17-2-165—17-2-178. Reserved**

**Property Transfers Made by Applicants for or Recipients of  
Town Assistance Benefits Which Result in Ineligibility  
for Such Benefits**

**Sec. 17-2-179.**

Repealed, September 23, 1988.

**Secs. 17-2-180—17-2-183.**

Repealed, December 21, 1990.

**Secs. 17-2-184—17-2-186. Reserved**

**Transfer of Assets**

**Secs. 17-2-187—17-2-188.**

Repealed, December 21, 1990.

**Secs. 17-2-189—17-2-204. Reserved**

**The AFDC Food Standard**

**Sec. 17-2-205.**

Repealed, December 21, 1990.

**Sec. 17-2-206. Reserved**

**Pilot Voluntary Work Program**

**Sec. 17-2-207. Pilot voluntary work program**

**(a) General**

The Department of Income Maintenance administers a Pilot Voluntary Work Program to serve heads of AFDC households, with an emphasis on persons who have received such aid for ten years or longer. Participation in the program is voluntary and the program operates in the Norwalk, Connecticut area. Persons who wish to participate must register with the Work Incentive (WIN) Demonstration

Program, “The Job Connection.” The Pilot Program prepares long-term recipients of AFDC to enter work directly, or to take part in additional training or education with the goal of becoming economically self-sufficient.

(b) **The Pilot Voluntary Work Program**

The Program is to serve at least 50 persons and includes:

- (1) an orientation and assessment of each participant’s vocational, academic and motivational strengths and weaknesses;
- (2) the design of an individualized employability plan for each participant;
- (3) pre-employment remedial education designed to place emphasis on the essential skills for daily living and for seeking, obtaining and sustaining employment;
- (4) individual counseling sessions with a career development counselor and group sessions to strengthen self-confidence and reinforce pre-employment skills;
- (5) integration of life skills with basic educational skills. Participants will receive life skills certificates upon achieving specific knowledge levels and for attainment of skills unrelated to academic achievements; and
- (6) referral to work, education or training upon completion of the program.

(c) **Support Services**

Support services such as child care and transportation are provided through the Work Incentive (WIN) Program, as is reimbursement for reasonable expenses needed to meet the requirements of the program.

(d) **Program Operator**

The program is operated by an outside agency under contract with the Department of Income Maintenance.

(e) **Duration**

The Pilot Voluntary Work Program shall continue for as long as funding is available as authorized by the legislature.

(Effective June 27, 1986)

**Secs. 17-2-208—17-2-213. Reserved**

**Public Assistance Checks Cashed by Banking Institutions**

**Sec. 17-2-214. Definition**

As used in section 17-2-215, “banking institution” means a state bank and trust company, national banking association, state or federally chartered savings bank, state or federally chartered savings and loan association, state or federally chartered credit union or other state or federally chartered banking institution having an office within this state.

(Effective October 28, 1988)

**Sec. 17-2-215. Public assistance checks cashed by banking institutions**

No banking institution shall be liable to reimburse the State of Connecticut for a loss incurred as a result of wrongful payment of any Public Assistance check provided that acceptable forms of identification as described in subsection (a) of this section are used and providing the procedures listed in subsection (b) of this section are followed.

(a) Documents issued by public or private organizations as a means of identifying an individual are considered acceptable forms of identification. The identification document must include the signature of the payee or a unique number by which the organization can identify the payee. Acceptable forms of identification may be issued by the following organizations:

- (1) the Department of Income Maintenance
- (2) the Department of Motor Vehicles
- (3) other State agencies
- (4) federal agencies
- (5) municipalities
- (6) employers
- (7) credit card companies
- (8) banking institutions
- (9) unions

(b) The following procedures will be adhered to when cashing checks:

(1) The check must be signed by the payee at the time of cashing, or signed again if previously signed.

(2) Two acceptable identification documents must be required.

(3) In combination the two acceptable identification documents must present the following:

(A) signature

(B) photograph

(C) a unique number by which the payee can be identified by the organization issuing the identification document

(4) The signature on any identification document must appear to match the signature on the check.

(5) The types of identification documents used must be clearly recorded on the check, or, if recorded on computer or other medium, must include the date of the transaction and be presented to the Department upon notification to the bank of a stop payment action.

(6) An identification number from the identification documents must be clearly recorded on the check, or, if recorded on computer or other medium, must include the date of the transaction and be presented to the Department upon notification to the bank of a stop payment action.

(7) A clear bank photograph may be substituted for a photo ID.

(Effective October 28, 1988)



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## Fair Hearings\*

### **Secs. 17-2a-1—17-2a-2.**

Repealed, December 21, 1990.

### **Sec. 17-2a-3. Time for request**

When a departmental decision or action is being appealed, the request for a fair hearing shall be mailed within thirty days from the date of the notice of action. When a request for a fair hearing results from the department's failure to render a decision on an application, the request may be mailed any time after sixty days from date of application.

(Effective April 4, 1967)

### **Sec. 17-2a-4. Scheduling of hearing**

Immediately upon receipt of a request for a fair hearing, the hearing officer shall schedule the hearing to be held within thirty days from the date of the request. The request shall be acknowledged by a letter to the appellant which shall inform him of the date, time and place scheduled for the hearing. If the date, time or place scheduled for the hearing is not convenient to the appellant, the hearing shall be rescheduled to suit the mutual convenience of the appellant and the department representatives. A fair hearing may also be rescheduled by the hearing officer to suit the convenience of the department representatives, in which case reasonable advance notice shall be given to the individual requesting the hearing. When a hearing is rescheduled, the new date, time and place shall be confirmed in writing.

(Effective April 4, 1967)

### **Sec. 17-2a-5. Disposal of request for hearing**

A request for a fair hearing may be disposed of only by one of the following definitive actions:

(1) Withdrawal of the request by the person who made it. This action shall be voluntary and may be made at any time prior to the hearing by a written statement of withdrawal, addressed to the welfare commissioner. The withdrawal shall be acknowledged in writing by the hearing officer.

(2) Dismissal of the request by the hearing officer. This action shall be taken if:

(A) The appellant fails to appear at the designated time and place, and if, within a reasonable time thereafter, it is determined that he wishes no further action taken on his request for a fair hearing; or

(B) the point at issue is revolved prior to the fair hearing and the request is not voluntarily withdrawn by the appellant. A written notice of dismissal shall be sent by the hearing officer to the person who requested the fair hearing.

(3) Decision by the hearing officer following a fair hearing. A request for a fair hearing shall be disposed of not later than sixty days from the date of receipt. If the fair hearing is postponed at the request of the applicant or beneficiary, or if it is continued in order to obtain additional information, an extension of not more than thirty days may be allowed for making final disposition of the request.

(Effective April 4, 1967)

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\*Regs. 17-2a-1—17-2a-12, 17-2b-1—17-2b-3 disapproved by interim regulation review committee, Feb. 13, 1968; reinstated as effective regulations on adjournment of 1969 session of general assembly sine die, no action having been taken thereon. (1969 Supp. § 4-48a.)

**Sec. 17-2a-6. Site of hearing. Hearing officer in charge**

(a) The fair hearing shall be held in the district office of the state welfare department unless other arrangements are necessary to suit the convenience of the person requesting the hearing.

(b) The hearing officer shall be in charge of the proceedings.

(Effective April 4, 1967)

**Sec. 17-2a-7. Witnesses**

The appellant shall act as a witness in his own behalf, and may bring additional witnesses. The department shall be represented at a fair hearing by the social worker, or investigator in a humane institutional case, and, if necessary, by a consultant who is acquainted with the technical aspect of property or medical questions involved. A supervisor may substitute for the worker, or investigator in a humane institutional case, or may act as a witness.

(Effective April 4, 1967)

**Sec. 17-2a-8. Testimony**

Testimony may be given by the appellant and his witnesses and by the social worker, or investigator in a humane institutional case, and other departmental representatives in response to questions asked by the hearing officer. Testimony may be freely given so long as it is reasonably relevant to the questions asked and is offered in a proper manner. The technical rules of evidence do not apply, although testimony is required by law to be given under oath. If the appellant is represented by legal counsel, his direct testimony is usually given in response to his attorney's questions. His attorney may also question departmental representatives. The appellant who is not represented by counsel may ask questions which are answered by the hearing officer or directed by him in turn to a departmental representative.

(Effective April 4, 1967)

**Sec. 17-2a-9. Exhibits**

Exhibits may be introduced by departmental representatives or other witnesses to substantiate or amplify their oral testimony. For example, bank books, deeds, mortgage notes, wage slips, medical bills and other papers or records may be introduced, if relevant to the case. If the individual wishes to retain possession of a document introduced as an exhibit, the substance of it may be dictated into the record by the hearing officer. The appellant has the right to examine all documents and records used at the hearing at any reasonable time.

(Effective April 4, 1967)

**Sec. 17-2a-10. Change in circumstances after hearing**

Any change in circumstances which occurs in the case after a fair hearing has been held shall have no effect on the fair hearing decision.

(Effective April 4, 1967)

**Sec. 17-2a-11. Subpoenas**

The hearing officer has the power to compel, by subpoena, the attendance and testimony of witnesses and the production of books and papers where such action becomes necessary.

(Effective April 4, 1967)

**Sec. 17-2a-12. Recording of proceedings. Transcripts**

A mechanical recording of the proceedings shall be made for use by the hearing officer as a basis for his decision and shall be available to the appellant or his designated representative on request. A stenographic transcript of the recording shall be made available to the court in case of appeal.

(Effective April 4, 1967)

**Secs. 17-2b-1—17-2b-3.**

Repealed, December 21, 1990.



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**Eligibility of Nonresidents Applying for Aid**

**Secs. 17-2d-1—17-2d-2.**

Repealed, December 16, 1969.

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**Sec. 17-2e-1.**

Repealed, December 21, 1990.

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**Provision of Emergency Shelter Services to General Assistance Applicants and Recipients by the Towns**

**Secs. 17-3a-1—17-3a-9.**

Repealed, September 23, 1988.

**Sec. 17-3a-10. General assistance policy manual**

Transferred, February 10, 1998.

<i>From</i>	<i>To</i>
17-3a-11	17b-78-11
17-3a-12	17b-78-12
17-3a-13	17b-78-13
17-3a-14	17b-78-14
17-3a-15	17b-78-15
17-3a-16	17b-78-16
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17-3a-37	17b-78-37
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17-3a-41	17b-78-41
17-3a-42	17b-78-42
17-3a-42.1	17b-78-42.1

(Effective September 23, 1988, amended June 29, 1989, June 30, 1989, September 29, 1989, October 25, 1989, December 7, 1989, January 3, 1990, March 22, 1990, May 23, 1990, September 4, 1990, September 25, 1990, October 29, 1990, February 1, 1991, March 1, 1991, April 19, 1991, June 28, 1991, July 25, 1991, December 3, 1991, March 2, 1992, July 1, 1992, November 3, 1992, December 23, 1992, January 5, 1994, January 13, 1994, April 22, 1994, March 3, 1995, transferred February 10, 1998)

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**Sec. 17-3f-1.**

Transferred to § 17b-10-1.  
(Effective January 31, 1996)

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### Statewide Listing of Income Maintenance Offices

#### Sec. 17-3g-1. Statewide listing of income maintenance offices

The department of income maintenance office locations by district are as follows:

- (a) **District 1**—Hartford District Office; Manchester Sub-district Office
- (b) **District 2**—New Haven District Office;
- (c) **District 3**—Bridgeport District Office; Stamford Sub-district Office; Danbury Sub-district Office; Norwalk Sub-district Office
- (d) **District 4**—Norwich District Office; Putnam/Danielson Sub-district Office;
- (e) **District 6**—Waterbury District Office; Torrington Sub-district Office; Bristol Sub-district Office
- (f) **District 7**—Middletown District Office; New Britain Sub-district Office; Meriden Sub-district Office.

(Effective August 29, 1989)



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## **Statewide Income Maintenance Offices Coverage**

### **Sec. 17-3h-1. Plan for statewide coverage for services provided by the department of income maintenance (DIM)**

(a) There shall be three types of offices maintained by DIM for the purpose of providing its services to applicants and recipients. These are the “district office,” the “sub-district office,” and the “field office.”

#### **(b) District Offices**

(1) The appropriate site for a main office of a district (the district office) will be a central city of a Standard Metropolitan Statistical Area (SMSA). In addition, to the degree possible, it will meet the following criteria:

(A) The site will be the largest urban community within the district boundaries or the largest community that is most central to the towns within the district boundaries;

(B) The city will have the largest population living below poverty of any town or city within the district;

(C) The city will have a local bus system that is extensive enough to provide transportation to any resident who is a recipient or an applicant who wishes to visit the office;

(D) The city will be within reasonable travel distance for the majority of current and potential recipients who live in the towns served by the district office. Optimally, it will be a city with public transportation facilities that reach into the towns on its borders.

(2) A district office serves people from specific surrounding towns who:

(A) Wish to apply for any program the department administers;

(B) Are receiving assistance and who must report major changes in circumstances which may have an effect on eligibility or benefits;

(C) Are eligible for one or several programs and must have eligibility redetermined at regular intervals in order to keep receiving benefits;

(D) Are aggrieved and authorized by law to request an evidentiary and/or fair hearing concerning the department’s treatment of their case.

(3) A district office is the administrative center for the district. The district director’s office is there. In addition, many functions are centralized in the office. These include case record maintenance, record keeping for management controls, and in some cases, the intake and resources processes.

#### **(c) Sub-District offices**

(1) The status of a sub-district office is given to a smaller service area: one that has smaller gross population and poverty population than does the main service area. In addition, any of the following factors may be considered to be valid criteria for determining the need for a sub-district office within a district:

(A) The district office is inaccessible to a large population of persons who are potentially eligible for public assistance either because of limited or non-existent public transportation to the main office or because of excessive travel distance;

(B) New concentrations of people who live at or below poverty level may be evident from a review of U.S. Census results or from an increase in applications for assistance;

(2) The appropriate site for a sub-district office will be the central city of an SMSA or the largest town or city within the sub-district that is the most central to the towns within the sub-district boundaries.

(3) A sub-district office serves people who live in specific towns within the district. It is managed by a program supervisor, who makes all major decisions

affecting the management of the sub-district office. The program supervisor reports to a district director. The district director determines what functions are necessary for the sub-district offices, in order to most effectively meet the needs of the potential and eligible recipients within the district as a whole. People from the towns that are served by the sub-district office are able to receive the same services that are offered in the district office as far as assistance programs are concerned. The can:

- (A) Apply for any program;
- (B) Have eligibility redetermined when necessary;
- (C) Report material changes in circumstances that affect eligibility or benefits;
- (D) If aggrieved and authorized by law, request an evidentiary and/or fair hearing concerning the department's treatment of their case.

(d) **Field offices**

(1) A field office is a temporary or part time office that is established at the discretion of the department to meet special community needs. A field office may be established when:

(A) A significant number or a significant concentration of potential applicants would have to travel an unreasonably long distance in order to apply for assistance. Twenty-five miles or more is considered by the department to be excessive distance;

(B) A significant portion of the eligible recipients in a part of the district have demonstrated an inability to get to the main district or sub-district office to meet the redetermination requirement due to lack of public transportation and excessive travel distance;

(C) A downturn in the economy results in high unemployment in a particular part of the State and potentially eligible population for certain program increases temporarily.

(2) A field office will offer persons in specified towns an opportunity to have more convenient access to the programs administered by the department. Most frequently needs can be met by taking applications for certain programs. In some places, redeterminations, as well as evidentiary and/or fair hearings, will also be carried out at the field offices. The type of program services provided at each site will be determined according to the department's best assessment of the needs in the community.

(Effective April 24, 1981)

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## **Food Stamp Basis of Issuance and Allotment Reduction**

### **Secs. 17-12a-1—17-12a-2.**

Repealed, December 21, 1990.

### **Secs. 17-12a-3—17-12a-14. Reserved**

### **Sec. 17-12a-15. Disclosure of and access to information contained in food stamp case records**

#### **(a) General**

Use and/or disclosure of information obtained from Food Stamp households is restricted to certain individuals, and agencies.

#### **(b) Access to Information**

(1) Access to information used in the determination of eligibility and benefit levels of individuals and households applying for or receiving food stamps is limited by Federal regulation to:

(A) persons directly connected with the administration or enforcement of the provisions of the Food Stamp Act or regulations;

(B) persons administering other Federal assistance programs;

(C) persons administering Federally assisted State programs which provide assistance on a means-tested basis to low income individuals such as Aid to Families with Dependent Children, Supplemental Security Income, and Medicaid;

(D) employees of the Comptroller General's Office of the United States for audit examination authorized by any provision of law;

(E) local, State or Federal law enforcement officials, upon their written request for the purposes of investigating an alleged violation of the Food Stamp Act or regulations.

(F) households applying for or receiving Food Stamp benefits, their Authorized Representative, or an individual acting on behalf of the household, upon their written request.

(2) Law enforcement officials and household members, prior to the case review, or obtaining information must submit a written request to the Department of Income Maintenance representative.

(A) A written request received from law enforcement officials must include:

(i) the identity of the individual requesting the information; and

(ii) the authority to do so; and

(iii) the violation being investigated; and

(iv) the identity of the person on whom the information is requested.

(B) The written request submitted by head of household, the household's authorized representative, or an individual acting on behalf of the household must include:

(i) name of the person making the request; and

(ii) date of request; and

(iii) reason for the request; and

(iv) signature of the head of household or its authorized representative.

(3) The food stamp case record is available for inspection during normal business hours.

(4) The Department of Income Maintenance can withhold confidential information such as:

(A) the names of individuals who have disclosed information about the household without the household's knowledge; or

(B) the nature or status of pending criminal prosecutions.

(Effective June 2, 1986)

**Sec. 17-12a-16.**

Repealed, December 21, 1990.

**Sec. 17-12a-17. Maximum income limitations – clarification of age 60 in the food stamp program****(a) General Statement**

Households applying for or receiving Food Stamp benefits must have income below an established maximum level as a factor of eligibility. The maximum income limitations are established by Federal Regulation.

**(b) Definitions****(1) Gross Income**

For the purposes of this section, gross income is considered to be all countable income received by a household during the month with no deductions.

**(2) Net Income**

For the purposes of this section, net income means the total of non-excluded earned and unearned income minus all allowable deductions.

**(3) Age 60**

For the purposes of this section an individual is considered to be 60 years of age on the first of the month in which the 60th birthday occurs.

**(c) Maximum Income Limitations**

The monthly income of households applying for or receiving Food Stamp benefits may not exceed limitations established by Federal Regulation.

Households with income in excess of the limitations are ineligible to participate in the program. The income limitation is specified in either the Gross Income or Net Income Table. The selection of the appropriate table is based on household circumstances.

**(1) Gross Income Table**

The Gross Income Table is used when the household does not contain any members:

(A) 60 years of age or older;

(B) blind or disabled receiving income under Title II of the Social Security Act;

(C) who are veterans, their spouses or surviving children receiving Veterans Disability benefits under Title 38 of the United States Code;

(D) with income from Supplemental Security Income.

**(2) Net Income Table**

The Net Income Table is used when the household contains one or more of the following:

(A) members 60 years of age or older;

(B) members who are blind or disabled receiving income under Title II of the Social Security Act;

(C) Veterans, their spouses or surviving children receiving Veterans Disability benefits under Title 38 of the United States Code.

(D) Members with income from Supplemental Security Income.

(Effective June 3, 1986)

**Sec. 17-12a-18. Household cooperation****(a) General**

As a condition of eligibility households are required to cooperate in the initial application process, in reviews generated by reported changes, in redeterminations and in Quality Control reviews.

**(b) Definition**

Quality Control annual review period is the twelve month period from October 1st of each calendar year through September 30th of the following calendar year.

**(1) At Intake**

(A) Households are responsible for cooperating with the Department of Income Maintenance in completing the application process. The application form must be:

(i) fully completed and signed; and

(ii) a responsible household member or authorized representative must be interviewed; and

(iii) certain information must be verified.

(B) An application is denied when a household refuses to cooperate with the Department of Income Maintenance. It must be clearly shown that the household has not taken the necessary steps to complete the application process in order for the household to be denied for refusal to cooperate.

**(2) Reported Changes and Redetermination**

(A) A household is determined ineligible if it refuses to cooperate with any subsequent review of eligibility including reviews generated by reported changes and redeterminations.

(i) Once denied or terminated for refusing to cooperate, the household can reapply. Ineligibility continues until the household cooperates.

**(3) Quality Control Review**

(A) A household is ineligible for Food Stamp benefits if it refuses to cooperate in a Quality Control review of eligibility. If a household is terminated for refusal to cooperate with a Quality Control reviewer ineligibility continues until it cooperates, or until 95 days after the end of the annual review period, whichever is first.

(B) If a reapplication is filed 95 days after the end of annual review period, noncooperation is no longer a factor of eligibility and the household's benefits are not denied as a result of its refusal to cooperate with Quality Control. Verifications of all eligibility factors is required at the time of reapplication.

(Effective June 2, 1986)

**Secs. 17-12a-19—17-12a-21. Reserved****Sec. 17-12a-22. Duplicate participation****(a) General Statement**

The Department of Income Maintenance has the responsibility to detect and terminate instances of duplicate participation.

**(b) Definition****Duplicate Participation**

Households or individuals receiving Food Stamp Benefits in two or more cases during the same issuance month.

**(c) Prohibition Against Duplicate Participation**

Households and individuals are prohibited from participating in the Food Stamp program as eligible members of two or more cases during the same issuance month.

(Effective June 3, 1986)

**Sec. 17-12a-23. Reserved****Sec. 17-12a-24. Restoration of lost food stamp benefits to public assistance and non-public assistance households****(a) General**

Food Stamp benefits are restored for not more than twelve months when a judicial action has found benefits to be wrongfully withheld, an agency error occurs, or an administrative disqualification for an intentional program violation is reversed.

**(b) Definitions****(1) Allotment**

An allotment is the total value of coupons a household is authorized to receive.

**(2) Agency error**

For the purposes of this section an agency error is one in which the Department of Income Maintenance causes an overissuance by failing to take prompt action on a reported change or by taking an incorrect action.

**(3) Judicial Ruling**

A judicial ruling is a Federal or a State Court mandate which issues a prescribed course of action that must be taken by the Department of Income Maintenance.

**(4) Lost Benefits**

Lost benefits are benefits to which the household is entitled but are not received.

**(5) Offsetting**

For the purposes of this section, offsetting is a method by which the Department of Income Maintenance recovers an overissuance by deducting the amount of the overissuance from an entitlement to lost benefits.

**(6) Restored Benefits**

Restored benefits are benefits issued to replace a loss which occurred during a period when the household was determined to be eligible participate in the food stamp program or to correct an allotment which was less than the amount to which the household was entitled.

**(7) Retroactive Benefits**

Retroactive benefits are benefits issued for the month in which an application is filed when the eligibility determination is completed in a subsequent month.

**(c) Entitlement to Restoration of Lost Benefits**

A household is entitled to restoration of lost benefits for not more than twelve months when:

(1) federal regulations specify that households are entitled to restored benefits; or

(2) a judicial ruling has found benefits to be wrongfully withheld; or

(3) an administrative disqualification for an intentional program violation is reversed; or

(4) an agency error has occurred.

**(d) Restoring Lost Benefits**

(1) Before taking action to restore benefits, the Department of Income Maintenance determines whether the household has received an overissuance during the same period, and whether the household has received any other documented overissuances. If so, the Department of Income Maintenance offsets the amount of the overissuance against that of the underissuance.

(2) If the amount of the underissuance exceeds that of the overissuance, the Department of Income Maintenance takes immediate action to restore those benefits. Benefits are restored regardless of whether the household is currently eligible or ineligible.

**(A) Agency Error**

Benefits lost as a result of an agency error are restored for not more than twelve months prior to whichever of the following dates occur first:

(i) the date the Department of Income Maintenance receives a request for restored benefits from the household; or

(ii) the date the Department of Income Maintenance is notified or otherwise discovers that a loss to the household has occurred.

**(B) Judicial/Court Ruling**

(i) Benefits which are found by any judicial ruling to be wrongfully withheld are restored for not more than twelve months from the date the court action is initiated if this is the first action taken by the household to obtain restoration of lost benefits.

(ii) When the judicial ruling is a review of a Department of Income Maintenance's action, benefits are restored for not more than twelve months from:

(aa) the date the Department of Income Maintenance receives a request for restored benefits; or

(bb) if no request for restored benefits is received, the date the fair hearing process is initiated; but

(cc) never more than one year from when the Department of Income Maintenance is notified of, or discovers the loss.

**(C) Reversal of Disqualification for an Intentional Program Violated**

(i) Household members who are disqualified for intentional program violations are entitled to those benefits which were lost during the months of disqualification if the decision which resulted in disqualification is reversed in a separate court action by a court of appropriate jurisdiction.

(ii) Benefits are restored for not more than twelve months prior to:

(aa) the date the Department of Income Maintenance receives a request for restored benefits from the household; or

(bb) the date the Department of Income Maintenance is notified or otherwise discovers that a loss to the household has occurred.

**(e) Eligibility Determination**

(1) An eligibility determination is completed for each month affected by the loss. If the food stamp record does not contain documentation that the household was eligible, the household is advised of:

(A) what information must be provided; and

(B) what months this information is needed for; and

(C) the requested information must be received in ten working days.

(2) The household is considered ineligible for each month for which it has not provided the information requested.

**(f) Method of Restoration**

(1) An allotment equal to the amount of lost benefits is issued after it has been established that a household is due restored benefits.

(2) The amount to be restored is equal to the difference between the amount received by the household and the amount to which the household was entitled less any benefits recouped through the offset method.

(3) The amount restored is issued in addition to the household's current entitlement.

(4) The Department of Income Maintenance will honor a reasonable request to have benefits issued in partial installments if:

(A) the household has reason to believe the allotment may be stolen; or

(B) the amount to be restored is more than the household can use in a reasonable period of time.

**(g) Benefit Computation**

After correcting the loss for future issuances and excluding those months for which benefits are lost prior to the twelve month time limit, the months affected by the loss are computed as follows:

(1) For an:

(A) incorrect allotment, benefits are restored only for those months the household participated;

(B) incorrect denial, benefits are restored from the month of initial application;

(C) incorrect delay, benefits are restored in accordance with the appropriate Section of the Food Stamp Handbook.

(D) incorrect termination, benefits are restored the first month they were not received as a result of the erroneous termination;

(E) eligible household filing a timely reapplication, benefits are restored the month following the expiration of its certification period.

(h) **Changes in Household Composition**

(1) If the household composition has changed, the Department of Income Maintenance issues restored benefits to the household containing the majority of the members who were household members at the time the loss occurred.

(2) If the Department of Income Maintenance is unable to locate or identify such unit, the Department of Income Maintenance restores benefits to the household containing the head of the household at the time the loss occurred.

(i) **Notification Requirements**

The household is provided written notification of its entitlement to restored benefits. The notification advises the household of:

(1) its entitlement; and

(2) the amount of benefits to be restored; and

(3) any offsetting that was used; and

(4) the method of restoration; and

(5) its right to request a fair hearing.

(j) **Fair Hearing Requests**

(1) When the household disagrees with either the amount of benefits to be restored as calculated by the Department of Income Maintenance or any other action taken by the Department of Income Maintenance to restore lost benefits, a fair hearing can be requested within 90 days of date notification is received.

(2) If a household requests restoration of lost benefits, but after review of the Food Stamp record, the request is denied the household has 90 days from the date of the denial to request a fair hearing.

(3) When a fair hearing is requested before or during the period lost benefits are restored, the household receives the benefits the Department of Income Maintenance determines it is entitled to until the fair hearing decision is rendered.

(k) **Offsetting**

(1) When a claim against a household is terminated as uncollectible or suspended, the amount to be restored is offset by the amount due on the claim before the balance, if any, is restored to the household. There is no time limit on claims which are subject to the offsetting process.

(2) Offsetting is Used:

(A) for any claim amount when a claim has been terminated as uncollectible or held in suspense; or

(B) when a claim against a household is the result of an administrative error, or an unintentional program violation; or

(C) when a determination of an intentional program violation has been made by an administrative disqualification hearing officer; or

(D) when a waiver of rights to an administrative disqualification hearing has been signed; or

(E) when the household has chosen a repayment method; or

(F) when the Department of Income Maintenance has selected a repayment method.

(3) Offsetting is not used:

(A) when benefits are issued retroactively; or

(B) when there is a court ordered repayment plan which specifies the amount to be repaid and the method of repayment.

(Effective June 2, 1986)

**Secs. 17-12a-25—17-12a-27. Reserved**

**Sec. 17-12a-28. Standard deduction and excess shelter/dependent care deduction in the food stamp program**

**(a) Standard Deduction**

A standard deduction of ninety-eight (\$98) dollars per household per month is used in the computation of available income in calculating the amount of Food Stamp benefits to be issued.

**(b) Excess Shelter Expense/Dependent Care Deduction**

The total excess shelter/dependent care deduction shall not exceed one hundred thirty-nine (\$139) dollars a month.

**(c) Affected Sections of DIM Food Stamp Manual**

These changes directly affect sections of the Department of Income Maintenance Food Stamp Manual, and those sections of the Manual are being revised accordingly.

(Effective August 4, 1986)



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**Disclosures by Professional Solicitors**

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**Disclosures by Professional Solicitors****Sec. 17-21t-1. Disclosures by professional solicitors**

Every professional solicitor who orally solicits persons in this state, including, but not limited to, use of a telephone, shall conspicuously and clearly state the following information to each prospective contributor at the commencement of each solicitation:

- (a) his true name;
- (b) that he is a professional solicitor; and
- (c) if he is an officer, employee, servant, agent or representative in whatever capacity designated of a professional soliciting firm, the name of such firm as it is on file with the Department of Consumer Protection.

(Effective December 1, 1977)



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**Essential Services**

**Secs. 17-31a-1—17-31a-5.**

Repealed, August 21, 1992.

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## **Before and After School Child Day Care Program**

### **Sec. 17-31aa-1. Definitions**

For the purpose of these regulations, the following definitions shall apply:

- (a) "Applicant" means a municipality, board of education or child care provider.
  - (b) "Commissioner" means the Commissioner of the Department of Human Resources or his authorized representative/designee.
  - (c) "Department" means the Department of Human Resources.
  - (d) "Grant" means the funds awarded by the department to a municipality, board of education, or a child day care provider to pay for specific costs incurred in the operation of a before and after school program.
  - (e) "Grant program" means the provision of funds by the department to approved applicants, within available appropriations, in order to encourage the use of school facilities for the provision of needed before and after school child day care services.
  - (f) "Program" means the supplemental day care services given by an applicant/provider to children before and after classes in a school facility.
  - (g) "Provider" means a person, group of persons, association, organization, corporation, institution or agency which provides child day care services.
  - (h) "School site" means a location in a school facility in which the program is conducted that meets Department of Health Services day care license requirements.
- (Effective August 28, 1989)

### **Sec. 17-31aa-2. Application and selection process**

- (a) An applicant/provider may apply for a grant for a before and after school program from the Department of Human Resources.
  - (b) Approval of the grant application is based on the following:
    - (1) conformity with the eligibility standards listed in Section 17-31aa-3, below;
    - (2) a review of the application, which include the program format and financial requirements.
  - (c) Priority shall be given to:
    - (1) applications received in completed form on a first come, first served basis, and
    - (2) depending on availability of funding, to new programs rather than established programs.
- (Effective August 28, 1989)

### **Sec. 17-31aa-3. Eligibility**

- (a) Eligibility to receive a grant under this program shall require an applicant/provider to submit the following in their application:
    - (1) documentation of need for a before and after school child day care program in the particular community;
    - (2) a written agreement from the appropriate authority for use of the school;
    - (3) copy of the fee schedule that limits the amount that may be charged for child day care services to the applicant/provider's base cost per capita, plus a percentage of such cost; and
    - (4) an agreement to provide liability insurance for the program.
- (Effective August 28, 1989)

### **Sec. 17-31aa-4. Use of grant funds**

A grant provided to a recipient under this program shall be used only for the following costs directly attributable to the program:

(1) Facility use costs:

Maintenance  
Utilities

(2) Program operation costs:

Transportation  
Liability insurance coverage

(Effective August 28, 1989)

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**Child Day Care Business Firm Tax Credit Program**

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## **Loans to Corporations for Child Care Facilities**

### **Sec. 17-31ee-1. Definitions**

As used in Sections 17-31ee-1 to 17-31ee-7, inclusive:

(a) "Borrower" means a corporation which intends to establish or improve a child care facility within Connecticut to serve primarily children of employees of such corporations and children of employees of the municipalities in which such facility is located.

(b) "Child care facility" means a facility which will be licensed by the Department of Health Services for a program of supplementary care for more than twelve (12) children outside of their own homes on a regular basis for a part of the twenty-four (24) hours in a day for one or more days in the week (i.e., a child day care center) or for not less than seven (7) or more than twelve (12) children outside of their own homes on a regular basis for a part of the twenty-four (24) hours in a day for one or more days in the week (i.e., a group day care home).

(c) "Commissioner" means the Commissioner of the Department of Human Resources.

(d) "Corporation" means all corporations as the term is defined in Connecticut's General Statutes including stock; nonstock; profit; nonprofit; municipal corporations; and specially chartered corporations; and any such corporation shall be registered and in good standing with the Office of the Secretary of State.

(e) "Department" means the Department of Human Resources.

(f) "Renovation" shall mean the repair or renewal of permanent fixtures of the child care facility. Such renovations may include, but not be limited to, the purchase or repair of partitions within the facility, built-in tables and benches, shelving for toys and games, sinks and toilet facilities, and stationary indoor or stationary outdoor playground equipment, installed carpeting, and major kitchen appliances.

(Effective August 28, 1989)

### **Sec. 17-31ee-2. Program administration**

(a) Application for a loan shall be submitted to the Department of Human Resources on loan application forms prescribed by the Department.

(b) No application shall be considered unless the exhibits and all information required by such forms are furnished.

(c) The borrower shall pay for all costs that the Commissioner determines are reasonable and necessary to process applications for loans or lines of credit under this program.

(d) If, upon examination of the application, supporting information and results of any investigation, the Commissioner rejects such application, then the loan may not be granted and the Department shall cause the applicant to be notified that the application has been denied.

(Effective August 28, 1989)

### **Sec. 17-31ee-3. Eligibility**

In order to participate in this loan program the applicant corporation shall satisfy the Department that:

(a) the borrower is a corporation;

(b) the loan funds shall be used to directly develop or improve a child care facility which may include planning, site preparation, construction, acquisition or renovation of the facility;

(c) the intended and eventual use over the period of the loan of the child care facility shall be primarily for children of employees of the applicant corporation and for children of employees of the municipality in which the facility in Connecticut is located or is to be located;

(d) the child care facility or planned child care facility shall meet local zoning requirements and shall comply with all state and local health and safety laws and regulations and, in particular, all such laws and regulations applicable to child care facilities. The facility or planned facility shall be licensable by the Department of Health Services for use as a child care facility; and

(e) the borrower shall demonstrate to the satisfaction of the Department that it has sufficient revenues, excluding state grants, and collateral to repay the principal and interest on the loan; and has sufficient financial resources to be able to maintain the operation of the child care facility.

(Effective August 28, 1989)

#### **Sec. 17-31ee-4. Loan agreement**

(a) Upon approval of an application by the Commissioner, the Department and the borrower shall enter into a loan agreement which shall set forth the terms and conditions required by these regulations and other terms and conditions applicable to the particular loan, which may be set by the Department.

(b) The loan agreement shall be executed on forms provided by the Department, and all costs of closing shall be paid by the borrower.

(c) Each loan agreement shall be effective only upon execution by the Commissioner and the borrower.

(d) Such loan agreement shall provide, without limitation, that the borrower agrees:

(1) To provide the Department with such financial and other reports as the Commissioner, in his discretion, may require from time to time.

(2) To notify the Department promptly of any material adverse change in the financial condition or business prospects of the borrower;

(3) To represent and warrant that it has the power and authority to enter into the loan agreement and to incur the obligations therein provided for, and that all documents and agreements executed and delivered in connection with the loan shall be valid and binding upon the borrower in accordance with their respective terms;

(4) To provide such security for the loan as the Commissioner may require pursuant to Section 5 (c) of these regulations and to execute and deliver all documents in connection therewith.

(5) The borrower shall submit yearly enrollment forms on the day care children, during the loan term, in order to ensure that the facilities are being used primarily for children of the borrower's employees, and children of municipal employees, as mandated by Connecticut General Statute 17-31ee.

(Effective August 28, 1989)

#### **Sec. 17-31ee-5. Loan guarantees**

(a) All loans shall be made at the discretion of the Commissioner for a period not to exceed five (5) years from the date of the loan agreement.

(b) Loans may be secured or unsecured at the discretion of the Commissioner.

(c) If the loan is to be secured, the Commissioner may require the borrower to provide as security any or all of the following: real property, accounts, chattel paper, documents, instruments, general intangibles, goods, equipment, inventory or other personal property, and may further require the borrower to have executed and

delivered to the Department such security agreements, financing statements, mortgages, pledges, assignments, subordinations, guarantees or other documents or evidences of security as required by the Commissioner, and in the form required by the Commissioner.

(d) Disbursement of the loan shall be made at the discretion of the Commissioner in accordance with the provisions of the loan agreement; and confirming use of funds by the borrower; and use of loan funds by the borrower shall be subject to monitoring and audit by the State.

(e) The loan shall be repaid on an amortized schedule of payments or upon such other method of payment of principal and interest as the Department considers necessary and appropriate in the particular circumstances.

(f) The rate or rates of interest shall be established by the state bond commission in accordance with subsection (t) of Section 3-20 of the Connecticut General Statutes.

(g) The loan funds shall not be used to refinance existing loans or existing indebtedness.

(Effective August 28, 1989)

#### **Sec. 17-31ee-6. Promissory note**

(a) Each loan shall be evidenced by a promissory note which shall contain a provision permitting the borrower to prepay the loan in whole upon any interest payment date without penalty.

(b) The promissory note shall provide for the payment of interest at a rate or rates established by the state bond commission in accordance with subsection (t) of Section 3-20 of the Connecticut General Statutes.

(c) The promissory note may provide for the collection of a late charge, not to exceed two (2) percent of any installment more than fifteen (15) days in arrears. Late charges shall be separately charged to and collected from the borrower.

(d) The promissory note shall contain a provision that the failure of the borrower's child care facilities to comply with all state and local health and safety regulations, and in particular, those applicable to child care facilities, may constitute a default.

(e) The failure of the borrower to abide by the terms of the loan agreement, the promissory note, or other documents signed by the borrower in connection with such loan shall be considered in default under such promissory note.

(f) The promissory note shall contain a provision that the failure of the borrower to make a full payment of any principal or interest due under the promissory note within thirty (30) days from the due date shall constitute a default.

(g) The promissory note shall provide that upon default, any and all sums owing by the borrower under the promissory note shall, at the discretion of the Commissioner, become immediately due and payable.

(h) The promissory note shall provide for payment of reasonable attorney's fees and legal costs in the event the borrower shall default in the payment of the note.

(i) Upon default the borrower will be ineligible to apply for funds under any other Department of Human Resources loan programs.

(Effective August 28, 1989)

#### **Sec. 17-31ee-7. Affirmative action plan**

Prior to closing the loan agreement, the borrower if mandated by federal and/or state law, shall submit its affirmative action plan to the Department.

(Effective August 28, 1989)



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**Child Support Enforcement Program**

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Repealed, November 28, 1994.

**Sec. 17-31i (b)-2.**

Repealed, November 26, 1991.

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**Security Deposits**

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### **Security Deposits**

#### **Secs. 17-31jj-1—17-31jj-6.**

Repealed, October 29, 1993.

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## **Shelter Services for Victims of Household Abuse**

### **Sec. 17-31k-1. Role of the department of human resources**

(a) The department of human resources is responsible for all aspects of the proposal, application and review process. The issuance of a request for proposal is not a commitment by the state to fund services listed in a given proposal.

(b) Proposals may be submitted to the department of human resources by non-profit organizations which are incorporated or are in the process of incorporating. Such organizations submitting a proposal must offer a single, legal entity which the department of human resources may contract with and hold responsible, even though the proposals may be made on behalf of more than one agency in a consortium arrangement.

(c) The department of human resources reserves the right to return proposals for revision or to negotiate with applicants during the preparation of contracts. The department also reserves the right to allow the selected organizations to form or expand a consortium or other cooperative arrangements among organizations, if in the department's opinion this would strengthen the program and benefit the population group.

(Effective August 28, 1981)

### **Sec. 17-31k-2. The application process**

The procedure to be followed by organizations in submitting proposals to the department of human resources is as follows:

(a) Proposals shall be submitted to the commissioner of the department human resources within 60 days of the issuance of the request for proposals.

(b) The program description shall include the organization's plan to provide the following:

(1) Services available 24 hours, 365 days, with 24 hour telephone coverage.

(2) Up to 72 hours of emergency crisis intervention services.

(3) Up to 60 days of support services.

(4) Services to children, including day care, education and counseling.

(5) Resource information for victims and their families.

(6) The development of community support systems to aid in the prevention of family crisis situations.

(7) The development of cooperative agreements with existing social service providers to avoid duplication of services.

(c) An organization submitting a proposal shall complete a line item budget detailing how such organization proposes to use funds from the department of human resources, funds from other sources, and volunteer services; and shall include plans for rental and maintenance of shelter facilities, and provisions for emergency food and living expenses.

(d) The commissioner of the department of human resources shall make a determination on each proposal within 90 days of receipt of the last proposal.

(Effective August 28, 1981)

### **Sec. 17-31k-3. The contract process**

(a) Contracts are negotiated with approved organizations.

(b) The State incurs no obligation until contracts are approved.

(Effective August 28, 1981)



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## **Assistance to Homeless Persons with AIDS Pilot Program**

### **Sec. 17-31kk-1. Definitions**

- (a) AIDS patients are persons who have acquired immune deficiency syndrome.
- (b) Application means the document whose requirements are described in Sections 6 and 7 of this regulation.
- (c) ARC patients are persons who have an AIDS related complex.
- (d) Commissioner means the Commissioner of the Department of Human Resources.
- (e) Department means the Department of Human Resources.
- (f) Financial assistance means funds granted by the Department of Human Resources to an eligible, non-profit corporation to assist in the cost of planning the development of housing, acquiring property to be used for housing, repairing, rehabilitating, constructing, and operating housing for AIDS and/or ARC patients.
- (g) Housing means a structure to be used as a primary residence for homeless persons suffering from AIDS and/or ARC, who wish to remain independent.
- (h) Initial inquiry means the information requested in Section 2 of this regulation.
- (i) Non-profit corporation means a non-profit corporation as defined in Connecticut General Statutes, Section 8-39 that has received IRS 501 (c) (3) status, and which plans to provide housing described in Section 1 (g) of this regulation.  
(Effective August 9, 1988)

### **Sec. 17-31kk-2. Initial inquiry and determination of eligibility**

An eligible non-profit corporation may apply to the Department for financial assistance by submitting the following data which comprises the initial inquiry:

- (a) A copy of the corporation by-laws;
- (b) A plan which indicates how, and to what extent, resources of existing social service agencies are to be utilized in the program;
- (c) Information that indicates the applicant has the managerial and administrative capability to undertake and successfully complete a physical development project;
- (d) A funding request that is limited to the following eligible costs:
  - (1) planning for housing development;
  - (2) acquisition of property for housing;
  - (3) construction, rehabilitation or repair of housing;
  - (4) operation of housing (includes maintenance, utilities cost).
- (e) Evidence of adequate financial resources for completion of housing to the Certificate of Occupancy;
- (f) Evidence of adequate financial resources and strategic planning to maintain the operational status of the program for a period of ten (10) years.  
(Effective August 9, 1988)

### **Sec. 17-31kk-3. Review and application processing**

- (a) The Department shall review the initial application for conformity to the information requested in Section 2 above and, subject to the availability of program funds, shall invite the applicant to submit an application whose requirements are described in Sections 6 and 7.
- (b) Upon receipt, the Department shall review the formal application and any accompanying plans and specifications. Primary responsibility for all information forwarded to the Department rests with the applicant.
- (c) Subsequent to the resolution of any questions between the Department and the applicant, and upon determination that the application meets all the required

criteria, such application shall be forwarded to the Secretary of the State Bond Commission with a recommendation that it be placed on its monthly agenda for review and a decision.

(d) If the application is approved by the State Bond Commission, the Department shall notify the applicant to proceed with the construction bid process. The applicant shall then notify the Department of the scheduled date for bid openings. For projects less than One Hundred Thousand Dollars (\$100,000), three (3) estimates may, at the discretion of the Commissioner, be submitted from independent contractors in lieu of a formal bid process.

(e) Subsequent to a bid opening, the applicant shall submit to the Department:

- (1) An affidavit of publication, or copy of the bid advertisement;
- (2) A copy of each bid submitted;
- (3) A copy of all bid bonds or certified checks.

(Effective August 9, 1988)

#### **Sec. 17-31kk-4. Execution of project**

(a) The applicant shall notify the Department of the date and time of the construction contract signing. Subsequent to the contract signing, the applicant shall submit to the Department:

- (1) one copy of the executed Contract;
  - (2) one copy of the Corporation Certificate;
  - (3) one copy of each: Performance Bond, and Labor and Material Payment Bond;
- for projects less than One Hundred Thousand Dollars (\$100,000), this provision may be waived at the discretion of the Commissioner.

- (4) one copy of Power of Attorney;
- (5) one copy of Certificate of Insurance.

(b) The applicant shall notify the Department of the groundbreaking and subsequent work schedule.

(c) The applicant shall notify the Department as soon as it is evident construction delays may require a budget extension.

(d) All change order requests must be submitted to the Department for prior approval.

(Effective August 9, 1988)

#### **Sec. 17-31kk-5. Project financing**

(a) The applicant shall submit a first payment request with the formal application, and shall submit, on forms approved by the Department, financial reports in duplicate with the second payment request and with each payment request thereafter, and upon completion of the project.

(b) Financial records shall be maintained in accordance with the Department's Manual for Grantee Accounting. These records, together with the financial reports submitted to the Department, shall provide a basis for a final independent audit.

(c) The final payment shall be made (1) after the applicant has obtained a Certificate of Occupancy for the project; (2) financial reports based on the completed program are submitted; (3) a final inspection of the facility has been made by Department staff; and (4) a Certificate of Termination, based on an independent audit supplied by the applicant, has been issued by the Department.

(Effective August 9, 1988)

#### **Sec. 17-31kk-6. Planning the AIDS/ARC housing**

The application for financial assistance shall address two components, (1) the physical development of the facility and (2) the program operation plan. Planning

results for each of these components shall be reflected in the narrative submitted with the Program Design and Financing Plan forms supplied by the Department and shall include:

(a) Physical Development Planning.

(1) Evidence of applicant ownership of land and/or building; include any deed restrictions and/or special conditions;

(2) Confirmation of zoning compliance for projected use, including description of public transportation access;

(3) Map showing site boundaries prepared by registered engineer/architect of land to be purchased;

(4) Two (2) independent appraisals for land and/or building purchase;

(5) One (1) copy of architectural plans and specifications for construction of building, or renovation costs of One Hundred Thousand Dollars (\$100,000) or more; one (1) copy of preliminary drawings if costs are less than One Hundred Thousand Dollars (\$100,000);

(6) Certification that property will meet building, health and fire codes when renovated.

(7) Architect's or applicant's estimate of complete project costs.

(b) Program Planning for the Operation of the Housing:

(1) Description of need for the program;

(2) Description of population to be served;

(3) Description of method of selection of residents of facility;

(4) Living arrangements for residents;

(5) Orientation process for residents, including tenant contract;

(6) House rules, including any infraction penalties;

(7) Rental fees, including any sliding fee scale;

(8) Assurance of applicant's intent and liability to comply with all federal, state and local laws and regulations pertaining to the operation of this type of facility;

(9) Table of organization which demonstrates administration, oversight and staffing of residential program.

(Effective August 9, 1988)

### **Sec. 17-31kk-7. Applicant check list for grant application submission**

The application submission shall include the following data for each of the components:

(a) The Physical Development Component:

(1) Two (2) copies of Certified Resolution of Applicant, each with seal and original signature.

(2) Two originally signed copies of the facility Program Design and Financing Plan, which form is supplied by the Department and includes information requested in Section 6 (a) Physical Development Planning;

(3) A statement that (A) establishes clear lines of responsibility for development of the physical facility; (B) designates qualified personnel to coordinate the physical and programmatic aspects of the project and act as liaison for the applicant as needed and to monitor construction and contract compliance; and (C) assigns an administrator of fiscal records and accounting for the project. The number of personnel required for this phase of the project shall depend on its extent and complexity, and can be negotiated with the Department.

(b) The Program Operation Component:

(1) One (1) original and four (4) copies of the Certified Resolution of Applicant.

(2) Two (2) originally signed copies of Page 1 of the Grant Action/Program Design and Financing Plan, which is supplied by the Department.

(3) One (1) original and four (4) copies of Pages 2–8, Program Budget of the Grant Action/Program Design and Financing Plan, and a copy of the Program Plan narrative, on a form supplied by the Department that includes information requested in Section 6 (b), Program Planning for the Operation of the Housing.

(4) A plan that (A) indicates continuous operational funding and management capability; (B) contains estimate of projected annual costs for personnel and operation of facility; and (C) cites specific public/private sources of financial support, with documentation.

(Effective August 9, 1988)

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## **Reporting Incidents of Suspected Spouse Abuse**

### **Sec. 17-31I-1. Suspected incidents of spouse abuse reporting forms**

The commissioner of human resources shall provide a supply of reporting forms to the state police division of the department of public safety, local police departments and hospital emergency rooms.

(Effective December 18, 1980)

### **Sec. 17-31I-2. Submission of spouse abuse reporting forms to the commissioner of human resources**

Police officers and hospital emergency room personnel who have reasonable cause to believe that an individual has physical injury or injuries which has or have been inflicted upon her or him by such individual's spouse, whether or not such individuals are living together, or by any adult member of the household who is of the opposite sex, shall report such incidents by completing forms supplied by the commissioner of the department of human resources. Such forms shall be submitted to the commissioner of human resources on or before the tenth day of the month following the month in which the incident of suspected spouse abuse occurred.

(Effective December 18, 1980)

### **Sec. 17-31I-3. Purpose of reports**

Such reporting forms shall not name the parties involved and shall be used for statistical purposes only.

(Effective December 18, 1980)



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**Personal Care Assistance for Handicapped  
Persons Program**

**Secs. 17-31m-1—17-31m-6.**

Repealed, September 18, 1986.

**Secs. 17-31m-1a—17-31m-9a.**

Repealed, January 26, 1990.

**Secs. 17-31m-10a—17-31m-18a.**

Repealed, December 21, 1990.

**Personal Care Assistance Program**

**Secs. 17-31m-1b—17-31m-9b. Reserved**

**Secs. 17-31m-10b—17-31m-18b.**

Transferred, July 23, 1991.

*Existing Section*

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- 17-31m-11b
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- 17-581-10a
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**Parent Subsidy Aid**

**Secs. 17-31n-1—17-31n-6.**

Repealed, September 5, 1990.

**Secs. 17-31n-7—17-31n-14.**

Transferred, July 23, 1991.

*Existing Section*

*New Section*

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Repealed, October 30, 1989.

**Sec. 17-31q-11. Reserved**

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**Fair Hearings**

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Repealed, October 2, 1991.

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**Provision of Grants to Public or Private Organizations or Agencies  
to Develop and Maintain Programs for Emergency  
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**Crime Prevention and Safety Measures**

**Sec. 17-31w-1. Crime prevention and safety measures**

(a) Crime prevention and safety measures shall be purchased and installed in residences of elderly or handicapped applicants who are eligible for weatherization assistance by Community Action Agencies or Municipal Agencies at the same time the dwelling unit is weatherized.

(b) The following are the materials to be used for the program:

(1) Locks on windows and doors.

(2) Devices which allow a person inside a dwelling unit to view the area outside the door.

(3) Purchase and installation of smoke detectors.

(c) Funding for this program shall be allocated between the CAAs based on the percentage of elderly or handicapped dwelling units that were weatherized from the caseload of each CAA during the previous program year.

(d) The purchase and installation of crime prevention and safety measures shall be subject to the availability of funds.

(Effective March 25, 1986)

**Secs. 17-31w-2—17-31w-13. Reserved**

**Energy Assistance**

**Secs. 17-31w-14—17-31w-25.**

Transferred, June 21, 1991.

*Existing Section*

*New Section*

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17-31w-15

17-591 (a)-15

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## **Bond Fund Grants to Establish Child Care Facilities for Children of Municipal and State Employees**

### **Secs. 17-31z-1—17-31z-7.**

Repealed, May 24, 1988.

### **Sec. 17-31z-8. Definitions**

(a) Applicant means a municipality or state agency that has submitted a child care facility grant application to the Department of Human Resources.

(b) Child Care Facility means a facility to house a program of supplementary care, primarily for infants and children of employees of municipalities and state agencies, which is licensed by the Connecticut Department of Health Services.

(c) Commissioner means Commissioner of the Connecticut Department of Human Resources.

(d) Department means the Connecticut Department of Human Resources.

(e) Grant Action means a Grant Action Request/Program Design and Financing Plan, which once executed, is legally binding on the signatories.

(f) Interagency Agreement means a document which formalizes the programmatic, fiscal and statutory requirements of the contract award among two or more state agencies, and is legally binding upon the signatories.

(g) Municipality means any one of the 169 towns and cities incorporated in the State of Connecticut.

(h) Operator means a person, group of persons, association, organization, corporation, institution or agency, public or private, to whom a Child Day Care License is issued by the Connecticut Department of Health Services.

(i) Primarily means that over a period of a year, at least 51% of the participants in a child care facility shall be the children of the employees of municipalities or state agencies, who have permanent employment status.

(j) State Agency means a department, agency or commission of the executive, judicial or legislative branches of the government of the State of Connecticut.

(Effective May 24, 1988)

### **Sec. 17-31z-9. Application and determination of eligibility**

Any municipality or state agency that, as a result of unmet needs as demonstrated to the Department has determined that there is a sufficient demand for child care services among municipal and state agency employees in their area, and who can meet the following criteria, may apply:

(a) Demonstrate that the applicant has the managerial and administrative capability to undertake and successfully complete a physical development project;

(b) Submit a program plan in accordance with Section 17-31z-10 for the operation of a child care program that is predicated on the selection of an operator for the planned child care facility;

(c) Demonstrate adequate financial resources to maintain the operational status of the program;

(d) Affirm that the facility shall be used for said purpose for a minimum period of ten (10) years from the completion of the project. This condition shall be incorporated in the appropriate Grant Action/Interagency Agreement;

(e) Determine that over a period of a year the population of the proposed child care facility shall be composed primarily of children of employees of municipalities and/or state agencies who have permanent employment status;

(Effective May 24, 1988)

**Sec. 17-31z-10. Determination of costs**

(a) **Eligible costs for inclusion in a child care facility application:**

- (1) Architectural/Engineering, or other professional planning costs;
- (2) Facility acquisition;
- (3) Physical Development: site preparation; demolition; construction or rehabilitation; utility connections; fixed equipment; landscaping, driveways and necessary exterior improvements;

(b) **Ineligible costs:**

- (1) Surveys, tests and borings;
- (2) Feasibility studies;
- (3) Furnishings and moveable equipment;
- (4) Operating expenses: Program operation; building/grounds maintenance.

(c) All project costs are subject to review, modification and/or disallowance at the discretion of the Commissioner.

(Effective March 27, 1990)

**Sec. 17-31z-11. Planning the child care facility**

The application shall address two components: the Physical Development of the facility and the Program Operation Plan. Planning results for each of these components shall be reflected in the narrative submitted with the application, and shall include, as appropriate:

(a) **Physical Development Plan:**

(1) Project Area: Description of land and/or building to be used, including any special or unusual conditions affecting any or all parts of the site. Include documentation of any required local, state or federal approvals; and the following pertinent documents:

(2) Evidence of applicant ownership or lease of land and/or building, or option to purchase/draft of lease;

(3) Any deed restrictions and/or special conditions arising from public or private controls;

(4) Two (2) appraisals, if land is to be purchased;

(5) Map showing boundaries;

(6) A-2 survey, if land is to be purchased;

(7) One copy of architectural schematics;

(8) Evidence of pre-review of plans (memos, letters) by local building inspector, State Department of Health Services and the Bureau of the State Fire Marshal;

(9) Confirmation of zoning compliance; and

(10) Project cost estimate.

(b) **Program Operation Plan:**

(1) Documentation of unmet needs among municipal and state employees which indicates present and long range support for a child care facility;

(2) Copy of operator's IRS 501 (c) (3) letter, or management contract;

(3) Evidence of continuous operational funding and management capability; and

(4) Description of planned program, including numbers to be served by age group and services to be provided.

(Effective March 27, 1990)

**Sec. 17-31z-12. Applicant check list for grant application**

The application shall include the following information:

(a) Two (2) originally signed copies of the Grant Action Request/Program Financing Plan and Budget.

(b) For Municipalities only: Two (2) copies of Certified Resolution of Applicant, each with seal and original signature, the guideline form to be supplied by the Department. The date of the Certified Resolution shall indicate it was approved by the governing body prior to the date on the signature page of the Grant Action Request/Program Financing Plan and Budget.

(c) Two (2) copies of program design:

Which includes: long range justification; current plans for utilization of facilities; summary of capital improvements to be funded; construction supervision responsibilities and safeguards.

(d) Two copies of the Program Plan Narrative (Guideline as follows).

(1) Need for project. (Statistics; benefits to community; current facilities, if any)

(2) Describe the extent of participation by the population to be served in the planning and operation of the facility (financial/programmatic, etc.). Indicate any additional support for the program.

(3) Describe any public relations and/or public information efforts for the geographic area and/or the population that would be served by the facility.

(4) Evidence of applicant's ability to financially support continuing operation of the facility. (Submit estimate of annual operating costs for facility and personnel; cite specific public/private sources of financial support, with documentation.)

(5) Physical description of planned facility and site: facility size, space utilization, outdoor play space, parking, transportation access, possible socio-economic impact of project on neighborhood, etc.

(6) Program and activities to be conducted in facility; personnel to be utilized.

(7) Description of selection process for the program operator; qualifications of program operator selected.

(8) All documentation requested under Section 17-31z-11.

(Effective March 27, 1990)

### **Sec. 17-31z-13. Application review and processing**

The application shall include the following information:

The Department's process for application review to the execution stage is as follows:

(a) The Department reviews the application. The primary responsibility for all information forwarded to the Department rests with the applicant and his architect.

(b) After all questions have been resolved a recommendation is forwarded to the Secretary of the State Bond Commission requesting that the applicant's request for funding be placed on its agenda for review and decision.

(c) Upon approval by the State Bond Commission, the applicant may forward the grant action to the Commissioner for his approval.

(d) The applicant shall notify the Department of the scheduled date for the bid openings. After the bid opening, the applicant shall submit to the Department:

(1) Affidavit of publication, or copy of bid advertisement;

(2) A copy of each bid;

(3) A copy of all bid bonds or certified checks, if required; and

(4) Any other documents required by the Department.

(Effective March 27, 1990)

### **Sec. 17-31z-14. Execution of project**

(a) The Department shall be notified of the date and time of the construction contract signing. After the contract signing, the applicant shall submit to the Department:

- (1) One copy of the Executed Contract;
- (2) One copy of each: Performance Bond; Labor and Material Payment Bond and Power of Attorney for Surety.
- (3) One copy of contractor's certificate of Insurance.
- (b) The Department shall be notified of date of "groundbreaking" and subsequent work schedule for the facility. Department staff may make periodic site visits during construction and may attend job meetings.
- (c) The Department shall be notified as soon as it is evident that delays in construction may require a budget period extension.  
(Effective March 27, 1990)

**Sec. 17-31z-15. Project financing**

- (a) The applicant shall submit financial reports in duplicate on Department forms with payment requests and upon completion of the program.
- (b) Financial records shall be maintained in accordance with the Department's Manual for Grantee Accounting, and shall provide a basis together with the financial reports, for a final independent audit.
- (c) Upon completion a final inspection will be made by department staff.  
(Effective March 27, 1990)

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**Fair Hearings**

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Transferred, February 1, 1994.

<i>Former Number</i>	<i>New Number</i>
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17-32-3	17a-90-3
17-32-4	17a-90-4
17-32-5	17a-90-5
17-32-6	17a-90-6
17-32-7	17a-90-7
17-32-8	17a-90-8
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Transferred, February 1, 1994.

<i>Former Number</i>	<i>New Number</i>
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17-32 (b)-2	17a-90 (b)-2
17-32 (b)-3	17a-90 (b)-3
17-32 (b)-4	17a-90 (b)-4
17-32 (b)-5	17a-90 (b)-5
17-32 (b)-6	17a-90 (b)-6
17-32 (b)-7	17a-90 (b)-7
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**Removal Hearings—Removal of a Child From a Foster Home**

**Secs. 17-37-1—17-37-9.**

Transferred, February 1, 1994.

<i>Former Number</i>	<i>New Number</i>
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Transferred . . . . . 17-38a-11—17-38a-13

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**Secs. 17-38a-1—17-38a-10.**

Transferred, February 1, 1994.

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Transferred, February 1, 1994.

<i>Former Number</i>	<i>New Number</i>
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17-38a-3	17a-101-3
17-38a-4	17a-101-4
17-38a-5	17a-101-5
17-38a-6	17a-101-6
17-38a-7	17a-101-7
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Transferred, February 1, 1994.

<i>Former Number</i>	<i>New Number</i>
17-38a (e)-1	17a-101 (e)-1
17-38a (e)-2	17a-101 (e)-2
17-38a (e)-3	17a-101 (e)-3
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Transferred, February 1, 1994.

<i>Former Number</i>	<i>New Number</i>
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17-43c-3	17a-114-3
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17-43c-6	17a-114-6
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17-43c-8	17a-114-8
17-43c-9	17a-114-9
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Repealed, January 29, 1988.

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Transferred, March 26, 1994.

<i>Former Number</i>	<i>New Number</i>
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17-44a-7	17a-116-7
17-44a-8	17a-116-8
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Transferred . . . . . 17-44e-3—17-44e-9

**Medical Expense Subsidy for Adoptive Parents  
of a Physically Handicapped Child**

**Secs. 17-44e-1—17-44e-2.**

Repealed, January 29, 1988.

**Medical Expense Subsidy for Adoptive Parents**

**Secs. 17-44e-3—17-44e-9.**

Transferred, March 26, 1994.

<i>Former Number</i>	<i>New Number</i>
17-44e-3	17a-120-3
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**Secs. 17-48-1—17-48-47.**

Repealed, March 19, 1981.

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Transferred, February 1, 1994.

<i>Former Number</i>	<i>New Number</i>
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17-48-54	17a-145-54
17-48-55	17a-145-55
17-48-56	17a-145-56
17-48-57	17a-145-57
17-48-58	17a-145-58
17-48-59	17a-145-59
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Repealed, December 21, 1984.

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Transferred, February 1, 1994.

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Transferred, February 1, 1994.

<i>Former Number</i>	<i>New Number</i>
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17-52b-10	17a-155-10
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Repealed, December 21, 1990.

**Sec. 17-82b-12.**

Repealed, December 30, 1981.

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Repealed, November 28, 1994.

**Secs. 17-82e-7—17-82e-9.**

Repealed, February 23, 1988.

**Secs. 17-82e-10—17-82e-11.**

Repealed, November 28, 1994.

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**Administrative Sanctions to be Invoked Against Vendors  
and/or Providers of Goods and Services Under  
the Title XIX (Medicaid) Program**

**Sec. 17-83k-1. General statement**

(a) **General statement.** Section 17-83k of the General Statutes provides for administrative sanctions against vendors of goods or services performed for or sold to beneficiaries under the medicare program, medicaid program, aid to families with dependent children program, state supplement to the federal supplemental security income program, or any federal or state energy assistance program or general assistance program, including suspension or termination from said programs. This act also provides for department notification of the proper professional society and licensing agency of any violation thereof.

The following are policies and procedures for Administrative Sanctions to be imposed against vendors or providers of goods or services performed for or sold to beneficiaries under said programs for violations including, but not limited to, those hereinafter set forth.

(b) **Definitions**

(1) 'Vendor' and 'provider' mean any person acting on his own behalf or on behalf of an entity and any entity furnishing goods or services.

(2) 'The commissioner' means the commissioner or his duly authorized representative.

(3) 'Suspension' means limiting program participation of vendors who, although not convicted of program-related crimes, are found by the department to have violated rules, regulations, standards, and/or laws governing said program.

(4) 'Termination' means foreclosing program participation by vendors who have been convicted of a crime involving program participation.

(5) 'Convicted' means that a judgment of conviction has been entered by a federal, state, or local court, regardless of the plea upon which it was based or whether an appeal from that judgment is pending.

(6) 'Violations' are (1) false statements of representations knowingly and willfully made or caused to be made for the purpose of claiming or determining payment, or (2) services furnished or ordered in excess of the recipient's need, or (3) failure to adhere to conditions of vendor participation in the program.

(7) 'Ownership or control interest' means a person or corporation that:

(A) Has an ownership interest totalling 5 percent or more in a disclosing entity;

(B) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;

(C) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;

(D) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;

(E) Is an officer or director of a disclosing entity that is organized as a corporation;

(F) Is a partner in a disclosing entity that is organized as a partnership.

(Effective October 29, 1985)

**Sec. 17-83k-2. Failure to meet or to continue to meet eligibility criteria**

Vendors must meet and maintain eligibility criteria of program participation specified in Federal and State Statutes and Regulations and in departmental contracts

or agreements. Failure to meet criteria for eligibility will result in the suspension of a vendor's participation.

Whenever the Department of Income Maintenance (hereinafter referred to as "Department") receives notification from the Licensing or Certifying Agency that a participating vendor has received either notice of denial of certification when such certification is required by Federal or State Statute or regulation, or has received notice of a denial of federal financial participation, or of an application for renewal of a license, certificate, permit or the like, when such license, certificate, permit or the like represents a prerequisite for participation, the Commissioner may suspend such vendor from further participation in the program.

(Effective October 29, 1985)

### **Sec. 17-83k-3. Violations of rules, regulations, standards and laws**

All vendors are subject to the federal and state laws and rules and regulations governing the programs in which they participate. Following are examples of violations by vendors of these laws, rules or regulations which constitute good cause for the imposition of administrative sanctions against such vendors:

(1) Accepting payment for goods provided to and/or services performed for any beneficiary under Chapter 302 of the Connecticut General Statutes, which payment exceeds the amount(s) due or authorized by law for such goods and/or services.

(2) Soliciting to perform services for and/or sell goods to any such beneficiary or recipient knowing that such beneficiary or recipient is not in need of such goods or services.

(3) Selling goods to or performing services for any such beneficiary or recipient without prior authorization by the Department of Income Maintenance when prior authorization is required by said Department for the buying of such goods or the performance of any such service.

(4) Accepting from any person or source other than the State an additional compensation in excess of the amount authorized by law for goods provided to or services performed for any such beneficiary or recipient.

(5) Knowingly and willfully making, or causing to be made, any false statement or misrepresentation of material fact for the purpose of claiming or determining payment.

(6) Furnishing or ordering services that are in excess of the recipient's needs or that fail to meet professionally recognized standards.

(7) Submitting or causing to be submitted to the program bills or requests for payment containing charges or costs that are in excess of customary charges or costs.

(8) Any of the fraudulent acts and/or false reporting proscribed under federal or state statutes.

(9) Failure of a vendor to comply with any provision of a contract or agreement which is in effect between said vendor and the Department of Income Maintenance.

(Effective October 29, 1985)

### **Sec. 17-83k-4.**

Repealed, October 29, 1985.

### **Sec. 17-83k-4a. Sanction procedures for non-convicted vendors**

If the Department has reason to believe that a vendor has committed a violation, which violation has not resulted in a criminal conviction, the Commissioner may impose one or more of the administrative sanctions outlined in Sec. 17-83k-5 of these Regulations, in accordance with the following procedures:

(a) **Written notice.** Before imposing a sanction, the Commissioner shall send by certified mail, return receipt requested, written notice to the vendor, which notice shall include:

- (1) A statement of the alleged violation or violations,
- (2) Notice of the right to a hearing,
- (3) A statement that proof of said violations may result in the imposition of sanctions,
- (4) A copy of this regulation.

(b) **Hearing procedure**

(1) The vendor shall send to the Office of Program Integrity, by certified mail, an answer to the allegations contained in the notice of violation. An answer must contain, but is not limited to, an admission or denial of each allegation and a clear and concise statement of all the facts on which the vendor relies.

(2) If the vendor fails to file an answer to the notice of violation within fifteen (15) days of receipt of the notice, the vendor shall be deemed to have waived his right to an adjudicatory hearing and the proposed sanction will be imposed, effective twenty (20) days after receipt of the notice of violation.

(3) The Department shall schedule an adjudicatory hearing as soon as practicable, which hearing shall be held in accordance with the provisions of the Uniform Administrative Procedures Act.

(Effective October 29, 1985)

**Sec. 17-83k-5. Sanctions**

(a) Sanctions shall include, but shall not be limited to any one or more of the following:

- (1) An order to make restitution, with interest at the rate provided by statute, as a condition of continued participation.
- (2) Suspension from participation.
- (3) Limitation on a provider's participation.

(b) The Department shall give written notice forthwith of its findings and decision to the proper professional society and/or licensing agency of any violation of program rules, regulations, standards and laws.

(Effective October 29, 1985)

**Sec. 17-83k-6. Termination upon conviction**

(a) Notwithstanding any other provisions of these regulations to the contrary, any vendor against whom a judgment of conviction has been rendered in any state or federal court of a crime involving fraud in said programs shall be terminated from participation. Termination shall be effective upon conviction, except that the Commissioner may delay termination for a period he deems sufficient to protect the health and well-being of beneficiaries receiving goods and/or services from such vendor. No vendor or person so terminated or denied reimbursement shall be readmitted to or be eligible for reimbursement in such programs for at least one year from the date of termination or conviction.

(b) The Commissioner shall notify said vendor of such termination by certified mail, return receipt requested. The notification shall inform the vendor of his/her ineligibility for reimbursement for any goods provided or services performed directly by, or under the supervision of, said vendor for the period of termination, and of the right to a hearing, provided the request is filed with the Commissioner in writing within ten (10) days of the notice date.

(c) The scope of the hearing shall be limited to (1) whether the vendor was convicted, (2) whether the conviction is related to the vendor's participation in programs conducted by the Department of Income Maintenance, (3) whether the amount of restitution sought by the Department is accurate, and (4) the appropriateness of the period of termination.

(d) In setting the termination period, the Department will consider:

- (1) The number and nature of the program violations and other related offenses;
  - (2) The nature and extent of any adverse impact the violations have had on beneficiaries;
  - (3) The amount of damages incurred by Medicaid, or other social service programs for which the Department is responsible;
  - (4) Whether there are any mitigating circumstances;
  - (5) The length of the sentence imposed by the court;
  - (6) Any other facts bearing on the nature and seriousness of the program violations, and
  - (7) The previous sanction record of the terminated party.
- (Effective February 26, 1990)

#### **Sec. 17-83k-7. Reinstatement**

(a) **After suspension.** Upon completion of all obligations imposed by sanction or 30 days prior to the expiration of the suspension period, whichever is later, the vendor may submit to the Commissioner a request for reinstatement. Approval of said request, if granted, shall be sent the vendor, and all who were informed of the sanction, in writing. In deciding whether to approve such request the Commissioner may consider the nature and degree of the offense leading to the sanction, the likelihood of its recurrence, and any other factors the Commissioner deems appropriate. The burden of proof shall be upon the vendor.

(b) **After termination.** Upon expiration of the period of termination the vendor may request reinstatement by making written request to the Commissioner for a hearing in accordance with Sections 4-177 to 4-180 of the Uniform Administrative Procedure Act. At said hearing the burden of proof shall be on the vendor seeking reinstatement.

(Effective October 29, 1985)

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## **Safeguarding Resident's Personal Funds Handled by Licensed Homes for the Aged**

### **Sec. 17-109a-1. Definitions**

For the purposes of Regulations Section 17-109a-2, the following definitions apply:

(a) "Home" shall mean a licensed home for the aged, and the person or persons authorized by the home to handle residents' personal funds.

(b) "Resident" shall mean a resident of such home who is a recipient of the State Supplement for the Aged, Blind or Disabled program.

(c) "Department" shall mean the Department of Income Maintenance.

(d) "Legally Liable Relative" shall mean the husband or wife of any resident, as defined above, of a licensed home for the aged, and the father and mother of any resident under the age of eighteen years.

(Effective July 29, 1993)

### **Sec. 17-109a-2. Safeguarding of residents' personal funds**

#### **(a) Purpose**

This regulation provides safeguards for residents' personal funds which are handled by licensed homes for the aged.

#### **(b) Cashing Checks**

When a home cashes a resident's check and funds are returned to the resident, the home shall require the resident to sign a receipt showing the date and the amount received.

#### **(c) Resident's Authorization**

(1) When a home assumes responsibility for a resident's funds, there shall be a statement on file signed by the resident authorizing the home to handle the personal funds.

(2) If the resident has been determined by a physician to be mentally incapable of understanding the terms of the authorizing statement, the statement shall be signed by a conservator, guardian or legally liable relative.

#### **(d) Resident Accounts**

(1) The home shall not commingle the resident's personal funds money with other funds. Personal funds for residents may be held in a single aggregate trust account or in individual accounts for each resident. If an aggregate trust account is used, it shall be clearly titled as such, and the owner or administrator of the home shall be a trustee of the account.

(2) Survivorship accounts with the home are prohibited.

(3) An account established with the home as trustee need not be interest bearing, but if it is, interest shall accrue for all the residents in an equitable manner.

#### **(e) The Accounting System**

(1) The home shall maintain an accounting system which reflects the activity of funds in and out of the bank account. The accounting system shall at a minimum provide for all of the following:

(A) Receipts register or acceptable equivalent as determined by the department

(B) Disbursement vouchers

(C) Resident's ledger

(2) The bank account statements and the resident's ledger shall be in agreement and reconcilable at any point in time. All bank statements and canceled checks of the trust account shall be kept in the home for at least three years.

(3) All of the personal fund portion of checks or cash received on behalf of the resident shall be deposited into the bank account within one week.

(4) Each resident for whom the home handles funds shall be listed in the receipts register, or its acceptable equivalent. All disbursements (cash or check) shall be charged directly to the resident's account.

(5) All payments to a third party made on a resident's behalf shall be authorized by the resident or the resident's conservator, guardian or legally liable relative. The authorization shall be signed by the resident, conservator, guardian or legally liable relative and shall show the date and amount authorized. All payments to a third party on behalf of a resident shall be consistent with the resident's needs and desires.

(6) Whenever goods or services are purchased on behalf of a resident, a receipt for the goods or services shall be obtained and signed by the resident.

(7) When cash is given to the resident from his or her account, he or she shall sign a receipt showing the date and amount received.

(8) A receipt is not required when funds are given to a resident in the form of a check. However, canceled checks shall be retained.

(9) All authorizations, receipts and canceled checks shall be retained for a period for at least three years to allow for audits of individual resident accounts, unless at the end of the three years there is an audit in progress, in which case such records shall be retained until the audit is completed.

(10) Authorizations, receipts and canceled checks shall be kept in individual envelopes or folders with the resident's name on the outside.

(11) All cash receipts and disbursements shall be recorded in the related registers as follows:

**(A) Cash Receipts**

- (i) Date of Entry
- (ii) Resident Name
- (iii) Resident Account Number
- (iv) Amount

**(B) Cash Disbursements**

- (i) Date
- (ii) Check Number
- (iii) Payee
- (iv) Amount
- (v) Resident Account to be charged
- (vi) Specific Item

**(C) Resident's Ledger**

- (i) Date of Entry
- (ii) Specific Item
- (iii) Amount
- (iv) Copy of resident's signature is kept on file. Whenever the resident signs a receipt or an authorization, his or her signature shall be verified.
- (v) Date or number of authorization, receipt, or check.

(12) Resident's ledger records shall be updated at least once a month.

(13) Funds shall be available to residents no less than fifteen (15) hours a week and no less than five (5) days a week, except for weeks that contain a bank holiday. In those weeks, funds shall be available no less than twelve (12) hours a week and no less than four (4) days a week. The residents shall be fully informed of the time when they may receive their money.

**(f) Distribution of Cash**

(1) For residents with sufficient funds, the home shall honor requests for withdrawals of petty cash up to \$10 per person per day.

(2) For residents with sufficient funds, the home shall honor requests for withdrawals of cash of more than \$10 by the end of the banking day following the date of the request. The resident shall have the choice of receiving this payment in cash or by check.

**(g) Availability of Records**

(1) All resident account records, including the accompanying bank statements, canceled checks and invoices, shall be kept in the facility at all times and must be available to the department personnel and the regional ombudsman upon request. The request may be made in person or by mail.

(2) A resident's account records shall be available to the resident, a conservator of the resident, or a person authorized by the resident to examine the records.

**(h) Use of Funds**

(1) A resident's funds are the property of the resident. They may be spent or saved, as the resident sees fit.

(2) The home may not charge the resident separately for items included in the monthly room and board rate, or for items covered by Medicaid.

**(i) Balances At or Above the Asset Limit**

Whenever the balance in a resident's account reaches two hundred dollars (\$200.00) less than the asset limit set by the Department of Income Maintenance, the home shall inform the resident that if his or her assets reach the maximum, the resident will not remain eligible for the State Supplement to the Aged, Blind or Disabled program. If the resident has been determined by a physician to be mentally incapable of understanding, the conservator, guardian or legally liable relative shall be notified whenever the balance in a resident's account reaches two hundred dollars (\$200.00) less than the asset limit set by the Department of Income Maintenance. This shall be done within the month the asset limit is reached.

**(j) Restriction**

At no time may any funds be withdrawn from the resident's accounts for use in the business or operating expense of the facility, or for the personal use of any employee, administrator, owner, or relative thereof. The personal funds are not available for loan to anyone.

**(k) Resident Moves From the Home**

When a resident moves from a home, all funds in his or her account shall be returned to him or her. Any bank account in the resident's name shall be closed and the canceled book returned to the resident. The resident's name shall be removed from an aggregate trust account.

**(l) Death of a Resident**

Upon the death of a resident, the home shall notify the District Office Resources Supervisor within 10 days. Any funds in the resident's account shall become part of his or her estate.

**(m) Annual Accounting**

(1) Each year an accounting shall be made to the Department reflecting the balance of the resident account for each resident for whom the home has handled funds. Also bank statements on all resident accounts shall be presented annually. The accounting shall consist of the following:

- (A) Recipient's name
- (B) D.I.M. number

- (C) D.I.M. district office
- (D) Petty cash held in the home for the resident
- (E) Balance held in a bank book for the resident
- (F) Balance held in a trustee account for the resident
- (G) Any other money being held for the resident for whom the home is trustee
- (H) If the home is not trustee for any resident's money, it shall so state by each June 1st to the Department of Income Maintenance.

(2) The accounting to the Department shall be submitted by June 1st of each year on a form designated by the Department and shall be dated, signed by the administrator of the facility, and mailed to the following address:

State of Connecticut  
Dept. of Income Maintenance  
Internal Audit Division  
110 Bartholomew Avenue  
Hartford, Connecticut 06115

**(n) Accounting of Residents Funds Upon Sale of a Home**

(1) If the home is sold, an accounting shall be made to the Department of the balance in the residents' accounts which are to be transferred to the new owner. This accounting shall be made on a form designated by the Department and shall be signed and dated by both the seller and the buyer. In the case of corporations, it shall be signed by a person authorized on behalf of the corporation. In a partnership, one or both partners may sign. The accounting shall be accompanied by the most current bank statement and must be reconciled accurately with this statement. The W-411 form shall be mailed to the address listed in subdivision (2) of subsection (m) of this section.

(2) If the home does not handle any recipient's funds, it shall so state upon sale of the facility.

(3) Should changes occur in personnel responsible for residents' funds accountability, appropriate changes in authorized signature for checking accounts or designated trustee for savings passbooks shall be made at financial institutions and documented. The supporting data shall be made available for review purposes.

**(o) Quarterly Reports to the Residents**

The home shall provide to the resident, in writing, a quarterly accounting of monies handled on his or her behalf.

(Effective July 29, 1993)

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## **Medical Assistance**

### **Sec. 17-134d-1.**

Repealed, December 21, 1990.

### **Sec. 17-134d-2. Medical and remedial care and services**

Medical assistance may be granted to eligible persons for the following items of medical and remedial care and services: (1) Inpatient hospital services; (2) outpatient hospital services; (3) other laboratory and x-ray services; (4) skilled nursing home services; (5) services of a physician whether furnished in the office, the patient's home, a hospital, or a skilled nursing home, or otherwise; (6) medical service and care or an other type of remedial care recognized under Connecticut law, furnished by licensed practitioners within the scope of their practice as defined by Connecticut law; (7) home health care services; (8) private duty nursing services; (9) clinic services; (10) dental services; (11) physical therapy and related services; (12) prescribed drugs, dentures and prosthetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist; (13) other diagnostic, screening, preventive and rehabilitative services; (14) the first three pints of whole blood, when they are not available to the patient from other sources; (15) any other medical care recognized under Connecticut law including transportation, ambulance, oxygen, and podiatry; (16) family planning services, drugs, supplies and devices when such services are under the supervision of a physician; (17) services of Christian Science Practitioners listed in the Christian Science Journal, published by the First Church of Christ Scientist, Boston, Massachusetts; (18) care and services provided in Christian Science Sanatoria operated by, or listed and certified by, the First Church of Christ Scientist, Boston, Massachusetts.

(Effective March 2, 1971)

### **Secs. 17-134d-3—17-134d-6.**

Repealed, December 21, 1990.

## **Services for Functionally Disabled Clients Who Have No Vocational Objective**

### **Sec. 17-134d-7. Definitions as used in these regulations**

(a) The term "Functionally Disabled" as used herein shall mean physically and/or mentally unable to perform minimum daily personal and home management requirements.

(b) The term "Therapy" as used herein shall mean the remedial treatment of a physical and/or mental disorder.

(c) The term "Functional Therapy" as used herein shall mean remedial treatment relating to, or training in, the performance of minimum daily personal and home management acts.

(d) The term "Functional Objective" as used herein shall mean the goal or aim of the individual to perform minimum daily personal and home management acts.

(e) The term "Vocational Objective" as used herein shall mean the goal or aim of the individual to become skilled in or learn a trade which will suffice as a career in a community setting.

(Effective October 9, 1980)

**Sec. 17-134d-8. General provisions of services for functionally disabled clients who have no vocational objective**

(a) Reimbursement is made for the following types of services rendered to Title XIX (Medicaid) recipients who are mentally and physically disabled and who have no vocational objective:

(1) Physicians Services

(b) Reimbursement is made for the following types of services when prior authorization is obtained:

(1) Physical Therapy

(2) Speech and Hearing Therapy

(3) Occupational Therapy

(4) Audiological Services

(5) Psychiatric and Psychological

(6) Day Care and Functional Therapy only if the service is part of a predominantly medical plan.

(c) Medical services are those services which are required in the diagnosis, treatment, care, or prevention of some physical or psychological problem which affects the health of an individual. Such services would be rendered by or under the direction of a physician or other health care practitioner under accepted standards of medical practice. For each individual receiving one of the above stated services, an individual plan of treatment is required. The plan must be implemented under the direct supervision of a health care professional and must address the total needs of the individual as well as clearly identify his medical needs. The evaluation to determine the needs of the individual need not be made at the facility, but all services must be provided at the facility.

(Effective October 9, 1980)

**Reimbursement for all Out-Patient Hospital Laboratory Services Received by Title XIX (Medicaid) Recipients**

**Sec. 17-134d-9.**

Repealed, August 5, 1988.

**Routine Medical Visits for Title XIX Recipients Residing in Homes for the Aged**

**Sec. 17-134d-10. Reimbursement for routine medical visits for title XIX recipients residing in homes for the aged**

The department of income maintenance will pay for no more than four (4) routine medical visits during any twelve (12) month period for Title XIX recipients residing in homes for the aged. Routine medical visits are defined as visits intended to check a resident's general medical condition rather than visits medically necessary to treat a specific medical problem of the resident. The Department of Income Maintenance reserves the right to review the medical necessity of visits and disallow reimbursement for those it determines not medically necessary.

(Effective June 1, 1981)

**Sec. 17-134d-11. Medicaid recipient surveillance and utilization review program**

(a) **Establishment of Recipient Surveillance and Utilization Review Program.**

In the Department of Income Maintenance a Recipient Surveillance and Utilization Review Program oversees, assesses and controls the use of medical services by recipients provided under the Medicaid Program by monitoring recipient utilization.

**(b) Identification of recipients' overutilization of services.**

Recipients who may be overutilizing, and/or unnecessarily or inappropriately using medical services under Medicaid shall be identified through recipient or provider exception reports, referrals from sources including town welfare departments and medical assistance providers of service, claims listing reports with additional information from billing invoices, or other appropriate means.

Provider and recipient exception reports show deviations from the statistical norm for the Medicaid recipient or provider population for the usage or provision of a particular service.

**(c) Recipient Surveillance and Utilization Review Committee.**

The Recipient Surveillance and Utilization Review Committee (R/SURC) is appointed by the Commissioner of the Department of Social Services and consists of a Medical Consultant (Physician), a Medical Social Worker and a professional consultant with expertise in the relevant area of utilization review to be conducted by the Department. The areas of utilization review and relevant consultants shall include, but are not limited to, the following:

- (1) Pharmacy—a Pharmacist,
- (2) Mental Health—a Psychiatrist/Psychologist,
- (3) Durable Medical Equipment—a Physical Therapist, etc.

Cases identified as possibly overutilizing medical services shall be reviewed by R/SURC to determine if further action is appropriate.

**(d) Implementation.**

The R/SURC Committee, based on a review of information and individual circumstances, recommends a course of action, which may consist of:

- (1) No Action
- (2) No immediate action but the Department notifies the recipient of the misutilization or overutilization and reviews the profile within three (3) months after the notification. If the inappropriate utilization is not satisfactorily resolved at the end of three (3) months, the case is referred back to R/SURC for further action.
- (3) Utilization Control

Upon the making of a determination by R/SURC that there has been unnecessary or inappropriate utilization of medical services, the Department may restrict or limit access to the medical services by a recipient to a specific provider or require prior authorization for all medical services when necessary to prevent duplication and/or abuse of services.

Such restrictions on the use of Medicaid are subject to the notice and fair hearing requirement.

If either restriction is recommended by R/SURC, a letter shall first be mailed to the recipient explaining the restriction being imposed and the reason for its imposition. The recipient is given ten (10) days to respond to the letter and include the name and address of the provider the recipient would like to have as the primary medical provider if it is a provider restriction. If no response is received within ten (10) days, the recipient is assigned to any one of the medical providers appropriate to the service being overutilized or placed on prior authorization restriction.

The recipient's notification also contains a statement of the right to appeal the restriction, along with an appeal application. Recipients are advised that the request for an appeal must be submitted within sixty (60) days.

Providers either chosen by recipients or selected on the basis of the recipient's most recent utilization profile are contacted by mail and asked to serve as the primary medical provider for the recipient in question for a period of no less than

six months. In the event that the provider refuses to assume this responsibility, another provider is selected. This provider is contacted by telephone to assure that an assignment is made within a reasonable period of time. Once a recipient has been assigned a primary provider, the recipient is sent a notification by registered mail of the assignment.

The recipient's Medicaid I.D. Card shall indicate the provider restriction or prior authorization requirement.

(A) Duration of Utilization Control Restrictions.

Utilization Control restriction is for a minimum of twelve (12) months, even if the recipient becomes ineligible for medical assistance and then eligible again.

Prior to the twelve (12) month restriction period the restricted recipient's claims history, and the subsequently submitted invoices, shall be reviewed by R/SURC to determine whether the restriction should be continued for another twelve (12) month period.

If the recipient is to continue on restriction, a summary of the recipient's continued misuse or abuse of services shall be prepared. The Department shall explain the continued restriction and effective dates to the recipient.

If the restriction is to be terminated the recipient shall be informed of the termination of restriction and future monitoring of recipient use of services.

(Effective March 1, 1994)

**Secs. 17-134d-12—17-134d-15. Reserved**

**Payment to Psychiatrists for Services Rendered by Non-Medical  
Allied Health Professionals in Their Employ**

**Sec. 17-134d-16.**

Repealed, May 11, 1998.

**Secs. 17-134d-17—17-134d-19. Reserved****Acute Care General Hospital Inpatient Weekend  
Admissions and Discharges under Title XIX (Medicaid)****Sec. 17-134d-20. Acute care general hospital inpatient weekend admissions  
and discharges under title XIX (Medicaid)**

The Department of Income Maintenance, Title XIX (Medicaid) program will not reimburse acute care general hospitals for inpatient weekend admittances (Friday/Saturday) or discharges (Sunday/Monday) unless they are medically necessary. Admissions and discharges on these restricted days must have medical necessity recorded by the attending or performing physician in the patient's medical record.

(Effective April 27, 1984)

**Secs. 17-134d-21—17-134d-22. Reserved****Coverage of Nurse-Midwife Services under Medicaid****Sec. 17-134d-23.**

Repealed, March 6, 1998.

**Provision of a Financial Incentive for Reporting  
Vendor/Provider Medical Assistance Fraud****Sec. 17-134d-24.**

Repealed, April 2, 1998.

**Sec. 17-134d-25. Reserved****Secs. 17-134d-26—17-134d-27.**

Repealed, December 21, 1990.

**Secs. 17-134d-28—17-134d-31. Reserved****Immediate Medical Coverage for Newborn Children****Sec. 17-134d-32.**

Repealed, December 21, 1990.

**Sec. 17-134d-33. Medical transportation services****(a) Scope**

These regulations set forth the requirements for payment of Medical Transportation Services rendered to persons determined eligible for such services under provisions of Connecticut's Medical Assistance Program in accordance with Section 17-134d of the General Statutes of Connecticut.

**(b) Definitions**

For purposes of Section 17-134d-33, the following definitions apply:

**(1) Additional Recipient**

An additional recipient is an eligible Medicaid recipient beyond the first recipient transported by a Medicaid transportation provider during the same trip.

**(2) Additional Stop**

All trips have one pickup point and one drop-off point. An additional stop is a pickup point or drop-off point other than the initial pickup and final drop-off points. Additional stops occur when multiple recipients are transported during a single trip.

(3) Air Transportation

Air transportation is transportation provided by a commercial airline.

## (4) Alternative Method of Transportation

If the most appropriate type of transportation for a recipient is not available, a different type of transportation may be utilized. This would be an alternative method of transportation.

## (5) Ambulance

An ambulance is a vehicle for transporting the sick and injured which is equipped and staffed to provide medical care during transit, and which is operating as an ambulance under the authority and in compliance with promulgated regulations of the Department of Health Services, Office of Emergency Medical Services, and registered as such by the Department of Motor Vehicles.

## (6) Ambulance Night Call Charge

An ambulance night call charge is an additional fee that may be paid when an ambulance service is dispatched between the hours of 7:00 P.M. and 7:00 A.M. inclusive.

## (7) Appropriate Method of Transportation

An appropriate method of transportation is the least expensive type of transportation which best meets the physical and medical circumstances of a recipient requiring transportation to a medical service.

## (8) Assistance

Assistance is when a recipient must be physically helped from within or into a building and/or from within or into the medical provider's site. Without such assistance it would be unsafe or impossible for the recipient to reach the livery vehicle or the medical provider's site.

This assistance is provided by an employee of the livery provider, the driver or a person in addition to the driver. This service is beyond a door-to-door service.

## (9) Attendant

An attendant is an employee of an invalid coach or wheelchair accessible livery provider, and is a person in the vehicle in addition to the driver, who provides assistance in the transportation of passengers.

## (10) Attendant Services

Attendant services are when an attendant must physically assist a recipient from within or into a building and from within or into the medical provider's site. Without such assistance it would be unsafe or impossible for the recipient to reach the invalid coach or wheelchair accessible livery vehicle or the medical provider's site. This service is beyond a door-to-door service.

## (11) Available Transportation

Available transportation means that a public transportation system, an enrolled Medicaid provider, organization, agency, or individual offers appropriate transportation services to a recipient who requires transportation.

## (12) Border Provider

A border provider is a provider located in a state bordering Connecticut, in an area that allows it to generally serve Connecticut residents, and who is enrolled as and treated as a Connecticut Medicaid provider. Such providers are certified and/or licensed by the applicable agency in their state.

## (13) Cancelled Call

A cancelled call is notification to the transportation provider not to provide services to a recipient, prior to the time the vehicle is enroute to the pickup point.

## (14) Critical Care Helicopter

A critical care helicopter is an aircraft which is operating as a critical care helicopter and in compliance with promulgated regulations under the authority of

the Department of Health Services, Office of Emergency Medical Services. A critical care helicopter has mobile intensive care capabilities and is called to the scenes of severe accidents or illness.

(15) Department

The Department means the Department of Income Maintenance.

(16) Emergency

An emergency is defined as a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(17) Emergency Ambulance Trip

An emergency ambulance trip is an ambulance trip made in accordance with the Department's definition of emergency and has as its destination:

(A) a hospital emergency room; or

(B) a general hospital or a psychiatric facility where a nonscheduled admission results; or

(C) a general hospital or a psychiatric facility where an emergency admission results after a recipient was seen at a hospital emergency room; or

(D) a second facility because an emergency medical service was not available at the original emergency room; or

(E) a critical care helicopter.

(18) Helicopter Assist

A helicopter assist is medical care provided at the scene to a recipient when such recipient is ultimately transported by a critical care helicopter.

(19) Invalid Coach

An invalid coach is a vehicle used exclusively for the transportation of non-ambulatory patients and is operating as an invalid coach under the authority and in compliance with promulgated regulations of the Department of Health Services, Office of Emergency Medical Services, and registered as such by the Department of Motor Vehicles, or is a wheelchair accessible livery vehicle.

(20) Livery

A livery vehicle is a sedan or van type vehicle capable of carrying up to ten passengers used for the transportation of ambulatory patients, who may require assistance, and which is operated by a livery carrier under the authority and in compliance with the statutes and regulations of the Department of Transportation and/or a transit district and registered as a livery vehicle by the Department of Motor Vehicles. Livery service is a door-to-door service.

A livery vehicle does not include a vehicle registered as a service bus vehicle with the following exception. If the Commissioner determines, in his/her sole discretion, that for access or other reasons use of service bus vehicles is appropriate, equitable and in the best interests of the state, he/she may authorize use of service bus registered vehicles and may impose any additional insurance or other requirements or limitations which he/she deems appropriate. Said authorization must be in writing.

(21) Loaded Mileage

Loaded mileage is the distance traveled by a motor vehicle while carrying passengers from a pickup point to a drop-off point. Mileage between Connecticut towns is determined in accordance with the Public Utility Control Docket Document (PUCA) #6770-A.

## (22) Noncontiguous Town

Noncontiguous town is a town which does not border the town in which a provider's headquarters is housed. Noncontiguous towns are towns which do not border each other.

## (23) Non-Emergency Ambulance Trip

Non-emergency ambulance trip is a pre-arranged ambulance trip that is not responding to an emergency injury or illness. However, ambulance services are needed because a recipient may require medical care during transit, which an ambulance is equipped and staffed to provide.

## (24) No-show

No-show is when a recipient fails to utilize a transportation service approved in writing by the Department, and which is not cancelled.

## (25) Not Ambulatory

An individual who is not ambulatory is unable to walk despite the possible use of assistive devices (e.g., cane, crutch, walker) and/or the assistance of an attendant.

## (26) Nursing Home

A nursing home is an intermediate care or skilled nursing facility (ICF, SNF, or ICF/MR) or Chronic Disease Hospital.

## (27) Other Commercial Carrier

Other commercial carriers are those regulated carriers other than taxi, livery, wheelchair accessible livery, ambulance, invalid coach, and air transportation that transport the public for a fee and which meet all applicable state and federal permit and licensure requirements to operate as such.

## (28) Out-of-State Trip

An out-of-state trip is a trip originating or ending outside Connecticut that is to transport a patient to or from a medical provider that is not located in Connecticut and is not a border provider.

## (29) Prior Authorization

Prior authorization means approval for a service from the Department or the Department's agent before the provider actually provides the service. In order to receive reimbursement from the Department a provider must comply with all prior authorization requirements. The Department in its sole discretion determines what information is necessary in order to approve a prior authorization request.

## (30) Private Transportation

Private transportation is transportation by a vehicle owned by a recipient or by a friend, relative, acquaintance or other individual, provided the vehicle is not licensed for commercial carriage. Individual does not mean communities, companies, corporations, societies or associations.

## (31) Provider Agreement

The provider agreement is the signed written contractual agreement between the Department and the provider of services or goods.

## (32) Provider Headquarters

Provider headquarters is the provider's base of operations closest to the pickup point. A provider may have more than one (1) headquarters.

## (33) PUCA Document

PUCA Document is the Department of Public Utility Control Docket Document #6770-A and all its supplements which specify the mileage between Connecticut towns.

## (34) Recipient

Recipient means a person eligible for services under the Department's Medical Assistance Program.

(35) Round Trip

A round trip is the dispatching of a vehicle to the recipient(s) pickup point, transporting the recipient(s) to a medical provider and transporting the recipient(s) back to the pick-up point.

(36) Shared Ride

A shared ride is when more than one recipient occupies a vehicle during the same trip.

(37) Special Attendant

A special attendant is a second attendant who is an employee of the ambulance provider, and who is in the vehicle in addition to the driver and one attendant. This attendant is needed due to the recipient's medical condition.

(38) Taxi

A taxi is a vehicle operating as a taxi under the authority and in compliance with promulgated regulations of the Department of Transportation and/or a transit district and registered as such by the Department of Motor Vehicles.

(39) Trip—Ambulance, Invalid Coach, Taxi and Wheelchair Accessible Livery

A trip is the dispatching of an empty vehicle to the recipient pickup point and transporting the recipient to a medical provider, or from a medical provider to the drop-off point.

(40) Trip—Livery

A livery trip is the dispatching of an empty livery vehicle to the recipient(s) pickup point and transporting the recipient(s) to a medical provider or from a medical provider to the drop-off point. A trip for livery services begins when an empty vehicle picks up a recipient(s) and ends when the last recipient is dropped off and the vehicle is empty.

(41) Unloaded Mileage

Unloaded mileage is the distance traveled by the motor vehicle carrying no passengers, enroute to the point of pickup or, enroute from the point of drop-off.

(42) Unpaid Health Care

Unpaid health care is a service(s) provided to a recipient which is voluntary in nature, and usually provided by a family member, neighbor, friend or other person(s) within the individual's support system.

(43) Waiting Time

Waiting time is the time that a vehicle is waiting at a medical provider's facility, to which the transportation provider transported the recipient, in order to transport the recipient to another destination, during the same trip.

(44) Wheelchair Accessible Livery

A wheelchair accessible livery vehicle is a vehicle specifically designed for the transportation of wheelchair mobile patients, and which is operating as a wheelchair accessible livery, under the authority and in compliance with promulgated regulations of the Department of Transportation and/or a transit district and registered as such by the Department of Motor Vehicles. Wheelchair accessible livery vehicles are treated the same as invalid coach vehicles.

**(c) Provider Participation**

In order to participate in the Medicaid program and receive payment directly from the Department, all commercial transportation providers must: 1. be regulated carriers, 2. meet and maintain all applicable state and federal permit and licensure requirements, and vehicle registration requirements, 3. provide the Department with a copy of their approved permit or license, 4. also meet and maintain all applicable Departmental enrollment requirements and 5. have a signed provider agreement on

file. It is signed by the provider upon application for enrollment into the Medicaid Program and is effective on the approved date of enrollment. The provider agreement specifies conditions and terms (regulations, standards and statutes) which govern the program and to which the provider is mandated to adhere in order to participate in the program. There are no enrollment requirements for private transportation.

(d) **Eligibility**

Payment for medical transportation services is available for all Medicaid eligible recipients subject to the conditions and limitations which apply to these services.

(e) **Services Covered and Limitations**

(1) **Services Covered**

(A) Medicaid assures that necessary transportation is available for recipients to and from providers of medical services covered by Medicaid, and, subject to this regulation, may pay for such transportation.

(B) Payment for transportation may be made for eligible recipients under the Medicaid program, except as otherwise provided in these regulations, when needed to obtain necessary medical services covered by Medicaid, and when it is not available from volunteer organizations, other agencies, personal resources, or is not included in the medical provider's Medicaid rate.

(C) Transportation may be paid only for trips to or from a medical provider for the purpose of obtaining medical services covered by Medicaid. If the medical service is paid for by a source other than the Department, the Department may pay for the transportation as long as the medical service is necessary and is covered by Medicaid.

(2) **Service Limitations**

(A) The Department reserves the right to make the determination as to which type of transportation is the most appropriate for a recipient.

(B) The Department reserves the right to limit its payment of transportation to the nearest appropriate provider of medical services when it has made a determination that traveling further distances provides no medical benefit to the recipient.

(C) The Department may pay for only the least expensive appropriate method of transportation, depending on the availability of the service and the physical and medical, circumstances of the patient.

(D) Trips for out-of-state medical services may be paid for when the medical service meets the conditions for payment. Out-of-state services shall be paid for to the same extent as in-state services. The conditions are:

(i) The out-of-state medical services are needed because of a medical emergency; or

(ii) Medical services are needed because the recipient's health would be endangered if required to travel to Connecticut; or

(iii) The Department determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in another state; or

(iv) It is general practice for recipients in particular localities of Connecticut to use the medical resources in another bordering state. The Department will allow for providers in these localities to be treated in the same manner as Connecticut providers. These providers are called border providers. *Note:* trips to receive a medical service from a border provider are not considered out-of-state trips.

(E) **Ambulance Transportation**

(i) Payment may be made for non-emergency and emergency ambulance trips if:

(aa) the patient's condition requires medical attention during transit; or,

(bb) the patient's diagnosis indicates that the patient's condition might deteriorate in transit to the point where medical attention would be needed; or,  
(cc) the patient's condition requires hand and/or feet restraints; or  
(dd) the ambulance is responding to an emergency; or,  
(ee) no alternative less expensive means of transportation is available as determined by the Department.

(ii) Loaded mileage may be paid for ambulance services if the vehicle must cross a town line in order to transport a recipient to or from a medical provider. One mileage charge for the mileage covered may be paid, regardless of the number of recipients transported. Mileage between towns is determined and paid according to the PUCA Document.

(iii) The Department shall not pay for a recipient who fails to utilize ambulance services.

(F) Invalid Coach

(i) Payment may be made for invalid coach trips if:

(aa) the patient is not ambulatory and must be transported in a wheelchair; or,  
(bb) no alternative less expensive means of transportation is available as determined by the Department.

(ii) Loaded mileage may be paid for invalid coach if the vehicle must cross a town line in order to transport a recipient to or from a medical provider. One mileage charge for the mileage covered shall be paid, regardless of the number of recipients transported. Mileage between towns is determined and paid according to the PUCA Document.

(iii) Wheelchair accessible livery services are treated the same as invalid coach services.

(iv) The Department shall not pay for a recipient who fails to utilize invalid coach services.

(G) Livery

(i) Payment may be made for livery transportation if:

(aa) the patient is ambulatory and may require assistance; or  
(bb) no alternative less expensive means of transportation is available as determined by the Department.

(ii) Livery providers are responsible for alerting the client of the vehicle's arrival and assisting the client into the vehicle if necessary.

(iii) If a recipient fails to use approved livery services and the trip was not cancelled, the provider may be paid only for a base rate, additional stop or mileage applicable to that recipient as set forth in subsection (i) (9) (D) Payment Limitations.

(iv) Payment may be made for waiting time, after the first fifteen minutes waited. No payment will be made for the first fifteen minutes waited.

(v) Loaded mileage may be paid for livery if the vehicle must cross a town line in order to transport a recipient to or from a medical provider. Mileage between Connecticut towns is determined and paid according to the PUCA Document.

(vi) Payment, in accordance with these regulations, shall be made by the Department for services provided which were approved by a written prior authorization form.

(H) Wheelchair Accessible Livery

(i) Payment may be made for wheelchair accessible livery services if:

(aa) the patient is not ambulatory and must be transported in a wheelchair or,  
(bb) no alternative less expensive means of transportation is available as determined by the Department.

(ii) Wheelchair accessible livery providers are responsible for alerting the client of the vehicle's arrival and assisting the client into the vehicle if necessary.

(iii) Wheelchair accessible livery providers must meet all Departmental regulations for invalid coach.

(iv) The Department shall not pay for a recipient who fails to utilize wheelchair accessible livery services.

(I) Taxi

(i) Payment may be made for taxi transportation provided no alternative less expensive means of transportation is available as determined by the Department.

(ii) The Department shall not pay for a recipient who fails to utilize taxi services.

(J) Air Transportation

Payment may be made for transporting a patient by airplane provided:

(i) a medical condition dictates the use of air transportation; or,

(ii) it is less expensive than an alternative means of transportation; or,

(iii) time constraints dictate the use of such transportation.

(K) Critical Care Helicopter

Payment may be made for critical care helicopter service if the utilization of this helicopter is justified rather than ground ambulance service. The factors that will be considered in determining if the use of a critical care helicopter was appropriate are those criteria published by the Department of Health Services, Office of Emergency Medical Services as Minimum Quality Standards for critical care helicopter responses, (Section 6.2), as they may be amended from time to time.

For informational purposes, as of the date of the adoption of this regulation, the factors are:

(i) condition of the patient;

(ii) time needed for rescue/extrication;

(iii) transport time to closest facility;

(iv) landing conditions;

(v) traffic conditions present at the time;

(vi) remoteness of the location; and

(vii) multiple number of patients.

(L) Other Commercial Carriers

Payment may be made for transportation by means of other commercial carriers provided no other alternative less expensive means of transportation is available as determined by the Department.

(M) Private Transportation

Payment may be made for the transporting of a patient by private transportation when no alternative less expensive transportation is available as determined by the Department.

(N) Exclusive Service Contracts

Providers who have contracts with organizations to provide transportation services shall not be paid higher rates for services than what the Department would pay another available provider for these same services. The Department is not bound to use the services of a provider because this provider has an exclusive contract with an organization.

(O) When an alternative method of transportation must be used for a recipient, the Department must approve the use of this type of transportation if it exceeds the appropriate type of transportation needed by the recipient.

(P) Services covered are limited to those listed in the Department's fee schedule.

(Q) When the Department approves a certain type of transportation and a provider uses a higher level of transportation, the Department is not bound to pay for the higher level of transportation.

(3) Services Not Covered

(A) For nursing home patients, transportation to a medical service shall not be paid:

(i) If the medical service is one that the nursing home is required to provide as part of the per diem payment to the home; or

(ii) If the service is one connected with the admission physical, annual physical or dental exams required by the public health code.

(B) Payment shall not be made to transport a relative or a foster parent of an eligible Medicaid recipient, unless the person needs to be present at and during the medical service being provided to the patient. For example, when family therapy is being provided to a child, the parent may be transported to the therapy service. Such payments shall be made in accordance with all other transportation regulations.

(C) Payment shall not be made for transportation services that are not approved, which require prior authorization by the Department.

(D) The Department shall not pay for transportation of a recipient to a medical provider when the visit is for the sole purpose of the recipient picking up a prescription or a written prescription order.

(E) The Department shall not pay for cancelled calls.

(F) The Department shall not pay for transportation to a medical provider when the visit is solely to pick up an item which does not require a fitting.

(G) The Department shall not pay for no shows for ambulance, invalid coach, wheelchair accessible livery or taxi services.

(H) Payment shall not be made to transport a recipient who is a hospital inpatient to any medical service outside the hospital except for a computerized axial tomography (CAT) scan and/or for magnetic resonance imaging (MRI). Transportation for these services is covered only when the services are not available in the hospital where the recipient is an inpatient.

(I) Payment shall not be made to transport a relative or a foster parent of a recipient who is a hospital inpatient, unless the person needs to be trained to provide unpaid health care in the home to the recipient. Without this health care being provided the recipient would not be able to return home.

(f) **Need for Service and Authorization Process**

(1) Need for Service

The Department may pay for transportation services which are required in order for a recipient to receive necessary medical care which is covered under the Medicaid Program.

(2) Prior Authorization

All transportation services require written prior authorization, except emergency ambulance, non-emergency ambulance with designated medical conditions, in-state invalid coach and wheelchair accessible livery services with designated diagnoses, bus, train, and private transportation within the same town.

Prior authorization for transportation services is required as listed below. Prior authorization, when required, may be given for single or multiple trips, depending on the circumstances. Multiple trips, where medical need has been shown, can be authorized for periods up to a maximum of three months at a time. An example would be a recipient receiving dialysis services.

(A) Ambulance

(i) Prior authorization is required for all non-emergency ambulance trips without designated medical conditions. A list of these conditions is contained in Appendix B to this policy.

(ii) Services taking place after Departmental working hours, that could not be arranged during working hours prior to the trip, require after-the-fact approval by the Department. These requests must be in writing. Written requests for such authorization must be received by the Department within fifteen (15) working days following the date the transportation services were provided. Otherwise the service shall not be covered. The same limitations and requirements for appropriateness of service apply for after hours services.

Consideration will be given to after-the-fact authorization requests received after fifteen (15) working days, if the failure to submit an authorization was for a recipient who had a pending application with the Department, or had other third party coverage. A written authorization request for the above situations must be received within ninety (90) working days of the date the transportation services were provided. Verification of other third party payment or denial must be attached to the request.

(B) Invalid Coach and Wheelchair Accessible Livery

(i) Prior authorization is required for all out-of-state trips regardless of the recipient's diagnosis.

(ii) Prior authorization is required for all in state trips unless the recipient's diagnosis indicates the need for an invalid coach. A list of these diagnoses is contained in Appendix A to this policy. The relevant diagnosis is the one that relates to the need for invalid coach services, and not necessarily the diagnosis for which the recipient is receiving treatment.

(iii) Services taking place after Departmental working hours, that could not be arranged during working hours prior to the trip, require after-the-fact approval by the Department. These requests must be in writing. Written requests for such authorization must be received by the Department within fifteen (15) working days following the date the transportation services were provided. Otherwise the service will not be covered. The same limitations and requirements for appropriateness of service apply for after hours services.

Consideration will be given to after-the-fact authorization requests received after fifteen (15) working days, if the failure to submit an authorization was for a recipient who had a pending application with the Department. A written authorization request for the above situations must be received within ninety (90) working days of the date the transportation services were provided.

(C) Livery and Taxi Services

(i) Prior authorization is required for all services by nursing homes for their nursing home recipients.

(ii) Services for recipients taking place after Departmental working hours, that could not be arranged during working hours prior to the trip, require after-the-fact approval by the Department. These requests must be in writing. Requests for such authorization must be received by the Department within fifteen (15) working days following the date the transportation services were provided. Otherwise the service will not be covered. The same limitations and requirements for appropriateness of transportation apply for after hours services.

Consideration will be given to after-the-fact authorization requests received after fifteen (15) working days, if the failure to submit an authorization was for a recipient who had a pending application with the Department. A written authorization request

for the above situations must be received within ninety (90) working days of the date the transportation services were provided.

(D) Other Commercial Carriers and Air Transportation

All non-emergency commercial carrier transportation except bus and train transportation within the same town require prior authorization.

However reimbursement will be made only if the recipient documents a visit to a medical provider for a needed service. Requests for reimbursement must be made within thirty (30) days of the date of the transportation.

(E) Private Transportation

Prior authorization is required for trips between towns and out-of-state private transportation. No prior authorization is required for private transportation for trips within a town. Reimbursement for all private transportation will be made only if the recipient documents a visit to a medical provider for a needed service. Requests for private transportation reimbursement must be made within thirty (30) days of the date of the transportation need.

(3) Prior Authorization Process

(A) Ambulance, Invalid Coach and Wheelchair Accessible Livery

Prior authorization for ambulance, invalid coach and wheelchair accessible livery trips is obtained from the Department's Central Office. The authorization request must be made by the transportation provider. Verbal authorization may be obtained during Departmental business hours from the Central Office.

To obtain authorization the following information is required:

- (i) The provider name.
- (ii) The recipient's name and Medicaid number.
- (iii) Relevant diagnosis of the recipient which indicates the need for the type of transportation.
- (iv) Origin and destination of trip.
- (v) Reason for trip.
- (vi) Date of trip.
- (vii) Town code(s).
- (viii) Procedure code(s).

(B) Livery, Taxi, Bus, Train, Air, Private and Other Commercial Carriers

(i) Out-of-State Trips

All out-of-state trips require prior authorization from the Department's Central Office, however, arrangements are made through the Department's District Office, as follows:

- (aa) the request for transportation is made to the District Office by the recipient, the medical provider or someone acting on behalf of the recipient;
- (bb) the District Office contacts Central Office;
- (cc) the Department's Central Office staff will determine if the out-of-state service meets the criteria for payment, determine if the service has been approved, if prior authorization is required, and determine the most appropriate level of transportation;
- (dd) Central Office will inform the District Office of the decision; and
- (ee) the District Office will arrange for livery, taxi, bus, train or private transportation and Central Office will arrange for air transportation.

(ii) Livery, Taxi Trips from Nursing Home

All livery, taxi trips from nursing homes require prior authorization from the Department's Central Office. The authorization request must be made by the transportation provider. Verbal authorization may be obtained during Departmental business hours from the Central Office.

To obtain authorization the following information is required:

- (aa) The provider name and provider number.
- (bb) The recipient's name and Medicaid number.
- (cc) Relevant diagnosis of the recipient which indicates the need for the type of transportation.
- (dd) Origin and destination of trip.
- (ee) Reason for trip.
- (ff) Date of trip.
- (gg) Town code(s).
- (iii) Other Livery, Taxi Trips

Trips by livery and taxi other than those listed in (i) and (ii) above are arranged and authorized by the District Office, as follows:

- (aa) the request for transportation is made to the District Office by the recipient, the medical provider, or someone acting on behalf of the recipient;
- (bb) the District Office is responsible for verifying that the trip is for a medical purpose, and that the particular type of transportation is appropriate, necessary, and the least costly means; and if so
- (cc) the District Office will then arrange and authorize the trip.
- (iv) Bus, Train and Private Transportation

No prior authorization is required for trips within the same town, however, reimbursement will be made to the Medicaid recipient, only if the Department receives documentation of a visit to a medical provider. Documentation consists of a signed statement by the medical provider or his authorized representative, or a completed Departmental W-610 Form. Requests for transportation reimbursement must be made within thirty (30) days of the date of the transportation need.

Trips between towns require prior authorization. These trips are approved and arranged by the District Office, as follows:

- (aa) the request for transportation is made to the District Office by the recipient, the medical provider, or someone acting on behalf of the recipient;
- (bb) the District Office is responsible for verifying that the trip is for a medical purpose, and that the particular type of transportation is appropriate, necessary, and the least costly means; and if so
- (cc) the District Office will arrange and authorize the trip; and then
- (dd) the District Office arranges for reimbursement to be sent to the recipient.
- (v) Other Commercial Carrier

When non-emergency transportation involves other commercial carriers, prior authorization must be obtained from the District Office. The District Office will either arrange the transportation through a travel agent or the provider of service.

- (vi) Air Transportation

Air transportation requires prior authorization from the Department's Central Office to be obtained as follows:

- (aa) The request for transportation is made to the Central Office by the District Office, recipient, medical provider, or someone acting on behalf of the recipient.
- (bb) Central Office will determine:
  - (11) if the medical service for which transportation is needed requires prior authorization, that the authorization has been approved;
  - (22) if the service is out-of-state, that the service meets the criteria for out-of-state services; and
  - (33) if air transportation is the most appropriate level of transportation, and, if so, will contact the ticket agent to make the arrangements.

(g) **Other**

(1) When two or more providers offer the same service, the least expensive one is used; there is no obligation to divide the business between them.

(2) When two or more providers offer the same service, at the same rate, the Department may consider whether to divide the business between them in proportion to the quantity of business each provider can furnish and based on a provider's past performance and any other factors the Department may deem appropriate. Whether to divide the business and how to divide the business shall be determined by the Department in its sole discretion.

(3) The Department shall not pay for transportation to a medical service if the provider of that medical service furnishes free transportation or has an obligation to furnish transportation.

(4) Providers of medical transportation must maintain records to support claims made for payment, including, but not limited to, daily drivers logs and other documents which record at least for each trip: patient's name, license number of vehicle used, the vehicle's pickup and drop-off time and place, the name of an attendant, if one is used, and the vehicle's pickup and drop off odometer reading for all out-of-state trips. All documentation shall be made available upon request to authorized Department, state and federal personnel in accordance with state and federal law.

(5) In addition to the records all providers must maintain for the Department, livery and taxi providers must keep a log for services that could not be authorized in advance, which is signed by a recipient when a transportation service is received.

(6) If the most appropriate transportation is not available, and prior authorization was not received for the alternative method of transportation utilized, the transportation company providing the service must document in the records and on the billing form why the appropriate transportation was not available. The Department in its sole discretion shall determine which level of payment is appropriate.

(7) The Department reserves the right to consider recipient and Departmental needs, when selecting which provider will render the service.

(8) Livery providers are responsible for alerting the recipient of the vehicle's arrival and assisting the recipient into and out of the vehicle.

(9) Mileage for a vehicle crossing Connecticut town lines is calculated and paid by the Department to providers according to the PUCA Document.

(10) The Department, in its sole discretion, may disallow some or all of the reimbursement paid to the provider for services rendered by a vehicle which was out of compliance with any of the requirements of subsection (c) Provider Participation as set forth above. The Department, in its sole discretion, in addition to, or in lieu of the disallowance of reimbursement, may suspend or terminate the provider from the Medicaid Program for any such violation.

(11) **Nursing Homes**

(A) Nursing home staff is responsible for assisting recipients to and from a livery vehicle at the nursing home site.

(B) Nursing home staff is responsible for determining if the cost of providing the medical service in the nursing home is less costly than providing the medical service outside the home. This cost effective determination would include the consideration of the cost of the transportation and the medical service compared to the cost of providing the medical service in the nursing home. When possible and appropriate, the needed medical service should be provided in the nursing home. If it is necessary to transport a recipient to a medical service because a medical

provider is not available to come to the home, written documentation must be entered in the recipient's case record.

(12) Payment for transportation may be made for an applicant with the Department, when the transportation is to a medical evaluation requested by the Department in order to determine eligibility.

(13) Failure to maintain any of the documentation required by this regulation may result in the Department disallowing some or all of the reimbursement paid to the provider for services rendered.

(h) **Billing**

(1) Ambulance, Invalid Coach and Travel Agents

The provider submits the bill for service on the HCFA 1500, "Health Insurance Claim Form," to the Department's fiscal agent.

(2) Livery

The provider of service submits the bill on the Departmental livery claim form to the Department's fiscal agent.

(3) Taxi

The provider of service submits the bill on the Departmental taxi claim form to the Department's fiscal agent.

(i) **Payment**

(1) For all transportation payment shall be made at the lower of:

(A) The usual and customary charge to the public, if applicable

(B) The Medicare rate, if one exists

(C) The fee, as published by the Department in its fee schedule or

(D) The amount requested or billed

(2) Ambulance

Ambulance providers may be paid for a trip, I.V. level life support services, advanced life support services, waiting time, loaded mileage, additional recipient transported, a night call charge, special attendant, paramedic intercept, helicopter assist, out-of-state tolls and for services provided to a recipient who is not subsequently transported by the ambulance provider in accordance with this regulation.

(3) Invalid Coach

Invalid coach providers may be paid for a trip, waiting time, loaded mileage, additional recipient transported and attendant services in accordance with this regulation.

(4) Livery

Livery providers may be paid for a trip, loaded mileage, additional stops, waiting time, assistance, "no shows", and out-of-state tolls in accordance with this regulation.

(5) Taxi

Taxi providers may be paid for trips by an all inclusive metered rate and out-of-state tolls in accordance with this regulation.

(6) Wheelchair Accessible Livery

Wheelchair accessible livery providers may be paid for a trip, waiting time, loaded mileage, an additional recipient transported, and out-of-state tolls attendant services in accordance with this regulation.

(7) Payment may be made to:

(A) the provider of service if an ambulance, invalid coach, taxi, or livery provider;

(B) either the provider of the service, or an enrolled ticket agent, if the provider of service is any other commercial carrier except bus, or train;

(C) the Medicaid recipient, if the transportation is by private means, bus or train.

(8) Payment Fees

(A) The Commissioner of the Department establishes the fees contained in the Department's fee schedule.

(B) Payment fees for out-of-state trips performed by out-of-state providers shall be established by the Commissioner of the Department.

(C) The maximum payment for transportation services shall be at the fees established by the Department.

(D) Wheelchair Accessible Livery.

The Department's fees for wheelchair accessible livery shall be the same as the Department's fees for invalid coach services.

(E) Private Transportation

Payment may be made at the per mile fee established by the Department, but only if the total payment exceeds \$1.00.

(F) Other Commercial Carrier and Air Transportation

Payment may be made at the lowest charge to the general public for the same service.

(9) Payment Limitations

(A) Multiple Passengers—Taxi

Taxi services are paid by the metered rate, regardless of the number of recipients transported.

(B) Multiple Passengers—Livery

(i) If during a trip, a livery vehicle picks up more than one recipient at the same point and transports those recipients to the same destination, the livery service may be paid as if the service were provided for one recipient.

(ii) In the event that a livery provider picks up several Medicaid recipients at several different pickup points and drops those recipients off at one common destination point, the livery provider may be paid one base rate, plus a shared ride fee for each additional pickup point. If the provider picks up several Medicaid recipients at one pickup point, and drops those passengers off at several different destination points, the livery provider may be paid one base rate, plus a shared ride fee for each additional drop-off point. If more than one recipient is picked up or dropped off at any additional stop, only one shared ride fee shall be paid for that stop.

(iii) In the event that a livery provider picks up several Medicaid recipients each at a different pickup point and drops those recipients off each at a different destination point (i.e. no common pickup or drop-off points) and all pickups and drop-offs occur within the same town, the livery provider may be paid one base rate for each recipient transported.

(iv) In the event that a livery provider picks up several Medicaid recipients each at a different pickup point and drops those recipients off each at a different destination point (i.e. no common pickup or drop-off points) and the trip involves loaded mileage between towns, the livery provider may be paid one base rate plus a shared ride fee for each additional drop-off point plus one loaded mileage charge for each unduplicated portion of the trip mileage. If multiple recipients are in the vehicle and travel together during a portion of the trip, only one mileage charge shall be paid for the common portion of the trip.

(v) Only one loaded mileage charge may be paid for the total miles traveled between towns, regardless of the number of recipients transported. If multiple recipients are transported in one trip, the total mileage for the trip cannot be charged for each recipient. Mileage between towns is calculated and paid according to the PUCA Document.

## (C) Cancelled Calls

The Department shall not pay for cancelled calls for any type of transportation.

## (D) No Show

The Department may pay for a livery service approved in writing by the Department and not cancelled, which a recipient does not utilize, provided the vehicle went to the pickup point. For livery the base rate may be paid for a “no show” for single recipient trips. For multiple recipient trips, a base rate or an additional stop, whichever is appropriate, and mileage if appropriate may be paid for the portion of the trip incurred for the “no show.” A “no show” fee will not be paid for nursing home residents.

## (E) Waiting Time

Waiting time shall only be paid when it is cost effective or the Department has determined it is necessary in order for a recipient to receive a medical service.

## (i) Ambulance

One-hour’s waiting time may be paid for all or any portion of the first hour. After one hour of actual waiting time, additional waiting time may be paid in fifteen (15) minute increments for all or any portion of the fifteen minutes.

When waiting time is provided as part of a round trip, the Department shall not pay for two base rates and waiting time. One base rate and waiting time may be paid.

## (ii) Invalid Coach

No payment shall be made for the first one-half hour of waiting; thereafter waiting time may be paid in fifteen (15) minute increments for all or any portion of the fifteen minutes.

When waiting time is provided as part of a round trip, the Department shall not pay for two base rates and waiting time. One base rate and waiting time may be paid.

## (iii) Livery

No payment shall be made for the first fifteen minutes of waiting; thereafter waiting time will be paid in 15 minute increments for all or any of the fifteen minutes.

When waiting time is provided as part of a round trip, the Department shall not pay for two trips and waiting time. One trip and waiting time may be paid.

## (iv) Taxi

Waiting time may be paid in accordance with the tariff established by the Department of Transportation and/or a state approved transit district and is considered part of the metered rate.

## (F) Mileage

## (i) Ambulance

The Department may pay for loaded mileage if the vehicle must cross a town line in order to transport a recipient(s) to or from a medical provider. Loaded mileage shall be paid and calculated by the Department in accordance with PUCA Docket #6770-A and all its supplements.

## (ii) Invalid Coach

The Department may pay for loaded mileage if the vehicle must cross a town line in order to transport a recipient(s) to or from a medical provider. Loaded mileage shall be paid and calculated by the Department in accordance with PUCA Docket #6670-A and all its supplements.

## (iii) Livery

(aa) The Department may pay loaded mileage for livery if the vehicle must cross a town line in order to transport a recipient(s) to or from a medical provider. This mileage shall be paid and calculated by the Department in accordance with PUCA Docket #6670-A and all its supplements.

(bb) Wheelchair accessible livery may be paid at the same fees as invalid coach.

(iv) Taxi

Mileage may be paid in accordance with the tariff established by the Department of Transportation and/or a state approved transit district and is considered part of the metered rate.

(G) Attendant

Invalid Coach

Attendant services may be paid when provided by an employee other than the driver.

(H) Assistance

Livery

Livery assistance services provided by the driver or another employee may be paid for each recipient assisted. Payment may be made for assistance at either or both the pickup point and drop-off point except assistance from or into a nursing home from a livery vehicle will not be covered. Physically helping a recipient only into or out of the livery vehicle is not considered assistance.

(I) Items Included in Fees

All payment rates include all expenses, including tolls and telephone calls.

(J) Private Transportation

Payment shall be made based on the mileage from the recipient's home to the medical provider.

(j) **Rates**

Payment is in accordance with the following schedule:

	<u>Ambulance</u>	<u>Invalid Coach</u>	<u>Wheelchair Livery</u>	<u>Livery</u>	<u>Taxi</u>
Trip (Base Rate)	X	X	X	X	Metered Rate
Waiting Time	X	X	X	X	All inclusive
Loaded Mileage	X	X	X	X	
Additional Pt.	X	X	X		
Additional Stop				X	
Attendant		X	X		
Special Attendant	X				
Assistance				X	
Advanced Life	X				
I.V. Level	X				
Paramedic Intercept	X				
No Show				X	
Night Call Charge	X				
Out-of-State Tolls	X	X	X	X	X
Helicopter Assist	X				
Special Services	X				

### Appendix A

The following are the diagnoses codes which would be acceptable justification for invalid coach transportation. Invalid coach trips with these diagnoses do not require prior authorization.

170.2	Malignant neoplasm of bone, vertical column
170.6	Malignant neoplasm of bone, pelvic bones, sacrum, and coccyx
170.7	Malignant neoplasm of bone, long bones of lower limb
170.8	Malignant neoplasm of bone, short bones of lower limb
333.4	Huntington's chorea
334.0	Friedreich's Ataxia
342	Hemiplegia
344.0	Quadriplegia
344.1	Paraplegia
357.2	Diabetic Neuropathy
444.22	Thrombosis—lower extremity
820	Fx neck femur (within six (6) months)
822	Fx patella (within six (6) months)
823	Fx tibia and fibula (within six (6) months)
896	Below knee amputation
897	Above knee amputation

### Appendix B

The following are conditions which would be acceptable justification for non-emergency ambulance. Non-emergency ambulance trips for clients with these conditions or needing these services do not require prior authorization.

Casts Which Prevent Hip Flexion  
 Four Point Restraints  
 Comatose  
 Intravenous Running  
 Suctioning During Transport  
 Isolette  
 Prone Positioning (e.g. due to decubiti or skin flaps)  
 (Effective July 25, 1989)

#### Sec. 17-134d-34. Reserved

#### Orthodontic Services Provided Under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program

#### Sec. 17-134d-35. Orthodontic services provided under the early and periodic screening, diagnosis and treatment (EPSDT) program

(a) **Orthodontic services will be paid for when**

- (1) provided by a qualified dentist; and
- (2) deemed medically necessary as described in these regulations.

(b) **Definition**

- (1) Qualified Dentist

“Qualified Dentist” means a dentist who:

(A) Holds himself out to be an orthodontist in accordance with section 20-106a of the Connecticut State Statutes, or

(B) Documents completion of an American Dental Association accredited post graduate continuing education course consisting of a minimum of two (2) years of orthodontic seminars, and/or submitting three (3) completed case histories with a comparable degree of difficulty as those cases meeting the department's requirements in section (e) of the department's orthodontic policy if requested by the orthodontic consultant.

(2) The Department

“The Department” means the State Department of Income Maintenance.

(3) Preliminary Handicapping Malocclusion Assessment Record

“Preliminary Handicapping Malocclusion Assessment Record” means the method of determining the degree of malocclusion and eligibility for orthodontic services. Such assessment is completed prior to performing the comprehensive diagnostic assessment.

(4) Comprehensive Diagnostic Assessment

“Comprehensive Diagnostic Assessment” means a minimum evaluative tool for an orthodontic case which determines the plan for treatment necessary to correct the malocclusion. The assessment includes, but is not limited to, the following diagnostic measures: Radiographs; full face and profile photographs or color slides.

**(c) Services Covered and Limitations**

The Department may reimburse a qualified dentist for the following orthodontic services (including permanent and/or deciduous dentition);

(1) Orthodontic screening—one (1) per provider of the same recipient;

(2) Orthodontic consultation—one (1) per provider for the same recipient;

(3) Preliminary assessment study models—one (1) per provider for the same recipient;

(4) Comprehensive diagnostic assessment—one (1) per provider for the same recipient;

(5) Initial appliance—one (1) per provider for the same recipient;

(6) Active Treatment—up to a maximum of thirty (30) months;

(7) Retainer appliances—retainers may be replaced only once, per dental arch, for the same recipient.

**(d) Other Limitations**

Orthodontic services are limited to recipients under twenty-one (21) years of age.

**(e) Need for Services**

When an eligible recipient is determined to have a malocclusion, the attending dentist should refer the recipient to a qualified dentist for preliminary examination of the degree of malocclusion.

(1) The need for orthodontic services shall be determined on the basis of the magnitude of the malocclusion. Accordingly, the “Preliminary Handicapping Malocclusion Assessment Record,” available from the Department, must be fully completed in accordance with the instructions sections of the form. The Department deems orthodontic services to be medically necessary when a correctly scored total of twenty-four (24) points or greater is calculated from the preliminary assessment. However, if the total score is less than twenty-four (24) points the Department shall consider additional information of a substantial nature about the presence of other severe deviations affecting the mouth and underlying structures. Other deviations shall be considered to be severe if, left untreated, they would cause irreversible damage to the teeth and underlying structures.

(2) If the total score is less than twenty-four (24) points the Department shall consider additional information of a substantial nature about the presence of severe

mental, emotional, and/or behavior problems, disturbances or dysfunctions, as defined in the most current edition of the Diagnostic Statistical Manual of the American Psychiatric Association, and which may be caused by the recipient's daily functioning. The department will only consider cases where a diagnostic evaluation has been performed by a licensed psychiatrist or a licensed psychologist who has accordingly limited his or her practice to child psychiatry or child psychology. The evaluation must clearly and substantially document how the dentofacial deformity is related to the child's mental, emotional, and/or behavior problems. And that orthodontic treatment is necessary and, in this case, will significantly ameliorate the problems.

(3) A recipient who becomes Medicaid eligible and is already receiving orthodontic treatment must demonstrate that the need for service requirements specified in subsections (e) (1) and (2) of these regulations were met before orthodontic treatment commenced, meaning that prior to the onset of treatment the recipient would have met the need for services requirements.

(f) **Prior Authorization**

(1) Prior authorization is required for the comprehensive diagnostic assessment. The qualified dentist shall submit:

- (A) the authorization request form;
- (B) the completed Preliminary Handicapping Malocclusion Assessment Record;
- (C) Preliminary assessment study models of the patient's dentition; and,
- (D) additional supportive information about the presence of other severe deviations described in Section (e) (if necessary).

The study models must clearly show the occlusal deviations and support the total point score of the preliminary assessment. If the qualified dentist receives authorization from the Department he may proceed with the diagnostic assessment.

(2) Prior authorization is required for orthodontic treatment for the initial appliance; first, second, and third year of active treatment; and for replacement of retainers. No authorization shall be given if there is evidence that little or no progress has been made at the end of each yearly period. In this case, the qualified dentist shall be required to resubmit the authorization request. The authorization shall be based on reasonable progress made in active treatment as deemed by the Department. There will be no monthly payment allowed during this period.

(A) For the initial appliance and the first year of active treatment (1st through 12th month) the qualified dentist shall submit, prior to initiating treatment:

- (i) the authorization request form;
- (ii) the diagnosis;
- (iii) a written treatment plan;
- (iv) a description of the appliance to be utilized;
- (v) the length of time treatment is necessary;
- (vi) the length of the retention period necessary after active treatment;
- (vii) a list of all other medical or dental treatment which is necessary in preparation for, or completion of, the orthodontic treatment.

(B) For the second year of active treatment (13th through 24th month) the qualified dentist shall submit, prior to initiating continued treatment:

- (i) the authorization request form covering the second (2nd) year of active treatment;
- (ii) study models and/or photographs clearly showing the progress of treatment to date.

(C) For the third (3rd) year of active treatment (25th through 30th month) the qualified dentist shall submit prior to initiating continued treatment:

- (i) the authorization request form covering the third (3rd) year of active treatment;
- (ii) study models and/or photographs clearly showing the case is ready for retention.

(D) Replacement of retainers with documentation to justify.

(E) Any requests for modification of the treatment plan as authorized by the Department's orthodontic consultant must be submitted to the orthodontic consultant in writing providing evidence in support of such a request. However, no authorization shall be given beyond thirty (30) months of active treatment.

(g) **Other Requirements**

(1) The recipients, together with the parent or guardian, should have the desire and the ability to complete an extended treatment plan as determined by the qualified dentist performing the treatment or other professionals involved with the recipient or family.

(2) When an orthodontic case is authorized by the Department, local Early Periodic Screening, Diagnostic and Treatment (EPSDT) staff will contact the recipient and the qualified dentist to help facilitate the recipient's participation in and completion of the treatment plan.

(3) The course of orthodontic treatment must be completed prior to the recipient's twenty first (21st) birthday.

(4) The qualified dentist shall maintain a specific record for each recipient eligible for Medicaid reimbursement including, but not limited to: name, address, birth date, Medicaid identification number, pertinent diagnostic information and X-ray, a current treatment plan, pertinent treatment notes signed by the qualified dentist; and documentation of the dates of service. Records or documentation must be maintained for a minimum of five (5) years.

(5) For the retention period the qualified dentist shall submit, prior to initiating placement of retainers, study models and/or photographs clearly showing the case is ready for retention.

(h) **Payment Limitation**

(1) Payment for orthodontic services shall be made in accordance with the Department's dental fee schedule.

(2) An initial payment and monthly payments are made for active treatment of orthodontic services.

(3) The initial payment covers the placement of the initial appliances.

(4) No payment is made for monitoring growth and development.

(5) A dentist, other than a qualified dentist as defined in these regulations, may receive payment for an orthodontic screening. The screening includes an oral examination and/or examination of the patient's records for the purposes of completing Sections I, II and IIIA-D of the Preliminary Handicapping Malocclusion Assessment Record Form No. W-1428.

(6) The fee for the orthodontic consultation includes a dental screening and the completion of the preliminary assessment form. No separate payment shall be made to a qualified dentist for the orthodontic screening.

(7) The number of monthly payments is limited to the number of months of active treatment stipulated in the treatment plan as approved by the Department.

(8) The monthly installment rate for active treatment is based on an average of one (1) visit per month and will be payable once a month during the authorized

active treatment period no matter how many times the orthodontist sees the patient during this period.

(9) Payment for the comprehensive diagnostic assessment includes all diagnostic measure, e.g., X-rays, photographs or slides, and the written treatment plan. No separate payment is made for individual diagnostic materials except the preliminary assessment study models.

(10) For a recipient who becomes ineligible for Medicaid during the authorized term of active treatment, the final payment from the Department shall be made for the month in which the recipient becomes ineligible for Medicaid or EPSDT services, whichever comes first.

(11) The cost of the initial retainer appliance, including: fitting, adjustments and all necessary visits, is included in the first twenty-four (24) monthly active treatment installments.

(12) The fee for the replacement of retainer appliances includes the fitting and all necessary visits.

(Effective January 27, 1988)

### **Sec. 17-134d-36. Administratively necessary days**

(a) Administratively Necessary Days are inpatient hospital days reimbursed by Medicaid for services to a Title XIX eligible patient and to a patient who will eventually be determined eligible. A patient qualifying for ANDs does not require an acute hospital level-of-care. Instead, the patient requires medical services at the skilled nursing or intermediate level-of-care. The patient is forced to remain in the hospital because the appropriate medical level-of-care placement in the skilled nursing or intermediate care facility is not available.

(b) ANDs are covered under the Title XIX program when the following procedures and conditions are met:

(1) The Medicaid patient is no longer at the acute care level of service but is at a skilled nursing level-of-care or at an intermediate level-of-care;

(2) Discharge to a skilled nursing facility or intermediate care facility level-of-care bed is impossible due to the unavailability of a bed;

(3) The patient's timely discharge and placement to the appropriate skilled nursing facility or intermediate care facility is planned and arranged by the hospital. Clear evidence of this active and continuous process is documented in the patient's hospital medical record;

(4) The hospital places the patient who is on administratively necessary day one (1) through administratively necessary day seven (7) on the active waiting list at five (5) skilled nursing facilities or intermediate care facilities, whichever is medically appropriate;

(5) In cases where additional ANDs are necessary beyond the seventh (7) day the hospital places the patient on the active waiting list of an additional five (5) facilities. The hospital is required to maintain the patient on the active waiting list of a minimum of ten (10) facilities at all times after the seventh (7) administratively necessary day.

(A) All contacts made by the hospital to facilities must be clearly documented in the patient's medical record with dates of contact and facility name;

(B) After the patient is discharged the name of the facility must be recorded in the patient's medical record.

(6) The patient receiving ANDs accepts the first available skilled nursing or intermediate care facility placement in the State of Connecticut that is medically appropriate.

(A) The Department will not pay for ANDs when the patient refuses to be placed in the first available facility. Payment ceases on the day of refusal.

(B) If the patient refuses the first available placement the hospital sends the following information to the Medical Director for Medicaid, Department of Income Maintenance, 110 Bartholomew Avenue, Hartford, CT 06106:

- Name and address of person refusing bed
- Patient's name and address (if different)
- Medicaid Number (if available)
- Name of hospital
- Date of admission
- Date bed available
- Name and address of facility with bed
- Date bed refused
- Reason for refusal

(C) The requirements in the Medical Services Policy, 150.1 F. IX, a., regarding prior authorization requirements for ANDs are repealed.

(D) ANDs shall be reviewed by the Department in accordance with Medical Services Policy on utilization review, 150.1 F. I.-V., as it exists now or as it may be amended from time to time.

(Effective October 1, 1986)

### **Coverage of Occupational Therapy Services by Home Health Agencies**

#### **Sec. 17-134d-37.**

Repealed, March 7, 2007.

#### **Sec. 17-134d-38. Reserved**

#### **Sec. 17-134d-39. Reimbursement plan for medical transportation under the medical assistance program**

(a) Medical Transportation Services provided under the Medical Assistance Program will be purchased through a Volume Purchase Plan (V.P.P.), if this method will be more cost efficient than the present method of reimbursement, which is based on a fee schedule and metered rate for taxi.

(b) Under the V.P.P. the Department will contract with a provider(s) who will provide one or more of the designated types of transportation. Such providers must meet state licensure requirements, certification and registration requirements, current Departmental Medical Assistance requirements and provide the most cost efficient medical transportation service available.

(c) The V.P.P. will be implemented through a competitive bidding process. The Department will define geographical areas, populations to be served and the type of transportation needed by the identified populations. These elements will be identified by the Department for purposes of the competitive bidding process.

(d) In order to assure that competitive bidding will result in cost savings to the State, the geographical area covered by the proposed bid must account for a minimum of ten percent (10%) of total expenditures for that particular type of transportation, and the estimated savings to the State resulting from the proposed bid must be at least 10 percent (10%) of the total expenditures for that particular type of transportation in that geographical area, or the Department will not award a contract.

(e) The contract will be awarded to the lowest responsible bidder(s), with the Department reserving the right to reject all or any bid and not award a contract to any of the bidders, if this best serves the interests of the State. The Department also reserves the right to award a contract for one, some, or all of the different types of medical transportation provided under the Medical Assistance Program.

(Effective September 30, 1986)

**Sec. 17-134d-40. Acute care hospital outpatient clinic reimbursement rate  
Hospital Outpatient Clinic Visit Rates**

Each outpatient clinic visit shall be reimbursed at a reasonable rate to be determined by the reasonable cost of such services, not to exceed one hundred sixteen percent (116%) of the combined average fee of the general practitioner and specialist for an office visit according to the fee schedule for practitioners of the healing arts approved under Section 4-67C of State Statutes.

(Effective June 27, 1986)

**Long Term Care Facility Preadmission Screening  
and Community Based Services Program**

**Sec. 17-134d-41.**

Repealed, July 8, 1998.

See § 17b-342

**Sec. 17-134d-42. Reserved**

**Sec. 17-134d-43. Medicaid requirements for organ transplantation**

(a) Organ transplantations are covered under the Medicaid program if they are of demonstrated therapeutic value, medically necessary and medically appropriate, and likely to result in the prolongation and the improvement in the quality of life of the applicant.

(b) The following organ transplantations have been deemed to satisfy the criteria of subsection (a) of section 17-134d-43, in all cases, and the costs associated with such procedures will be covered under Medicaid without the necessity of the patient obtaining prior authorization from the Department:

- (1) bone;
- (2) bone marrow;
- (3) kidney;
- (4) cornea.

(c) Except as provided in subsection (b) of section 17-134d-43, prior authorization must be obtained from the Department before the costs associated with an organ transplantation will be covered under Medicaid.

(d) The final decision as to whether authorization will be granted for a patient to incur Medicaid covered costs associated with an organ transplantation is made by the Department on a case-by-case basis. No such authorization will be granted unless the Department is fully satisfied that the conditions of subsection (a) of section 17-134d-43 have been met.

(e) In order to assist the Department in determining whether a request for prior authorization satisfies the criteria of subsection (a) of section 17-134d-43, there has been established a Transplant Advisory Committee of the Department of Income Maintenance. The members of the committee are appointed by the Commissioner, provide the Department with technical assistance and expertise in the field of organ transplantation, and are drawn from the medical health and insurance communities.

(f) The Transplant Advisory committee has developed, and continues to review and modify, specific medical criteria as they relate to particular organ transplantation procedures. In addition, the committee may provide technical assistance to the

Department in reviewing a particular prior authorization request. In no event, however, are the criteria (guidelines) or recommendations of the committee binding on the Department. A final decision that a prior authorization request fails to satisfy the provisions of subsection (a) of section 17-134d-43 would not be rendered without considering the medical opinion of a qualified organ transplantation expert(s) in the community.

(g) The medical criteria developed by the Transplantation Advisory Committee, and any amendments thereto, are on file in the Department and available to all interested parties. The advisory nature of any such criteria, to assist the Department in determining whether the subsection (a) of section 17-134d-43 prior authorization standards have been satisfied, is emphasized.

(Effective May 1, 1987)

**Sec. 17-134d-44. Reserved**

**Sec. 17-134d-45.**

Repealed, July 11, 2011.

**Sec. 17-134d-46. Customized wheelchairs in nursing facilities as defined in 42 USC 1396r(a), as amended from time to time, and ICFs/MR as defined in 42 USC 1396(d)d, as amended from time to time**

**(a) Conditions of Participation**

Nursing facilities as defined in 42 USC 1396r(a), as amended from time to time, and ICFs/MR as defined in 42 USC 1396(d)d, as amended from time to time, are required as conditions of participation in the Medical Assistance Program to provide or to arrange for the provision of customized wheelchairs and related services on behalf of Title XIX assisted patients who require such customized wheelchairs and related services.

**(b) Definition of Customized Wheelchair**

A customized wheelchair is defined as a wheelchair specifically manufactured to meet the special medical, physical and psychosocial needs of a recipient who cannot independently maintain proper body alignment. The wheelchair must be individualized to preclude the use of the wheelchair by any other person except the recipient for whom it was originally developed.

**(c) Identification of Potential Patients**

Nursing facilities and ICFs/MR shall identify Title XIX patients who potentially require customized wheelchairs as a result of the patient's possessing certain physical disabilities. These physical disabilities would be of such a nature as to require adaptations to a standard wheelchair needed to support and properly position the disabled person's body in proper body alignment in a wheelchair. An Interdisciplinary Team (IDT) assessment shall be performed in accordance with subsections (d) through and including (h) of this section as follows for each disabled person who potentially requires a customized wheelchair. The IDT assessment shall determine whether or not such person in fact requires a customized wheelchair, and shall determine the appropriate design and characteristic of any such customized wheelchair. It is the facility's obligation to identify recipients who may require customized wheelchairs and related services, and to initiate required interdisciplinary assessments. The Department's medical review teams may identify patients who potentially

require such services in the regular course of periodic inspections of the adequacy of care provided by such facilities. Upon notification from the Department that a Title XIX assisted patient may require a customized wheelchair and related services, nursing facilities and ICFs/MR are required to conduct an interdisciplinary assessment in accordance with subsections (d) through and including (h) of this section.

**(d) Assessment Appropriateness**

An assessment of a disabled patient's need for a customized wheelchair must be made whenever an assessment is appropriate. This is indicated by the presence of disabilities which preclude effective use of a standard wheelchair, and which require adaptations to be made to a wheelchair to properly position and support the disabled person's body.

**(e) Composition of Interdisciplinary (IDT) Team**

(1) An assessment to be adequate must be made by an Interdisciplinary Team (IDT) process. The IDT shall include at a minimum, the participation of all the following:

- (A) The patient's attending physician;
- (B) A physician who is board certified or board eligible in orthopedics or physical medicine;
- (C) A registered physical therapist (RPT) who is licensed by the State of Connecticut and is qualified to assess the patient's needs or by a registered occupational therapist who is licensed by the State of Connecticut (L/OTR) and qualified to assess the patient's needs; and
- (D) A representative of the professional nursing staff of the facility (registered nurse) or licensed practical nurse.

(2) The Interdisciplinary Team may include any other professional deemed appropriate to assess the patient's needs.

(f) **Purpose of the ID Team**

(1) The purpose of the Interdisciplinary Team is as follows:

- (A) To ensure appropriate assessment of the patient's need for a customized wheelchair;
- (B) To ensure appropriate design of any required customized wheelchair; and
- (C) To provide appropriate instructions to the facility on the appropriate use and maintenance of the customized wheel chair.

(2) It is not necessary that all of the members of the Interdisciplinary Team required by this subsection for purposes of assessment be members of the staff of the facility or be retained on an ongoing basis as consulting members of a standing facility-based Interdisciplinary Team.

(3) Nursing facilities and ICFs/MR are encouraged to obtain the required Interdisciplinary Team assessment of a patient's need for an adaptive wheelchair by arranging for consultations by qualified orthopedists, physiatrists, physical therapists, and occupational therapists who have experience in the provision of such equipment on behalf of disabled patients.

(g) **Facilitator**

(1) The description of a Facilitator is as follows:

A professional member of the staff of the facility or regularly retained consultant to the facility shall be nominated as the "facilitator" of the Interdisciplinary Team and may include the attending physician, a registered physical therapist, a registered speech therapist, a registered occupational therapist, or a registered nurse. Preferably, the facilitator should be a registered physical therapist or registered occupational therapist.

(2) Responsibilities of the Facilitator

The individual selected by the facility is responsible for all the following:

- (A) Must attend and participate in the assessment performed by the orthopedist or physiatrist;
- (B) Must attend and participate in any assessment performed by a physical or occupational therapist (if such physical or occupational therapist is not also the facilitator);
- (C) Be responsible to ensure that all required assessments are performed; and
- (D) Ensure that all required documentation is processed in a timely fashion, and that communication with the vendor is maintained throughout the prior authorization process.

(h) **IDT Assessment Requirements**

The recipient must receive all of the following:

- (1) A physical examination by the attending physician;
- (2) An orthopedic or psychiatric examination by an orthopedist or physiatrist; and

(3) A rehabilitative examination by a physical therapist or occupational therapist. The examinations shall be a part of the recipient's medical records and must have been done within three (3) months prior to the date of request for a customized wheelchair on the Form W619, see subsection (j) of this section. The examinations shall include films as deemed appropriate by the attending physician and the medical consultant.

(i) **Application Process for Customized Wheelchair**

(1) Requirements of Facility

Nursing facilities and ICFs/MR shall incorporate the required IDT assessments into the patient care plan. Whenever the required interdisciplinary assessment indicates that a Title XIX assisted patient requires a customized wheelchair, the facility is required to arrange with the supplier of durable medical equipment for the provision of an appropriate customized wheelchair.

**(2) Prior Authorization Requirements**

Prior authorization by the Department is required in order for the Department to make payment to a supplier of durable medical equipment for the cost of a customized wheelchair. Prior authorization procedures must be followed in accordance with Section 189 (Durable Medical Equipment) of the Department's Medical Services Policy Manual.

**(j) Inservice Training**

(1) The Durable Medical Equipment provider is responsible on date of delivery to assist in the teaching and training of the recipient and nursing facility staff as to the proper use and care of the customized wheelchair. Date of delivery is defined as the final delivery of the product as authorized on the Form W619 "Authorization Request for Medical and Surgical Supplies" and Form W628 "Customized Wheelchair Prescription," with the customized wheelchair set up and in place at the recipient's place of residence.

(2) The monitor, see subsection (1) (2) of this section, shall ensure that the nursing staff of the facility (including all direct care staff who provide basic care on behalf of the patient) receive appropriate training in the proper use and care of the customized wheelchair.

(3) Documentation of all inservice training must be evident.

**(k) Twenty-four (24) Hour Positioning Plan****(1) Responsibility for Development**

A 24 hour positioning plan must be in place on the date of the delivery of the customized wheelchair. The 24 hour positioning plan must be developed by the professional staff of the facility (nursing, physical, occupational, or speech therapy in conjunction with the attending physician), monitored as per subsection (1) (2) of this section and incorporated into the patient's plan of care pursuant to an order of the attending physician.

**(2) Components of Twenty-four (24) Hour Positioning Plan**

The 24 hour positioning plan shall describe periods of time when the patient shall be seated in the customized wheelchair and shall also describe a time schedule for the patient to be therapeutically positioned in bed, on mats or with other pieces of adaptive equipment. The positioning plan shall take into account the patient's ability to be seated in a customized wheelchair for limited or extended periods of time, depending on the circumstances of the patient. Emphasis must be placed on seating the patient in a customized wheelchair at mealtime. The positioning plan must be modified, as needed, depending on the circumstances of the patient in order to promote enhanced psychosocial functioning made possible by seating in a customized wheelchair for longer periods of time as the patient develops increased physical capacity for being adaptively seated. The 24 hour positioning plan adopted by the attending physician must indicate the name and title of the individual responsible for overseeing implementation.

**(l) Monitoring Program Requirement****(1) Establishment of Monitoring Program**

A monitoring program must be established by the professional staff of the facility (nursing, physical therapy, occupational therapy in conjunction with the attending physician) and incorporated into the patient's plan of care pursuant to an order of the attending physician.

**(2) Assignment of Responsibility**

The monitoring program must assign responsibility to a monitor who is an individual member of the professional staff of the facility, identified by name and title, to

monitor the patient's physical adaptation to the customized wheelchair (including monitoring for decubitus or any other adverse health effects) and for monitoring the compliance of the facility's nursing and direct care staff with the 24 hour positioning plan. The monitor is also responsible for overseeing the documentation of all monthly and quarterly progress notes. The monitor shall be the head nurse of the unit in which the patient resides.

(3) Reassessment

In addition, at least yearly, the attending physician in conjunction with the rehabilitative staff must reassess the patient and determine whether or not the design of the customized wheelchair continues to be appropriate to meet the patient's needs.

Payment for X-rays, or orthopedic, psychiatric consultation will be made by the Department if needed as part of the reassessment.

(4) Monthly Progress Notes

A member of the professional nursing staff of the facility must make progress notes at least monthly in the patient's permanent record which shall address any health issues related to use of a customized wheelchair (e.g., any problems or change with the condition of the patient's skin), whether the nursing and direct care staff are complying with instructions on the use of the customized wheelchair and are properly implementing the required 24 hour positioning plan, and whether any modifications should be made on the use of the wheelchair or in the 24 hour positioning plan.

(5) Quarterly Progress Notes

A member of the rehabilitation staff (physical, occupational, or speech therapist) must make progress notes at least quarterly which shall address any health issues related to the customized wheelchair, facility compliance with instructions on the use of the customized wheelchair and the 24 hour positioning program, whether the customized wheelchair continues to be appropriate to meet the needs of the patient and whether any modifications should be made on the use of the customized wheelchair or to the 24 hour positioning plan. In addition, the rehabilitation staff progress notes must consider and make recommendations to the attending physician on whether any other rehabilitation (physical therapy, occupational therapy, or speech therapy) services are indicated as a result of the seating of the patient in a customized wheelchair, e.g., occupational therapy services designed to promote independent feeding.

(6) Maintaining Medical Records

All medical records required by this Section, including any assessments, the plan of care (with incorporated 24 hour positioning plan and monitoring program) and progress notes shall be maintained by the facility and be available for inspection by authorized Department personnel as well as by the personnel of other state agencies who are authorized by law to make investigations concerning the quality of health care.

(m) **Costs and Methods of Payment for Services**

(1) Per Diem Rate Inclusion

All costs pertaining to required physical therapy, occupational therapy, speech therapy and nursing services, including any retention of expert consultancy services for assessment and training purposes as well as the cost of required monitoring services, must be incurred by the facility and are reimbursed to the facility through the per diem rate system established pursuant to Section 17-314 of the Connecticut General Statutes as required for reimbursable nursing facility services.

(2) Direct Payment

The costs of physician services, including attending physician services and consulting orthopedic or psychiatric physician services, as well as the costs of X-ray services and any necessary medical transportation services, are paid directly to the provider of such ancillary services subject to the limitations, conditions and prior authorization requirements contained in Department policy applicable to physician, X-ray and medical transportation services. The cost of the customized wheelchair is paid directly to the durable medical equipment provider as an ancillary service, subject to the limitations, conditions and prior authorization requirements contained in Section 189 (Durable Medical Equipment) of the Department's Medical Services Policy Manual.

**(n) Services Required of Nursing Facilities and ICFs/MR**

Required services related to the provision of customized wheelchairs which nursing facilities and ICFs/MR shall provide as conditions of participation in the Medical Assistance Program are those related services mandated by subsections (c) through (n) of this Section, including all of the following:

- (1) identifying of potential recipients of customized wheelchairs;
- (2) conducting interdisciplinary assessment;
- (3) arranging for and ordering of the customized wheelchair where appropriate;
- (4) training of facility staff (including direct care staff);
- (5) implementing a 24 hour positioning program; and
- (6) developing and implementing a monitoring program including periodic nursing notes and physical, occupational, or speech therapy progress notes.

(Effective April 24, 1989; amended October 1, 2001)

**Sec. 17-134d-47.**

Repealed, October 1, 2001.

**Sec. 17-134d-48.**

Repealed, March 7, 2007.

**Sec. 17-134d-49. Reserved****Sec. 17-134d-50. Medicaid reimbursement clinical diagnostic laboratory services furnished by acute care hospitals****(a) Definitions**

(1) This regulation defines the method of reimbursement of clinical diagnostic laboratory services provided by acute care hospitals to Connecticut Medical Assistance recipients.

(2) For the purposes of this regulation, "Clinical Diagnostic Laboratory Services" means those clinical diagnostic laboratory tests and related specimen collections subject to the statewide Clinical Diagnostic Laboratory Test Fee Schedule established by the State Medicare carrier for outpatient hospital-based laboratories effective July 1, 1984 in accordance with Section 2303 of Public Law 98-369. The procedures covered by this definition shall include or exclude any subsequent additions or deletions made by the State Medicare carrier for outpatient hospital-based laboratories. Each test covered is identified and described using the Health Care Financing Administration Common Procedures Coding System (HCPCS) five (5) digit procedure code and terminology or local codes and descriptions assigned by the State Medicare carrier.

(3) "Hospital Outpatient" means a person who has not been admitted by the hospital as an inpatient but is registered on the hospital records as an outpatient and is directly receiving outpatient hospital services (rather than supplies alone). Where the hospital uses the category "day patient," i.e., a person who directly receives hospital services during the day and is not expected to be lodged in the hospital at midnight, the individual is classified as an outpatient.

(4) "Hospital Nonpatient" means a person who is not registered on the hospital records as an outpatient or is not directly receiving services from the hospital but the hospital provides all or part of the required testing.

(5) For the purposes of these regulations, "hospital" means acute care Connecticut-based or border hospital.

(6) "Department" means the Department of Income Maintenance.

(7) "Rate Year" means beginning January 1, 1987 the Medicaid rate year shall be concurrent with the Medicare rate year.

**(b) Services Covered**

Clinical Diagnostic Laboratory Services, as defined in these regulations, and Specimen Collection Fees, as provided in these regulations, are eligible for payment as set forth below provided the requirements set forth below are met.

**(c) Services Not Subject to the Fee Schedule**

Laboratory tests not subject to the fee schedule pursuant to this regulation include:

(1) Laboratory tests furnished to a hospital inpatient as defined in § 150.1B of the Department's Medical Services Policy Manual;

(2) Those laboratory tests furnished by hospital-based end-stage renal dialysis (ERSD) facilities the cost of which are included in the ERSD composite rate payment;

(3) Laboratory tests and services as identified by the State Medicare carrier to be performed by a physician; and

(4) Certain blood tests and test primarily associated with the provision of blood products as identified by the State Medicare carrier.

(d) **Need for Service**

In order to be eligible for reimbursement any clinical diagnostic laboratory service performed and for which payment is sought must be reasonable, necessary, and furnished under the direction of a physician for the diagnosis or treatment of a particular illness or injury of the patient upon whom the test was performed.

(e) **Payment Rate**

(1) Pursuant to Section 2303 (g) (2) and (j) (2) of Public Law 98-369 enacted effective July 18, 1984, clinical diagnostic laboratory services provided to hospital outpatients and nonpatients and performed on and after July 1, 1984 and paid on or after October 1, 1984 shall be reimbursed no more than the statewide fee schedule for clinical diagnostic laboratory tests, including amounts for specimen collections as permitted under these regulations, established by the State Medicare carrier for outpatient/nonpatient hospital-based laboratories; or the amount of the charges billed for the tests. Effective for outpatient clinical laboratory services rendered on or after July 1, 1986, the rate shall be the lesser of the amount determined under such Medicare fee schedule, the limitation amount for that test pursuant to Section 9303 (b) of the Public Law 99-272 enacted effective July 1, 1986, or the amount of the charges billed for the tests;

(2) In order to remain in compliance with Section 2303 (g) (2) and (j) (2) of Public Law 98-369 for the rate period July 1, 1985 through June 30, 1986 and Section 9303 (b) of the Public Law 99-272 enacted effective July 1, 1986 for the rate period July 1, 1986 through December 31, 1986 and the current rate year, i.e., January 1, 1987 through December 31, 1987 and all subsequent Medicare rate years, the rates for clinical diagnostic laboratory services as defined in these regulations shall be reimbursed as follows:

(A) For the Medicare rate period July 1, 1985 through June 30, 1986, payments by the Department shall be made in accordance with the Medicare Fee Schedule as it existed on July 1, 1985. The rates established by the Department shall be the lesser of the Medicare Fee Schedule for such period or the amount of the charges billed for the tests;

(B) For the Medicare rate period July 1, 1986 through December 31, 1986, the rates established by the Department shall be the lesser of the Medicare Fee Schedule in effect on July 1, 1985, the limitation amount pursuant to Section 9303 (b) of the Public Law 99-272 for the amount of the charges billed for the tests.

(C) For the Medicare rate period beginning on and after January 1, 1987, the rates of payment shall be based upon the lesser of the amount of the Medicare Fee Schedule, the limitation amount pursuant to Section 9303 (b) of the Public Law 99-272 or the amount of the charges billed for the tests;

(D) Any subsequent changes mandated by Congress or of the United States Department of Health and Human Services shall be implemented by the Department as soon as practicable retroactive to the effective date of said mandatory change.

**(f) Payment Limitations**

(1) The amount paid by the Department for the clinical diagnostic laboratory services including amounts for specimen collections as permitted under these regulations constitutes payment in full to the provider hospital.

(2) There is no payment of Medicare coinsurance and deductible for clinical diagnostic laboratory tests subject to these regulations.

(3) When the hospital obtains laboratory tests for outpatients or nonpatients under arrangements with independent laboratories or other hospital laboratories, either the originating hospital (or hospital laboratory) may receive payment for all tests, or the originating hospital and the reference laboratories may receive payment for the tests they perform. The hospital may not receive payment for tests under arrangement if it does not operate a laboratory.

(4) Pursuant to said Section 2303 (g) (2) and (j) (2) of Public Law 98-369, it will be necessary to verify that any amounts expended by the Department between October 1, 1984 and January 31, 1986 inclusive, for clinical diagnostic laboratory tests did not exceed the amount that would be recognized under the Social Security Act by Medicare. If any such payments are found to exceed the amount permitted by Federal law, said amounts shall be adjusted so as not to exceed the maximum amount permitted by Federal law.

(5) The methodology to be employed to accomplish this verification in subsection (f) (4) of these regulations will be one of the two methodologies set forth below at the election of the hospital. However, once a hospital has elected one methodology it may not wait for the results of that methodology and then request the other methodology. Each hospital must notify the Department of its election by March 31, 1986. Failure of a hospital to provide notification of said election or failure of a hospital to provide the necessary information required by whichever option the hospital has selected may result in the Department's deferral of payment for clinical

diagnostic laboratory services of that hospital until said hospital has furnished the required information.

### **METHOD I**

(6) The Department will take a random sample of claims paid for clinical diagnostic laboratory services under the applicable UB82 revenue codes for each hospital using the Department's claims payment history for each hospital. The sample will be randomly taken from all hospital claims paid using the summary, ratio-to-cost methodology and for which payment was made by the Department on or after October 1, 1984 for dates of service between July 1, 1984 and January 31, 1986 inclusive. The claims data base will be collected until the Department, at its sole discretion, determines that a sufficient number of clinical tests within said dates of service have been paid. The Department will provide each hospital with a record of each recipient claim payment included in the sample. The record will show the amount billed by the hospital, dates of service, the amount paid, and the date of payment by the Department for each applicable revenue code. This method will require the hospitals to provide to the Department a corresponding report indicating the details of each recipient claim in the sample. The detail report must include:

- (A) the recipient's name and Medicaid identification number;
- (B) the HCPCS for each test in the sample claim;
- (C) the corresponding fee schedule rate, if available, and hospital charge for each test in the sample claim;
- (D) date of service of each test and specimen collection;
- (E) the total of the above details including the totals of the amounts that would have been billed and the amount that would have been paid using the Medicare Fee Schedule (if available);
- (F) the hospital should report applicable specimen collection fees in the same manner as described above as long as the collection fees are in conformance with the specimen collection section below;
- (G) it is possible that some of the sample claims selected may represent a mixture of tests which are subject to, and tests which are not subject to, the Medicare Fee Schedule. The total charges for the tests which are not subject to the Medicare fee schedule must also be set forth on the hospital's detail report in order to reconcile the total of the charges on this report with the total charges on the Department's claims sample report sent to the hospital. Details for tests not subject to the fee schedule, as provided for in these regulations, need only show the aggregate amount billed.

(H) the Department will compare the ratio of the total amount billed by the hospital and paid by the Department with the ratio of the total amount billed by the hospital and paid using the Medicare Fee Schedule. The ratio of the amount paid to the amount billed is the percent of the amount billed to the amount paid. If the ratio resulting from the Department's sample claims is larger than the ratio resulting from the hospital's details of the sample claims using the fee schedule, an overpayment will exist. To determine the actual amount of the overpayment, the total amount billed by the hospital corresponding to the claims paid for the period beginning October 1, 1984 through January 31, 1986 will be multiplied by the ratio resulting from the total amounts calculated from the hospital's detailed report. If the total actually paid for said period is greater than the amount calculated to be the amount the Department should have paid, the resulting difference between said amounts shall be the total amount of the overpayment for clinical diagnostic laboratory services paid to the hospital for the period October 1, 1984 through January

31, 1986. If the Department determines that the hospital has been overpaid, the Department shall notify the hospital. If payment arrangements satisfactory to the Department are not made by the hospital within thirty (30) days of said notification, the Department, in its sole discretion, may recoup the overpayment from the next payment or payments due from the Department to the hospital.

## **METHOD II**

(7) At the election of the hospital, the Department will collect claims data for clinical diagnostic laboratory services from each hospital's record of payments for a sample period. The sample period will reflect claims paid at the current Medicare fee schedule including related specimen collection fees which meet the requirements of the specimen collection section below. The sample period shall include dates of service for a three month period beginning February 1, 1986 through April 30, 1986 which have been paid pursuant to the Medicare Fee Schedule.

(A) The Department will use its Medicaid Management Information System (MMIS) to collect the data necessary to determine any overpayment. The data will be collected until the Department, in its sole discretion, determines that a sufficient number of clinical tests with dates of services within the sample period have been paid.

(B) The data to be collected will be the total of the amounts billed by each hospital during the sample period and the total amount paid by the Department to each hospital covering dates of service in the same period. The amount billed should represent the hospital's usual and customary charges for clinical laboratory services and the Department's payment will be the amounts allowed in accordance with the current Medicare Fee Schedule.

(i) For the retroactive period covered by dates of service commencing July 1, 1984 (and paid by the Department on or after October 1, 1984) through June 30, 1985, the total amount billed in the sample period shall be adjusted for any across-the-board changes in the hospital's usual and customary charges set for clinical diagnostic laboratory services subject to the Medicare Fee Schedule and occurring on and after July 1, 1985. If such increases occurred, the hospital will be required to furnish the Department with the following information regarding its usual and customary charge history for clinical diagnostic laboratory services and specimen collection fees as defined in these regulations during the period July 1, 1985 through April 30, 1986:

(aa) the date(s) the across-the-board charge rate change(s) became effective between July 1, 1985 and April 30, 1986;

(bb) the amount of across-the-board change, e.g., percent or dollar amount.

The total amount paid for the sample period will be adjusted by the amount of the Medicare Fee Schedule rate increase which became effective July 1, 1985. The ratio of the adjusted amounts billed to the adjusted amount paid during the sample period shall represent the ratio of the total amount that should have been billed and paid during the aforementioned retroactive period for clinical laboratory services. Said ratio will be applied to the total amount actually billed by the hospital for the aforementioned retroactive period. The resulting amount shall represent the total amount which the Department should have paid to the hospital in said period. If the total amount which was actually paid to the hospital for said period is greater than the amount calculated to be the amount the Department should have paid, the resulting difference between said amounts shall be the amount of the overpayment for clinical diagnostic laboratory services paid to the hospital for said retroactive period.

(ii) For the retroactive period beginning with dates of service July 1, 1985 through January 31, 1986, the unadjusted ratio calculated from the actual amount billed and paid for the sample period shall be applied to the total amount billed for said retroactive period. If the total amount which was actually paid to the hospital for said retroactive period is greater than the amount calculated to be the amount the Department should have paid, the resulting difference between said amounts shall be the total amount of the overpayment for clinical diagnostic laboratory services paid to the hospital for said retroactive period.

(iii) The Department shall notify the hospital of the overpayment resulting from either or both retroactive periods. If payment arrangements are not made by the hospital within thirty (30) days of said notification satisfactory to the Department, the Department in its sole discretion, may recoup said overpayment(s) from the next payment or payments due from the Department to the hospital.

(iv) If the amount of difference for either retroactive period utilizing Method I or Method II reveals that the Department paid less than would have been paid pursuant to Medicare, no payment shall be made by the Department to the hospital.

(8) Should any claims for clinical diagnostic laboratory services rendered prior to February 1, 1986 be submitted after the date that any overpayment has been calculated, the ratio used in determining the overpayment using either Method I or Method II shall be applied in calculating the amount of reimbursement for said services.

(9) Pursuant to said Section 9303 (b) of the Public Law 99-272, it will be necessary to verify that any amounts expended by the Department for dates of service on and after July 1, 1986 and received for payment on or before November 30, 1986, for clinical diagnostic laboratory tests did not exceed the amount that would be recognized under said Section. If any such payments are found to exceed the amount permitted by Federal law, said amounts shall be adjusted so as not to exceed the maximum amount permitted by Federal law.

(10) Such amount of overpayment found pursuant to subsection (f) (9) of these regulations will be recouped from the next payment or payments due from the Department to the hospital.

(g) **Specimen Collections**

(1) Payment for drawing or collecting specimens is allowed for those hospitals who have an established rate and routinely charge for specimen collections.

(2) The payment of specimen collections is the lower of:

(A) the Medicare rate;

(B) the Medicaid prevailing rate; and

(C) the hospital's usual and customary charge.

(3) Payment will be made only in those cases in which the hospital has drawn or collected the specimen from the patient.

(4) Only one (1) collection fee is allowed for each type of specimen (e.g., blood, urine, etc.) for the same patient encounter regardless of the number of specimens drawn or collected.

(5) Payment is allowed in circumstances such as drawing blood samples through venipuncture (i.e., inserting into vein a needle with syringe or vacutainer to draw the specimen) or collecting a urine sample by catheterization.

(6) When a series of specimens is required to complete a single test (e.g., glucose tolerance test), the series is treated as a single encounter.

(7) A specimen collection fee is not allowed for samples where the cost of collecting the specimen is minimal (such as a throat culture, a routine capillary puncture for clotting, or bleeding time).

(8) A specimen collection fee is allowed when it is medically necessary for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient. The technician must personally draw the specimen, e.g., venipuncture or sample by catheterization. A specimen collection fee is not allowed the visiting technician where a patient in a facility is not confined to the facility or the facility has on duty personnel qualified to perform the specimen collection. It must be indicated in the SNF patient record that no staff is available to draw the sample.

(9) The amount allowed by the Department for drawing or collecting a specimen at the laboratory facility covers the specimen drawing service and materials and supplies used.

(10) The amount allowed for drawings done in the recipient's home or in a nursing home covers the travel expenses of the technician, specimen drawing service, and materials and supplies used.

(Effective August 5, 1989)

**Sec. 17-134d-51. Reserved**

**Sec. 17-134d-52.**

Repealed, June 26, 1989.

**Secs. 17-134d-53—17-134d-55. Reserved**

**Sec. 17-134d-56. Reimbursement of clinic outpatient services and clinic off-site medical services furnished by free-standing clinics**

**(a) Definitions**

(1) "Free-Standing Clinic" means a facility providing medical or medically related clinic outpatient services or clinic off-site services by or under the direction of a physician or dentist and the facility is not part of, or related to, a hospital. Such facilities provide mental health, rehabilitation, dental and medical services and are subject to Sections 171 through 171.4 of the Department's Manual.

(2) In addition to the provisions set forth in the Department's Manual, Section 171B, "Clinic Outpatient Services" means services performed at the clinic, a satellite site, school, or community center.

(3) "Clinic Off-Site Services" means diagnostic, preventive, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician or dentist employed by or under contract to a free-standing clinic to a Medicaid eligible recipient at a location which is not a part of the clinic. Such locations are the recipient's home, acute care hospital, skilled nursing facility, intermediate care facility, or intermediate care facility for the mentally retarded. Off-site services, as may be restricted by location in accordance with Section (b) of this regulation, include: Mental Health Services, Occupational Therapy Services, Physical Therapy Services, Speech Therapy Services, Audiological Services, Physician's Services, Respiratory Therapy Services, Primary Care Services, and Dental Services. Such services are subject to the provisions of the Department's Manual Sections 171 through 171.4 except as modified by this regulation.

(4) "By or under the direction of a physician or dentist" means a free-standing clinic's services may be provided by the clinic's allied health professionals (as defined in Sections 171.1.B through 171.4.B of the Department's Manual) whether or not a physician is physically present in the clinic at the time that services are provided. The physician:

(A) must assume professional responsibility for the services provided;

(B) assure that the services are medically appropriate, i.e., the services are intended to meet a medical or medically-related need, as opposed to needs which are social, recreational or educational;

(C) need not be on the premises, but must be readily available, meaning within fifteen (15) minutes.

(5) "Outpatient" means a patient of an organized medical facility, or distinct part of that facility who is expected by the facility to receive and who does receive professional services for less than a 24-hour period regardless of the hour of admission, whether or not a bed is used, or whether or not the patient remains in the facility past midnight.

(6) "Plan of Care" means a written individualized plan. Such plan shall contain the diagnosis, type, amount, frequency, and duration of services to be provided and the specific goals and objectives developed and based on an evaluation and diagnosis for the maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level.

(7) "Satellite Site" means a location separate from the primary clinic facility at which clinic outpatient services are furnished on an ongoing basis meaning with stated hours per day and days per week.

(8) "Home" means the recipient's place of residence which includes a boarding home or home for the aged. Home does not include a hospital, skilled nursing facility, intermediate care facility, or intermediate care facility for the mentally retarded.

(9) "Department's Manual" means the Department of Income Maintenance Medical Services Policy Manual. References to manual sections in this regulation shall mean those sections as they may be amended from time to time.

(10) "Medical or Medically-Related Service" means services which are required in the diagnosis, treatment, care, or prevention of some physical or emotional problem.

(11) "Eligible Person" means a person eligible for the Medical Assistance Program in accordance with Section 17-134b of the General Statutes of Connecticut and regulations promulgated pursuant to Section 17-134d of the General Statutes of Connecticut

**(b) Service Limitations**

In addition to the provisions set forth in the Department's Manual, Sections 171.1E, 171.2E, 171.3E, 171.4E which are incorporated by reference herein, the following limitations apply:

(1) Clinic outpatient services and clinic off-site services as defined in Section (a) of this regulation which are provided to a resident of a skilled nursing facility, intermediate care facility or intermediate care facility for the mentally retarded, and which are deemed routine services for such facilities are not covered for patients in such facilities. These services may include but are not limited to: occupational therapy services, physical therapy services, audiological services, speech services, respiratory therapy services, routine laboratory and routine radiologic services, consultation services, skilled nursing, other rehabilitative and personal care services;

(2) Reimbursement of a visit for a clinic patient is limited to one (1) per day for the same clinic provider to the same patient involving the same treatment modality, illness or injury regardless of the location at which the service is furnished. Encounters with more than one health professional and multiple encounters with the same health professional employed by or under contract to the same clinic provider that take place on the same day, regardless of the location, constitute a single visit,

except when the patient, after the first encounter, suffers a new illness or injury requiring additional diagnosis or treatment.

(3) Clinic off-site services as defined in Section (a) of this regulation which are provided to hospital patients are covered only for services personally performed by clinic-based physicians and dentists who are not providing such services as salaried staff of the hospital.

**(c) Need For Service**

In addition to the provisions set forth in the Department's Manual, subsections 171.1F.I, 171.2F.I, 171.3F.I, and 171.4F.I, which are incorporated by reference herein, the following conditions apply to clinic outpatient and clinic off-site services:

(1) Such services are performed within the scope of the clinic's license or permit issued under State law; or, within the scope of the accreditation award; whichever applies;

(2) Such services are made a part of the eligible person's individual medical record;

(3) Such services are prescribed by a physician;

(4) Each recipient shall have an individual written plan of care.

**(d) Documentation Requirements**

(1) A record of each service performed must be on file in the recipient's individual medical record.

Such service record must include, but is not limited to:

(A) the specific services rendered;

(B) the date the services were rendered;

(C) for therapy services, the amount of time it took to complete the session on that date;

(D) the name and title of the person performing the services on that date;

(E) the location at which the services were rendered;

(F) for mental health and rehabilitation clinics, the recipient's individual medical record must contain at least a monthly summary documenting the progress made toward the goals and objectives in accordance with the recipient's plan of care;

(G) for medical and dental clinics the recipient's individual medical record must contain a progress note for each encounter.

(2) All documentation must be entered in ink and incorporated into the patient's permanent medical record in a complete, prompt, and accurate manner. All documentation shall be made available to authorized Department personnel upon request in accordance with Title 42 Section 431.107 of the Code of Federal Regulations. Failure to maintain documentation required in these regulations may result in disallowance of payment for any service for which documentation was not maintained.

(3) Documentation as required in these regulations must be maintained for a minimum of five (5) years.

(4) In the case of clinic off-site services, all individual medical records must be on file at the clinic in the manner prescribed in this subsection.

**(e) Prior Authorization**

The following services whether performed at the clinic, a satellite site, school, community center, or off-site require prior authorization from the Department as follows:

(1) Individual, group and family psychotherapy or counseling, and parent interviews, provided by mental health clinics in accordance with Section 171.1 of the Department's Manual, in excess of thirteen (13) visits in ninety (90) days or twenty-six (26) visits in six (6) months to the same recipient when performed at the clinic,

a satellite site, school, community center, recipient's home, or hospital. The number of visits accumulate regardless of the location where the services are performed;

(2) Individual, group, or family psychotherapy or counseling performed in a skilled nursing facility, intermediate care facility, or intermediate care facility for the mentally retarded, from the date of first treatment;

(3) Individual, group, or family psychotherapy or counseling provided by a rehabilitation clinic, from the date of first treatment, regardless of the location;

(4) Individual, group, or family psychotherapy or counseling provided by mental health clinics to individuals whose etiology stems from alcohol or drug dependence, from the date of first treatment;

(5) Occupational therapy, physical therapy, speech, language, or hearing therapy, and respiratory therapy, from the date of first treatment, regardless of the location;

(6) Partial evaluations and medical check-ups provided by rehabilitation clinics in accordance with the provisions of Section 171.2F of the Department's Manual, regardless of the location;

(7) Complete evaluations, provided by rehabilitation clinics in accordance with the provisions of Section 171.2F of the Department's Manual, regardless of the location;

(8) Dental services in accordance with subsection 171.3 F.II of the Department's Manual;

(9) Day Treatment programs with the exception of Methadone Maintenance Treatment Programs;

(10) Respiratory Therapy.

**(f) Other Requirements**

(1) Clinics providing medical day treatment programs including, but not limited to: psychiatric; traumatic brain injury; early childhood; substance abuse; and other rehabilitative day programs; are required to furnish all services at the clinic except for a home visit for the purposes of evaluating the recipient's home environment if required by the recipient's plan of care.

(2) In addition to the provider enrollment eligibility provisions set forth in the Department's Manual, Section 120C, which are incorporated by reference herein, the following enrollment requirements pertain to clinics and satellite sites as defined in Section (a) of this regulation.

(A) All clinics and satellite sites operated by clinics established under Section 17-424 of the Connecticut State Statutes must comply with all Department of Children and Youth Services (DCYS) statutory, regulatory and preferred practice requirements and document to the Department DCYS approval of such sites.

(B) All satellite sites operated by clinics licensed by the Department of Health Services (DOHS) must also be approved by the DOHS to provide clinic services at such locations, and document to the Department DOHS approval of such sites.

(C) Rehabilitation clinics operating satellite sites must document to the Department that the clinic has applied for or received accreditation for services at such sites.

(D) All satellite sites operated by dental clinics must have received a permit from the Connecticut State Dental Commission to provide dental services at such locations and document to the Department the Commission's approval of such sites.

(E) All clinics must document to the Department the names and titles of satellite clinical staff and scheduled hours of operation (hours per day/days per week) and description of services provided at such sites.

(F) All such sites must otherwise comply with the provisions of Sections 171 through 171.4 of the Department's Manual covering clinic services.

(G) In cases in which the clinic has a special arrangement to provide services in another organized facility, the clinic must submit to the Department a copy of a written agreement between the clinic and such facility stipulating the services to be provided at such facility.

(H) There must be adequate private office space in which to conduct direct patient care and treatment and administrative services.

(g) **Payment**

(1) Clinic outpatient services and clinic off-site services shall be paid in accordance with the provisions set forth in the Department's manual Sections 171.1I, 171.2I, 171.3I, and 171.4I which are incorporated by reference herein.

(2) Travel costs incurred by clinic staff in furnishing clinic outpatient and clinic off-site services as defined in Section (a) of this regulation, are considered to be included in the amount the Department shall pay for such services in accordance with Section 171.1I, 171.2I, 171.3I and 171.4I of the Department's Manual.

(3) All payments that are made utilizing the fee schedule shall be made in accordance with the fee schedule in effect on the date the service is furnished.

(Effective December 11, 1989)

**Secs. 17-134d-57—17-134d-59. Reserved**

**Sec. 17-134d-60.**

Repealed, March 7, 2007.

**Sec. 17-134d-61. Reserved**

**Sec. 17-134d-62.**

Repealed, March 7, 2007.

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**Sec. 17-134d-63. Medicaid payment to out-of-state and border hospitals****(a) Definitions**

For the purposes of this regulation, the following definitions apply:

(1) “Allowed Cost” means the Medicaid costs reported by each Connecticut in-state hospital in their most recent inpatient cost report as filed as of July 31st of each year by the hospitals for the hospital fiscal year.

(2) “Border Hospital” means an out-of-state general hospital which has a common medical delivery area with the State of Connecticut and is deemed a border hospital by the Department on a hospital by hospital basis.

(3) “Connecticut In-state Hospital” means a general hospital located within the boundaries of the State of Connecticut and licensed by the Connecticut State Department of Health Services.

(4) “Department” means the State of Connecticut Department of Income Maintenance.

(5) “Department’s Manual” means the Department’s Connecticut Medical Assistance Provider Manual which contains the Medical Services Policy as amended from time to time.

(6) “Emergency” means a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the patient’s health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(7) “General Hospital” means a short-term hospital having facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a wide range of acute conditions, including injuries, and shall include a children’s general hospital which means a short-term hospital having facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a wide range of acute conditions among children, including injuries.

(8) “Inpatient” means a patient who has been admitted to a general hospital for the purpose of receiving medically necessary, appropriate, and quality medical, dental, or other health related services and is present at midnight for the census count.

(9) “Medical Necessity” means medical care provided to:

(A) Correct or diminish the adverse effects of a medical condition;

(B) Assist an individual in attaining or maintaining an optimal level of well-being;

(C) Diagnose a condition; or

(D) Prevent a medical condition from occurring.

(10) “Out-of-State Hospital” means a general hospital located outside of the State of Connecticut and is not deemed by the Department to be a border hospital.

(11) “Outpatient” means a person receiving medical, dental, or other health related services in the outpatient department of an approved general hospital which is not providing room and board and professional services on a continuous 24-hour-a-day basis.

(12) “Prior Authorization” means approval for a service from the Department or the Department’s agent which may be required by the Department before the provider actually provides the service. Prior authorization is necessary in order to receive reimbursement from the Department. The Department in its sole discretion determines what information is necessary in order to approve a prior authorization request.

(13) “Provider Agreement” means the signed written contractual agreement between the Department and the provider of medical services or goods. It is signed

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by the provider upon application for enrollment and is effective on the approved date of enrollment. The provider is mandated to adhere to the terms and conditions set forth in the provider agreement in order to participate in the program.

(14) “Rate Year” means the twelve (12) month period beginning on October 1st of each year.

(15) “Total Customary Charges” means the revenue generated by the aggregate of the total customary charges reported by each Connecticut in-state hospital in their most recent inpatient cost report as filed as of July 31st of each year by the hospitals for the hospital fiscal year.

**(b) Rate Setting**

(1) For inpatient and outpatient services rendered on and after the effective date of this regulation, the Department shall pay out-of-state and border hospitals, at a fixed percentage of each out-of-state and border hospital’s usual and customary charge. The standard methodology to be employed shall be the fixed percentage calculated in accordance with subsections (b) (1) (A) and (B) of this regulation. However, for inpatient services, the hospital may elect to have its fixed percentage determined in accordance with subsection (b) (1) (C) of this regulation.

(A) For inpatient services the standard fixed percentage shall be calculated by the Department based on the ratio between the allowed cost and total customary charges for Title XIX recipients for all Connecticut in-state general hospitals.

(B) For outpatient services the standard fixed percentage shall be calculated by the Department based on the ratio between the aggregates of the amount paid by the Department and the amount billed to the Department for all Connecticut in-state hospital outpatient services. The amount billed represents the hospital’s usual and customary charges for outpatient services and the Department’s payment represents the amount paid up to the amount allowed in accordance with the Department’s current outpatient fee schedule for each Connecticut in-state hospital and as may be amended from time to time. The amount paid by the Department to Connecticut in-state hospitals shall include amounts paid in accordance with limits of payments as may be required by federal law. The fixed percentage shall be determined by the Department utilizing data taken from its most recent and deemed the most complete twelve (12) month period as reported in its Medicaid Management Information System.

(C) However, for inpatient services as defined in this regulation, each out-of-state and border hospital may have its fixed percentage optionally determined based on its total allowable cost under Medicare principles of reimbursement pursuant to Title 42 of the Code of Federal Regulations, Part 413, and as may be hereafter amended. The hospital must submit its most recently available Medicare cost report within the time period specified in subsection (b) (2) (A) below. The Department shall determine from the filed Medicare cost report the ratio of total allowable inpatient cost to gross inpatient revenue. The resulting ratio shall be the hospital’s fixed percentage not to exceed 100%. If an out-of-state or border hospital chooses to file for a fixed percentage under this subsection it must maintain all the supporting documentation to justify the amounts claimed. The Department, in its discretion, may audit said hospital and make any adjustment required in favor of the provider or the state resulting from the audit.

(D) The Department shall pay out-of-state and border hospitals utilizing the methodology as set forth in subsection (b) (1) (A), or (B), or (C) of this regulation unless a different methodology is required by federal law, in which case, the required federal methodology shall be employed.

(2) Upon the effective date of this regulation and annually thereafter, meaning at the beginning of the rate year, as defined in this regulation, the Department shall notify each out-of-state and border hospital enrolled in the Connecticut Medicaid Program as to the standard fixed percentages for that rate year.

(A) Each year each out-of-state and border hospital shall have ten (10) days from the date of receipt of said notification to submit a request in writing to the Department, if it wishes to have its inpatient fixed percentage calculated using the optional methodology set forth in accordance with subsection (b) (1) (C).

(B) Failure of the hospital to notify the Department of said election within ten (10) days or failure of the hospital to provide the necessary information described in subsection (b) (1) (C) within said time shall result in the Department making payment to the hospital for inpatient services for the applicable rate year using the standard methodology in accordance with subsection (b) (1) (A) of this regulation.

(C) Upon the effective date of this regulation, the fixed percentages set in accordance with subsections (b) (1) (A) or (B) or (C) of this regulation shall expire at the end of the rate year in which this regulation is made effective.

(D) A hospital which enrolls in the Connecticut Medicaid Program during any rate year may elect to have its inpatient fixed percentage determined in accordance with subsection (b) (1) (C) of this regulation. Such initial fixed percentage shall expire at the end of the rate year in which said fixed percentage is approved by the Department. Thereafter, if the hospital wishes to elect the optional methodology it must comply with the provisions of subsection (b) (1) (C).

(E) If a hospital elects to have its inpatient fixed percentage set in accordance with subsection (b) (1) (C), it may not request a change in said methodology during the rate year in which the fixed percentages are approved by the Department.

(c) **Provider Participation**

In order to receive payment from the Connecticut Medicaid Program:

(1) Out-of-state and/or border hospitals must submit a copy of a current and effective license or certification as a hospital issued by the appropriate official state governing body within the boundaries of the state in which the hospital is located.

(2) The out-of-state and/or border hospital must enter into a provider agreement with the Department.

(3) The Department shall determine when an out-of-state hospital qualifies for enrollment as a border hospital.

(d) **Prior Authorization**

(1) **Border Hospitals**

Prior authorization, as defined in this regulation, for inpatient and outpatient services, shall be required for such services in accordance with the Department's Manual, Sections 150.1 and 150.2 pertaining to Connecticut in-state hospitals.

(2) **Out-of-state Hospitals**

(A) Prior authorization for inpatient and outpatient services shall be required for all non-emergency cases as described in subsection (e) of this regulation.

(B) The following services shall *not* require prior authorization:

(i) Care in an emergency situation as defined in this regulation;

(ii) Newborns and/or deliveries; or

(iii) Outpatient services for a child for whom the State of Connecticut makes adoption assistance or foster care maintenance payments under Title IV-E of the Social Security Act.

(e) **Need for Service**

(1) Out-of-state hospitals who treat Connecticut Title XIX recipients and are enrolled in the Connecticut Medicaid Program as a border hospital are bound by the same rules and regulations as Connecticut in-state hospitals participating in Title XIX program as set forth in the Department's Manual.

(2) The Connecticut Title XIX program reimburses for medically necessary and appropriate services provided in out-of-state hospitals, other than border hospitals as defined in this regulation, under the following conditions:

(A) For emergency cases as defined in this regulation and necessitating the use of the most accessible general hospital available that is equipped to furnish the services;

(B) For non-emergency cases, when prior authorization is granted by the Department, for the following reasons:

(i) Medical services are needed because the recipient's health would be endangered if they were required to travel to Connecticut; or

(ii) On the basis of the attending physician's medical advice that the needed medical services or necessary supplementary resources are more readily available in the other State.

(Effective May 23, 1990)

**Secs. 17-134d-64—17-134d-67. Reserved**

**Sec. 17-134d-68. Requirements for monitoring psychiatric admissions to nursing homes**

(a) **Scope**

(1) Medicaid is a program of "cooperative federalism" wherein federal financial participation is available for a percentage of the cost of medical assistance provided by a state under its Medicaid program. Under federal requirements, however, federal financial participation is not available for the cost of nursing facility services that are provided by facilities that are also considered to be institutions for mental diseases (IMDs) except for patients aged 65 and older. The purpose of these regulations is to establish requirements designed to prevent nursing homes which participate in the Medicaid program from being characterized as IMDs unless the IMD serves only patients aged 65 and older or unless the IMD is prepared to accept payment from some source other than Medicaid for all patients under 65 years of age. Specific remedies available to the Department under these regulations include the denial of authorization for the admission of psychiatric patients, the termination of Medicaid provider agreements, and the imposition of fiscal sanctions equal in amount to the loss of federal financial participation attributable to the facility's characterization as an IMD.

(b) **Definitions**, for purposes of this section, are as follows:

(1) "Department" unless otherwise specified, means the Department of Income Maintenance.

(2) "Facility" means a nursing home as defined in subsection (b) (5) below.

(3) Institution for mental disease (IMD), is defined as an institution which is primarily engaged in providing diagnosis, treatment, or care of individuals with mental diseases, including medical attention, nursing care and related services in accordance with 42 CFR 435.1009 as amended from time to time. Interpretive guidelines issued by the Health Care Financing Administration indicate that a final determination of a facility's status rests on a cumulative weighing of all applicable guidelines and that a key criterion is the presence in the facility of 50% or more patients with a disability in mental functioning.

(4) “Mental disorder” means a mental disease as defined in the International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM) with the exception of mental retardation, senile dementias (including Alzheimer’s disease) and organic brain syndromes. Specifically, nursing home placements primarily for ICD-9-CM diagnosis 295.0-309.9 and 312-314.9 are considered psychiatric placements. Alcoholism is not treated as a psychiatric condition except in the cases in which federal guidelines so direct.

(5) “Nursing Home” means any chronic and convalescent facility or any rest home with nursing supervision, as defined by Section 19a-521 of the general statutes, which has a provider agreement with the Department of Income Maintenance to provide services to recipients of medical assistance pursuant to Part IV of Chapter 302 of the General Statutes of Connecticut and to accept reimbursement for the cost of such services pursuant to said program, or which receives payment from the state for rendering care to indigent persons. For purposes of this regulation only, intermediate care facilities for the retarded are specifically excluded from this definition.

(6) “Patient Review Team” means the unit of the Department of Income Maintenance which is responsible for completing inspections of care in nursing homes in accordance with the requirements of federal law.

(7) “Provider” means a nursing home as defined in subsection (b)(5) above or the designated representative(s) of the facility.

(8) “Psychiatric patient” means a patient whose primary reason for institutionalization is a mental disorder as defined in subsection (b) (4) above. For purposes of residence in the nursing home, a patient admitted primarily for non-psychiatric reasons and who also has a psychiatric condition that is stable will not be considered a psychiatric patient. If the condition changes such that the primary reason for continued institutionalization falls inside the diagnoses specified above as mental disorders, the patient will be considered a psychiatric patient. If the condition of the patient changes during residence in a nursing home such that the primary reason for continued institutionalization falls outside the diagnoses specified as mental disorders, the patient will no longer be considered a psychiatric patient for purposes of residence in the nursing home.

(c) **Remedies**

(1) In order to assure that a facility which participates in the Medicaid program does not operate as an institution for mental diseases, the Department is authorized to impose any combination of the following remedies:

(A) require the facility to submit a plan of correction;

(B) require the facility to receive prior authorization for new admissions of psychiatric patients who are or will be eligible for Medicaid;

(C) refuse payment to the facility for new psychiatric admissions or newly eligible psychiatric patients;

(D) terminate the provider agreement; and

(E) recover the amount of all federal disallowances from the facility by recoupment from current Medicaid payment to the facility as per Regulations of Connecticut State Agencies, Section 17-311-53 or by bringing any appropriate legal action against the facility.

(2) Whenever a federal disallowance is made as a result of a facility being determined to be an institution for mental diseases, the facility shall be deemed to be indebted to the Department in the amount of such disallowances unless such penalties are waived under the terms in subsection (f) (5).

(3) Nothing herein shall authorize the Department to impose sanctions against facilities on the basis of these regulations for services delivered prior to the effective date of these regulations.

(d) **Procedures**

The following procedures will be instituted in order to assure that nursing homes which participate in the Medicaid program do not operate as institutions for mental disease:

(1) The Department of Income Maintenance will identify facilities which are at risk of classification as institutions for mental disease.

(A) Determination that a facility is “at risk” of classification as an institution for mental disease does not mean that the facility is, in fact, an IMD as defined above. Rather, the “at risk” determination is an early warning signal designed to allow the Department and the facility to initiate advanced corrective measures to avoid endangering future federal financial participation.

(B) Criteria which shall be considered in making a determination that a facility is at risk of IMD classification may include any of the following:

(i) The facility advertises or holds itself out as a facility for the care and treatment of individuals with mental diseases;

(ii) The facility is accredited as a psychiatric facility by the Joint Commission on Accreditation of Hospitals;

(iii) The facility specializes in providing psychiatric care and treatment;

(iv) The facility is under the jurisdiction of the Connecticut Department of Mental Health;

(v) More than 40% of the facility’s Medicaid patients are psychiatric patients as defined in subsection (b) (8) above;

(vi) More than 40% of the patients in the facility have been transferred from a state mental institution for continuing treatment of their mental disorders;

(vii) The average age in the facility is significantly lower than that of a typical nursing home;

(C) Information which will be used in making the determination that a facility is at risk of IMD classification includes but is not limited to:

(i) Primary diagnoses as reported on billing documents submitted to the Department by the facility;

(ii) Information about the primary reason for institutionalization as collected by the Patient Review Team from the facility’s medical records; and

(iii) Statistics on discharges provided by the Department of Mental Health.

(2) Any facility which meets the criteria listed in subsection (d) (1) (B) above may be determined to be at risk of IMD classification. The Department of Income Maintenance shall notify each facility in writing that has been determined to be at risk of IMD classification that the facility:

(A) is considered at risk of classification as an institution for mental diseases;

(B) must receive prior authorization from the Department prior to the admission of Title XIX psychiatric patients or psychiatric patients with a Title XIX application pending;

(C) will normally not receive prior authorization for Medicaid payment for new psychiatric admissions or newly eligible psychiatric patients until the Medicaid psychiatric population is below 45% of the total Medicaid patient population or until the total psychiatric population is below 50% of the facility’s total census;

(D) must submit an acceptable plan of correction as a condition of continued participation in the Medicaid program; and

(E) will be held responsible for any federal financial penalties imposed on the Department because of the failure of the facility to comply with federal requirements.

(3) Although the Department will provide guidance through this monitoring effort, the burden of responsibility shall rest with the facility to assure that it is in compliance with federal regulations and interpretive guidelines issued by Health Care Financing Administration in relation to its total patient census.

(4) The Department may, at its discretion, terminate the provider agreement for failure to comply with these regulations.

(e) **Plan of Correction**

(1) A facility which is determined to be at risk of being classified as an IMD must submit an acceptable plan of correction to the Department. The plan of correction must:

(A) be submitted in writing to the Department within thirty (30) days from the issuance of notice by the Department;

(B) include steps which have been taken and/or steps which shall be taken in order to assure that the facility will be in compliance with this regulation and applicable federal requirements;

(C) include a timetable which outlines the deadlines for each step;

(D) establish a procedure for internal evaluation to assure that the plan of correction will be implemented properly; and

(E) be approved by the Department.

(2) Among the options available to the facility in order to continue participating in the Medicaid program, are the following steps as appropriate depending upon the circumstances of the facility:

(A) Gradually decrease the percentage of psychiatric patients through attrition;

(B) Develop plans for orderly transfer of psychiatric patients; or

(C) Request reclassification of the facility or a unit within the facility as an institution for mental diseases with Title XIX reimbursement available only for persons aged sixty-five (65) and older.

(f) **Effective Date of Adverse Action**

(1) Adverse action taken by the Department shall be effective on the eleventh (11th) day following the issuance of notice by the Department provided that the facility has not perfected a timely appeal.

(2) The provider shall have the opportunity to appeal provided that the appeal is received in writing by the Commissioner of Income Maintenance on or before the tenth (10th) day following the issuance of notice by the Department. If such appeal is filed, the adverse action shall be effective on the date the decision is reached.

(3) Regardless of whether an appeal has been filed, the provider shall submit a plan of correction within thirty (30) days following the issuance of notice by the Department.

(4) Computation of time in subsections (f) (1) and (f) (2) above and in subsection (g) (1) below shall be subject to the exclusion of weekends and holidays to the extent that they are excluded in Section 17-311-15 of the Regulations of Connecticut State Agencies, as amended from time to time.

(5) The Department may waive the imposition of remedies against a facility which has submitted an approved plan of correction and which has demonstrated good faith in attempting to implement the terms of the plan of correction, but which has been prevented from compliance due to conditions out of its control.

(g) **Appeals**

(1) Appeals Process for Providers

The provider may appeal a decision of the Department in accordance with Section 17-311-27 through 17-311-40 of the Regulations of Connecticut State Agencies, provided that the appeal is received on or before the tenth (10th) day after the issuance of notice by the Department. The following actions may be appealed:

- (A) determination that the facility is at risk of classification as an IMD;
- (B) imposition of fiscal sanctions against the facility; or
- (C) termination of the provider agreement.

(2) Appeals Process for Recipients

The recipient may appeal the following actions by the Department:

- (A) classification as a psychiatric patient in accordance with the definition above;
- (B) abuse of discretion in denying prior authorization to the facility determined to be at risk of IMD classification; or
- (C) determination to suspend, reduce or discontinue assistance.

(h) Admission policies which limit admissions of psychiatric patients to nursing homes which have been determined to be at risk of classification as institutions for mental diseases under the terms of these regulations shall not be deemed or considered in violation of Section 19a-533 of the General Statutes of Connecticut (the "waiting list" statute) provided that:

(1) the admission policy was fairly and consistently applied to all applicants for admission, irrespective of the source of payments for each applicant;

(2) the intent of the admission policy is not to discriminate against indigent applicants and that the policy, fairly and consistently applied, has not had the effect of discriminating against such applicants by denying admission to a disproportionate number of such applicants.

(Effective February 3, 1989)

**Sec. 17-134d-69. Reserved**

**Sec. 17-134d-70. Definitions for the purposes of this regulation**

"Allowable Primary Health Services Cost" means the costs as reported in the annual report after any cost adjustment, cost disallowances or reclassifications.

"Annual Report" means the annual cost and performance reporting document which consists of forms provided by the Department and other documents submitted by the Community Health Centers. The annual report shall include but not be limited to actual revenues, actual costs, actual visits, imputed visits, projected grants and contributions, cost adjustments, cost disallowances, and audited financial statements.

"Annual Report Period" means the period from July 1st through June 30th.

"Billable Primary Health Service Visit" means any visit which is billable to any payer whether or not the visit is actually billed.

"Commissioner" means the Commissioner of Income Maintenance or his designated representative.

"Cost Adjustments" means the disallowed primary health services overhead costs which are in excess of 30% of the total primary health services costs.

"Cost Disallowances" means costs such as, but not limited to: Entertainment; Fines and penalties; Bad debts and cost of action to collect receivables; Advertising except for recruitment of personnel; Contingency reserves; Legal, accounting and professional services incurred in connection with rehearings, arbitrations or judicial proceedings pertaining to the reimbursement approved by the Commissioner; Fund Raising; Amortization of Goodwill; Directors Fees; contributions; membership dues for public relations, advertising and political contributions and costs not related to patient care. Medicare rules will be used to determine the allowability of specific

cost items as set forth in Subchapter 18, Part A of Title 42 of the U.S. Code, Section 1395 et. sec. and the regulations promulgated thereunder.

“Community Health Center (CHC)” means a non-profit medical facility which is not a part of a hospital but is organized and operated to provide primary health and supplemental health services as defined in this regulation. Such facilities are further distinguished by their service to low income and medically underserved populations.

“Department” means the Department of Income Maintenance.

“Full-Time Equivalent” means the total number of hours paid for the year divided by 2080.

“Imputed Primary Health Services Visits” means the minimum number of visits based on the following standards which are assessed as visits per full time equivalent:

- 3,500 visits per full time equivalent for the services of physicians
- 2,100 visits per full time equivalent for the services of physician assistants
- 2,100 visits per full time equivalent for the services of nurse practitioners

“Primary Health Services Operating Revenue” means the operating revenue for primary health services reported in the Annual Report.

“Primary Health Services” means services of physicians, physicians’ assistants, nurse practitioners, and other allied health professionals, for the ongoing, continuous or repetitive management of a patient’s health care inclusive of services and supplies and the overall coordination of all services provided to the patient. Services include but are not limited to:

- (1) first-step management for acute patient problems and follow-up management of current problems including emergency medical services;
- (2) chronic disease management;
- (3) health education;
- (4) nutrition counseling;
- (5) preventive health services (including perinatal services and well child services);
- (6) medical social work services (including counseling, outreach, referral for assistance, and follow-up);
- (7) women’s health services;
- (8) family planning services;
- (9) diagnostic laboratory and x-ray (where such services are *not* independently certified);
- (10) transportation as required for primary care visits (where such transportation is furnished by the health center).

“Projected Primary Health Services Grants and Contributions” means the anticipated primary health grants and contributions for the rate period following the annual report period.

“Public Health Service Grants” means funds awarded to community health centers to support the cost of operation of such facilities pursuant to 42 U.S.C. 254c.

“Rate Period” means the 12 month period from April 1st through March 31st.

“Supplemental Health Services” means services necessary for the adequate support of primary health services. Services include but are not limited to:

- (1) mental health services;
- (2) pharmaceutical services (where such services are independently certified);
- (3) dental services;
- (4) rehabilitation services, such as: physical therapy, occupational therapy; speech, language and/or hearing services;

- (5) laboratory and x-ray (where such services are independently certified);
- (6) vision care services.

“Title XIX Rate” means the rate established pursuant to these regulations to reimburse Community Health Centers for primary health services for eligible Title XIX recipients.

(Effective October 12, 1989)

### **Sec. 17-134d-71. Submission of annual report**

(a) On or before March 1, 1989 and December 1, 1989 and on December 1 annually thereafter, each Community Health Center, hereafter called “CHC,” shall submit its annual report in a form and manner prescribed by the Commissioner.

(b) The annual report shall cover the period from July 1 to June 30 immediately preceding the filing date and shall be used to determine Title XIX rates effective April 1.

(c) By January 31 for those CHCs which have filed their annual reports on or before December 1, 1989 and annually thereafter, the Department will review the Annual Report and communicate with the CHCs in writing the Department’s comments and/or questions about the submitted Annual Report.

(Effective October 12, 1989)

### **Sec. 17-134d-72. Determination of the Title XIX rates by the commissioner**

The rate for each CHC shall be derived from the annual report and shall be established by the Commissioner on a prospective basis as follows:

(a) For each CHC allowable primary health services cost shall be subtracted from primary health services operating revenue.

(1) If a gain results, meaning a positive amount, the commissioner will determine whether to allow the projected primary health services grants and contributions, excluding public health service grants, in whole or in part for enhancement of primary health services.

(2) If a shortfall results, meaning a negative amount, the dollar amount of the shortfall is subtracted from projected primary health services grants and contributions excluding public health service grants. If this calculation results in a positive amount the Commissioner will determine whether to allow the excess revenue in whole or in part for enhancement of primary health services.

(3) The amount of projected primary health services grants and contributions, excluding public health service grants, not allowed by the Commissioner for enhancement of primary care services shall be subtracted from allowable primary health services costs to determine adjusted primary health services costs.

(b) The lower of allowable primary health services cost or adjusted primary health services cost determined in (a) of this Section is divided by the larger of actual billable primary health services visits or imputed primary health services visits to determine the cost per a primary health services visit.

(c) The cost per a primary health services visit determined in (b) of this Section shall be adjusted for the 21 month time lag between the annual report period and the rate period by use of the Gross National Product (GNP) deflator percentage increase or decrease to determine a per visit cost adjusted by the GNP.

(d) The per visit cost adjusted by the GNP as determined in (c) of this Section for each CHC shall be ranked from high to low and the median per visit cost determined. The maximum allowed per visit cost shall be 125% of the median per visit cost.

(e) For each CHC the Title XIX rate shall be the lower of the per visit cost adjusted by the GNP as determined in (c) of this Section or the maximum allowed per visit cost as determined in (d) of this Section.

(f) Subsequent to the first rate period, the median per visit cost shall be the lower of the median per visit cost as determined in (d) of this Section or the previous year's median per visit cost as adjusted for the 12 month time lag between the rate periods by use of the consumer price index related to medical care services percentage increase or decrease.

(Effective October 12, 1989)

### **Sec. 17-134d-73. Reconsideration of Title XIX rates**

(a) If at any time a CHC becomes aware that its projected primary health services grants and contributions, excluding public health services grants may have a 25% variance above or below the amount used to determine its Title XIX rate, the CHC must report such variance to the Commissioner. The Commissioner may adjust the current Title XIX rate or may consider such variance in the next annual determination of Title XIX rates.

(b) In the event of material changes in circumstances during a rate period any CHC may submit a written request to the Commissioner for a revised Title XIX rate. As used in this subsection "material" is defined as a 25% change in the Title XIX rate. The written request shall include at a minimum:

- the rate requested,
- the requested effective date, and
- the documentation in support of the requested rate.

(c) In no event shall the rates established pursuant to subsection (a) or (b) of this section exceed the maximum allowed per visit cost for the particular rate period.

(Effective October 12, 1989)

### **Sec. 17-134d-74. Request for a rate by a new CHC entering the Title XIX program**

(a) A new CHC shall file a pro forma annual report based on budgeted data. The Commissioner shall establish a Title XIX rate in accordance with Sections 17-134d-70 through 17-134d-78 of these regulations.

(b) A Title XIX rate established under this section shall remain in effect until the ensuing April 1. In the event that an annual report is not available for a six month period ending June 30th, the rate to be established the ensuing April 1 shall be the current rate adjusted by the GNP percentage increase or decrease from the current rate period to the next rate period.

(c) In no event shall the Title XIX rates established pursuant to subsection (a) or (b) of this section exceed the maximum allowable per visit cost for the particular rate period.

(Effective October 12, 1989)

### **Sec. 17-134d-75. Record maintenance and retention**

Each CHC shall maintain all supporting records of its annual report for a minimum period of 10 years. The records shall be available for review without regard for changes in ownership. Any cost for which adequate documentation is not maintained may be disallowed.

(Effective October 12, 1989)

### **Sec. 17-134d-76. Audits**

The Department shall have the right to audit all supporting accounting and business records and all records relating to the provision of services to clients funded by the

Department. If the audit discloses discrepancies in the accuracy and/or allowability of actual cost and actual statistical data as submitted in the annual report, the Title XIX rate for the rate period will be adjusted. Payment either in favor of the CHC or the State shall be made.

(Effective October 12, 1989)

**Sec. 17-134d-77. A statutory limitation on the Title XIX rate**

Title XIX rates paid by the State for care of persons eligible for assistance under the provision of Chapter 302, Part III of the Connecticut General Statutes shall not exceed the rate of payment for similar services to the general public.

(Effective October 12, 1989)

**Sec. 17-134d-78. Hearings**

Any CHC which is aggrieved by any rate decision pursuant to these regulations may within ten days after written notice of such rate decision obtain by written request to the Commissioner, a hearing on all items of aggrievement. The hearing shall be conducted in accordance with the procedures specified in Sections 17-311-1 through 17-311-40 of the Regulations of Connecticut State Agencies.

(Effective October 12, 1989)

**Sec. 17-134d-79. Requirements for the reservation of beds in nursing homes**

**(a) Definitions**

(1) The definitions contained in Section 19a-537 of the Connecticut General Statutes apply to this subsection and subsections (b), (c) and (d) of this section; and

(2) "Level of Care" is further clarified, for purposes of this section, to refer to the level of care for which the nursing home is licensed, i.e., a chronic and convalescent nursing home or a rest home with nursing supervision. A change in level of care would occur only when the patient, upon return from the hospital, requires care consistent with these licensing standards which is different from his/her care requirements just prior to the time of admission to the hospital. This determination of change in level of care also applies when a patient is required to change from one licensed level to another within a facility which is licensed to provide both chronic and convalescent nursing home care and rest home with nursing supervision care.

(3) "Objective information," for purposes of this section, means an estimate of the patient's projected length of hospital stay obtained by the nursing home from a hospital staff person. This prognosis may be obtained from the patient record or the plan of care or given by a physician or other health professional under his direction or by another qualified professional such as a social worker or discharge planner.

**(b) Requirements**

(1) Nursing homes are required to reserve the bed of a self-pay resident who is hospitalized as long as payment is available to reserve the bed and to inform the self-pay resident and his/her relatives or other responsible person upon admission to the nursing home and upon transfer to a hospital about this requirement.

(2) Nursing homes are required to inform residents who are recipients of medical assistance and their relatives or other responsible person upon admission to the nursing home and upon transfer to a hospital of the conditions under which the nursing home is required to reserve the bed of a resident.

(3) Nursing homes are required to reserve the bed of a resident who is a recipient of medical assistance for each admission to the hospital for up to fifteen days unless the nursing home documents that it has obtained objective information from the

hospital that the patient will not return to the nursing home at the same level of care within fifteen days of hospitalization including the day of admission to the hospital.

(4) The bed reserved for a hospitalized resident shall not be made available for use by any other person unless the nursing home records in the resident's medical record the medical or administrative reasons justifying the change in the resident's bed and documents that a consultation between the medical director or nursing staff of the nursing home and the treating physician has determined that the change in bed assignment is not anticipated to result in serious harm to the resident.

(5) Nursing homes shall be reimbursed for reserving the bed of a resident who is a recipient of medical assistance except as shown in subsection (b) (5) (C) of this section providing the following conditions are met:

(A) For reimbursement to a maximum of seven days including the day of admission to the hospital, the nursing home must document

(i) that on the date of admission it has a vacancy rate of not more than three beds or three percent of licensed capacity, whichever is greater, at the same level of care as the hospitalized person, and

(ii) that it has contacted the hospital, documented the contact in the patient's file, and did not receive information that the person would be unable to return to the same level of care within fifteen days of admission to the hospital.

(B) For reimbursement to a maximum of eight additional days, the nursing home must document

(i) that on the seventh day of hospitalization it has a vacancy rate of not more than three beds or three percent of licensed capacity, whichever is greater, at the same level of care as the hospitalized person, and

(ii) that on or before the seventh day but after the third day of hospitalization the nursing home contacted the hospital for an update of the patient's status, documented the contact in the patient's file, and the updated information obtained did not indicate that the patient would be unable to return to the same level of care within fifteen days of admission to the hospital.

(C) If at any time the nursing home receives or obtains objective information from the hospital that the resident will not return to the same level of care within fifteen days of admission to the hospital, then the nursing home shall not request or receive reimbursement for reserving the resident's bed for any days after such information is received including the day the information is received.

(6) If the nursing home is not required to reserve the resident's bed under this section or the hospitalization period exceeds the period of time that a nursing home is required to reserve the resident's bed, the following conditions apply:

(A) The nursing home shall provide the first available bed at the time notice is received of the resident's discharge from the hospital;

(B) The nursing home shall grant to resident priority of admission over applicants for new admission to the nursing home;

(C) If reservation of the bed is requested by the resident who is a recipient of medical assistance, his/her relative or other responsible person, the nursing home may charge a fee to the resident or other responsible person to reserve the bed not exceeding the per diem Medicaid rate for the number of days the resident is absent from the facility; and

(D) If reservation of the bed is required by residents who are not recipients of medical assistance, their relative or other responsible person, the nursing home may

charge a fee not exceeding the maximum self-pay rate established by the Department for the reserved bed.

(7) Documentation for compliance with this section is required as follows:

(A) Upon a resident's admission to the hospital, the nursing home must document in the resident's medical record the contact with the hospital as described in subsection (b) (3) of this section to determine if the reservation of the resident's bed is required. Any subsequent contact with the hospital which affects reservation of bed requirements is subject to these same documentation requirements.

(B) For a change in bed assignment as described in subsection (b) (4), of this section, the nursing home must document in the patient's medical record

(i) the medical or administrative reasons for the change, and

(ii) the date and results of the consultation between nursing home medical staff or nursing staff and the treating physician.

(C) For reimbursement for the first seven days and the additional eight days of bed reservation or any part thereof as described in subdivisions (5) (A) and (5) (B) of this subsection, the nursing home must document

(i) the vacancy rates on the first and seventh day of the resident's admission to the hospital. The daily log, patient census, or other similar nursing home record may be used for documentation provided it clearly shows the date of vacancy rate determination and the level of care of the vacant beds, and

(ii) in the resident's medical record, the contacts with the hospital on the first day of admission and on or before the seventh day but after the third day of the resident's admission to the hospital.

(D) Information obtained from hospital contacts which is recorded in the resident's medical record as required in subparagraphs (A) and (C) (ii) of this subdivision shall include the date of the contact, the hospital contact person's name, the source of the information and the length of stay information.

(c) **Violations**

Violations listed in subdivisions (1) through (7) of this subsection are separate and distinct from each other and one penalty may be imposed for each one of the seven subdivisions that are violated per incidence of hospitalization.

Violations include:

(1) The nursing home made the bed assigned to a hospitalized resident available to another person in violation of subsections (b) (1)–(4) of this section;

(2) The nursing home made an undocumented change in the resident's bed as described in subsection (b) (4) of this section;

(3) The nursing home requested reimbursement for reserve-bed days after it had objective information indicating that the hospitalized resident would not return to the nursing home at the same level of care or within fifteen days of admission in violation of subsection (b) (5) of this section;

(4) The nursing home failed to provide a resident with the first available bed at the time notice is received of the resident's discharge from the hospital in violation of subsection (b) (6) (A) of this section;

(5) The nursing home failed to grant the resident priority of admission over applicants for new admissions to the nursing home in violation of subsection (b) (6) (B) of this section;

(6) The nursing home failed to document the appropriate vacancy rate or hospital contacts;

(7) The nursing home charged hospitalized residents who are recipients of medical assistance for reserving their beds when the nursing home was required to reserve

the bed but was ineligible for Medicaid reimbursement because it did not meet the vacancy rate requirement set forth in subsections (b) (5) (A) (i) and (b) (5) (B) (i) of this section.

(d) **Remedies**

(1) Compliance with this section shall be monitored by the Department on a post-audit basis or whenever a complaint is received. The Department is authorized to impose a penalty not greater than \$8500 for each violation; and

(2) In addition, the Department shall recoup any payments made to the facility for reserve-bed days for cases in violation of requirements by setting off the amount of such payments against any other payments due the facility or by other methods.

(3) If a violation is discovered prior to payment for reserve-bed days which, because of the violation, would result in inappropriate payment, the Department may deny payment for those reserve-bed days.

(4) Prior to imposing a penalty, and/or recouping payments, the Department shall notify the nursing home of the alleged violation and the accompanying penalty and/or recoupment.

(5) The provider may appeal a decision or a finding of an alleged violation by the Department in accordance with Section 17-311-27 through Section 17-311-40 of the Regulations of Connecticut State Agencies, provided that the appeal is received on or before the fifteenth (15th) day after the receipt of notice of violation or issuance of denial. Computation of time within which an appeal must be received by the Department shall be computed in accordance with Section 17-311-15 of the Regulations of Connecticut State Agencies, as amended from time to time. Imposition of any penalty and/or recoupment shall be stayed pending the outcome of the administrative hearing for the appeal.

(Effective March 26, 1990)

**Sec. 17-134d-80. Title XIX utilization review requirements for medicaid services in general hospitals**

(a) **Definitions**

For purposes of this regulation, the following definitions apply:

(1) Acute Care means the medical care needed for an illness, episode, or injury which requires short term, intense care and hospitalization for a short period of time.

(2) Admission means the formal acceptance by a hospital of a patient who is to receive health care services while lodged in an area of the hospital reserved for continuous nursing services.

(3) Adverse Determination means the initial negative decision by a reviewing body regarding the medical necessity, quality, or appropriateness of health care services provided or proposed to be provided to a patient.

(4) Appropriateness of Setting Review means the review of services provided or proposed to be provided to determine if the services could have been delivered safely, effectively and more economically in another setting.

(5) Criteria means the pre-determined measurement variables on which judgment or comparison of necessity, appropriateness or quality of health services may be made.

(6) Department means the State of Connecticut Department of Income Maintenance or its agent.

(7) Department's Manual means the Department's Connecticut Medical Assistance Provider Manual, which contains the Medical Services Policy, as amended from time to time.

(8) Diagnosis

(A) Admitting Diagnosis means the patient's condition which necessitated or prompted the admission to the hospital, and coded according to International Classification of Diseases, 9th Revision, Clinical Modification, and as amended from time to time.

(B) Principal Diagnosis means the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care and coded using International Classification of Diseases, 9th Revision, Clinical Modification, and as amended from time to time.

(9) Emergency means a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(10) Evaluation means an assessment or examination in which actions and their results are measured against predetermined criteria in order to verify medical necessity, appropriateness, and quality.

(11) Free Standing Clinic means a facility providing medical or medically related clinic outpatient services or clinic off-site services by or under the direction of a physician or dentist and the facility is not part of, or related to, a hospital. Such facilities provide mental health, rehabilitation, dental and medical services and are subject to Sections 171 through 171.4 of the Department's Manual, as may be amended from time to time.

(12) General Hospital for purposes of this regulation means a short-term hospital having facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a wide range of acute conditions, including injuries, and shall include a children's general hospital which means a short-term hospital having facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a wide range of acute conditions among children, including injuries. It shall also include a border hospital as defined in Section 150.1 of the Department's Manual, as may be amended from time to time.

(13) Inpatient means a recipient who has been admitted to a general hospital for the purpose of receiving medically necessary, appropriate, and quality medical, dental or other health related services and is present at midnight for the census count.

(14) Medical Appropriateness means medical care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care and is delivered in the appropriate medical setting.

(15) Medical Necessity means medical care provided to:

- (A) Correct or diminish the adverse effects of a medical condition;
- (B) Assist an individual in attaining or maintaining an optimal level of well being;
- (C) Diagnose a condition; or
- (D) Prevent a medical condition from occurring.

(16) Override Option means a decision, used in utilization review, when "overriding" circumstances of clinical significance justify changing the conclusion of the objective criteria.

(17) Patient means an individual who receives a health care service from a provider and is also a Medicaid recipient.

(18) Preadmission Review means a review prior to or in the case of an emergency admission, immediately thereafter, a patient's admission to a hospital to determine the medical necessity, appropriateness, and quality of the health care services proposed to be delivered, or in the case of an emergency, delivered in the hospital.

(19) Principal Procedure means the procedure most closely related to the principal diagnosis, that is performed for definitive treatment rather than one performed for diagnostic or exploratory purposes and/or was necessary to care for a complication, and coded according to International Classification of Diseases, 9th Revision, Clinical Modification, and as amended from time to time.

(20) Prior Authorization means approval for a service from the Department or the Department's agent before the provider actually provides the service. In order to receive reimbursement from the Department a provider must comply with all prior authorization requirements. The Department in its sole discretion determines what information is necessary in order to approve a prior authorization request.

In the case of an emergency admission to a general hospital, prior authorization means approval obtained within two business days of admission.

(21) Quality of Care means the evaluation of medical care to determine if it meets the professionally recognized standard(s) of acceptable medical care for the condition and the patient under treatment.

(22) Recipient means an individual who has been determined eligible for Medicaid.

(23) Reliability means a measure of the consistency of a method in producing results. A reliable test gives the same results when applied more than once under the same conditions.

(24) Retrospective Review means the review conducted after services are provided to a patient, to determine the medical necessity, appropriateness, and quality of the services provided.

(25) Utilization Review means the evaluation of the necessity, appropriateness, and quality of the use of medical services, procedures and facilities. Utilization review evaluates the medical necessity, and medical appropriateness of admissions, the services performed or to be performed, the length of stay and the discharge practices. It is conducted on a prospective and/or retrospective basis.

(26) Validity means a measure of the extent to which an observed situation reflects the true situation or an indication of medical quality measures what it purports to measure.

**(b) Utilization Review Program in General Hospitals**

(1) The Department's Utilization Review Program conducts utilization review activities for services delivered to general hospital inpatients, where Medicaid has been determined to be the appropriate payer.

(2) The Department's objectives for performing utilization review include:

(A) To determine the medical necessity and appropriateness of general hospital inpatient services;

(B) To assure that the quality of service meets accepted and established standards;

(C) To safeguard against unnecessary and inappropriate utilization;

(D) To effectively monitor provider patterns of utilization; and

(E) To identify inappropriate patterns and services.

(3) To evaluate services the Department through its staff or its agent, uses utilization review techniques that have withstood tests for validity and reliability. For example: Professional Activity Study (PAS) Norms, Appropriateness Evaluation Protocol (AEP), InterQual ISD Review System (Intensity of service, severity of illness discharge screens).

(4) As part of the Utilization Review process, reviewers may use an override option. The purpose of the override option is to:

(A) Allow the reviewer to indicate that the criteria are not sufficiently comprehensive to meet non-criteria circumstances or factors necessitating admission and/or hospitalization; or

(B) Conversely, to judge that the service which meets the criteria are not justified on clinical grounds.

(5) When the Hospital Utilization Review Program makes an adverse determination on a preadmission review, the provider is notified by telephone and in writing and is given the opportunity to request a second review. The second review to present additional information, can be requested by telephone or in writing within ten (10) calendar days of the adverse determination, unless, for good cause shown in the discretion of the Commissioner, the time for submission is extended. The provider sends the information to Director, Medical Care Administration, or his/her designee. Following receipt of said additional documentation, the Department shall make its final determination and shall notify the provider by telephone and in writing.

(6) When the Hospital Utilization Review Program makes an adverse determination on a retrospective review providers are sent a written summary of findings by the Department. The provider is given an opportunity to request a second review and present additional information in writing, provided said request is submitted in writing to the Department within twenty (20) calendar days of the date of receipt of notice of adverse determination unless, for good cause shown in the discretion of the Commissioner, the time for submission is extended. The date of receipt is presumed to be five (5) days after the date on the notice, unless there is a reasonable showing to the contrary. The provider sends the information to Director, Medical Care Administration, or his/her designee. Following receipt of said additional documentation, the Department shall make its final determination and shall notify the provider in writing.

**(c) Payment for Medicaid Services**

(1) Payment by Connecticut Medicaid is only for definitive medical care, treatment and services that are judged to be medically necessary. The Department will not pay for any principal procedure or other procedures or service of an unproven, experimental, social, educational or research nature or for service(s) in excess of those deemed medically necessary by the Department to treat the patient's condition or for services not directly related to the patient's diagnosis, symptoms or medical history.

(2) Medical care, treatment and services must be provided to eligible Medicaid recipients in accordance with the Department's policies, procedures, conditions and limitations and billed for in accordance with the billing section of the Department's Manual.

(3) Payment will be denied for hospital inpatient services, and also for physicians (including physicians in free-standing clinics), dentists, and podiatrists services provided to hospital inpatient recipients if the Department determines that the medical care, treatment or service does not or did not meet the established medically necessary and/or utilization review standard in accordance with generally accepted criteria and standards of medical practice, or if they do not or did not comply with the other policies, procedures, conditions, and limitations established by the Department. This determination may be made at the time of prior authorization, preadmission review, or retrospective review. The fact that a denial was not made at an earlier stage shall not preclude such a determination at a later stage. The Department is entitled to disallow the entirety or any portion of the stay and services provided

which the Department finds not to meet the medically necessary or utilization review standard.

(d) **Requirements for Establishment of Medical Necessity**

(1) To determine that inpatient general hospital services or admissions are medically necessary, the Department or its agent:

(A) Shall require prior authorization of each general hospital inpatient admission including emergency admissions unless the Department notifies the providers that a specific diagnosis or procedure does not require such prior authorization. In addition the Department, in its discretion, may perform preadmission review and/or reviews of any or all general hospital inpatient admissions unless the Department notifies the providers that a specific diagnosis or procedure does not require such review.

(B) Shall perform retrospective reviews in the Department's discretion which may be of a random or targeted sample of general hospital admissions and services delivered. The review may be focused on the appropriateness, necessity, and quality of the health care services provided.

(2) If the Department decides to reimpose prior authorization or preadmission review requirements which it has previously notified providers it will no longer require, the Department shall notify all affected providers at least thirty (30) days in advance of the imposition of preadmission review or prior authorization requirements.

(3) All claims for payment for admission and all days of stay and services provided must be documented with the medical records required by section 150.1F.V. of the Department's Manual. Lack of said documentation itself may be adequate ground for the Department, in its discretion, to deny payment for the admission of some or all of the days of stay or services provided.

(e) **Special Requirements for Retrospective Review of Emergency Admissions When Prior Authorization Had Not Been Obtained On A Timely Basis.**

Payment for an emergency admission where prior authorization was not obtained may be made pursuant to the following:

(1) The hospital shall request retrospective review within thirty (30) calendar days of the date the patient was admitted to the hospital. The hospital may request that the Department waive the thirty (30) calendar day time limit if the hospital proves to the satisfaction of the Department that: (a) the failure to make the request within the thirty (30) day time limit was caused by reasons beyond the control of the hospital; and (b) the hospital neither knew nor had any reason to check the eligibility of the individual within the thirty (30) day time period or checked with the Department's eligibility verification unit and was given erroneous information (the "Good Cause Exception"). The total number of Good Cause Exceptions, per hospital fiscal year, shall not exceed the greater of one, or .125% (.00125) of such hospital's Medicaid discharges for the most recent fiscal year documented in the most recent "Cost Settlement Summary-Inpatient Fiscal Year" in the Department's possession on July 1, from the Department's Medicaid Management and Information System (MMIS);

(2) The retrospective review will be done at the hospital's expense at the standard charge of the department's contractor to hospitals;

(3) For each fiscal year commencing October 1, the hospital may request, in total, retrospective reviews up to the maximum number for which it has received authorization pursuant to subsection six (6) below;

(4) The patient for whom the retrospective review is requested was an emergency admission (i.e. admitted through the emergency room or transferred from another hospital on an emergency basis due to the original hospital's inability to treat the patient due to the severity or complexity of the illness or injury). No request may be made for consideration of patients admitted directly or via transfer if the admission was not an emergency admission;

(5) The retrospective review reveals that all requirements for payment are met except for the failure to obtain prior authorization.

(6) In July of each year, the Department shall notify each hospital of the maximum number of retrospective reviews. Said number shall be one percent (1%) of its Medicaid discharges for the most recent fiscal year documented in the most recent "Cost Settlement Summary-Inpatient Fiscal Year" in the Department's possession on July 1, from the Department's Medicaid Management and Information System (MMIS).

(Effective February 24, 1993)

### **Sec. 17-134d-81. Policy and procedures governing the billing and payment for prescription drugs on behalf of title XIX medicaid recipients**

#### **(a) Scope**

This regulation governs the billing and payment for prescription drugs and Pharmaceutical Services provided to persons determined eligible for such goods and services under provisions of Connecticut's Medical Assistance Program in accordance with Section 17-134d of the General Statutes of Connecticut.

#### **(b) Definitions**

For the purpose of Regulation Section 17-134d-81, the following definitions apply:

(1) "Average Wholesale Price" (A.W.P.) means the published wholesale price as determined by the Department from the price listed by one or more national publications recognized by the Department.

(2) "Brand Name/Trade Name" means the name assigned to a drug by the pharmaceutical innovator, i.e., manufacturer and/or distributor for the purpose of distribution to wholesalers or retailer, whether or not this name is registered in the United States Patent Office.

(3) A "Compounded Prescription" means two or more drugs mixed together and at least one ingredient must be a legend drug. A compounded prescription must include name, strength, and amount of each prescribed ingredient.

(4) "Connecticut Over-the-Counter Formulary" means the formulary of O.T.C. (nonlegend) drugs which are reimbursable by the Department.

(5) "Department" means the Connecticut Department of Income Maintenance.

(6) "Dispensing Fee" means an amount of money paid to a pharmacist for rendering a professional service involving the preparation and dispensing of a prescribed drug order by a licensed authorized practitioner.

(7) "Documented in Writing" means that the prescription has been handwritten, typed or computer printed. Computerized systems must meet all of the requirements of the Commission of Pharmacy Regulations Chapter 382 Sections 20-164b-1 through 20-164b-11 for non-controlled drugs and Sections 21a-244-1 through 21a-244-6 for controlled drugs and as they may be amended from time to time. (Note: Record retention for all Medicaid claims extends to a five (5) year period per (g) (2) of this regulation.)

(8) "Drug Efficacy Study Implementation (DESI) Program" means the program through which the Food and Drug Administration has identified certain products which lack sufficient evidence of their effectiveness for the approved indication(s).

(9) “Estimated Acquisition Cost” (E.A.C.) means the Department’s best estimate of the price generally and currently paid by providers for a drug marketed or sold by a particular manufacturer or labeler in the package size most frequently purchased by providers.

(10) “Federal Acquisition Cost/Federal Upper Limit” (F.A.C.) means the upper limit allowable cost established and published by HCFA for those multiple source drugs which appear on HCFA’s list of multiple source drugs for which upper limits have been established and as revised from time to time.

(11) “HCFA” means the Health Care Financing Administration of the United States Department of Health and Human Services.

(12) “Legend Drugs” means any article, substance, preparation or device which bears the legend: “Caution Federal Law prohibits dispensing without a prescription.”

(13) “Licensed Authorized Practitioner” means any physician or other licensed practitioner who is authorized to prescribe drugs within the scope of his or her professional practice as defined and limited by Federal and State law.

(14) “Multiple-source Drug” means a drug marketed or sold by two or more manufacturers or labelers, or a drug marketed or sold by the same manufacturer or labeler under two or more different proprietary names, or both under a proprietary name and without such a name.

(15) “Nutritional Supplements” means commercially prepared products, the primary purpose of which is to treat a diagnosed deficiency or potential deficiency in the patient’s diet or nutrition.

(16) “Over-the-Counter/Nonlegend Drugs” (O.T.C.) means drugs which do not require a prescription by Federal or State law (O.T.C. items are available for purchase by the general public with or without a prescription) and generally are used for persons residing in the community and is usually administered or used by the patient on the basis of self-diagnosis.

(17) “Pharmacy” means a facility licensed by the Commission of Pharmacy in the Department of Consumer Protection under Section 20-168 of the Connecticut General Statutes, or by the appropriate regulatory body of the state in which it is located.

(18) “Prescribed Drug” means a single drug or compound or mixtures or substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that is:

(A) Prescribed by a licensed authorized practitioner within the scope of his or her professional practice as defined and limited by Federal and State law; and

(B) Dispensed by the licensed pharmacist on a written or oral prescription issued in accordance with the State Medical Practice Act and that is recorded and maintained in the pharmacist’s records.

(19) “Prescription” means an order issued by a licensed authorized practitioner and documented in writing by either the practitioner or the pharmacist. In nursing homes the signed order of a licensed authorized practitioner will be accepted in lieu of a written or oral prescription. The written prescription includes:

(A) the name and address of the patient; and

(B) whether the patient is an adult or a child, or the patient’s specific age; and

(C) the compound or preparation ordered; and

(D) its strength when applicable and the specific amount thereof, to be dispensed at one time; and

(E) directions for the use of the medication and any cautionary statements required; and

(F) the number of times that the prescription may be refilled, if applicable; and

(G) date of issuance; and

(H) name and address of the prescribing practitioner and his/her Drug Enforcement Act number when appropriate.

(20) “Prior Authorization” (P.A.) means approval for a service from the Department before the provider actually provides the services. In order to receive approval from the Department a provider must comply with all prior authorization requirements found in regulation. P.A. does not, however, guarantee payment unless all other eligibility requirements are met.

(21) “Usual and Customary Charge to the General Public” means a charge which will be made for the particular prescription by the provider to the patient group accounting for the largest number of non-Medicaid prescriptions. In determining such charge, all charges made to third party payors and special discounts offered to an individual such as a senior citizen will be excluded.

**(c) Provider Participation**

In order to participate in the Medicaid program and receive payment directly from the Department all pharmaceutical providers must:

(1) be licensed by the appropriate regulatory body of the state in which it is located to operate a pharmacy and provide the Department with a copy of the license; and

(2) meet and maintain all applicable license requirements of Federal and State statutes and regulations; and

(3) meet and maintain all applicable Departmental enrollment requirements; and

(4) have a valid provider agreement on file which is signed by the provider and the Department upon application for enrollment into the Medicaid program and periodically thereafter as required by the Department and which is in effect for the period as stated in the agreement. The provider agreement specifies conditions and terms (Federal and State statutes, regulations and standards) which govern the program and to which the provider is mandated to adhere to in order to participate in the program.

**(d) Eligibility**

Payment for Pharmaceutical Services is available for all Medicaid eligible recipients subject to the conditions and limitation which apply to these services.

**(e) Services Covered and Limitations**

**(1) Services Covered**

Except for the limitations and exclusions listed below, the Department will pay for drugs which are prescribed by a licensed authorized practitioner as a result of accepted methods of diagnosis and treatment.

**(2) Service Limitations**

**(A) Maximum Allowable Supply**

The Department will not reimburse for an original prescription or refill that exceeds the supply requirement for a period of thirty (30) days not to exceed two hundred and forty (240) units except in the following instances:

(i) Prescriptions for chronic conditions or maintenance drugs shall be for at least a thirty (30) day supply not to exceed two hundred and forty (240) units unless a lesser amount is prescribed.

(ii) For prescriptions for oral contraceptives, a supply sufficient for a maximum period of three (3) months may be dispensed at any time.

**(B) Refills**

Payment will be made for a refill of a prescription as authorized by the licensed authorized practitioner for an acute, or chronic illness, or condition as follows:

(i) Payment will be made for the original prescription and as many refills as ordered by the licensed authorized practitioner covering a maximum period of six (6) months. This does not apply to those items which fall within the “Controlled Substance Act,” that being five (5) refills or six (6) months whichever comes first as is governed by 21 U.S.C. Section 829 (b) and Section 21a-249 (h) of the Connecticut General Statutes and as they may be amended from time to time.

(ii) Payment shall be made for a refill of a prescription for oral contraceptives which may cover a maximum period of twelve (12) months, including the original filling.

(C) The Department will not pay for any nonlegend drugs for nursing home patients when these items are used in usual and customary amount of routine care and treatment; the cost of such items is included in the nursing home’s daily rate as set by the Department.

(D) The Department will not pay for any nutritional supplements for nursing home patients; the cost of such items is included in the nursing home’s daily rate as set by the Department.

(E) A licensed authorized practitioner may telephone prescription orders to a pharmacist. These orders must be documented in writing and countersigned or initialed by the pharmacist and must include the date of the telephone call.

**(3) Services Not Covered**

The Department will not pay for:

(A) Any vaccines and/or biologicals which can be obtained free of charge from the Connecticut State Department of Health Services. The Department will notify pharmacists of such vaccines and biologicals.

(B) Any drugs used in the treatment of obesity.

(C) Drugs included in the DESI program. The Department will notify providers of such drugs.

(D) Controlled Substance dispensed to Medicaid recipients which are in excess of the product manufacturer’s recommendation for safe and effective use for which there is no documentation of medical justification in the pharmacy’s file.

(E) Drugs for a Lock-In recipient who is not locked into the billing pharmacy.

(F) Alcoholic liquors.

(G) O.T.C.s except those on the State of Connecticut’s “O.T.C. Formulary” or as otherwise provided in these regulations.

(H) Anything of an unproven, experimental or research nature.

(I) Items used for personal care and hygiene or for cosmetic purposes.

(J) Drugs not directly related to the patient’s diagnosis, when diagnosis is required by the Department to be written on the prescription.

(K) Drugs solely used to promote fertility.

(L) Drugs used to promote smoking cessation.

**(f) Need for Service and Authorization Process****(1) Need for Service**

A patient’s need for pharmaceutical service is indicated when a licensed authorized practitioner prescribes a legend or nonlegend drug for treatment of or prevention of an illness or condition as documented in the patient’s medical record.

**(2) Prior Authorization**

(A) The Department will not require P.A. for certain prescribed drugs which otherwise would require P.A. when prescribed by a licensed authorized practitioner for certain specified diagnoses. The diagnoses must be written on the prescription either by the authorized practitioner, or the pharmacist, after verification with the prescriber. The Department will notify providers of such medications with the corresponding diagnosis and diagnosis indicator.

The following drugs require prior authorization for all patients:

(B) Any prescribed nonlegend (O.T.C.) medication or its equivalent used in the treatment of specific condition and which does not appear on the Connecticut's "O.T.C. Formulary," or on the NDC/Diagnosis cross reference list with an appropriate diagnosis indicator (see (f) (2) (A)).

(C) All Vitamins, except pediatric vitamins for children prior to the child's seventh birthday, vitamins with fluoride and Legend Hematinic alone or in combination with vitamins, or any product so specified by the manufacturer as a hematinic.

(D) Nutritional supplements (not covered under (f) (2) (A)).

(E) Amphetamines, amphetamine-like drugs (not covered under (f) (2) (A)).

(3) Authorization Procedures

(A) Prior authorization for prescribed drugs is obtained by submitting the Department's P.A. form, "Authorization Request and Bill for Prescription Drugs" to:

Department of Income Maintenance

110 Bartholomew Avenue

Hartford, Connecticut 06106

Attention: Medical Unit

(B) Prior authorization will be approved covering a maximum of a three (3) month period. The effective starting date will be the date service is initially rendered and approved. If the need for service exceeds the authorization period, a request for an extension must be submitted on a form provided by the Department and approved prior to the onset of the period of extension. The request is sent to the Department with documentation by the physician that the medication continues to be medically necessary.

(C) A pharmacist receiving a prescription for medication requiring prior authorization must complete the pharmacy section of the P.A. form. The licensed authorized practitioner (prescriber) must complete all relevant portions of the P.A. form. The pharmacist will then submit the request to the Department for consideration.

(D) In emergency situations, the pharmacist may telephone the Department to obtain verbal authorization. The written request for authorization must be submitted to the Department within fifteen (15) working days following verbal authorization.

(E) In emergency situations, which occur after normal working hours, the pharmacist must call the Department for verbal approval on the following work day. The written request for authorization must be submitted to the Department within fifteen (15) working days following the date the medication was dispensed.

(g) **Other**

(1) Information Required on Prescriptions

All prescriptions must be processed in accordance with the regulations of the Commission of Pharmacy.

(2) Retention of Prescriptions

All claims for covered drugs must be substantiated by a prescription from a licensed authorized practitioner on file in the pharmacy supplying the service, in accordance with Section 20-184c of the Connecticut General Statutes. In addition, documentation of prescriptions and/or medication orders must be retained by the

pharmacy for a period of five (5) years or if any dispute arises concerning a prescription, until such dispute has been finally resolved.

(3) **Patient Profile**

A patient profile record listing prescriptions must be maintained by the pharmacy for Title XIX patients.

(4) **Oral Prescriptions**

An oral prescription which is telephoned by a licensed authorized practitioner to a pharmacist must be documented in writing by the pharmacist for his records. These orders must be countersigned or initialed by the pharmacist and must meet the requirements as contained in Section 20-184b of the General Statutes and as it may be amended from time to time.

(h) **Billing**

Bills for covered drugs from pharmacy providers, are submitted on the Pharmacy Claim form or electronically transmitted to the Department's billing fiscal agent and must include all information required by the Department to process the claim for payment.

(i) **Payment**

(1) **Payment for Legend Drugs**

Except for vaccine(s) utilized in mass inoculation, payment for legend drugs shall be based on the quantities set forth in A.W.P. for one hundred units, a pint if liquid or pound if powder, or as determined by the Department. Reimbursement will be made under E.A.C. or F.A.C., whichever is applicable to the particular drug dispensed plus the dispensing fee, or the usual and customary charge to the general public, whichever is lower.

The Department will pay for mass inoculation of Influenza, Pneumovax or Hepatitis-B vaccine(s) provided they are prescribed by a licensed authorized practitioner and documented in the patient's medical record. The reimbursable amount and reimbursement procedures will be determined by the Department and supplied to providers via a fee schedule.

(A) **Estimated Acquisition Cost**

The Department of Income Maintenance must determine an E.A.C. for all legend drugs not covered by the F.A.C.

(i) The Department's E.A.C. will be the Department's best estimate of the price generally and currently paid by providers for a drug marketed and sold by a particular manufacturer or labeler in the package size of drugs most frequently purchased by providers. E.A.C. will be set at a percentage of A.W.P. The Department will notify providers in the event that the Department's best estimate of the appropriate percentage changes.

(ii) The Department shall reimburse providers at the lower of the following:

- a. The Department's E.A.C. plus the applicable dispensing fee; or
- b. The provider's usual and customary charge to the general public; or
- c. The amount billed by the provider.

(B) **Multiple-source Drugs**

For each multiple-source drug for which HCFA has identified and designated a F.A.C., reimbursement shall be the lower of the following:

- (i) The F.A.C. as established by HCFA plus the applicable dispensing fee; or
- (ii) The provider's usual and customary charge to the general public; or
- (iii) The amount billed by the provider.

(C) **Certification of Brand Name Drugs**

Reimbursement for multiple-source drugs for which HCFA has designated a F.A.C. is not limited to the F.A.C. if a licensed authorized practitioner determines that a specific brand is medically necessary for a particular patient, provided the following requirements are met:

(i) A licensed authorized practitioner may certify in writing that there shall be no substitution for a specified brand name drug product prescribed for a particular patient, by writing the phrase "Brand Medically Necessary," on the prescription form. The phrase shall be in the practitioner's handwriting and shall not be preprinted, stamped, initialed, or checked off in a box on such form.

(ii) If the licensed authorized practitioner specifies by telephone that there shall be no substitution, handwritten certification bearing the phrase "Brand Medically Necessary," must be mailed to the pharmacy within ten days. The written certification must be kept by the pharmacist as part of his or her permanent records.

(D) Compounded Prescriptions

The Department will pay for compounded prescriptions at the lower of:

(i) The E.A.C. or F.A.C., whichever is applicable to the given drug, for each ingredient plus an applicable dispensing fee; or

(ii) The provider's usual and customary charge to the general public; or

(iii) The amount billed by the provider.

(E) Unit Dose Packaging

The Department will not pay providers for unit dose packaging or any other specially packaged drugs when standard packages are available and/or where the special packaging is strictly for convenience and does not contribute to the therapeutic benefit of the drug.

(2) Payment for Nonlegend Drugs

(A) The Department of Income Maintenance will pay for all O.T.C. drugs listed on the Connecticut O.T.C. Formulary, provided they are prescribed for a specific illness and/or condition by a licensed authorized practitioner.

(i) The reimbursable amount shall be established by the Commissioner. The Department will publish the reimbursable amounts via a fee schedule.

(ii) The Commissioner shall appoint a committee to periodically review the drugs listed on the Connecticut O.T.C. Formulary. Periodically a report of the committee's recommendations will be submitted to the Commissioner for consideration. The committee may include one or more of the following; a physician, a pharmacist and a nurse consultant.

(iii) For any non-legend drug prescribed in less than the standard packaged amount, the Department will pay for the contents of the full package size which is closest to the amount ordered and still be sufficient to supply the amount prescribed.

(3) Dispensing Fees

Dispensing fees will be established by the Department after periodic review of pharmacy operational cost. Pharmacy providers will be advised of such fees and any changes.

(4) Substitution of generically Equivalent Drugs

(A) The Department will pay a pharmacist a professional dispensing fee of fifty cents (\$.50) per prescription in accordance with Section 17-134q of the Connecticut General Statutes in addition to any other dispensing fee, for substituting a generically equivalent drug product, in accordance with Section 20-185b of the Connecticut General Statutes, for the drug prescribed by the licensed authorized practitioner for a Medicaid recipient, except in the following instances:

(i) When a drug product is dispensed for which HCFA has designated a F.A.C.; or

- (ii) When a compounded prescription is dispensed; or
  - (iii) When a nonlegend drug is dispensed; or
  - (iv) When the substitution is required by Federal law or regulation.
- (Effective July 29, 1992)

**Sec. 17-134d-82. Requirements for payment of case management services**

**(a) Scope**

These regulations set forth the requirements for payment of Case Management Services provided by the State of Connecticut Department of Mental Retardation to persons determined eligible to receive services under Connecticut's Medical Assistance Program pursuant to Section 17-134d of the General Statutes of Connecticut.

**(b) Definitions**

For the purposes of Regulation Section 17-134d-82, the following definitions shall apply:

(1) "Case manager" means the person responsible for assisting an eligible person to gain access to needed services, managing the development of a plan of services, securing and coordinating needed services, monitoring an eligible person's progress, maintaining family contact, collecting or disseminating data and information.

(2) "Case management services" means a continuum of supportive activities systematically carried out by an individual case manager that are available to assist and enable an eligible person to gain access to needed medical, social, educational, or other services.

(3) "Calendar quarter" means the periods of time in any state fiscal year inclusive of July 1 through September 30; October 1 through December 31; January 1 through March 30; and April 1 through June 30.

(4) "Department" means the State of Connecticut Department of Income Maintenance.

(5) "Eligible person" means a person who qualifies to receive services under the Connecticut Medical Assistance Program pursuant to Section 17-134b of the General Statutes of Connecticut, as amended from time to time, and regulations promulgated pursuant to Section 17-134d of the General Statutes of Connecticut.

(6) "Needed services" means any medical, social, educational, or other services identified as required by an eligible person in a plan of services.

(7) "Plan of services" means a written document which is developed by a team on an annual basis that identifies an eligible person's unique characteristics, needs, needed services, and public agencies or private entities that will provide or may provide the needed services.

(8) "Representative" means any person, organization, or entity authorized to act on the behalf of an eligible person through an agreement, or a family member, or a court appointed delegate of the eligible person pursuant to provisions in the General Statutes of Connecticut, as amended from time to time.

(9) "Target group" means those eligible persons specified by the Department to receive case management services by age, type or degree of disability, illness or condition, or any other identifiable characteristics, or geographic areas or political subdivisions, or combination thereof.

(10) "Team" means a group of persons which consists of the case manager and shall include one or more of the following: the eligible person or his representative; actual or potential providers of needed services; pertinent professionals from various disciplines; and any other persons whose participation is relevant who convene to develop or review a plan of services.

**(c) Provider Participation**

In order to participate in the Connecticut Medical Assistance Program and receive payment from the Department for the case management services rendered, the Department of Mental Retardation shall:

(1) Provide case management services pursuant to all applicable provisions under federal and state statutes and regulations promulgated thereunder;

(2) Meet and maintain all Department provider enrollment requirements;

(3) Have a valid Connecticut Medical Assistance Program provider agreement on file with the Department which is signed by the Department of Mental Retardation Commissioner or the Commissioner's designee. The provider agreement will be effective upon the Department approved date of enrollment. The provider agreement specifies conditions and terms (Federal and State regulations, standards and statutes) which govern the Connecticut Medical Assistance program and to which the Department of Mental Retardation is mandated to adhere to in order to participate in the program; and

(4) Assign an individual case manager to serve as the primary person responsible for case management services.

(5) Pursuant to subsection (f) (2) below a case manager is limited to qualified case managers designated by the Department of Mental Retardation.

**(d) Eligibility**

Payment for case management services is available only on behalf of all persons specified as members of a target group pursuant to subsection (f) (1) below who are eligible to receive services pursuant to the Connecticut Medical Assistance Program subject to conditions and limitations which apply to such case management services.

**(e) Services Covered**

Covered case management services may include a continuum of supportive activities performed by an individual case manager which enable an eligible person to gain access to needed services. At a minimum, such case management services shall include one or more of the following types of case management activities in a calendar quarter:

(1) Case advocacy to enable an eligible person to make his preferences known, to ensure the smooth flow of information and minimize conflict between service delivery systems and to mobilize resources to obtain or access needed services;

(2) Collaboration through direct or collateral contacts with an eligible person or his representative to support a person-or family-centered planning process for development and maintenance of a plan of services;

(3) Coordinating or attending team meetings to develop or revise a plan of services;

(4) Liaison activities to arrange for assessments that may be necessary to determine an eligible person's needed services;

(5) Coordination of a plan of services through direct or collateral contacts with the eligible person or his representative, members of their informal support networks, and public or private entities that provide or may provide needed services;

(6) Monitoring the quality and quantity of needed services that are being provided as they relate to an eligible person's needs, plan of services, and safety;

(7) Providing information and referral; and

(8) Review and maintenance of an eligible person's plan of services.

**(f) Limitations**

(1) Target Group Limitations

Payment for case management services is limited to case management services provided to eligible persons with mental retardation as defined in the General Statutes of Connecticut Section 1-1g and to eligible persons with conditions related to mental retardation as defined in subsection (e) (7) (G) (ii) of section 1919 of the Social Security Act and implementing federal regulations, as amended from time to time, who receive case management services from the Department of Mental Retardation pursuant to subsection (f) (2) below.

**(2) Provider Limitations**

(A) For eligible persons with mental retardation or with conditions related to mental retardation the Department of Mental Retardation shall be the sole entity enrolled with the Department to provide case management services to eligible persons and to enter into a provider agreement with the Department for the provision of such services.

(B) For eligible persons with mental retardation or with conditions related to mental retardation qualified case managers are limited to case managers designated to render services to said persons by the Department of Mental Retardation in accordance with the General Statutes of Connecticut and rules regarding provision of services adopted by said agency, as amended from time to time.

**(3) Payment Limitations**

(A) Payment for case management services will be made only when the eligible person or his representative has requested or applied to receive services from the Department of Mental Retardation.

(B) Payment for case management services may not duplicate payments made under the Connecticut Medical Assistance Program for other services that are covered under the program. Specifically, separate payment for case management services is not available when the same case management service is provided as an integral and inseparable part of another Connecticut Medical Assistance program covered service, including as part of intermediate care facility services for the mentally retarded (ICF/MR).

(C) Payment for case management services by the Department will not be made unless one or more of the case management activities pursuant to subsection (e) above are rendered in a calendar quarter.

**(g) Need for Services**

Payment for case management services will be made by the Department only if the eligible person evidences a need for case management services. If the eligible person meets the requirements to receive services from the Department of Mental Retardation in accordance with the General Statutes of Connecticut and rules regarding provision of services adopted by said agency, as amended from time to time, the eligible person evidences a need for case management services.

**(h) Documentation Requirements**

Case management services will be reimbursed by the Department only when the following requirements are documented and are on file with the Department of Mental Retardation:

**(1) Plan of Services Requirement**

Case management services are provided in accordance with the eligible person's plan of services. At a minimum, the plan shall:

(A) Be developed by a team based upon the outcome of a team meeting conducted at least annually or more frequently if needed; and

(B) Be based on a uniform assessment, in accordance with the Department of Mental Retardation's regulations or policies as amended from time to time, of an

eligible person's needs which may include: assessments of medical, social, educational and other needs;

(C) Be reviewed and followed by the case manager;

(D) Indicate that the eligible person or his representative has participated in, or has been given the opportunity to participate in, the development of the eligible person's plan of services;

(E) Identify issues, needs, and goals relevant for the eligible person for the coming year;

(F) Identify the needed services required by an eligible person and the anticipated frequency, duration, and limitations of needed services;

(G) Indicate the case management services needed, and the anticipated frequency, duration, and limitations of case management services; and

(H) Indicate the various public agencies or private entities that will or may provide the needed services as identified by the team.

(2) **Permanent Service Record**

An individualized permanent service record for an eligible person must be maintained. At a minimum, the record shall contain the following:

(A) The eligible person's name, address, and other relevant historical and financial information;

(B) Assessments of the eligible person performed as necessary, to determine needed services;

(C) A plan of services pursuant to subsection (h) (1) above;

(D) Signed monthly service entries indicating the date, place of service, and type of case management services rendered; and

(E) A quarterly summary progress note reviewing the eligible person's needs and the plan of services which is dated and signed by the case manager.

(3) **Other Documentation Requirements**

All documentation shall be incorporated into the eligible person's permanent service record in a complete, prompt, and accurate manner. All documentation shall be made available to authorized Department personnel upon request as permitted by federal statute.

(i) **Billing Requirements**

All bills submitted to the Department for payment of case management services must be substantiated by documentation in the eligible person's permanent service record pursuant to subsection (h) above.

(j) **Payment**

Payment by the Department for case management services rendered to eligible persons shall be based on the Department of Mental Retardation's actual direct and indirect costs to provide case management services. Said costs shall be filed at the end of each state fiscal year with the Department by the Department of Mental Retardation.

For each state fiscal year the Department shall establish a payment rate based upon the said costs for the previous state fiscal year which shall be updated for inflation, using the most recent estimates of the price deflator for the gross national product as published in February of said state fiscal year in the "Economic Report of the Governor" of the State of Connecticut.

(k) **Audit**

All supporting accounting and business records, statistical data, and all other records relating to the provision of case management services paid for by the Department shall be subject to audit. If an audit discloses discrepancies in the

accuracy and/or allowableness of actual direct or indirect costs or statistical data as submitted for each state fiscal year by the Department of Mental Retardation, the Department's payment rate for the said rate period shall be subject to adjustment.  
(Effective August 31, 1990)

**Sec. 17-134d-83. Policy and procedures governing oxygen therapy on behalf of Title XIX medicaid recipients**

**(a) Scope**

Section 17-134d-83 through Section 17-134d-85 of the regulations of Connecticut State Agencies governs the billing and payment for Oxygen Therapy provided to persons determined eligible for such goods and services under the provisions of Connecticut's Medical Assistance Program in accordance with Chapter 302 of the General Statutes of Connecticut.

**(b) Definitions**

For the purpose of Regulation Section 17-134d-83 through Section 17-134d-85, the following definitions apply:

“Ambulatory” means an individual who is independently mobile or wheelchair mobile and is able to participate in the active daily living available to them in their living environment.

“Chronic Disease Hospital” means a long-term hospital having facilities, medical staff and all necessary personnel for the diagnosis, care and treatment of a wide range of chronic diseases as licensed by the Department of Health Services.

“Department” means State of Connecticut Department of Income Maintenance.

“Home” means the recipient's place of residence which includes a boarding home or Home for the Aged. Home does not include a hospital or long-term care facility.

“Hospital” means an establishment for the lodging, care and treatment of persons suffering from disease or other abnormal physical or mental conditions licensed by the Department of Health Services and includes inpatient psychiatric services in general hospitals.

“Long-Term Care Facilities” (LTC) are institutions licensed and certified under State law which have a provider agreement with the Department of Income Maintenance to provide a variety of medical, personal care, rehabilitative, and social services for recipients of Medical Assistance who are afflicted with acute, chronic or convalescent diseases or injuries or who because of their mental or physical condition require health-related care and services above the level of room and board which can be provided only through an institutional setting. These facilities include nursing facilities licensed as chronic and convalescent nursing homes, rest homes with nursing supervision and intermediate care facilities for the mentally retarded (ICFs/MR).

“Medical Equipment, Devices and Supplies” (MEDS) means Durable Medical Equipment, Medical Surgical Supplies, Orthotic and Prosthetic Devices and Oxygen Therapy.

“Oxygen Concentrator” means an electrically operated device that draws room air, separates the oxygen from the other gases in the air, and delivers the oxygen at high concentrations to the patient.

“Oxygen Therapy” means oxygen, equipment, supplies and services related to the delivery of oxygen.

“Oxygen Therapy Supplies” means all supplies needed for an oxygen system to function; such as cannula or mask, tubing, regulator with flow gauge and container.

“Portable Oxygen System” means oxygen in a portable unit which weighs less than 12 lbs. allowing the user greater ambulatory capability.

“Prescription” — The Certification of Medical Necessity form (Medicare Form HCFA-484) shall be the prescription form used for all oxygen therapy orders. This fully completed form signed by the prescribing physician will be the only acceptable initial certification form for oxygen services.

“Prior Authorization” (P.A.) means approval for a service from the Department of Income Maintenance *before* the provider actually provides the service. In order to receive approval from the Department a provider must comply with all prior authorization requirements found in Section 17-134d-84 (b) and (c). P.A. does not guarantee payment unless all other eligibility requirements are met. Payment may not be made, however, if P.A. is required and not obtained.

“Provider” means the vendor/supplier of oxygen therapy who is enrolled with the Department as a MEDS supplier or supplier of oxygen therapy.

“Pro Re Nata” (P.R.N.) means as the situation demands.

“Psychiatric Hospital” means a facility that is engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons and which has been accredited by the Joint Commission on Accreditation of Hospitals.

“Usual and Customary Charge to the General Public” means a charge which will be made for the particular service by the provider to the patient group accounting for the largest number of non-Medicaid services. In determining such charge, all charges made to third party payors and special discounts offered to an individual such as a senior citizen will be excluded.

**(c) Provider Participation**

In order to participate in the Medicaid program and receive payment directly from the Department all MEDS providers must:

(1) meet and maintain all applicable licensing and certification requirements of Federal and State statutes and regulations; and

(2) meet and maintain all Departmental enrollment requirements; and

(3) have a valid provider agreement on file which is signed by the provider and the Department upon application for enrollment into the Medicaid program and periodically thereafter as required by the Department and which is in effect for the period as stated in the agreement. The provider agreement specifies conditions and terms (Federal and State statutes, regulations and standards) which govern the program and to which the provider is mandated to adhere in order to participate in the program.

**(d) Eligibility**

Payment for oxygen therapy is available for all Medicaid eligible recipients who have a documented medical need, when it is prescribed by a physician subject to the conditions and limitations which apply to these services.

**(e) Services Covered**

(1) Except for the limitations and exclusions for oxygen therapy listed below, the Department will pay in accordance with Regulation Sections 17-134d-83 through Section 17-134d-85 for oxygen therapy in accordance with sections 1861 (s) (6) and 1862 (a) (1) (A) of the Social Security Act, 42 C.F.R. 410.38 and Medicare Carrier’s Manual Chapter II, Coverage and Limitations, Section 2100.5 including Section 60-4 in the Coverage Issues Appendix of the Medicare Coverage Issue Manual, and as these may be amended from time to time.

(2) Payment for oxygen products and services via oxygen concentrators in LTC facilities shall be included in the per diem reimbursement rate established by the Commissioner of Income Maintenance. (LTC facilities must purchase oxygen concentrators in sufficient numbers to meet the needs of their residents and may have up to one reserve unit for each nursing station. These requirements supplement the emergency system required in the Public Health Code, as applicable.)

**(f) Service Limitations**

Services covered are limited to those listed in the Department's fee schedule.

**(g) Oxygen Therapy Services Not Covered**

The Department will not pay for:

(1) Anything of an unproven, experimental or research nature or for services in excess of those deemed medically necessary by the Department to treat the recipient's condition or for services not directly related to the recipient's diagnosis, symptoms or medical history.

(2) Oxygen therapy supplied to hospital inpatients including Chronic Disease and Psychiatric Hospitals are routine services and are included in the hospital daily rate.

(3) The P.R.N. use of oxygen therapy.

(4) Oxygen concentrators in long-term care facilities.

(A) The purchase of oxygen concentrators are available to nursing facility residents.

(B) LTC facilities with built in wall oxygen systems are exempt from the requirements pertaining to purchase of oxygen concentrators. Concentrators may not be used for P.R.N. oxygen therapy in a facility with this type of oxygen system.

(5) Information furnished to the recipient over the telephone by the provider or prescribing physician.

(6) Demurrage, delivery, or set up charges.

(Effective May 27, 1992)

**Sec. 17-134d-84. Policy and procedures governing the need for service for oxygen therapy on behalf of Title XIX medicaid recipients**

**(a) Need for Services**

The Department will pay for oxygen therapy for any recipient who meets the criteria established by Medicare pursuant to sections 1861 (s) (6) and 1862 (a) (1) (A) of the Social Security Act, 42 C.F.R. 410.38 and Medicare Carrier's Manual, Chapter II, Coverage and Limitations, Section 2100.5 including Section 60-4 in the Coverage Issues Appendix of the Medicare Coverage Issue Manual, and as they may be amended from time to time. This includes all medical criteria including medical documentation, laboratory and health conditions, with the exception of (a) (1) and (2) of this section.

(1) A measure of arterial oxygen saturation obtained by ear or pulse oximetry, will also be acceptable when ordered and evaluated by the attending physician *and* performed under his/her supervision or when performed by a Licensed Nurse, Physician, a licensed supplier of Laboratory services, a Registered Respiratory Therapist or a Certified Respiratory Therapy Technician as recognized by the National Board Of Respiratory Care.

(2) Those recipients residing in the home and receiving oxygen therapy prior to the effective date of this regulation may continue to do so as long as the oxygen therapy is continuous. For the purpose of this provision continuous means that oxygen therapy remains necessary and is actively being used by the recipient at the beginning of every rental month. If at anytime the service is discontinued and is

prescribed again at a later time the requirements set forth under Sections 1861 (s) (6) and 1862 (a) (1) (A) of the Social Security Act, 42 C.F.R. 410.38 and Medicare Carrier's Manual, Chapter II, Coverage and Limitations, Section 2100.5 including Section 60-4 in the Coverage Issues Appendix of the Medicare Coverage Issue Manual and as they may be amended from time to time must be met. All residents of longterm care facilities must meet the requirements as set forth in the Medicare Carrier's Manual, Chapter II, Coverage and Limitations, section 2100.5; and as they may be amended from time to time; effective upon passage of these regulations in order to receive oxygen therapy services from a MEDS provider. Oxygen concentrators owned by nursing facilities may be used at the discretion of the nursing facility.

(3) **Prescription Requirements**

The Certification of Medical Necessity form (Medicare Form HCFA-484) shall be used for all orders of oxygen therapy. This fully completed form must be signed by the prescribing physician. The form shall be completed (1) annually for patients who require oxygen on a lifetime basis, and (2) every six (6) months for all other patients requiring oxygen.

(b) **Prior Authorization**

Prior authorization is required only for the rental of stationary gaseous or liquid oxygen systems in LTC facilities. However, if LTC facilities choose to purchase the stationary systems and include the cost in the per diem rate calculation, prior authorization is not required.

(c) **Prior Authorization Procedure**

Provision of service must be initiated within six (6) months of the date of authorization.

(1) Form W-619 "Authorization Request for Professional Services" is used to obtain prior authorization. The form must be completed and signed by the prescribing physician and the supplier and is submitted to the Department.

(2) **Authorization Period**

The initial authorization period for oxygen therapy can be up to 6 months. If the medical need continues beyond the initial authorization period, a request for the extension of the authorization using Form W-619 must be submitted to the Department with documentation by the attending physician, prior to expiration of the authorized period, that service continues to be medically necessary.

(3) The provider of service may request verbal approval from the Department during normal working hours, when such authorization may be given for initial service coverage. Authorization will be based on the Need for Service criteria as described in Section 17-134d-84 subsection (a). A completed prior authorization form must then be submitted to the Department within fifteen (15) working days stating the name of the consultant giving verbal approval and date approval was given.

(d) **Other**

(1) It will be the Department's decision to rent or purchase oxygen equipment and supplies except in cases where Medicare is the primary insurance carrier.

(2) All equipment purchased by the Department shall be new.

(3) All equipment purchased by the Department for a recipient will be the property of the recipient upon receipt by the recipient or her/his representative.

(4) The provider will furnish technical assistance to the recipient to teach the recipient and/or his or her family in the proper use and care of the equipment.

(5) Used equipment, when rented, must be completely refurbished and in proper condition to meet the recipient's specific medical need.

(6) Subject to the aforementioned limitations, exclusions, and definitions, oxygen therapy may be provided to eligible recipients in:

(A) Recipient's home;

(B) Long-term care facilities (LTC facilities will provide oxygen concentrator services to the fullest extent, possible after considering the patient's medical need and capability to ambulate. Only after these considerations have been satisfied and the need for alternative system has been documented will the Department pay a MEDS provider for oxygen services provided to LTC facility residents.)

(7) All required documentation must be maintained for at least five (5) years in the provider's file subject to review by the authorized Department personnel. This requirement survives any intervening change of ownership. In the event of a dispute concerning a service provided, documentation must be maintained until the end of the dispute or 5 years whichever is greater.

(8) For residents of long term care facilities proper documentation for the coverage of a portable oxygen system for a particular ambulatory patient must be maintained by both the facility and the provider. The supplier should secure from the LTC facility such documentation for their records.

(9) Failure to maintain all required documentation may result in the disallowance and recovery by the Department of any amounts paid out for which the required documentation is not maintained and provided to the Department upon request.

(Effective May 27, 1992)

**Sec. 17-134d-85. Policy and procedures governing the billing and payment for oxygen therapy on behalf of title XIX medicaid recipients**

(a) **Billing Procedure**

(1) Form H.C.F.A. 1500 "Health Insurance Claim Form" is used to bill for oxygen therapy. The bill is mailed to the Department's claims processing agent.

(2) All claims submitted for payment which include prior authorized items must include the authorization number from the current authorization.

(3) All claims submitted for services not requiring prior authorization must include the name of the prescribing physician.

(4) The provider shall enter its usual and customary charge on the claim form.

(b) **Payment**

Payment for oxygen therapy will be made at the lower of:

(1) the usual and customary charge to the public, or

(2) the amount as contained in the fee schedule as published by the Department, or

(3) the amount billed by the provider.

(c) **Payment Rate for Oxygen Therapy**

The Commissioner of Income Maintenance establishes the oxygen therapy rate as contained in the Department's fee schedule.

(d) **Payment Limitations**

(1) All prices quoted for equipment and services include delivery costs fully prepaid by the provider, F.O.B. destination; no additional charges are to be made for packing, shipping, or delivery to the recipient.

(2) If the estimated cost of repairs to any equipment exceeds replacement cost, the item will be replaced.

(3) Payment for repairs or replacement of equipment which is purchased by the Department is contingent upon any unexpired manufacturers or dealer warranties. The supplier must first utilize existing warranties covering such servicing, repairs, and replacement.

(4) The cost of oxygen therapy includes all services and supplies necessary including, but not limited to: (1) installation and/or set up of prescribed equipment; (2) teaching and training the recipient, recipient's family, and long-term care facility professional staff in the use and care of the equipment as shall be necessary; (3) oximetry test.

(5) The rental fee for the delivery of oxygen therapy includes a nasal cannula, mask, and disposable humidifier as needed.

(Effective May 27, 1992)

**Sec. 17-134d-86. Medicaid payment for general hospital outpatient emergency and non-emergency visits to a hospital emergency room and outpatient clinic visits**

**(a) Definitions**

(1) "Department" means The State of Connecticut Department of Income Maintenance or its agent.

(2) "Emergency room" means that part of a general hospital that is designed, organized, equipped, and staffed to provide initial diagnosis and treatment of patients requiring immediate physician, dental, or allied services.

(3) "Emergency visit" means an urgent encounter requiring the immediate decision-making and medically necessary action to prevent death or any further disability for patients in health crises (including labor and delivery). Such medical conditions are manifested by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. In order to be considered urgent, the encounter must occur within seventy-two (72) hours from the onset of the presenting medical condition.

(4) "General hospital" means a short-term hospital having facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a wide range of acute conditions, including injuries, and shall include a children's general hospital which means a short-term hospital having facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a wide range of acute conditions among children, including injuries.

(5) "Medically necessary" means medical care provided to:

- (A) Correct or diminish the adverse effects of a medical condition;
- (B) Assist an individual in attaining or maintaining an optimal level of well being;
- (C) Diagnose a condition; or
- (D) Prevent a medical condition from occurring.

(6) "Non-emergency visit" means a medically necessary non-urgent encounter presenting a medical condition which does not meet the requirements for an emergency visit as defined in this section but, rather, requires a routine level of ambulatory health care. Such conditions may be characterized by the fact that they may also be treated in an alternate health care setting, such as: community-based physician's office, walk-in clinic, comprehensive health center, neighborhood health center and other free-standing primary health care clinics because such medical conditions do not require the skills, resources and equipment of a hospital emergency room. Such visits may include primary health care or the initial diagnosis and treatment of routine acute or chronic illnesses whether on a scheduled or unscheduled basis.

(7) "Outpatient" means a patient of an organized medical facility, or distinct part of that facility who is expected by the facility to receive and who does not receive professional services for less than a 24-hour period regardless of the hour

of admission, whether or not a bed is used, or whether or not the patient remains in the facility past midnight.

(8) “Outpatient clinic visit rate” means the rate set by the Department using the methodology as required by subsection 17-312 (d) of the General Statutes of the State of Connecticut.

(b) **Payment**

(1) The Department shall pay general hospitals for each outpatient clinic visit at the outpatient clinic visit rate not to exceed the charges made by such hospital for comparable services to the general public.

(2) The Department shall pay all non-emergency visits to a general hospital emergency room at the hospital’s outpatient clinic visit rate but not to exceed the charges made by such hospital for comparable services to the general public.

(3) There is no payment for emergency room services provided on the same day as an inpatient admission for the same recipient.

(4) **Emergency Room Visit Rate**

(A) The rate for an emergency room visit is calculated by the Department effective July 1st of each year.

(B) Payment for emergency visits to the emergency room shall be calculated as follows: Hospital emergency room costs must be submitted in writing under oath by each hospital by June 1st annually on forms acceptable to the Department. Each hospital’s cost is adjusted by the lesser of: (i) the percent of change in its own emergency room costs over the last four years; or (ii) the percent of change in the emergency room costs for all hospitals for the same period. The rate authorized by the Department shall be the lower of the hospital’s adjusted cost, as set forth above, or the rate calculated at the 66<sup>2</sup>/<sub>3</sub> percentile of the statewide adjusted cost for all hospitals, ranked in ascending order.

(C) A hospital emergency room visit includes a facility cost component and a professional cost component.

(D) Each hospital may annually elect to have the rate for its facility component and professional component determined separately or with the components combined. Said election shall be made at the time the emergency room costs are filed with the Department in accordance with subsection (b) (4) (A) and (B) of this regulation.

(5) The Department shall pay general hospitals for each emergency room visit at the rate authorized herein not to exceed the charges made by such hospital for comparable services to the general public.

(Effective September 25, 1990)

**Secs. 17-134d-87—17-134d-90. Reserved**

**Sec. 17-134d-91.**

Repealed, May 10, 2000

**Title XIX Inpatient Psychiatric Hospital Services**

**Secs. 17-134d-92—17-134d-102.**

Repealed, March 6, 1998.

**Secs. 17-134d-103—17-134d-138. Reserved**

## **Requirements for Payment of Case Management Services for Persons with Chronic Mental Illness**

### **Sec. 17-134d-139. Scope**

Sections 17-134d-140 to 17-134d-149 inclusive set forth the requirements for payment of Case Management Services provided by the State of Connecticut Department of Mental Health to persons determined eligible to receive services under Connecticut's Medical Assistance Program pursuant to Section 17-134d of the General Statutes of Connecticut.

(Effective February 23, 1993)

### **Sec. 17-134d-140. Definitions**

For the purposes of Regulation Sections 17-134d-139 through 17-134d-149, the following definitions shall apply:

(a) "Case Manager" means the person employed by the Department of Mental Health or performing provider responsible for assessing the eligible person's needs, developing a plan of services with the eligible person and others to meet those needs, linking the eligible person to the services identified in the plan of services, supporting and monitoring the eligible person in the utilization of the identified services, advocating on the eligible person's behalf and maintaining client files and recording services provided.

(b) "Case Management Services" means the continuum of assessment, planning, linkage, support and advocacy activities systematically carried out by an individual case manager that are available to assist and enable an eligible person to gain access to needed medical, clinical, social, educational or other services.

(c) "Collateral Contact" means a contact with other individuals/agencies within the person's natural support networks.

(d) "Department" means the State of Connecticut Department of Income Maintenance.

(e) "Eligible Person" means a person who qualifies to receive services under the Connecticut Medical Assistance Program pursuant to Section 17-134b of the General Statutes of Connecticut, as amended from time to time, and regulations promulgated pursuant to Section 17-134d of the General Statutes of Connecticut.

(f) "Needed Services" means any medical, clinical, social, educational or other services identified as required by an eligible person in a plan of services.

(g) "Performing Provider" means any designated grantee agency, or other entity employed by the Department of Mental Health in the delivery of case management services to eligible persons.

(h) "Plan of Services" means a written document which is developed on an annual basis identifying an eligible person's unique set of needed services and the public or private entities that will or may provide those services.

(i) "Representative" means any person, organization or entity authorized to act on behalf of an eligible person through an agreement, or, a family member of court appointed delegate of the eligible person pursuant to provisions in the General Statutes of Connecticut, as amended from time to time.

(j) "Target Group" means those eligible persons who are part of the target population of the Department of Mental Health as defined in Department of Mental Health policy and amended from time to time.

(Effective February 23, 1993)

**Sec. 17-134d-141. Provider participation**

In order to participate in the Connecticut Medical Assistance Program and receive payment from the Department for the case management services rendered, the Department of Mental Health shall:

(1) provide case management services directly or via its performing providers pursuant to all applicable provisions of federal and state statutes and regulations promulgated thereunder;

(2) meet and maintain all Department provider enrollment requirements;

(3) have a valid Connecticut Medical Assistance Program provider agreement on file with the Department which is signed by the Department of Mental Health Commissioner or the Commissioner's designee. The provider agreement will be effective upon the Department approved date of enrollment. The provider agreement specifies conditions and terms (federal and state regulations, standards and statutes) which govern the Connecticut Medical Assistance Program and to which the Department of Mental Health is mandated to adhere in order to participate in the program;

(4) assign an individual case manager to serve as the person primarily responsible for case management services or assure that an individual case manager is assigned by one of its performing providers; and

(5) insure that, pursuant to subsection 17-134d-144 (b) below, a case manager is an individual employed by the Department of Mental Health or one of its performing providers.

(Effective February 23, 1993)

**Sec. 17-134d-142. Eligibility**

Payment for case management services is available only on behalf of all persons specified as members of the target group, pursuant to subsection (a) of 17-134d-144, who are eligible to receive services pursuant to the Connecticut Medical Assistance Program subject to conditions and limitations which apply to such case management services.

(Effective February 23, 1993)

**Sec. 17-134d-143. Services covered**

Case management services may include the continuum of activities systematically carried out by an individual case manager that are available to assist and enable an eligible person to gain access to needed medical, clinical, social, educational or other services. At a minimum, such case management services shall include the provision of one or more of the following types of case management activities, through either direct or collateral contact, in a calendar month:

(1) assessing the eligible person's needs;

(2) developing a plan of services with the eligible person and others to meet those needs;

(3) linking the eligible person to the services identified in the plan of services;

(4) supporting and monitoring the eligible person in the utilization of the identified services; and

(5) advocating on the eligible person's behalf.

(Effective February 23, 1993)

**Sec. 17-134d-144. Limitations****(a) Target Group Limitations**

(1) Payment for case management services is limited to case management services provided to eligible persons with chronic mental illness as defined in the Department of Mental Health target population definition, as amended from time to time.

**(b) Provider Limitations**

(1) For eligible persons with mental illness, the Department of Mental Health shall be the sole entity enrolled with the Department to provide case management services to eligible persons and to enter into a provider agreement with the Department for the provision of such services.

(2) For eligible persons with mental illness, qualified case managers are limited to case managers designated to render services to said persons by the Department of Mental Health. Such providers are limited to programs operated by the Department of Mental Health or its performing providers.

**(c) Payment Limitations**

(1) Payment for case management services will be made only when the receipt of said services occurs at the option of the eligible person or their representative.

(2) Payment for case management services may not duplicate payments made under the Connecticut Medical Assistance Program for other services which are covered under the program. Specifically, separate payment for case management services is not available when the same case management service is provided as an integral and inseparable part of another Connecticut Medical Assistance Program covered service or included as part of a Medicaid funded service, including but not limited to the following: outpatient clinic services; partial hospital services; emergency crisis intervention services; inpatient services; substance abuse treatment services; psychiatric/psychological evaluation; individual therapy; group therapy; or; family therapy.

(3) Payment for case management services by the Department will not be made unless one or more of the case management activities pursuant to Section 17-134d-143 above are rendered in a calendar month.

(Effective February 23, 1993)

**Sec. 17-134d-145. Need for services**

Payment for case management services will be made by the Department only if the eligible person evidences a need for case management services, and if they meet the requirements to receive services from the Department of Mental Health in accordance with its target population definition and rules regarding provision of services, as amended from time to time.

(Effective February 23, 1993)

**Sec. 17-134d-146. Documentation requirements**

Case management services will be reimbursed by the Department only when documentation of compliance with the following requirements is on file with the Department of Mental Health or its performing providers:

**(a) Plan of Services Requirement**

Case management services are provided in accordance with the eligible person's plan of services. At a minimum, the plan shall:

(1) be developed by the case manager at least annually or more frequently if needed, and indicate that the eligible person or their representative has participated in, or has been given the opportunity to participate in, the development of the eligible person's plan of services;

(2) be based on an assessment of an eligible person's needs which may include: assessments of medical, clinical, social, educational and other needs;

(3) be reviewed and monitored by the case manager;

(4) identify issues, needs and goals relevant to the eligible person from the date of admission to the date of plan review;

(5) identify the needed services required by an eligible person and the anticipated frequency, duration and limitations of needed services;

(6) indicate the case management services needed, and the anticipated frequency, duration and limitations of case management services; and

(7) indicate the various public agencies or private entities that will or may provide the needed services.

**(b) Permanent Service Record**

An individualized permanent service record for an eligible person must be maintained. At a minimum, the record shall contain the following:

(1) The eligible person's name, address and other relevant historical and financial information;

(2) Assessments of the eligible person, performed as necessary, to determine needed services;

(3) A plan of services pursuant to subsection (a) of Section 17-134d-146;

(4) Signed monthly service entries indicating the date(s), place of service and type of case management services rendered.

**(c) Other Documentation Requirements**

All documentation shall be incorporated into the eligible person's permanent service record in a complete, prompt and accurate manner. All documentation shall be made available to authorized Department personnel upon request as permitted by federal statute.

(Effective February 23, 1993)

**Sec. 17-134d-147. Billing requirements**

All bills submitted to the Department for payment of case management services must be substantiated by documentation in the eligible person's permanent service record pursuant to Section 17-134d-146.

(Effective February 23, 1993)

**Sec. 17-134d-148. Payment**

Payment by the Department for case management services rendered to eligible persons shall be based on the providers' actual direct and indirect costs to provide case management services. Said costs shall be filed at the end of each state fiscal year with the Department by the Department of Mental Health.

For each state fiscal year the Department shall establish a payment rate based upon the said costs for the previous state fiscal year which shall be updated for inflation, using the most recent estimates of the price deflator for the gross national product as published in February of said state fiscal year in the "Economic Report of the Governor" of the State of Connecticut.

(Effective February 23, 1993)

**Sec. 17-134d-149. Audit**

All supporting accounting and business records, statistical data, and all other records relating to the provision of case management services paid for by the Department shall be subject to audit. If an audit discloses discrepancies in the accuracy and/or allowability of actual direct or indirect costs or statistical data as submitted for each state fiscal year by the Department of Mental Health and its grantee agencies, the Department's payment rate for the said rate period shall be subject to adjustment.

(Effective February 23, 1993)

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## An Act Creating a Nursing Home Ombudsman Office

### Sec. 17-136d-1. Purpose

The purpose of these regulations is to establish procedures for implementing Public Act #77-575, An Act Creating a Nursing Home Ombudsman Office, under the Connecticut Department on Aging.

The purpose of the Nursing Home Ombudsman Office is to receive and resolve health and human services complaints affecting patients or residents in nursing home facilities in the State of Connecticut, as defined in Section 19-602 of the general statutes.

(Effective August 30, 1978)

### Sec. 17-136d-2. Nursing home ombudsman office

(a) **Established Within Department on Aging and Responsible For.** There is established within the State Department on Aging a Nursing Home Ombudsman Office (hereinafter referred to as "NHO") under the supervision of the Commissioner on Aging (hereinafter referred to as the "Commissioner").

On or before September 1st of each year, commencing in 1978, the State NHO shall submit, through the Commissioner, a report to the Governor and the General Assembly on the activities of the NHO during the prior fiscal year and a projected budget for the coming fiscal year. This report shall be available to the public and shall be widely distributed by the NHO.

(b) **Assistant Regional Nursing Home Ombudsmen.** There shall be five Assistant Regional Nursing Home Ombudsmen (hereinafter referred to as "Regional Ombudsmen"), with one Regional Ombudsman to serve in each Department on Aging planning and service area.

(c) **Patients' Advocates.** (1) Term, Expenses and Removal

(A) The patients Advocates shall serve for terms coterminous with those of the Ombudsmen. Reappointments of Patients' Advocates for additional terms may be made by the State Ombudsman, after consultation with the Regional Ombudsman. There shall be no limit to the number of terms a Patients' Advocate may serve. The initial appointment shall be a 90 day probationary period. If the person is continued after the 90 day probationary period, the appointment shall be considered permanent for the remainder of the term.

(B) Patients' Advocates shall serve without compensation but may be reimbursed for reasonable expense incurred in the performance of their duties, within available appropriations. A schedule of allowable expenses and reimbursement rates and procedures shall be issued by the Commissioner.

(C) Patients' Advocates may be removed, by written notice by the State Ombudsman whenever he finds such Patients' Advocate guilty of misconduct, material neglect of duty or incompetence in the conduct of the office. Unless the Patients' Advocate's performance is so seriously delinquent that it merits immediate dismissal, the State Ombudsman should provide the Patients' Advocate with at least one written and one verbal notice, to that effect, at least two weeks prior to the dismissal notice.

(D) Until such time as the State Ombudsman appoints Patients' Advocates in accordance with these regulations, those Patients' Advocates previously appointed, under Section 19-621 of the General Statutes, shall continue to perform their assigned duties and responsibilities. When the State Ombudsman has made his appointments of Patients' Advocates, he shall, within thirty (30) days notify all previously appointed Patients' Advocates of their status.

(E) In the event that, because of over enrollment, a number of Patients' Advocates must be chosen from among several volunteers, the choice will be made on the basis of (1) present or past satisfactory work as a Patients' Advocate and a desire to continue; (2) previous work or volunteer experience in a nursing home facility; (3) a better than average understanding of the operation and the population of nursing homes; (4) a genuine interest in helping to improve care in nursing home facilities. As stated in the Ombudsmen Procedural Manual, the criteria for selection of Advocates are the following:

(i) Minimum age at least 18 years with a maturity in attitude towards the role of advocate.

(ii) Must be a good listener and confidant of the patient. Must also have the capacity for learning skills and techniques of interviewing and observation, as well as providing the patient with a sense of participation and self-determination.

(iii) Must be able to sort out extraneous material in order to zero in on problem.

(iv) Must be impartial and non-judgmental (i.e. not biased against facilities) in approach to problems.

(v) Must be available to visit facility at least once a week to receive problems from patients, families, staff and administration concerning quality of care and welfare of patients.

(vi) Must be able to get to the facility either by car or public transportation.

(vii) Must be physically able to fulfill the responsibilities of the job.

(viii) Must have tact and diplomacy.

(ix) Must be verbally articulate in presenting facts in the advocacy role.

(x) It is desirable that applicant be bilingual.

(xi) Must be a secure person, able to cope with individuals who are physically and/or mentally incapacitated.

(xii) Must have the capacity of learning the medical, financial and psychosocial problems of aging as well as understanding statutes, policies and administrative regulations as they relate to nursing homes.

(xiii) Must have a sense of humor.

(xiv) Must not have financial interest in a nursing home.

(xv) Must state whether any family member is a patient in a nursing home. No advocate shall be appointed to a facility in which a family member is a patient or resident.

(xvi) Must not have direct relationship with nursing homes.

(2) Training. (A) Every person (except when training is waived by the Commissioner in consultation with the State Ombudsman pursuant to Section 3 (b) of Public Act 77-575) who is to act as a Patients' Advocate is required to complete training consisting of a two-day course coordinated by the Regional Ombudsman in each region and monthly follow-up training sessions.

(B) The training manual, Nursing Home Patient Advocate Manual, is provided for each trainee and consists of sections on "The Role of the Advocate," "Communicating with Patients," and "Referral Information."

(C) The specific content of the training course is outlined as follows:

#### ADVOCATE TRAINING COURSE

I. Legislation and Procedures. A. Familiarization with legislation.

B. Clarification of procedures.

II. Patients' Bill of Rights. A. What is its purpose?

B. Posting and distribution requirements.

III. Connecticut Department of Health. A. Role in regulating facilities.

B. Commission on Hospitals and Health Care.

C. Utilization Review.

D. Levels of care. 1. criteria; 2. federal standards.

IV. Connecticut Department of Social Services. A. DSS Patient Review.

B. Professional Standards Review Organization.

V. Gerontology. A. Explanation of the aging process.

B. Family guilt.

C. Drug utilization in nursing home facilities.

D. Brain damage and mental illness in residents of facilities.

VI. Aging Legal Services. A. Familiarization with benefit programs. 1. Medicare; 2. Medicaid; 3. Social Security; 4. Supplemental Security Income; 5. C A M A D

B. Common problems with benefit programs.

C. Role of Aging Legal Services as referral agency.

D. Transfer of power. 1. representative payee. 2. power of attorney. 3. conservator of estate. 4. conservator of person.

(D) If, in the opinion of the Ombudsman, the advocate trainee exhibits an adequate understanding of the legislation and the responsibilities of the Patients' Advocate, the Ombudsman may appoint that person as a Patients' Advocate.

(E) During each month following the training course, the Patient's Advocate is required to attend a one half-day follow-up training session conducted by the Regional Ombudsman and speakers from those programs in the community that may impact nursing home care. The most frequently called upon professionals include, but are not limited to the following fields:

VII. Monthly Follow-up Sessions. A. Mental Retardation.

B. Mental Health.

C. Services for the Blind.

D. Alcoholics Anonymous.

E. Commission on Deaf and Hearing Impaired.

F. Department of Vocational Rehabilitation.

G. Department of Adult Education.

(F) Any person previously appointed a Patient's Advocate under Section 19-621 of the General Statutes, who is reappointed under this regulation as a Patients' Advocate must pass the training course. If, within a reasonable time after such appointment, as determined by the State Ombudsman, the Patients' Advocate fails to complete said course, the State Ombudsman or the Regional Ombudsman for the region in which the Patients' Advocate serves may remove the person, by means of written notice.

(3) Responsibilities. The Patients' Advocates shall be responsible for the following:

(A) Assisting the Regional Ombudsman in carrying out the policies and procedures of the NHO program in the cities and towns in the region in which they are assigned to serve as Patients' Advocates;

(B) Assisting the Regional Ombudsman, and possibly the State Ombudsman, on the evaluation, investigation and resolution of certain complaints which are determined to require such joint action;

(C) Reporting, in writing, to the Regional Ombudsman on any complaints received and actions taken by the Patients' Advocate;

(D) In assisting the Regional Ombudsman, when a complaint can be acted on by the advocate in the nursing home facility, the advocate may take action. Following action, a written report shall be made of the complaint and the action taken to the

Regional Ombudsman. It is the responsibility of the Regional Ombudsman, upon receipt of a report, to review the complaint and any action taken and to make a determination as to whether or not the action taken was appropriate and satisfactory. If the Ombudsman is satisfied with the action, the complaint is filed at the Office. If not, the Ombudsman shall investigate the problem further and take the necessary action toward resolution. In no instance shall the Patients' Advocate make the final determination as to the resolution of a complaint;

(E) Under supervision of the Ombudsman, assisting nursing home patients to locate and retain legal representation in those cases in which the problem appears in the judgment of the Patients' Advocate and Ombudsman to require legal action and when the patient explicitly requests assistance in retaining legal counsel and/or representation. Such legal counsel will be at the patient's expense;

(F) Aiding and assisting nursing home patients in administrative procedures relating to transfers and discharges, including, but not limited to, informing patients of their rights, assisting them in obtaining legal counsel, and advocating on their behalf and at their request in dealings with the nursing home administrator, friends, family and/or appropriate public agencies;

(G) Aiding and assisting patients in insuring that they are satisfied with the management of their financial affairs, including, but not limited to, informing them of their rights regarding knowledge of and control of their assets, advocating on the patient's behalf and at his or her request in dealings with the nursing home administrator, family, friends and/or appropriate public agencies;

(H) Assisting state and local health agencies in the performance of certain of their duties as specifically listed below:

(i) Assuring that the Patients' Bill of Rights, as established in Section 19-622, is properly posted and is distributed to each patient, or if such patient is a minor or incompetent, to his relative, guardian, conservator or sponsoring agency, and, if it is not, informing the nursing home administrator and the appropriate state or local health agency in writing requesting that compliance be forthcoming forthwith;

(ii) Assuring that all mandated posting of the availability of reports has been complied with, including the conspicuous posting of the names of the Patients' Advocates assigned to the nursing home and name, address and telephone number of the Regional Ombudsman for the region in which the nursing home is located, and, if it has not, informing the nursing home administrator and the appropriate state or local health agency in writing requesting that compliance be forthcoming forthwith.

Nothing in this section shall be construed to be a limitation on the powers and responsibilities assigned by law to other state and local department or agencies.

(Effective August 30, 1978)

### **Sec. 17-136d-3. Complaints and reports of abuse, neglect, exploitation or abandonment**

(a) **Definition of "Complaint" or "Report."** For purposes of these regulations the term "complaint" or "report" shall mean a complaint or report filed in good faith and shall not include any complaint or report which, in the opinion of the State Ombudsman, or of a Regional Ombudsman, or of a Patients' Advocate, is deliberately false, or has been filed in bad faith or with malicious purpose.

(b) **Content of Complaint or Report.** (1) Any complaint or report filed with the NHO under these regulations shall contain the name and address of the nursing facility, the name of the involved patient or patients or the statement that all the

patients are affected, information regarding the nature and extent of the abuse, neglect, exploitation or abandonment, and any other information which the reporter believes might be helpful in an investigation of the case and for the protection of the patient.

(2) If the person filing a complaint or report with the NHO wishes to be notified of the findings of any investigation conducted by the NHO pursuant to the complaint or report he/she shall, at the time of filing of the complaint or report, request such notification.

(c) **Method of Filing and Withdrawing Complaints or Reports.** (1) A complaint or report may be filed with the NHO in person, by mail, or by telephone. If the complaint or report is filed in person or by telephone, the complainant shall be asked to submit the complaint in writing. A form for this purpose shall be supplied by the NHO. A complaint or report may be signed by the complainant, and the complainant's address requested.

(2) Complaints or reports may be filed with local Patients' Advocate, with the Regional Ombudsman, or with the State Ombudsman. For information and/or for filing complaints or reports with the State Ombudsman, persons may contact the NHO, Department on Aging, 90 Washington Street, Hartford, Connecticut 06115, Telephone: (203) 566-7770.

(3) A complaint or report filed by an individual who refuses to reveal his/her identity shall be considered an anonymous complaint and shall be investigated by the NHO only if the NHO considers the nature of the complaint to be of such seriousness as to warrant follow-up. Every complaint will be given an initial examination; with follow-up investigation when the Ombudsman deems necessary. The State Ombudsman shall maintain a registry of all complaints.

(4) If a complaint is initially received verbally and a written statement is expected, the NHO may commence a preliminary investigation prior to receipt of the complaint in writing.

(5) Any complaint filed with the NHO may be withdrawn by the complainant(s) involved except those complaints involving abuse, neglect, abandonment or exploitation, the reporting of which is mandatory. If a request for withdrawal is made, the NHO shall decide whether to permit withdrawal of the complaint and shall base this decision on the welfare of the patient(s) involved.

(Effective August 30, 1978)

#### **Sec. 17-136d-4. Investigation of complaints and reports**

(a) **Initial Evaluation of Complaints and Reports.** (1) Upon receipt of a complaint or report by the NHO, the complaint or report shall be evaluated immediately by a Patients' Advocate—although the evaluation may in some cases be conducted by a Regional Ombudsman or the State Ombudsman—to determine, whether there are reasonable grounds for an investigation.

(2) If it is determined that reasonable grounds do not exist for an investigation, the complainant or the person making the report shall be notified of this determination within five (5) working days after the receipt of the complaint or report. The notification shall include a brief explanation of the reasons upon which the NHO concluded that an investigation was not warranted.

(3) If such reasonable grounds are found, the Patients' Advocate, the appropriate Regional Ombudsman or the State Ombudsman shall investigate such report or complaint within ten (10) working days after the determination that the complaint or report warrants further investigation, but no more than fifteen (15) days after

receipt of the complaint or report. A copy of the report shall be sent to the State Ombudsman who shall maintain a registry of said reports. A copy of the report, together with such additional information as appears necessary, shall be sent to the person who filed the complaint or report upon request.

**(b) Investigation of Complaint or Report and Access to Facility and Records.**

(1) The appropriate Patients' Advocate under the direct supervision of the appropriate Regional Ombudsman—or in some cases, the State Ombudsman—shall conduct an impartial investigation of the complaint or report. The investigation shall normally involve fact-finding meetings and interviews with the complainant, the residents of the applicable nursing home facility, the administrator of the applicable nursing home facility, and any other persons may include, source of information. These other persons may include, but are not limited to, the family or friends of the patient involved, if there is such a specific patient, the staff of the facility, representatives from involved or relevant public and private agencies, and the legal representative of the patient. The NHO may manually or electronically record all statements by all persons being interviewed, provided that the person being interviewed is informed that his/her remarks are being so recorded.

(2) The State Ombudsman or any Regional Ombudsman or any Patients' Advocate may observe the functioning of the entire facility and may interview residents at random. Except when the facts warrant immediate action, investigations shall be carried out at reasonable times and without interference with patient care.

(3) Nothing in these Regulations shall be construed as permitting a nursing home, the State Ombudsman, a Regional Ombudsman, a Patients' Advocate, or any other person, to interfere with the proper medical treatment of any resident of or patient in a home, to inspect his or her medical records or personal files or personal effects without proper consent.

**(c) Confidentiality of Reports of Findings.** (1) Consistent with the Freedom of Information Act, the report of findings maintained by the State Ombudsman in a registry per Section 4. A (3) of these regulations is available for review by the parties involved in the complaint. However, the complaint or report filed by the complainant shall not be available for review, nor shall the name of the complainant or any person or any identifying information mentioned in the report or complaint or in the report of findings be disclosed unless such complainant or person specifically requests such disclosure or unless a judicial proceeding results therefrom.

(2) Requests by the parties involved in a complaint to review the report of findings must be made in writing to the State Ombudsman, Department on Aging, 90 Washington Street, Hartford, Connecticut 06115. The report of findings, with the identifying information removed, will be made available to the party within five (5) working days after receipt of the written request. The exact date when the report of findings will be available for review will be communicated to the requesting party by the State Ombudsman upon receipt of the request. The report of findings must be reviewed within the Department on Aging's offices, but adequate space and time will be provided to the interested party.

(3) No records, which by state or federal regulation must be kept confidential, will be released to any party except with the written consent of the patient.

(4) Materials, reports, records or other information utilized by the Patients' Advocate, appropriate Regional Ombudsman or State Ombudsman in the investigation of a complaint or report and used to prepare a report of findings shall not be considered public information and shall, therefore, not be available for review.

(Effective August 30, 1978)

**Sec. 17-136d-5. Resolution of complaints and reports by the nursing home ombudsman office**

(a) **Resolution When a Violation of the Public Health Code is Indicated.** (1) When the investigation indicates that there is a possible violation of the provisions of the public health code with respect to licensing requirements, the appropriate Regional Ombudsman or the State Ombudsman shall refer the complaint or report, together with the NHO report of findings, to the Commissioner of Health for appropriate action under the provisions of Section 19-606 to 19-620, inclusive, of the General Statutes, as amended. This referral shall be made known to the complainant or the person making the report, pursuant to Section 4.A (3) of these regulations.

(2) Pursuant to Sections 19-602, 19-603, and 19-606 to 19-626, inclusive, of the General Statutes, as amended, or any regulation in the public health code or the fire safety code relating to the operation or maintenance of a nursing home, the Commissioner of Health shall review and further investigate, if necessary, the complaint referred to his/her by the Regional Ombudsman or State Ombudsman and determine whether a violation is involved. If such a violation is determined, the Commissioner of Health may initiate the appropriate action to enjoin such nursing home facility from continuing such violation or violations.

(3) The Commissioner of Health, within ten (10) working days of receipt of a complaint or report from a Regional Ombudsman or State Ombudsman, shall furnish the appropriate Regional Ombudsman or State Ombudsman a written report of any action taken pursuant to Sections 19-607 to 19-610, inclusive, of the General Statutes, as amended, on the complaint or report. A copy of such report shall be maintained in a registry by the State Ombudsman.

(4) Upon receipt of such a written report from the Commissioner of Health, the appropriate Regional Ombudsman or the State Ombudsman shall, within five (5) days of receipt of the report, review the response, follow-up on the case, and determine whether the action taken appears to be sufficient to resolve the problem indicated in the complaint or report.

(A) If the action taken appears to be sufficient to resolve the problem, the case shall be closed, and a report to that effect shall be submitted to the complainant or the person making the report and to the State Ombudsman who shall maintain a registry of said reports.

(B) If the action taken appears not to have resolved the problem, the appropriate Regional Ombudsman or the State Ombudsman shall take such action(s) as he/she deems necessary to resolve the problem. When sufficient action has been taken to indicate to the appropriate Regional Ombudsman that the complaint has been resolved, the Regional Ombudsman shall follow-up on the case and if the follow-up indicates that the complaint or problem has been resolved, the case shall be closed, and a report to that effect shall be submitted to the complainant or the person making the report and to the State Ombudsman who shall maintain a registry of such reports.

(C) There may be some cases in which a valid complaint cannot be resolved due to legal, administrative, or other limitations beyond the control of the NHO. In such instances, the State Ombudsman may declare the case closed without resolution. A report to that effect, including a brief statement of the reason(s) for taking such action, shall be submitted to the complainant or person making the report and to the Commissioner on Aging, and a copy shall be filed in the registry maintained by the State Ombudsman.

**(b) Resolution When a Violation of the Public Health Code is Not Indicated.**

(1) When the investigation indicates that no violation of the public health code is indicated, the appropriate Regional Ombudsman or the State Ombudsman shall take whatever action he/she deems necessary, and shall notify the complainant or the person making the report of the action taken within fifteen (15) working days after receipt of the complaint.

The action taken to resolve the complaint or reported problem may include, but is not limited to the following:

(A) The complaint or problem may be referred to another public or private agency including the Office of the Attorney General or the State Board of Medical Examiners or any appropriate state licensing board should the Regional Ombudsman or the State Ombudsman believe that the referral is the most effective means of resolving the complaint or problem. Such referral shall only be made if the complainant or person making the report, and/or the patient if the patient is not the complainant or reporter, is informed of the availability of the referral agency and agrees verbally or in writing to such referral of the case. The NHO may informally discuss the case with possible referral agencies prior to the complainant's agreement to the referral, but confidentiality must be maintained.

(B) Negotiations may be entered into between the appropriate Regional Ombudsman or Patient Advocate and the administrator of the nursing home facility to reach an informal agreement or a formal written agreement to resolve the complaint or problem. This agreement may include target dates for specific remedial action(s) to be taken by the nursing home facility administrator.

(2) When the appropriate Regional Ombudsman is not satisfied that the actions taken have resolved the complaint or problem, the Regional Ombudsman shall follow-up on the case. When the follow-up indicates to the Regional Ombudsman that the complaint or problem has been resolved, the case shall be closed. A report to that effect shall be submitted by the Regional Ombudsman to the complainant or the person making the report and to the State Ombudsman who shall maintain a registry of said reports.

(Effective August 30, 1978)

**Promotion of Independent Living for the Elderly Program**

**Secs. 17-136d-6—17-136d-12.**

Transferred and amended, June 2, 1992

**Secs. 17-136d-13—17-136d-49. Reserved**

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**Secs. 17-136i-1—17-136i-19.**

Transferred, February 26, 1992

**Correlated Table**

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17-136i-4	17a-306-4
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## **Licensure of Private Dwellings as Community Residences for the Mentally Retarded**

### **Sec. 17-174-1. Purpose of licensing**

The purpose of licensing community residences owned by private parties or agencies is to insure the maintenance of adequate standards of care for the retardates who need protective and developmental living arrangements in other than the facilities of the office of mental retardation.

(Effective July 22, 1969)

### **Sec. 17-174-2. Definitions**

For the purpose of sections 17-174-1 to 17-174-7, inclusive, a private dwelling used as a community residence for the mentally retarded means a residence privately owned and managed in which the director or superintendent of an office of mental retardation facility may place the retarded who are under his legal supervision and jurisdiction. An office of mental retardation facility is any of the regional centers or state schools for the retarded under authority of the office of mental retardation.

(Effective July 22, 1969)

### **Sec. 17-174-3. Standards for community residences**

#### **(a) General conditions.**

(1) The facility including general equipment and the sanitation and maintenance of the home shall insure the health, comfort and safety of the residents at all times.

(2) Adequate housekeeping, laundry and maintenance services shall be provided.

(3) Provisions for visiting shall be as liberal as may be consistent with good resident care.

(4) Any accident, disaster or other unusual occurrence in the residence shall be reported promptly to the office of mental retardation placing facility responsible for the assignment of the resident.

(5) In the absence of the licensee a competent person shall be present on the premises at all times when the resident is there responsible for the conduct of the residents until the return of the licensee.

#### **(b) Physical plant.**

(1) The buildings shall be of sound construction and shall provide adequate and proper space and equipment for resident accommodations.

(2) No more than four individuals shall be allowed to regularly sleep in any one room.

(3) Minimum square footage, exclusive of closets, toilets, lockers, or wardrobes, etc., shall be adequate and proper subject to the local fire marshal's approval.

(4) Each room for sleeping purposes shall have an outside exposure above grade level and have windows permitting adequate ventilation and light and allowing emergency exit.

(5) There shall be a minimum of one complete bathroom, including lavatory, water closet, and tub or shower for each eight occupants.

(6) There shall be appropriate wardrobe or closet space for each resident's needs.

(7) There shall be a dining area available so that all residents may eat at a table or tables with suitable provisions accounting for the needs of each resident.

(8) There shall be, within the home, activity space available to allow for such educational and diversional activities as each resident may require other than in bedrooms.

(9) Proper heat, hot water, lighting and ventilation shall be maintained at all times.

(10) Private water supplies and/or sewage if installed shall be in accordance with the state public health code (regulations 19-13-B39, 19-13-B50, 19-13-B51) and with written approval by the director of health.

(c) **Medical supervision.** When medical supervision is not furnished by the office of mental retardation or in the event of an extreme emergency or illness of a resident, the licensee of the home or the person in charge is responsible for obtaining the services of a physician on an emergency basis.

(Effective July 22, 1969)

**Sec. 17-174-4. License application: Investigation: Issuance, transfer**

(a) **Application.** The office of mental retardation shall prescribe and furnish application forms to be submitted to it by all applicants for a license.

(b) **References and health certificate.** The licensee shall furnish with the initial application character references from three responsible people unrelated to him and shall also furnish with his initial and each subsequent annual application a current certificate of physical and mental health signed by a physician.

(c) **Investigation.** After receipt of a completed application the office of mental retardation representative shall determine compliance (1) with the standards prescribed by the office of mental retardation under section 17-174-3 and (2) with the state and local fire and safety regulations as indicated by the local fire marshal's written approval. The substance and extent of the home study or investigation made by the office of mental retardation representative shall insure that the standards set forth in this regulation are full met.

(d) **Non transferable.** Licenses are not transferable and are in effect only for the operation of the residence as it is organized at the time the license is issued.

(Effective July 22, 1969)

**Sec. 17-174-5. License not required**

License for a community residence shall not be required for the care of a single child placed under authority of an office of mental retardation facility only if no other child or adult under similar authority or under other agency auspices is currently in residence. An emergency placement in such a home may be made with prior knowledge and acceptance of the home by the placing authority or agency and a formal written home study or investigation of such a home shall be made within thirty days of placement.

(Effective July 22, 1969)

**Sec. 17-174-6. Expiration and license renewal: Reinvestigation**

(a) All licenses issued by the office of mental retardation shall be for a term not to exceed one year from the date of issuance, unless revoked prior to the expiration of the time specified therein. June thirtieth, annually, shall be the renewal date for all licenses. Licenses issued during the year shall expire as of June thirtieth which shall be the renewal date for all licenses.

(b) The office of mental retardation or its representatives, shall annually re-examine every community residence licensed under the provisions of these regulations. If, upon reinvestigation, the office of mental retardation is satisfied that the residence continues to comply with prescribed standards it shall, without charge, renew the license.

(Effective July 22, 1969)

**Sec. 17-174-7. Revocation: Refusal to renew license**

The office of mental retardation may revoke or refuse to renew the license of any community residence, if the licensee fails to comply with these regulations at any time. Notice thereof in writing shall be given to the licensee.

(Effective July 22, 1969)



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## **Reporting of Statistics by Private Facilities**

### **Sec. 17-183-1. Reporting of statistics by private facilities**

The person in charge of every private hospital for mental illness in the state shall, on a quarterly basis, supply the commissioner of mental health in writing with statistics which state the number of admissions and discharges of mentally ill persons for the preceding quarter. For the purpose of this regulation, "private hospital for mental illness" shall mean any private hospital, retreat, institution, house or place in which any mentally ill adult is received or detained as a patient and a person shall be considered "mentally ill" only if his or her primary diagnosis is one of mental illness.

(Effective July 1, 1980)

### **Sec. 17-183-2. Procedure for reporting statistics**

(a) Said statistics shall be reported on forms provided by the department of mental health on or before February 1, May 1, August 1, and September 1 of each year. Each such report shall cover the period of the preceding quarter, i.e., the May 1 report shall cover the period from January 1 to March 31.

(b) Each report shall contain separate listings for each patient being reported. No patient shall be identified but may be listed by a non-identifying number. Each listing shall contain the primary mental illness diagnosis, secondary mental illness diagnosis (if any) and a notation stating whether the patient is a readmission or first admission. Such listings may consist of the appropriate code number, if the facility utilizes a recognized system of codes for individual diagnoses. In addition, each report of a discharge shall state where discharge was made to, e.g., home, state institution, nursing facility, etc., or that discharge was due to the death of the patient.

(c) Facilities with an average length of stay of 30 days or less may report on patients at the time of discharge only, provided that the date of admission is also included.

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**Boarding Homes for Mental Patients**

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## **Transportation of Mentally Ill or Alcohol-Dependent Persons**

### **Sec. 17-205a-1. Definitions**

As used in §§ 17-205a-1 to 17-205a-3, inclusive:

(a) “Ambulance” means a motor vehicle specifically designed to carry patients which is in compliance with regulations adopted by the Department of Health Services, Office of Emergency Medical Services;

(b) “Department” means the Department of Mental Health, 90 Washington Street, Hartford, Connecticut 06115;

(c) “Expenses” means the allowable and reasonable costs incurred in the transportation of patients under these regulations as determined by appropriate state and/or federal agencies;

(d) “Emergency certificate” means a certificate signed by a physician under § 17-183 of the general statutes or a certificate signed by an eligible person under § 17-155x of the general statutes;

(e) “Invalid coach” means a vehicle used exclusively for the transportation of non-ambulatory patients to or from a medical facility or the patient’s home in non-emergency situations or utilized in emergency situations as a backup vehicle when insufficient emergency vehicles exist;

(f) “Licensed public treatment facility” means a treatment agency operating under the direction and control of the department, or providing treatment under chapter 304c through a contract with the department under subsection (f) of section 17-155q, and meeting the standards prescribed in and licensed under the provisions of section 17-227;

(g) “Necessary” means the authorities at the sending facility have determined that such transportation is needed or, in the case of voluntary patients, the patient has requested such transportation (verification of necessity by the receiving facility may be required by the department);

(h) “Provide” means any person, corporation or organization which provides transportation to persons requiring it under section 17-205a and includes any person, corporation or organization which provides payment to the transporter in expectation or reimbursement from the patient;

(i) “State-operated facility” means those hospitals or other facilities providing treatment for mentally disordered adults which are operated in whole or in part by the Department of Mental Health. Such facilities include, but are not limited to, Connecticut Valley Hospital, Norwich Hospital, Fairfield Hills Hospital, the Connecticut Mental Health Center, the Whiting Forensic Institute, Blue Hills Hospital, Ribicoff Research Center, the DuBois Day Treatment Center, Cedarcrest Regional Hospital, and the Bridgeport Mental Health Center, but shall not include those portions of such facilities transferred to the Department of Children and Youth Services for the purpose of consolidation of children’s services.

(j) “Transportation” means transporting a person in an ambulance, an invalid coach or other suitable mode of transportation;

(k) “Voluntary patient” means any person who is a patient at a state-operated facility at his own request; any person who wishes emergency treatment for conditions defined in § 17-183 of a state-operated facility; or any person subject to a commitment order under this chapter who has left the state-operated facility without permission and wishes to return.

(Effective June 25, 1979)

**Sec. 17-205a-2. Payment of transportation expenses**

(a) Upon receipt of a bill from any provider of transportation to any qualified person under § 17-205a (b) and this regulation, the department shall request that the Department of Administrative Services conduct an investigation to determine if such person is able to pay for the service provided. The department shall pay the expenses of the transportation, provided:

(1) The transportation was necessary. A. Proof of necessity shall be:

1. In the case of a person transported under an emergency certificate, the person signing the emergency certificate shall certify that the transportation was necessary.

2. In the case of voluntary patients or patients on leave, the provider shall certify that the patient requested the transportation. The receiving facility may be requested to verify that the transportation was necessary, considering the patient's circumstances at the time of the request for transportation.

(2) In the case of a person transported under subdivision (1) of (§ 17-205a (b)), the transportation was from a state-aided, town-aided or other municipal-aided hospital to a state-operated facility.

A. Information as to the origin and destination must be stated on Form MHCC-15, Transportation Authorization/Certification, submitted with the provider's bill.

(3) In the case of persons transported under subdivisions (2) (voluntary patients) and (4) (patients on leave) of § 17-205a (b), the destination was a state-operated facility.

(4) In the case of persons transported under subdivision (3) (alcohol patients) of § 17-205a (b), the destination was a licensed public treatment facility.

A. In the case of a person transported under the authority of § 17-155x, the provider must submit on Form MHCC-15, Transportation Authorization/Certification, the signature of the person signing the emergency certificate, certifying that transportation is necessary.

(5) The transportation was for one of the reasons enumerated in § 17-205a (b).

A. The reason for the transportation must be stated on Form MHCC-15, Transportation Authorization/Certification, which must be submitted with the provider's bill for services rendered.

(6) The Department of Administration Services has not determined through its investigation that the person transported is able to pay the expenses of his or her transportation.

A. The department may pay bills submitted pending the outcome of the investigation. If the investigation shows the person is able to pay, the provider shall be required to return any payment made on that person's behalf by the department, or, in the alternative, that payment will be applied to subsequent bills.

(7) The bill is presented to the department prior to the expiration of one year since the date of the delivery of service.

A. Any partial payment received from any source (patient, third party, Medicare, etc.) must be indicated on the provider's bill which is presented to the department.

(1) The department shall pay only for what it is otherwise liable and which the patient is unable to pay.

B. Providers must return any payment made by the department where payment has been obtained from any other source, either prior to or subsequent to payment by the department.

(Effective June 25, 1979)

**Sec. 17-205a-3. Least expensive transportation; transporting two or more persons**

(a) Transportation shall be by method which is (1) the least expensive alternative and (2) provides the necessary safeguards to insure the person is properly treated during the transportation. If the sending authority determines that an invalid coach is sufficient and asks that such a vehicle be sent, charges for an ambulance will not be allowed.

(b) If more than one person is transported in the same vehicle at the same time, only one mileage charge will be paid.

(Effective June 25,1979)



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## Rules of Practice

### Part 1

#### General Provisions

##### **Sec. 17-210a-1. Application**

These regulations define the rules of practice before the department of mental health and set forth the nature and requirements of all formal and informal procedures available under the applicable laws of the state of Connecticut.

(Effective April 13, 1978)

##### **Sec. 17-210a-2. Definitions**

As used in these regulations:

(a) "Application" means a formal, written request for a license from the department, filed in accordance with § 17-227 of the general statutes and regulations adopted under said section;

(b) "Commissioner" means the commissioner of mental health or his or her designee;

(c) "Contested case" means a proceeding in which the legal rights, duties or privileges of a party are required by statute to be determined by the department after an opportunity for a hearing or in which a hearing is in fact held;

(d) "Department" means the department of mental health;

(e) "Hearing" means a formal procedure wherein a presentation of evidence and argument occurs, which is preceded by due notice and which includes both an opportunity to present to the department such evidence and argument as the presiding officer deems appropriate and an opportunity to examine and cross-examine any witness giving testimony therein;

(f) "License" means any permit, approval, registration or similar form of permission which the department is authorized by statute to issue;

(g) "Party" means each person or agency named or admitted as a party, or properly seeking and entitled as of right to be admitted as a party to a contested case;

(h) "Person" means any individual, partnership, corporation, association, governmental subdivision, or public or private organization of any character;

(i) "Petition" means a formal, written request for the department to adopt regulations or for a declaratory ruling;

(j) "Presiding officer" means the commissioner or any hearing examiner duly designated by the commissioner who presides at any hearing conducted by the department.

(Effective April 13, 1978)

##### **Sec. 17-210a-3. Waiver of rules**

Where good cause appears, the commissioner and any presiding officer may permit deviation from these rules, except where precluded by statute.

(Effective April 13, 1978)

##### **Sec. 17-210a-4. Communications; identification**

Communications with the department should be in writing, should concern mainly one matter, should contain the name and address of the communicator and an appropriate identification of the subject matter of the communication.

(Effective April 13, 1978)

**Sec. 17-210a-5. Filing**

All orders, decisions, findings of fact, correspondence, motions, petitions, applications, and any other documents shall be deemed to have been filed or received on the date on which they are issued or stamped received by the department at its principle office.

(Effective April 13, 1978)

**Sec. 17-210a-6. Effect of filing; public records**

(a) The filing with the department of any complaint, application, petition or other request of any nature whatsoever shall not relieve any person of the obligation to comply with any statute of the state of Connecticut or any regulation or order of the department.

(b) Any complaint, application, petition or other request of any nature whatsoever filed with the department shall be considered public records of the department.

(Effective April 13, 1978)

**Sec. 17-210a-7. Office**

The principle office of the department of mental health is located on the second floor of 90 Washington Street in Hartford, Connecticut. The office is open from 8:30 A.M. to 4:30 p.m. each day, excluding Saturdays, Sundays and legal holidays.

(Effective April 13, 1978)

**Sec. 17-210a-8. Rules of conduct**

Where applicable, the canons of professional ethics and the canons of judicial ethics adopted and approved by the judges of the superior court govern the conduct of the commissioner, any employees of the department, and all attorneys, agents, representatives and any other persons who shall appear before the department in any proceeding.

(Effective April 13, 1978)

**Part 2**

**Regulations**

**Sec. 17-210a-9. General rules**

These rules set forth the procedure to be followed by the department in the adoption, amendment or repeal of departmental regulations.

(Effective April 13, 1978)

**Sec. 17-210a-10. Petitions**

Any interested persons may at any time petition the department to adopt, amend or repeal any regulation. The petition shall clearly and concisely set forth the text of the proposed regulation, amendment or repeal. Such petition shall also state the facts and arguments that favor the action it proposes by including such data, facts and arguments either in the petition or in a brief accompanying such petition. The petition shall be addressed to the commissioner and sent to him by mail or delivered during normal business hours. The petition shall be signed by the petitioner and shall include his or her address and the name and address of any agent or counsel, if applicable.

(Effective April 13, 1978)

**Sec. 17-210a-11. Procedure after filing**

Within thirty days following the receipt of the petition, the commissioner shall determine whether to deny the petition or to initiate regulation making proceedings in accordance with the petition. If the petition is denied, the petitioner shall be notified in writing of the reasons for said denial.

(Effective April 13, 1978)

**Sec. 17-210a-12. Notice of intent to adopt regulations**

(a) **General.** Notice of the intended action to adopt, amend or repeal regulations shall be given by the commissioner at least twenty (20) days prior to its proposed action, unless some other time is specified by any applicable law. The commissioner shall cause the notice to be published in the Connecticut Law Journal and in such other publications as the commissioner may determine. The commissioner shall likewise notify in writing any person specified by any law and any person who has filed a request for notice pursuant to Section 17-210a-15 of these regulations.

(b) **Form.** The notice shall contain the following: (1) the commissioner's statutory authority to adopt the proposed regulation; (2) the procedure for submitting data, views or arguments including the time and place of a public hearing, if any; (3) the terms of the proposed regulations or the substance of the subjects and issues involved and the intended action; and (4) any additional matter required by any law.

The above notwithstanding, the commissioner shall also comply with any applicable statute which contains provisions for notice which differ from those contained herein.

(c) **Procedure.** Within such period as may be stated in the notice, but not less than fifteen (15) days, any interested person may submit a signed letter, brief or other memorandum stating his views or arguments concerning the proposed action. The letter, brief or memorandum shall be addressed to the commissioner and sent to the department by mail or delivered in person during normal business hours. The commissioner may hold a hearing for the purpose of receiving oral submissions, and shall hold a hearing, in the case of a proposal to adopt, amend, or repeal substantive regulations if requested by twenty-five (25) or more persons or by an association having not less than twenty-five members. The hearing shall be public. Upon completion of the hearing, the commissioner may permit additional written material to be filed during such period as he may determine.

(d) **Withdrawal of proposed regulations.** The commissioner may withdraw any proposed regulation or rulemaking action by notice as provided in Subsection (a) hereof, and upon such notice such proposed regulation or action shall be of no further force or effect.

(Effective April 13, 1978)

**Sec. 17-210a-13. Effective date of regulation**

All regulations adopted, amended or repealed by the department, except emergency regulations, shall not be effective until approved by the Attorney General and the Legislative Regulation Review Committee, as provided by the general statutes, and filed with the Secretary of the State. The regulation shall take effect upon such filing unless a later date is specified in the regulation or required by statute.

(Effective April 13, 1978)

**Sec. 17-210a-14. Request for notice of hearings**

Any person may file with the commissioner a request in writing to receive notice of proposed regulation making actions. Any such request shall contain the name

and the address of the person, and shall be effective until the end of the calendar year in which it was filed.

(Effective April 13, 1978)

### **Part 3**

#### **Declaratory Rulings**

##### **Sec. 17-210a-15. General rules**

These rules set forth the procedure to be followed by the commissioner in the disposition of requests for declaratory rulings as to the applicability of any statutory provision or of any regulation or order of the commissioner. Such a ruling of the commissioner disposing of a petition for a declaratory ruling shall have the same status as any decision or order of the commissioner in a contested case.

(Effective April 13, 1978)

##### **Sec. 17-210a-16. Petitions for declaratory rulings**

Any interested person may at any time request a declaratory ruling from the commissioner with respect to the applicability to such person of any statute, regulation or order enforced, administered, or promulgated by the commissioner. Such request shall be addressed to the commissioner and filed at the principal office of the commissioner. It shall give the address of the person inquiring and the name and address of such person's attorney, if any. The request shall state clearly and concisely the substance and nature of the request; it shall identify the statute, regulation or order concerning which the inquiry is made and shall identify the particular aspect thereof to which the inquiry is directed. The request for an advisory ruling shall be accompanied by a statement of any supporting data, facts and arguments that support the position of the person making the inquiry.

(Effective April 13, 1978)

##### **Sec. 17-210a-17. Procedure after filing of petition**

(a) **Notice to other persons.** The commissioner may give notice to any person that such a declaratory ruling has been requested and may receive and consider data, facts, arguments and opinions from persons other than the person requesting the ruling.

(b) **Provision for hearing.** If the commissioner deems a hearing necessary or helpful in determining any issue concerning the request for a declaratory ruling, the commissioner shall schedule such hearing and give such notice thereof as shall be appropriate.

(c) **Decision on petition, ruling denied.** If the commissioner determines that a declaratory ruling will not be rendered, the commissioner shall within ten (10) days thereafter notify the person so inquiring that the request has been denied and furnish a statement of the reasons on which the commissioner relied in so deciding.

(d) **Decision on petition, ruling granted.** If the commissioner rendered a declaratory ruling, a copy of the ruling shall be sent to the person requesting it and to that person's attorney, if any, and to any other person who has filed a written request for a copy with the commissioner.

(Effective April 13, 1978)

## Part 4

### Contested Cases

#### Sec. 17-210a-18. Designation of parties

In issuing the notice of hearing, the commissioner will designate as parties any persons known to the commissioner whose legal rights, duties or privileges are being determined in the contested case and any person whose participation as a party is then deemed by the commissioner to be necessary to the proper disposition of such proceeding. Subsequent to the issuance of such notice no other person shall have standing as a party except upon the express order of the presiding officer.

(Effective April 13, 1978)

#### Sec. 17-210a-19. Pre-hearing conferences

(a) **Informal dispositions.** The commissioner may call and hold conferences to consider simplifying, clarifying or joining issues, and disposing of any action by consent order or license, unless prohibited by statute. Within a reasonable time prior to any such conference, the commissioner shall notify the parties of it. If the parties who attend the conference agree to a disposition of the action, the commissioner shall issue a consent order or license which shall embody the terms of such disposition, and which shall be a final decision of the department.

(b) **Pre-hearing conferences.** The commissioner may direct the parties to appear at specified times and places for conferences to consider (1) simplification and clarification of issues for hearing; (2) consolidation or joinder of parties; (3) stipulations and admissions of fact and of documents; (4) limitation of expert witnesses, exchange of lists of witnesses and summaries of testimony, and other steps to expedite the presentation of evidence; and (5) such other matters as may aid in the orderly disposition of the hearing. The commissioner shall notify the parties of the date, time, and place of the conference. Following any conference, the commissioner may enter an order which (1) recites the action taken at the conference, and any agreements made by the parties as to any of the matters considered; (2) states the issues for the hearing; (3) consolidates parties at hearing; or (4) otherwise aids in the orderly disposition of the hearing. Any such order shall control the subsequent course of the action unless modified by the commissioner for good cause.

(Effective April 13, 1978)

#### Sec. 17-210a-20. Hearings; procedure

(a) The purpose of any hearing the department conducts under Chapter 54 of the general statutes shall be to provide to all parties an opportunity to present evidence and argument on all issues to be considered by the department.

(b) In hearings on complaints, applications and petitions, the party that shall open and close the presentation of any part of the matter shall be the complainant, applicant or petitioner.

(c) To avoid unnecessary cumulative evidence, the presiding officer may limit the number of witnesses or the time for testimony upon a particular issue in the course of any hearing.

(d) The commissioner may by order of the presiding officer permit any party to offer testimony in written form. Such written testimony shall be received in evidence with the same force and effect as through it were stated orally by the witness who has given the evidence, provided that each such witness shall be present at the hearing at which testimony is offered, shall adopt the written testimony under oath,

and shall be made available for cross examination as directed by the presiding officer. Prior to its admission such written testimony shall be subject to objections by parties.

(Effective April 13, 1978)

#### **Sec. 17-210a-21. Notice of hearings**

(a) Except when the commissioner shall otherwise direct, the commissioner shall give written notice of a hearing in any pending matter to all parties, to all persons who have been permitted to participate as intervenors, to all persons otherwise required by statute to be notified, and to such other persons as have filed with the commissioner their written request for notice of hearing in a particular matter. Written notice shall be given to such additional persons as the commissioner shall direct. The commissioner may give such public notice of the hearing as the commissioner shall deem appropriate.

(b) Notice of a hearing shall include but shall not be limited to the following: (1) a statement of the time, place and nature of the hearing; (2) a statement of the legal authority and jurisdiction under which the hearing is to be held and the particular sections of the statutes and regulations involved; (3) a short and plain statement of fact describing the purpose of the hearing and the principal facts to be asserted therein.

(Effective April 13, 1978)

#### **Sec. 17-210a-22. Place of hearings**

Unless by statute or by direction of the commissioner a different place is designated, all hearings of the department shall be held at the principle office of the department at 90 Washington Street, in Hartford, Connecticut.

(Effective April 13, 1978)

#### **Sec. 17-210a-23. Representation**

Each person authorized to participate in a contested case as a party or as an intervenor shall file a written notice of appearance with the commissioner. Such appearance may be filed in behalf of parties and intervenors by an attorney, an agent, or other duly authorized representative subject to the rules hereinabove stated. The filing of a written appearance may be excused by the presiding officer.

(Effective April 13, 1978)

#### **Sec. 17-210a-24. Participation by other persons**

(a) **Permission to participate.** At any time prior to the commencement of oral testimony in any hearing on a contested case any person may request that the presiding officer permit that person to participate in the hearing. Any person not a party who is so permitted to participate in the hearing will be identified an intervenor in these regulations and will participate in those portions of the contested case that the presiding officer shall expressly allow.

(b) **Status of a non-party that has been admitted to participate.** No grant of leave to participate in the hearing as an intervenor or in any other manner shall be deemed to be an admission by the commissioner that the person he has permitted to participate is a party in interest that may be aggrieved by any final decision, order or ruling of the commissioner unless such grant of leave to participate expressly so states.

(Effective April 13, 1978)

**Sec. 17-210a-25. Service**

(a) Service of all documents and other papers filed in all proceedings, including but not limited to motions, petitions, applications, notices, briefs and exhibits shall be by delivery in person or by first class mail, except as otherwise provided by statute.

(b) All such documents and other papers shall be served by the person filing the same on all parties to the proceeding and all such additional persons as the commissioner may require.

(c) A copy of any document or other papers served by the department, showing the addresses where such document or other paper was mailed shall be placed in the commissioner's files and shall be prima facie evidence of such service and the date thereof.

(Effective April 13, 1978)

**Sec. 17-210a-26. Rules of evidence**

The following rules of evidence shall be followed in the admission of testimony and exhibits in all hearings held under Chapter 54 of the general statutes.

(a) **General.** Any oral or documentary evidence may be received; but the presiding officer shall, as a matter of policy, exclude irrelevant, immaterial or unduly repetitious evidence. The commissioner or presiding officer shall give effect to the rules of privilege recognized by law in Connecticut where appropriate to the conduct of the hearing. Subject to these requirements and subject to the right of any party to cross examine, any testimony may be received in written form as herein provided.

(b) **Documentary evidence, copies.** Documentary evidence may be received at the discretion of the commissioner or presiding officer in the form of copies or excerpts, if the original is not found readily available. Upon request by any party an opportunity shall be granted to compare the copy with the original, which shall be subject to production by the person offering such copies, within the provisions of Section 52-180 of the general statutes.

(c) **Cross examination.** Such cross examination may be conducted as the presiding officer shall find to be required for a full and true disclosure of the facts.

(d) **Facts noticed.** The commissioner may take administrative notice of judicially cognizable facts, including the records and the prior decisions and orders of the department. Any exhibit admitted as evidence by the commissioner in a prior hearing may be offered as evidence in a subsequent hearing and admitted as an exhibit therein; but the commissioner shall not deem such exhibit to be cognizable in whole or in part for this purpose and shall not consider any facts set forth therein unless such exhibit is duly admitted as evidence in the matter then being heard.

(e) **Facts noticed, scope and procedure.** The commissioner may take administrative notice of generally recognized technical or scientific facts within the commissioner's specialized knowledge. Parties shall be afforded an opportunity to contest the material so noticed by being notified before or during the hearing, or by an appropriate reference in preliminary reports or otherwise of the material noticed. The commissioner shall nevertheless employ the experience, technical competence, and specialized knowledge in evaluating the evidence presented at the hearing for the purpose of making a finding of facts and arriving at a final decision.

(Effective April 13, 1978)

**Sec. 17-210a-27. Decision in contested case**

(a) The commissioner will proceed in the following manner in contested cases where the commissioner has not heard the case or read the record. If the decision is to be adverse to a complainant, applicant, petitioner, or any other party, the

decision shall not be adopted by the commissioner until a proposal for decision is served upon all of the parties, and until an opportunity has been afforded to each party adversely affected by the proposed decision to file exceptions, to present briefs, and to make oral argument before the commissioner.

(b) In the proposal for decision to be served upon the parties, the commissioner will set forth a summary of each issue of fact or law that he finds necessary to reach the conclusion contained in the proposed decision.

(c) Compliance with the above-stated requirement concerning the proposal for decision may be waived by a written stipulation of the parties.

(Effective April 13, 1978)

#### **Sec. 17-210a-28. Final decisions**

All decisions and orders of the commissioner concluding a contested case shall be in writing. The commissioner will serve a copy of his decision on each party in the manner required by these rules and Chapter 54 of the general statutes.

(Effective April 13, 1978)

#### **Sec. 17-210a-29. Uncontested disposition**

Unless precluded by law, any complaint, application or petition may be resolved by stipulation, agreed settlement, consent order or default, subject to the order of the commissioner. Upon such disposition a copy of the order of the commissioner shall be served on each party.

(Effective April 13, 1978)

#### **Sec. 17-210a-30. Record**

The record in a contested case shall include: (1) all motions, applications, petitions, complaints, responding pleadings, bills of particulars, notices of hearing, and intermediate rulings; (2) the evidence received and considered by the commissioner; (3) questions and offers of proof, objections, and the presiding officer's rulings thereof during the hearing; (4) the decision, opinion or report by the presiding officer to the commissioner.

(Effective April 13, 1978)

#### **Sec. 17-210a-31. Ex parte communications**

Unless required for the disposition of matters authorized by statute, neither the commissioner nor any presiding officer shall communicate directly or indirectly with any party concerning any issue of fact or law involved in any contested case that has been commenced under these rules, except upon notice and opportunity for all parties to participate. Any presiding officer and the commissioner may communicate with each other ex parte and may have the aid and advice of such members of the department staff as are assigned to assist them in such contested case.

(Effective April 13, 1978)

### **Part 5**

#### **Miscellaneous Provisions**

#### **Sec. 17-210a-32. Investigative hearings**

The commissioner may hold investigative hearings for the purpose of (1) ascertaining compliance with any statute or regulation within the department's jurisdiction to administer or enforce; or (2) receiving information concerning any matter which reasonably may be the subject of regulation by the department. The commissioner

shall provide reasonable notice of any such hearing to all interested persons and the general public.

(Effective April 13, 1978)

**Secs. 17-210a-33—17-210a-49. Reserved**

**Transportation of Mentally Ill Alcoholic or  
Drug-Dependent Persons**

**Secs. 17-210a-50—17-210a-52.**

Repealed, June 25, 1979.



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## **Duties of the Commissioner of Mental Health**

### **Sec. 17-210a (p)-1. Definitions**

As used in these regulations:

(a) “Clinical staff” means a psychiatrist, physician, registered nurse, licensed practical nurse, psychologist, psychiatric social worker, licensed physician’s assistant or pharmacist employed by the Department of Mental Health or a crisis intervention program funded by the Department of Mental Health.

(b) “Crisis intervention program funded by the Department of Mental Health” means a program, which either is operated by the Department of Mental Health or is funded through a grant or contract with the Department of Mental Health, to provide emergency psychiatric services and to assist with crisis resolution.

(c) “Department” means the Department of Mental Health.

(d) Department of Mental Health Facilities means those hospitals or other facilities operated by the Department of Mental Health which provide treatment for adults with mental illnesses. These facilities include: Capitol Region Mental Health Center, Cedarcrest Regional Hospital, Connecticut Mental Health Center, Connecticut Valley Hospital, Franklin S. DuBois Center, Fairfield Hills Hospital, Greater Bridgeport Community Mental Health Center, Norwich Hospital, and Whiting Forensic Institute.

(e) “Diagnosis” means the process of identifying or determining the existence or nature of a disorder through examination or the opinion derived from such an examination.

(f) “Disclosure” means to make information in the patient’s record known, whether in written or oral form.

(g) “Patient” means any person who presents for diagnosis or treatment in a Department of Mental Health facility or a crisis intervention program funded by the Department of Mental Health.

(h) “Patient consent” means consent given in writing by the patient or his authorized representative in compliance with Section 52-146e (b) of the Connecticut General Statutes.

(i) “Records of previous treatment” means patient medical information pertaining to diagnosis or treatment obtained from the patient and other sources, including the medical record, and maintained at a Department of Mental Health facility or crisis intervention center funded by the Department of Mental Health.

(j) “Treatment” means the engaging of persons in a particular plan of action, the aim of which is to arrest, reverse, ameliorate or stabilize the patient’s presenting disorders; primarily, but not solely, focussing on the mental condition of the patient.

(Effective October 4, 1995)

### **Sec. 17-210a (p)-2. Disclosure process**

The procedure for disclosure is as follows:

(a) A clinical staff member who is engaged in the diagnosis or treatment of a patient may request access to the patient’s record of previous treatment in order to accomplish the objectives of diagnosis or treatment of the patient.

(b) Disclosure of information related to the identity of prior or current clinicians, drug dosage reaction allergies, tolerance to medication, presenting symptoms and behaviors, and/or substance abuse automatically shall be deemed necessary to accomplish the objectives of diagnosis or treatment of the patient.

(c) The clinical staff member in possession of any requested record may, without patient consent, release any information, in addition to that listed in subsection (b)

of this section, from that record if, in his or her judgment, that information would assist in the accomplishment of the objectives of diagnosis or treatment.

(Effective October 4, 1995)

**Sec. 17-210a (p)-3. Maintenance of records**

Each record of a patient's previous treatment obtained under these regulations shall be filed with the patient's medical record at the Department of Mental Health facility or crisis intervention program which requested this information. The provisions of Section 4-193 (c) of the Connecticut General Statutes shall apply to any disclosures of records made in accordance with these regulations.

(Effective December 21, 1990)

**Sec. 17-210a (p)-4. Confidentiality**

Each Department of Mental Health facility or crisis intervention program funded by the Department of Mental Health shall have and utilize a written policy and procedure for ensuring the confidentiality and security of records which conforms to the requirements of state and federal confidentiality laws, including but not limited to:

(a) a description of the process and requirements for disclosure of confidential information;

(b) copies of forms for documenting the disclosure of confidential information and for obtaining the written consent of the patient when such consent is required; and,

(c) staff training in the requirements of state and federal laws related to confidentiality of client records.

(Effective December 21, 1990)

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## **Minimum Standards for Eligibility to Receive State Funds**

### **Sec. 17-226b-1. Definitions**

As used in Section 17-226b-1 to Section 17-226b-8, inclusive:

(a) “Award” means those funds provided general hospitals or nonprofit organizations for the establishment, expansion or maintenance of psychiatric or mental health services under the authority of Section 17-226b of the general statutes;

(b) “Awardee” means the recipient of an award made under the authority of Section 17 226b of the general statutes. The awardee shall be the agency making the application for an award and providing the psychiatric or mental health services;

(c) “Capital expenditure” means the cost of construction or renovation of buildings made with the expectation of existence for an indefinite period and includes the depreciation thereof. Routine maintenance shall not be considered a capital expenditure;

(d) “Catchment Area Council” means the council appointed under the authority of Section 17-226k of the general statutes;

(e) “Commissioner” means the Commissioner of the Department of Mental Health;

(f) “Department” means the Department of Mental Health, 90 Washington Street, Hartford, Connecticut 06115, or the address of the appropriate Regional Director’s office;

(g) “General hospital” means a short-term hospital having facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a wide range of acute conditions, including injuries and shall include those facilities licensed as such by the Department of Health Services;

(h) “Letter of award” means the document evidencing the agreement between the award and the department for funding of psychiatric or mental health services;

(i) “Psychiatric or mental health services” means comprehensive services, both medical and non-medical, designed to (1) decrease the prevalence and incidence of mental illness, emotional disturbance and social disfunctioning, and (2) promote mental health in individuals, groups and institutions and includes, but is not limited to, the following: Outreach and case funding, inpatient treatment, outpatient treatment, partial hospitalization, diagnosis and screening, aftercare and rehabilitation, education, consultation, emergency services, research, evaluation, training and services to the courts;

(j) “Regional Board” means the regional mental health board as defined in Section 17-226j of the general statutes;

(k) “Regional Director” means the regional mental health director appointed under the authority of Section 17-226e of the general statutes.

(Effective July 25, 1979)

### **Sec. 17-226b-2. Application for funds**

(a) Application for funds under Section 17-226b of the general statutes shall be made on forms provided by the department. The properly completed application forms shall be submitted to the regional director for the region in which the prospective program is located. The application shall be accompanied by (1) a definition of the towns and areas to be served; (2) a plan by means of which the applicant proposes to coordinate its activities with those of other local agencies presently supplying psychiatric or mental health services or contributing in any way to the mental health of the area; (3) a description of the services to be provided, and the methods through which those services will be provided; and (4) indication of the

methods that will be employed to effect a balance in the use of state and local resources so as to foster local initiative, responsibility and participation.

(b) The application shall be accompanied by the following information pertaining to the applicant's program (if applicable):

- (1) The actual expenses of the program for the previous year;
- (2) The latest audited financial statement;
- (3) The fee schedule for services;
- (4) The latest detailed budget for the applicant organization;
- (5) The catchment area council or regional board evaluation report (if already funded by the department);
- (6) A list of the Board of Directors of the applicant organization with addresses;
- (7) Document showing allocation of federal and other funding;
- (8) The name and telephone number for: (a) Chairman of the Board of Directors; (b) Administrator of the program; (c) Program Director; and (d) Chief Fiscal Officer.
- (9) Documentation of approval by: (a) Health Systems Agency (HSA) and (b) Commission on Hospitals and Health Care.

(c) Each applicant must have copies of the following on file at the department (if applicable):

- (1) All professional licenses;
- (2) All facility licenses;
- (3) Certificate of incorporation;
- (4) Contracts and/or agreements for: (a) professional consultants; (b) maintenance; (c) food service;
- (d) third party payments; (e) town-city; (f) private individuals; and (g) lease/rental agreements;
- (5) Letters of affiliation of working agreements with other programs/facilities;
- (6) Certificates of compliance with: (a) health codes; (b) fire and safety codes; (c) building codes; and (d) zoning requirements;
- (7) Employee surety bonds;
- (8) Insurance coverage (cost and extent) for: (a) casualty; (b) liability; (c) malpractice;
- (9) Program's organization, policies and procedures;
- (10) Program job descriptions.

(d) The applicant shall submit the above information and documents in accordance with the requirements of the application form, as well as any other information the department may reasonably require.

(Effective July 25, 1979)

### **Sec. 17-226b-3. Review by regional director**

The regional director and the regional mental health board shall review each application submitted to the regional director in accordance with subdivision (4) of subsection (b) of Section 17-226g and subdivisions (1) and (2) of subsection (a) of Section 17-226l.

(Effective July 25, 1979)

### **Sec. 17-226b-4. Letter of award**

(a) The allocation of funds shall be by a letter of award. Each letter of award shall set forth the specific conditions under which the award is made and the manner in which payments are to be made. The application shall be attached to and become a part of the letter of award. All letters of award shall continue for an indefinite

period unless modified, suspended or terminated in accordance with the term of the letter of award and this regulation.

(b) The department must be notified at the time of the quarterly report of income and expenses of any variance in the awardee's budget as submitted to the department, and any such variances must be approved in writing by the department. Notwithstanding the above, the awardee may make the following variance without department approval: (1) line item of expenses (excluding salary and fringe benefits) up to 20 percent of the budget or \$500.00, whichever is less; (2) program to program shifts up to 10 percent of the budget or \$2,000.00, whichever is less.

(Effective July 25, 1979; amended July 6, 1998)

### **Sec. 17-226b-5. Accounting and reports; fiscal year**

(a) **Audits.** Within 90 days of the completion of each full fiscal year during the term of the award and also within 90 days of the termination of the award, the awardee will, at its expense, cause to be prepared and delivered to the department an audit performed by an independent public accountant as defined in § 7-391 of the general statutes. Such audit shall be performed in accordance with generally accepted accounting principles and shall identify any expenditures made by the awardee that are not in compliance with the letter of award. The awardee shall also grant access to all records and accounts concerning each fiscal year that the award is in effect to the auditors of public accounts of the State of Connecticut. To provide such access, the awardee shall preserve all of its records and accounts engineering the award for a period of three years after the termination of the award.

(b) **Records.** The awardee shall maintain and have available records sufficient to determine the usage of all state funds in the awardee's program. Such records shall be maintained for a period of three years after the termination of the award.

(c) **Reports.** Payments will be made by the department only after receipt and approval of a quarterly report of income and expenses for the preceding quarter as well as such other information concerning the awardee's program which the department may reasonably require. Payments made under the letter of award and acceptance of reports of income and expenses are provisional, subject to audit of the awardee's records.

(d) **Access to records.** The awardee shall grant the department access, at any reasonable time, to records pertaining to the programs funded by any letter of award.

(e) **Fiscal year.** The fiscal year for reporting and accountability shall be as stated on the letter of award, for the purposes of the letter of award and state grants.

(Effective July 25, 1979)

### **Sec. 17-226b-6. Miscellaneous provisions**

(a) **Acknowledgment.** An awardee shall acknowledge the department's support in all public statements, including annual reports, statements through media, etc. Evidence of conformance with this section shall be submitted to the department along with the reports of income and expenses.

(b) **Preference of Services.** The awardee shall provide first preference of services to identified ex-state hospital patients or potential state hospital admissions.

(c) **Admission and Discharge Reports.** The awardee shall notify the department of each admission and discharge and such other routine information as the department requires on such forms as provided by the department.

(d) **Notification of Additional Funding.** In the event the awardee receives additional funding from any source for services provided for in the letter of award, the

awardee shall notify the regional director of such funding and its proposed use within ten days after receiving notice of such additional funding.

(e) **Program Revisions.** Any proposed revisions in one or more agency programs as described in the grant application which substantially alters the nature or scope of such programs shall not be implemented until approval has been received in writing from the regional director.

(f) **Capital Expenditure Restriction.** No funds allotted by the department under a letter of award may be used for capital expenditures.

(g) **Sub-contracts.** The department shall have the right of approval on all sub-contracts for services made by the awardee concerning programs funded by the department's grants.

(Effective July 25, 1979)

**Sec. 17-226b-7. Termination, suspension or modification of letter of award**

The department may modify the letter of award or suspend or terminate any grant of funds thereunder at will upon thirty days notice to the awardee. Reasons for modifying, suspending or terminating include, but are not limited to the following: (1) Failure of the awardee to provide those program services which it has agreed to provide in its application; (2) Reduction of the appropriation from which the grant is made to the awardee by the General Assembly; (3) A general departmental or state deficit requiring a reduction in spending; (4) A substantial loss in income to the state, thereby, requiring a reduction in spending; (5) Failure of the awardee to comply with the conditions of the letter of award or of these regulations.

(Effective July 25, 1979)

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**Regional Mental Health Planning Councils**

**Secs. 17-226c-1—17-226c-8.**

Repealed, October 13, 1976.

**Regional Mental Health Boards**

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**Minimum Standards of Eligibility for Commission  
Funding for Private Nonprofit Organizations  
and Municipalities**

**Sec. 17-226d-1. Definitions**

For the purpose of sections 1 through 11 inclusive

(A) “Awardee” means the municipality or nonprofit organization which is a recipient of Commission funding.

(B) “Chart of Accounts” means a listing of the various fund accounts, income and expense classifications and their respective numerical designations, if any, that an organization utilizes to account for its financial transactions.

(C) “Client” means a person receiving services from an alcohol or drug abuse treatment program which is a recipient of Commission funding.

(D) “Commission” means the Connecticut Alcohol and Drug Abuse Commission.

(E) “Commission Staff” means one or more persons employed by the Commission in a professional capacity whose duties include responsibility for reviewing and evaluating program performance.

(F) “Continuum of Care” means the array of services including prevention, intervention and treatment services designed to meet a variety of needs resulting from potential or actual substance abuse.

(G) “Counseling Session” means a scheduled meeting of 30 minutes or longer duration where group, individual, or family counseling is provided.

(H) “Direct Costs” means those costs which can be identified specifically with a particular cost objective.

(I) “Eligible Clients” means those persons who are unable, either directly or through third party reimbursement or through a combination of both, to pay the full charge for services provided by an awardee under a fee for service award.

(J) “Employee Assistance” means a service funded by the Commission for the purpose of assisting employers in motivating and referring to appropriate professional assistance, those employees whose personal problems, which may include substance abuse, have seriously interfered with their job performance.

(K) “Excess Payments” means any payment made by the Commission pursuant to a fee for service award which exceeds the amount authorized for the actual services provided.

(L) “Executive Director” means the executive director of the Commission except where the context of a particular section indicates otherwise.

(M) “Fee-For-Service Award” means an agreement between the Commission and an awardee whereby the Commission reimburses the awardee for designated services at a predetermined rate up to a maximum amount specified in the contract or letter of award.

(N) “Governing Authority” means the person or persons with ultimate authority and responsibility for the overall operation of the awardee.

(O) “Grant” means an agreement between the Commission and a private nonprofit organization or municipality whereby the Commission awards funds to carry out specified programs, services or activities related to the prevention of, treatment of, or education about, substance abuse pursuant to the authority of Connecticut General Statutes section 17-226d.

(P) “Indirect Costs” means those costs incurred for a common or joint purpose benefiting more than one cost objective and not readily assignable to the cost objectives specifically benefited.

(Q) “Non competitive continuation award” means a subsequent award made to an awardee based on a history of satisfactory compliance with Commission requirements so that the awardee may continue to offer the services originally funded by the Commission.

(R) “Policy” means a statement of the principles which guide and govern the activities, procedures and operations of a program.

(S) “Probation” means a Commission decision to impose additional conditions on an awardee who is in violation of Commission requirements rather than terminate the awardee’s letter of award or contract in order to provide an opportunity for the awardee to come into compliance with Commission requirements.

(T) “Procedure” means a series of activities designed to implement program goals or policy.

(U) “Program” means an organizational entity operated by an awardee which provides alcohol and/or drug abuse related services. A program may be an identified administrative unit within a larger organization or it may consist of more than one component.

(V) “Review and evaluation” means an assessment by Commission staff of an awardee’s compliance with Commission regulations and the terms and conditions of the awardee’s contract or letter of award. The assessment may include review of an awardee’s records, review of an awardee’s reports, on site visits, and interviews with the awardee’s employees and any persons who receive services from the awardee’s program.

(W) “Service Recipient” means a person who receives any type of services from a program which is a recipient of Commission funding.

(X) “State methadone authority” means the person having the powers and duties described in the Federal Methadone Regulations, 21CFR 291.505.

(Y) “Substance abuse” means the use of one or more drugs, including alcohol which significantly and negatively impacts one or more major areas of life functioning.

(Z) “Supplemental funding” means additional funding granted to an awardee by the Commission during the term of the awardee’s contract or letter of award.

(AA) “Surplus” means the total amount awarded by the Commission plus the income received by the awardee for award supported activities which exceeds the total of allowable expenses.

(BB) “Terminate” means a unilateral decision by the Commission to end its financial support of an awardee because the awardee has been found to be in violation of Commission requirements.

(CC) “Treatment and rehabilitation” means one or more meetings between a client and a program’s treatment staff wherein a broad range of planned services may be extended to the client including diagnostic evaluation, counseling, medical, psychiatric, psychological and supportive services which are designed to influence the behavior of clients toward identified goals and objectives.

(DD) “Treatment staff” means those persons employed by an awardee who are directly involved in client care and treatment.

(EE) “Unallocated funds” means those funds which, although appropriated by the Legislature for use by the Commission, have not been specifically designated for a particular type of recipient by the Commission.

(FF) “Unencumbered funds” means those funds which become available during a fiscal year due to underexpenditure of grant funds by awardees or delayed start-up of newly funded programs.

(Effective September 20, 1984)

**Sec. 17-226d-2. General provisions****(a) Applicability**

(1) Sections 17-226d-1 to 17-226d-11, inclusive, apply only to those private nonprofit organizations and municipalities which apply for or receive state or federal funding, or both from the Commission for the purpose of establishing, expanding or continuing one or more of those alcohol and/or drug abuse services authorized by Connecticut General Statutes section 17-226d.

(2) The provisions of sections 17-226d-1 to 17-226d-11 apply to each applicant or awardee except where the content of a regulation or any portion thereof is expressly applicable only to a specific group of applicants or awardees, or expressly exempts a specific group of applicants or awardees.

**(b) Minimum standards**

(1) Sections 17-226d-1 to 17-226d-11 comprise the minimum standards of eligibility for Commission funding. Meeting the minimum requirements does not guarantee that an applicant or awardee will receive Commission funding, nor that funding will be awarded in subsequent fiscal years.

(2) The Commission may impose additional requirements beyond those contained in sections 17-226d-1 through 17-226d-11 on any individual applicant or awardee either through terms in the letter of award or contract between the awardee and the Commission, or by at least 30 days written prior notice from the Commission that additional requirements must be met by the applicant or awardee in order to qualify for, or continue to receive Commission funding. Additional requirements may be imposed when an applicant or awardee has limited financial management or service delivery experience, or has an inadequate performance record, or in order to correct a specific weakness identified by the Commission, or in order to fulfill special service or information needs.

**(c) Requirements of other agencies**

(1) In order to be eligible for Commission funding:

(A) an awardee or applicant who is required to be licensed by the Department of Health Services pursuant to Chapter 368v of the Connecticut General Statutes or by the Department of Children and Youth Services pursuant to Section 17-432 of the Connecticut General Statutes must obtain and retain such license.

(B) an awardee or applicant who is required by Chapter 368c to obtain a certificate of need or other approval from the Commission on Hospitals and Health Care must obtain such certificate of need or approval.

(2) The Commission may refuse to fund an applicant or awardee unless such applicant or awardee can demonstrate that the physical facility at which it offers or proposes to offer services is in compliance with all applicable local and state zoning building, health, fire and safety standards.

**(d) Commission's discretion in awarding funds**

(1) The specific amount of every award, whether by grant or by fee for service award, is within the sole discretion of the Commission.

(2) All Commission awards are made subject to the availability of appropriated state and federal funds.

(3) Available funds, except for those funds which are required to be allocated to specific geographic area or type of service by state or federal statute or regulation, shall be allocated to types of services and geographic areas of the state by majority vote of the Commission at a regularly scheduled meeting held in accordance with the requirements of Connecticut General Statutes, sections 1-21.

**(e) Waiver**

(1) At the request of the applicant or awardee the executive director may issue a written waiver of any of the requirements of sections 17-226d-1 through 17-226d-11 which are not otherwise required by law and for which the Commission has authorized the executive director to grant waivers.

(2) The request for a waiver must be in writing and must be signed by the executive director of the applicant or awardee. The waiver may be granted only if accompanied by documentation which demonstrates that the waiver is in the best interest of the applicant or awardee's service recipients.

(3) Waivers shall only be issued prospectively.

**(f) Utilization**

The Commission may reduce the funding of any Awardee who does not maintain the projected utilization described in the awardee's approved funding application.

**(g) Review and evaluation**

(1) The performance of each awardee shall be reviewed and evaluated at least annually for the Commission by Commission staff. Such reviews and evaluations may be performed by examining the awardee's documents and reports, by site visits to Commission funded facilities administered by the awardee, or by a combination of both document review and site visits.

(2) An awardee's performance shall be evaluated by a review of:

(A) its compliance with all applicable state and federal laws and regulations including sections 17-226d-1 through 17-226d-11, and the terms and conditions of its individual letter of award or contract;

(B) the degree of achievement of its own self-described goals and objectives as negotiated with the awardee and described in the awardee's approved funding application;

(C) its financial reports to the Commission and annual audit; and

(D) The economy and efficiency of its operations.

(3) During any site visit, Commission staff shall be given access to:

(A) all program records, service recipient records including client treatment records and clinical records, and required personnel information related to Commission funded activities and all fiscal records whether or not they pertain to Commission funds;

(B) any person employed at the site who is present at the site at the time of the visit, or any individual member of the awardee's governing body whom the Commission staff wish to interview, such interviews with members of the governing body shall be scheduled at the convenience of the members of the governing body;

(C) all physical facilities which are utilized for Commission funded activities;

(D) service recipients, including clients, to whom the awardee is providing alcohol or drug abuse related services funded by the Commission and who agree to be interviewed. No client identifying information shall be removed from the program premises as a result of such interview.

**(h) Required reporting**

(1) Each awardee shall send the Commission upon the request of the Executive Director copies of any written policies, manuals, guidelines and any other documents required by sections 17-226d-1 through 17-226d-11, except client records as defined in section 17-226d-6. Commission staff shall have access to all such required documents during site visits.

(2) Any reports required by sections 17-226d-1 through 17-226d-11 or by an awardee's contract or letter of award shall be submitted to the Commission in the form, manner and at the times designated by the Commission.

(3) An awardee whose funding is canceled or terminated or who unilaterally closes a Commission funded program providing alcohol or drug abuse services shall submit a final financial report to the Commission within 30 days of the date of the cancellation, termination or program closure.

(i) **Technical assistance**

(1) Technical assistance may be made available to any awardee who requests it in writing. Such assistance shall be provided only if the executive director determines that:

(A) The awardee is in need of assistance and

(B) The Commission has the resources to provide the requested assistance.

(j) **Research projects**

Individual awardees shall, upon written notification from the Commission, cooperate and make available that information necessary for the conduct of research and evaluation activities undertaken or sanctioned by the Commission.

(k) **Acknowledgement of Commission support**

Each awardee shall acknowledge Commission support and funding in any brochures, newsletters, pamphlets, annual reports or other written material pertaining to programs and activities funded by the Commission.

(Effective September 20, 1984)

**Sec. 17-226d-3. Grants process**

(a) **Application procedure**

(1) All applicants

(A) Each applicant for Commission funding shall apply on forms designated by the Commission and shall submit all information requested on the application form and copies of all documents required by sections 17-226d-1 through 17-226d-11 and copies of all subcontracts.

(B) The application of a nonprofit organization shall be signed by a signatory authorized by the organization's board of directors. The application of a municipality shall be signed by a signatory authorized by the municipality.

(C) The services for which an applicant seeks Commission funding must be consistent with plans adopted by the Commission.

(2) Each awardee applying for noncompetitive continuation awards shall prepare and submit a yearly funding application at a time and in a manner designated by the executive director and shall include with such application all information and documents required by sections 17-226d-1 through 17-226d-11 and the Commission.

(3) Unsolicited proposals

(A) New and expanded services

Any organization or municipality which intends to submit an application to the Commission for funding for new or expanded services shall send notice of intent to submit such application to the executive director for staff review and comment at least 30 days prior to submission of a formal application.

An applicant seeking funding for new or expanded services shall, in addition to fulfilling the requirements of section 17-226d-3 (a), demonstrate and document either:

(i) that there is a need for new or expanded services and that the need is currently unmet or,

(ii) that the level of service available is inadequate in the area the applicant proposes to serve or,

(iii) that funding from other sources is inadequate or is no longer available or was never available.

**(B) Supplemental funding for existing services**

To qualify for supplemental funding an awardee's program must be in current compliance with Commission regulations and requirements.

Awardees applying for supplemental funding for existing services may submit applications for such funding at any time on a form designated by the Commission. The awardee shall submit:

- (i) information which demonstrates that supplemental funding is needed, and,
- (ii) documentation that demonstrates attempts have been made by the awardee to garner funds from other sources and that such attempts have been wholly or partially unsuccessful.

(4) The Commission may, in its discretion, request proposals to meet service needs or to establish research or demonstration projects. Applicants responding to such Commission requests for proposals shall submit their proposals in the form, time and manner stated in the Commission's request for such proposal.

**(b) Review of applications**

(1) Applications for noncompetitive continuation awards shall be reviewed for completeness, compliance with Commission requirements and to determine whether the applicant's proposed budget is consistent with the amount of available funds allocated to the program by the Commission.

(2) New and competitive applications, including applications submitted in response to Commission requests for proposals, shall be reviewed for completeness and compliance with Commission requirements. The staff shall make recommendations based on this review which the executive director shall report to the Commission.

**(3) Review of unsolicited proposals**

The Executive Director shall notify the Commission of the receipt of all unsolicited proposals. Such notice shall occur at regularly scheduled Commission meetings.

(A) Unsolicited proposals for new and expanded services shall be reviewed only if unallocated funds are available. Proposals which are not reviewed shall be retained at the Commission's offices for one year from the date of receipt and shall be reviewed at any time during the one year period that unallocated funds become available.

An unsolicited proposal for new or expanded services will be presented to the Commission by the executive director only if all of the following criteria are determined to have been met:

- (i) The service is needed in the area to be served.
- (ii) No less costly or more effective alternative to provide the needed services is available.
- (iii) All Commission application requirements have been fulfilled.
- (iv) Funding is demonstrably available from other sources to fund the portion of the applicant's budget in excess of the award sought from the Commission.
- (v) The applicant is able to demonstrate the ability to provide the proposed services.
- (vi) The applicant has proposed a reasonable start up time and demonstrates the ability to meet scheduled goals.

(B) Applications for supplemental funding for existing services shall be reviewed only if unallocated or unencumbered funds are available. Applications which are not reviewed shall be retained at the Commission offices until the end of the fiscal year and shall be reviewed if and when unencumbered funds become available

during that time. Applications for supplemental funding shall be presented to the Commission by the executive director only if all the following criteria are determined to have been met:

(i) All Commission application requirements have been fulfilled;

(ii) The applicant can demonstrate that attempts to obtain funding from other sources have been unsuccessful or only partially successful; and,

(iii) The applicant does not intend to annualize the supplemental award.

(C) The Commission may choose to accept, reject, modify or table for further study any unsolicited proposal presented to it by the executive director.

**(c) Notice and acceptance**

(1) Each applicant shall receive notice that the Commission has received its proposal within thirty days of the date the Commission receives the proposal. When the Commission votes to accept or reject an applicant's proposal the applicant will receive written notice of the Commission's action within thirty days of such action.

(2) The Commission's award is contingent upon the applicant's acceptance of any additional or special terms and conditions listed in the letter of award or contract and any changes in the funding application. The applicant shall indicate acceptance of the award and any special or additional conditions it contains by signing and returning it to the Commission's offices. The award shall become final only upon receipt by the applicant of a fully executed copy of the contract or letter of award.

**(d) Amount and duration of the award**

The amount and duration of each award is the sole discretion of the Commission. All awards are made subject to the availability of appropriated funds.

**(e) Subcontracting**

No work or services funded by a Commission award shall be performed for the awardee by a subcontractor without the prior written approval of the executive director. Subcontractors are subject to all the requirements and conditions imposed on the awardee or applicant by sections 17-226d-1 through 17-226d-11 and the awardee's letter of award or contract.

**(f) Modifications**

(1) The awardee shall obtain the prior written approval of the executive director before making modifications which would alter the awardee's program as described in the awardee's approved funding application.

(2) All revisions to the awardee's budget except those revisions explicitly permitted by the terms of the letter of award or contract:

(i) must have the prior approval of the awardee's governing authority or be signed by the chairperson of the awardee's Board of Directors;

(ii) must be requested on the form designated by the Commission;

(iii) must be submitted and approved by the executive director no later than 30 days after the end of the fiscal year for which the revision is being sought.

The awardee shall be notified of the action taken on the budget revision request within 30 days of receipt of the request by the Commission.

**(g) Payments**

(1) Awardees shall use funds awarded by the Commission only for expenditures which are properly documented and which are authorized by the terms and conditions of the awardee's letter of award or contract, or by the written permission of the Commission.

(2) Periodic payments of funds to awardees are contingent upon the awardee's continuing compliance with Commission requirements including but not limited to submission of periodic progress reports as required by the letter of award or contract.

(3) Initial payments under new awards shall be made only after the letter of award or contract has been fully executed; all Commission requirements and conditions have been met; a certificate of need, if required, has been obtained from the Commission on Hospitals and Health Care; and the awardee is ready to begin program implementation.

(4) Payments for continuation awards shall be made periodically. An initial advance payment shall be made to the awardee at the beginning of each fiscal year. Subsequent payments will be processed in advance provided the awardee's previous quarterly report was received when due and was approved by the Commission. Advance payments will not be processed for any awardee who has failed to submit a quarterly report for the previous quarter. If any awardee submitted his previous quarter's report more than 15 days after the day it was due, or is not in compliance with the Commission's requirements, subsequent payments to that awardee will not be processed until after the awardee's quarterly report has been received, reviewed and approved by Commission staff. Quarterly and year end reports shall be submitted on a form and in a time and manner designated by the Commission but no later than 15 calendar days after the end of each award quarter.

When staff review of any financial report or on site examination of an awardee's financial records indicates underexpenditures of award funds are likely to occur at the end of the fiscal year, or the awardee has refused access to service recipient or financial records during a review or evaluation by Commission staff the executive director may withhold or reduce one or more subsequent payments to the awardee. In the case of a fee for service award, if staff review of the awardee's financial reports or on site examination of the awardee's financial records indicates that the services covered by the fee for service award will be underutilized as defined in the individual awardee's fee for service award at the end of the fiscal year, the executive director may alter the payment schedule for the balance of that fiscal year.

An awardee may request an advance or emergency payment by making a written request explaining the need for such payment to the executive director. The executive director may authorize such payment if he determines that there is justification to do so. Any emergency or advance payment is made subject to approval of subsequent documentation of expenditures.

**(h) Termination or probation**

(1) The Commission may vote to terminate an award or place an awardee on probation if it finds:

(A) A documented history of noncompliance with Commission regulations or the terms and conditions of the contract or letter of award.

(B) The awardee or any person employed by the awardee has made false or misleading statements to the Commission in order to obtain Commission funding.

(C) The awardee or any person employed by the awardee has permitted, aided or abetted an unlawful act or acts at the program facility.

(D) The awardee has altered the nature and scope of the program without prior Commission approval.

(E) The awardee has refused to grant access to Commission staff to the awardee's program records including client treatment records and client clinical records or program financial records during a review and evaluation visit to the awardee's program.

(Effective September 20, 1984)

**Sec. 17-226d-4. Fiscal requirements****(a) Accounting system**

(1) Each awardee shall utilize an accounting system which conforms to generally accepted accounting principles applicable to recipients of state and federal funds. Such system shall separately account for income and expenditures related to Commission funded projects and programs.

(2) The awardees accounting system shall meet the following minimum requirements:

(A) The system shall have a chart of accounts

(B) The system shall provide sufficient information to separately identify the receipt and expenditure of Commission funds and shall keep on file copies of all financial reports submitted to the Commission.

(C) The following accounting records and related documentation shall be made and retained:

(i) a general ledger,

(ii) a cash receipts journal,

(iii) a cash disbursement journal,

(iv) individual payroll records for all staff members employed by the awardee,

(v) all bank statements and canceled checks,

(vi) all invoices, purchase orders, vouchers and paid bills,

(vii) employee attendance records,

(viii) copies of all contracts and lease agreements to which the awardee is a party, and,

(ix) any other financial documentation that the Commission may require by regulation or by the terms and conditions of the awardee's individual letter of award or contract.

(D) The system shall provide accurate and current financial reporting information.

(E) The system shall be integrated with systems of internal controls designed to safeguard funds and assets, check the accuracy and reliability of accounting data, promote operational efficiency and encourage adherence to management policies.

(F) The system shall include procedures for regular inventories and procedures for the disposition of property and funds derived from the sale of property purchased in whole or in part with Commission funds.

(G) The system shall include procedures for recording the actual time each employee of the awardee works.

(3) Each awardee's accounting records and related documentation shall be maintained by the awardee for a period of at least three years from the end of the fiscal year. Such records shall be stored in a place safe from loss or damage by fire, theft, water or other causes. Such records shall be made readily available for review and inspection upon the request of the Commission staff.

**(b) Allowable and unallowable costs**

(1) Awardees may include in their budgets direct and indirect costs including use charges for buildings, capital improvements and usable equipment.

(2) Individual expenditures may be made for items and services listed in an awardee's approved budget without obtaining any additional Commission approval.

(3) An awardee must obtain the prior written approval of the executive director for the recovery during one award period of unrecovered allowable costs incurred during a previous award period, or for any costs listed in the awardee's letter of award or contract which require such prior written approval.

(4) The following costs are unallowable:

- (A) capital expenditures for construction or renovation,
  - (B) bad debts,
  - (C) costs of idle facilities,
  - (D) royalties,
  - (E) depreciation or use charges for donated assets,
  - (F) fines and penalties resulting from violations of federal, state or local law,
  - (G) monetary judgments against the awardee or the cost of out of court settlements from any civil lawsuits to which the awardee is a party,
  - (H) actual losses which could have been covered by insurance but were not, unless such losses are specifically provided for in the awardee's letter of award or contract,
  - (I) costs of investment counsel,
  - (J) an excess of costs over income from another grant or contract,
  - (K) contributions to a contingency reserve fund, and,
  - (L) major medical equipment.
- (5) When reporting income received from fund raising, an awardee may deduct the costs of fund raising from the total amount received to determine the amount of income.

**(c) Review and disallowance of costs**

(1) An awardee's specific expenditures from each budget category shall be reviewed and may be disallowed by Commission staff during on site reviews or reviews of the reports and annual audits which awardees are required to submit to the Commission if such costs are determined to be unallowable, unreasonable or improperly allocated or if there is improper, inadequate or no documentation supporting the costs. In review of such reports and audits, the Commission staff shall utilize the following criteria:

(A) Reasonableness: A cost shall be deemed to be reasonable if:

- (i) it does not exceed that which would be incurred by an ordinarily prudent person;
- (ii) it is ordinary and necessary for the awardee's operation of the funded program within the restraints and requirements imposed by generally accepted business practices, arms length bargaining, federal and state law and regulation and the terms and conditions of the awardee's contract or letter of award;
- (iii) it is consistent with the purposes for which the funded program was organized; and,
- (iv) it does not significantly deviate from the awardee's established practices

(B) Allocability. A cost shall be deemed to be allocable if:

- (i) it is chargeable to a particular award in accordance with the relative benefits received;
- (ii) it benefits and is incurred for the funded program; and,
- (iii) it is necessary to the overall operation of the awardee.

(2) When, during the course of a review by Commission staff of financial reports or the annual audit or an onsite review of the awardee's financial records, a cost is identified as unallowable, unreasonable or improperly allocated, or the supporting documentation is inadequate, improper or there is no documentation, the awardee shall be notified in writing that such cost has been questioned and will be disallowed unless the awardee submits documentation within 30 days of receipt of such notification, which supports the awardee's position that such cost is allowable, reasonable or properly allocated.

(3) If the awardee fails to submit such documentation as required in subsection (2) above, or if such documentation fails to support the awardee's contention that

such cost should be allowed, the executive director shall notify the awardee that the cost has been disallowed and the awardee shall return to the Commission funds equivalent to the portion of the award expended on the disallowed cost.

**(d) Procedures for determining client eligibility under fee for service award**

(1) Each fee for service awardee must have documentation for each client charged to the fee for service award which demonstrates that there was a determination made at the time of intake of the client's ability to pay and the availability of third party reimbursement. Redeterminations of eligibility shall be done whenever there is a change in the clients employment, financial or third party reimbursement status.

(2) Each client who is determined by the awardee to be able to pay the full fee is ineligible for coverage under a fee for service award. In such cases where fees have been assessed but not paid they may be designated as bad debts by the awardee.

**(e) Disposition of surplus or excess funds**

(1) When the Commission staff determines through a review of an awardee's audited financial statement or final expenditure report that the awardee has a surplus, the surplus shall be disposed of in the following manner:

(A) The awardee shall return to the Commission that portion of the surplus which is proportionate to the Commission's award of state funds applied to the awardee's approved operating expenses.

(B) That portion of the surplus which is proportionate to the Commission's award of federal funds applied to the awardee's approved operating expenses, shall, upon written notice to the awardee, be disposed of at the sole discretion of the Commission in one of the following ways:

(i) The surplus may be offset against a continuation award to the awardee,

(ii) The surplus may be used as a carryover in a subsequent budget of the awardee, or,

(iii) The surplus may be returned to the Commission.

(2) The awardee may designate a portion of unrestricted operating income or public support which is in excess of funding received from the Commission for special or future use if such funds are not needed for current operating expenses. Funds so designated shall not be deemed a surplus and the requirements of subsection (1) of this section shall not apply if such designation was authorized by the awardee's governing authority and received the executive director's approval.

(3) The requirements of subsection (1) of this section shall not apply to any awardee who operates an employee assistance program funded by the Commission. Any funds received by such awardee for employee assistance services provided by contract to an organization shall not be deemed surplus for the purposes of this section.

(4) Whenever the Commission staff determines, through a review of any awardee's final expenditure report, or fiscal or client records that excess payments have been made under a fee for service award, the awardee shall return to the Commission a payment representing the amount of the excess.

**(f) Requirements for handling Commission funds**

(1) Each awardee shall have written policies and procedures to safeguard the awardee's assets against loss from unauthorized use or disposition and to ensure the reliability of financial records and maintain fiscal accountability.

(2) All funds received from the Commission shall be deposited only in federally insured accounts. Interest earned on Commission funds deposited in such accounts shall be reported as program income and may be used only for those activities authorized by the terms of the letter of award or contract.

(3) When an awardee is a nonprofit organization each check drawn on an account in which Commission funds are deposited shall be signed by two signatories, who shall be authorized by the awardee's board of directors to be signatories.

**(g) Procurement standards**

Each awardee shall establish written policies and procedures governing the procurement of goods and services. Such policies and procedures shall be based on the principle of free competition among potential suppliers.

**(h) Fee schedules and billing**

(1) Awardees providing services other than treatment may impose a charge on service recipients for all or part of the cost of the services rendered.

(2) Awardees shall impose a charge on service recipients for all or part of the cost of treatment services rendered by the awardee to such service recipients.

(3) Whenever an awardee imposes a charge for services, such charge shall be in accordance with a written fee schedule which shall be based on a determination of the actual cost of the services rendered and the service recipients' ability to pay the fee. The fee schedule shall be reviewed and revised at least once each year to reflect actual changes in the cost of rendering services to service recipients and the charges assessed to each individual service recipient shall be made according to a sliding scale based on the service recipient's ability to pay. Each awardee imposing a charge for services shall design and implement a system for the collection of delinquent accounts.

(4) Awardees shall endeavor to obtain reimbursement for services rendered either from the recipient of such services or from third party payors from whom the service recipient may be eligible to receive benefits or from both.

**(i) Annual audits**

(1) Each awardee shall have prepared an annual audit of its financial operations and records. The audit shall be prepared by an independent Certified Public Accountant having no direct or indirect financial interest in the awardee's program. The auditor shall utilize generally accepted auditing standards and whatever tests are normally considered necessary to meet the standards of the profession.

(2) The scope of the audit may be limited to Commission funded activities provided such activities are separate and distinct, from other activities not funded by the Commission. When Commission funded activities are not separate and distinct, a total audit of the awardee's program shall be done and shall include a supplemental statement identifying all expenditures associated with Commission funding. The decision on whether or not an audit must include all of the awardee's activities is in the sole discretion of the Commission.

(3) The auditor shall prepare a management letter which shall be submitted with the audit to the Commission within 120 days of the end of the fiscal year. At the written request of the executive director the awardee shall supply information to the Commission concerning the auditor's professional qualifications.

(4) The Commission staff shall review the audit and shall determine whether it meets minimum standards of acceptability in that it conforms to the requirements of sections 17-226d-1 through 17-226d-11 and that it conforms to generally accepted auditing standards. If an audit is determined to be unacceptable, the awardee shall be notified in writing of the deficiencies in the audit and the remedial action that is required of the awardee.

**(j) Insurance and bonding**

(1) The awardee shall ensure that all persons employed by the awardee who are engaged in accounting functions or are responsible for guarding assets are bonded at a level acceptable to the Commission.

(2) The awardee shall obtain insurance coverage sufficient to protect the awardee against full or partial losses of the awardee's physical and financial assets and to hold harmless the State of Connecticut from any insurable cause whatsoever. Insurance coverage shall include but not necessarily be limited to:

- (A) Property insurance covering losses due to fire, theft and accident;
- (B) Liability insurance on the awardees property and vehicles;
- (C) Worker's compensation insurance for the awardee's employees; and,
- (D) Officer's and director's liability insurance.

**(k) Transfer of funds**

(1) With the prior written permission of the executive director an awardee may temporarily transfer funds between one program operated by the awardee and funded by the Commission under one contract or letter of award and a second program operated by the awardee and funded by the Commission through another contract or letter of award.

(2) The awardee shall apply for permission to make a temporary transfer of funds by making a written request to the executive director, which shall include reasons justifying the transfer, the anticipated duration of the transfer and a description of how the transferred funds will be repaid. Such request shall be signed by the presiding officer of the awardee's governing authority.

(3) Upon receipt of a request to transfer funds between two programs funded by the Commission, the executive director may authorize the transfer if he determines that:

- (A) The transfer is necessary to ensure uninterrupted program operation;
- (B) The funds will not be needed by the transferor during the period of time they are to be used by the transferee; and,
- (C) The transferee can realistically expect to repay the transferred funds at the time stated in the request.

**(l) Equipment and inventory**

(1) The Commission shall have an interest in all equipment which was purchased by the awardee in whole or in part with Commission funds. The Commission's interest shall be equivalent to the percentage of the Commission's contribution toward the purchase price. The Commission shall not have an interest if the equipment was purchased with funds accumulated in the awardee's depreciation account.

(2) When Commission funding to an awardee ceases because the program no longer operates or because the Commission award was terminated, the Commission may in its sole discretion require any of the following dispositions of property in which it has an interest:

- (A) The awardee may be permitted to retain and use the property.
- (B) The property may be sold, in which case the awardee may deduct and retain 10% of the proceeds of the sale to compensate it for the costs of selling the property and shall return to the Commission a percentage of the remaining proceeds equivalent to the percentage of Commission funds used to purchase the property originally.
- (C) When the Commission has provided 100% of the purchase price of the property it may:

- (i) transfer the property to another Commission funded program or,
- (ii) take possession of the property and use it as it sees fit in the performance of its duties.

(3) Awardees shall prepare yearly inventories of all equipment purchased with Commission funds which has a value of \$300 or more and has a useful life of three or more years; or that has a value of \$500 or more if the useful life is less than three years.

**(m) Commission rights to material produced with Commission funds**

The Commission shall have an unrestricted right to publish, disclose, distribute and otherwise use in whole or in part any reports, data, curricula or any other material including printed, written or photographic material, films and video and audio tapes without the payment of royalties to the awardee, when such material has been produced in whole or in part with Commission funds pursuant to an award that specifically requires the awardee to produce such material.

**(n) Local resources**

(1) Each private, non profit organization which receives Commission funding shall actively attempt to utilize local resources for financial support or goods or services to supplement the funds received by the Commission.

(2) Awardees shall document their compliance with this requirement by indicating in their funding applications for continuation awards the efforts they have made and plan to make to encourage local participation, and the results of such efforts.

(3) Applicants for Commission funding for new programs shall indicate in their applications the means by which they will obtain local participation.

**(o) Maintenance of effort**

Commission funding shall not be used by any awardee to supplant or replace funding from other sources unless the Commission's contract or letter of award with the awardee explicitly authorizes the awardee to do so.

**(p) Financial reporting to the governing authority**

Each awardee's board of directors or other governing authority shall require that the chief administrative officer employed by the awardee shall make regular reports to the governing authority concerning the financial status of the programs operated by the awardee.

(Effective September 20, 1984)

**Sec. 17-226d-5. Organization and administration****(a) Governing authority**

(1) Each awardee shall have a governing authority which shall be ultimately responsible for ensuring the awardee's compliance with Commission requirements.

(2) The governing authorities of nonprofit organizations shall be boards of directors, which shall be representative of the community and the target population which the awardee serves. Awardees shall endeavor to include former service recipients among the board membership and each board of directors shall include at least one health care professional knowledgeable about the treatment or prevention of substance abuse.

(3) Each awardee's board of directors shall have by-laws which shall include, but need not be limited to:

(A) a list of the officers of the board;

(B) a description of the officer's duties;

(C) a description of the way in which the board conducts business; and,

(D) the terms of office of board members and officers and the method by which each are chosen.

(4) The board shall provide an orientation program for all new board members which shall familiarize them with the awardee's operations and their duties, responsibilities and potential liabilities as members of the board.

(5) Each board of directors shall meet at least quarterly and shall keep written minutes of each meeting.

**(b) Governing authority responsibilities**

The responsibilities of each awardee's governing authority shall include, but need not be limited to overseeing and approving:

(1) establishment of the awardee's philosophy, goals and objectives which shall be formulated to demonstrate the awardee's awareness of the demographic characteristics of the population it proposes to serve;

(2) establishment of accounting policies and procedures which fulfill the requirements of section 17-226d-4 and include, but are not necessarily limited to:

(A) listing the type of records to be kept;

(B) accounting procedures;

(C) procurement policies;

(D) the method of inventory control;

(E) guidelines for controlling expenditures;

(F) fulfilling Commission accounting requirements;

(G) a method for preparing financial statements;

(H) responsibility for the budget preparation process; and,

(I) responsibility for the chart of accounts.

(3) management and use of, and accounting for, the awardee's assets;

(4) control and approval of the awardee's activities and major financial transactions;

(5) review and approval of the awardee's annual budget and any revisions thereof;

(6) review and approval of awardee's executive director's salary increases;

(7) fund-raising efforts;

(8) review and approval of the awardee's policies and procedures;

(9) appointment, review and evaluation of the awardees executive directors and assignment of the executive director's duties;

(10) designation of two or more persons to act as signatories on checks as required by section 17-226d-4 (e) (3); and,

(11) yearly planning, review and revision of the awardee's goals and objectives.

**(c) Organizational chart**

Each awardee shall have an organizational chart which shall be reviewed and updated annually. Such charts shall illustrate the organizational structure, lines of authority and all staff positions within the awardee's organization.

**(d) Philosophy and policy**

(1) Each awardee shall include in its philosophy a statement of the awardee's philosophical approach to services which shall include, but need not be limited to:

(A) a description of the relationship between the needs of the persons served by the awardee and the awardee's approach to treatment; and,

(B) a description of the relationship between community needs and the awardee's approach to treatment.

(2) Each awardee shall have a written description of its treatment or service policy which shall be used in inservice training, staff recruitment and orientation and as a basis for relationships with the community and shall be reviewed at least annually and updated when necessary.

**(e) Nondiscrimination policy**

(1) No awardee shall discriminate or permit discrimination against any person or group of persons in outreach, admission or treatment activities on the basis of race, color, religious creed, age, marital status, national origin, sex, sexual preference, mental retardation or physical disability, including but not limited to blindness.

(2) Each awardee shall have and utilize a written policy on nondiscriminatory practices.

(3) A program which has been established to provide services to a specific target population shall not be deemed to be in violation of subsection (1) of this section provided such program refers any individual found ineligible for admission to the program to an appropriate facility.

(4) No person shall be denied admission to a Commission funded program or service solely or jointly because of:

(A) the inability to pay all or part of the cost of services, directly or through third party reimbursement.

(B) the number of prior admissions to treatment, except where the programs admission criteria requires a certain number of prior admissions.

(C) the length of time since last treatment.

(D) the location of last treatment.

(E) a refusal to undergo previous treatment.

**(f) Confidentiality**

Each awardee shall have and utilize a written policy and procedure for ensuring the confidentiality and security of service recipient records and identifying information which conforms to the requirements of state and federal confidentiality law and regulations including, Connecticut General Statutes Section 17-155bb and 42 CFR 2. Such policy shall include, but need not be limited to:

(1) a description of the process and requirements for disclosure of confidential information;

(2) copies of forms for documenting the disclosure of confidential information and for obtaining the written consent of the service recipient when such consent is required; and,

(3) staff training in the requirements of state and federal laws related to confidentiality of client records.

**(g) Awardee's executive director**

Each awardee shall appoint an executive director whose duties and qualifications shall be established by the awardee's governing authority and who shall be responsible for day-to-day operations.

**(h) Personnel requirements**

(1) Each awardee shall have and follow written personnel policies for all staff and consultants which shall be included in a Personnel Policies' and Procedures' Manual which shall include but need not be limited to:

(A) a description of the methods and procedures to be used to supervise all personnel;

(B) A job description for each staff or consulting position which includes at least a description of:

(i) the credentials required for employment in the position;

(ii) the duties and responsibilities of the position;

(iii) the minimum levels of education and training required for the position;

(iv) related work experience required for the position;

(v) reporting and supervisory responsibilities of the position;

(vi) salary range of position; and,

(C) A description of policies covering at least the following topics:

(i) recruitments, benefits, promotion;

(ii) training and staff development;

(iii) employee assistance available to the awardee's staff;

- (iv) disciplinary systems, suspension and termination policies;
- (v) performance review;
- (vi) rules of conduct;
- (vii) wages, hours and salary administration;
- (viii) grievance mechanisms; and
- (ix) equal employment opportunity and affirmative action policies.

(2) Each person hired or promoted by the awardee shall meet the qualifications of the position to which that person is appointed, and the various disciplines represented on the program staff shall meet any state or federal legal requirements for certification, licensing and/or registration within their respective disciplines.

(3) All counselors providing counseling services to clients in each awardee's program shall receive direct supervision at least one hour per week from a senior member of the awardee's clinical staff.

(4) The awardee shall maintain a personnel record for each employee. Such records shall be kept confidential. Each personnel record shall include, but need not be limited to:

- (A) a copy of the employee's application for employment;
- (B) verification of the employee's credentials or certification;
- (C) verification of the employee's education and training;
- (D) the employee's salary history;
- (E) appraisals of the employee's performance;
- (F) a record of any disciplinary action taken against the employee within the preceding two year period and the reasons for such action;
- (G) commendations of the employee; and,
- (H) incident and accident reports involving the employee and the results of any investigations taken in response to such reports.

(5) Awardees shall not discriminate against any person or group of persons in hiring or promotion of employees on the basis of race, color, religious creed, age, marital status, national origin, sex, sexual preference, mental retardation or physical disability, including but not limited to blindness, unless it is shown by such Awardee that such disability prevents performance of the work involved in any manner prohibited by the laws of the United States or of the State of Connecticut, and shall provide the Commission on Human Rights and Opportunities with such information requested by that Commission concerning the employment practices and procedures of the Awardee as relate to the provisions of Section 4-114a of the Connecticut General Statutes, as amended. The awardee shall make reasonable efforts to take into account the composition of service recipients and the community when hiring and promoting employees.

(6) Awardees shall have and use a plan for staff development and training which shall include training in the requirements of state and federal laws which are applicable to the awardee's program and training in emergency medical care for staff providing direct services to clients.

(7) Awardees shall employ sufficient clinical staff with documented experience and training in substance abuse to adequately meet the treatment goals for each of the persons serviced by the awardee's program or programs and to meet the awardee's goals and objectives.

(i) **Conflict of interest**

(1) No person shall serve as a member of an awardee's governing authority or be employed by an awardee if a conflict of interest exists between the person's

responsibilities as a member of the governing authority or employee and his personal financial interests or those of any member of his immediate family.

(2) Business dealings for profit between the awardee and a member of the awardee's governing authority, a paid employee of the awardee or a member of the immediate family of either; are deemed a conflict of interest unless an open bid system is used, the basis for accepting the bid is documented in the program's financial records and, if a member of the governing authority or member of the immediate family is involved, the member of the governing authority refrains from voting on the issue.

(3) Whenever an employee or member of the governing authority sells goods or services to the awardee at cost, the actual cost shall be documented in the awardee's financial records.

**(j) Policies and procedures**

(1) Every awardee shall have a written policies' and procedures' manual which shall include, at a minimum, all written policies and procedures required by sections 17-266d-1 through 17-266d-11, which shall be written in language understandable to the average person, and shall be reviewed at least annually and revised as needed.

(2) The manual shall be available upon request to staff, volunteers, service recipients, members of the community and Commission staff and shall be routinely used in orientation and training programs for new members of the governing authority, staff and volunteers.

**(k) Volunteers**

The services of volunteers may be utilized by awardees provided:

(1) the volunteers are supervised by qualified paid staff;

(2) the use of volunteers is in accordance with the provisions of a written volunteer plan;

(3) all volunteers receive training and a thorough orientation to program rules, operations, all program policies and procedures and federal confidentiality regulations and client's rights before beginning to work in the program.

(Effective September 20, 1984)

**Sec. 17-226d-6. Treatment and rehabilitation programs**

**(a) Admission criteria**

(1) Each program shall have and utilize written admission criteria which shall be available to clients, staff, the community and the Commission.

(2) No person shall be admitted to a program unless he meets the program's admission criteria and any person who is ineligible because he does not meet the admission criteria shall be referred back to the original referring agency or to another appropriate agency.

(3) The written admission criteria shall include, but need not be limited to consideration of the following factors:

(A) age

(B) sex

(C) physical health

(D) mental status

(E) previous treatment history

(F) history of substance abuse

(G) current use of mood altering substances

**(b) Intake procedure**

(1) Each program shall have and utilize a written intake procedure which shall include, but need not be limited to:

(A) A procedure for making and accepting referrals pursuant to the requirements of section (i) of this regulation.

(B) A procedure for determining whether or not the client meets the program's admission criteria and is appropriate for the program.

(C) A time limit or number of visits within which initial assessment of persons admitted to the program will be completed. In no case shall the time for completing the intake procedure exceed 90 days or 3 counseling sessions.

(2) Each program shall, during the intake procedure, collect at least the following demographic information on a standardized form from each person seeking admission to the program:

- (A) name
- (B) home address
- (C) telephone number
- (D) date of birth
- (E) sex
- (F) race/ethnicity
- (G) marital and family status
- (H) employment status and employer
- (I) education
- (J) current family income
- (K) next of kin
- (L) social security number
- (M) criminal justice system status
- (N) referral source
- (O) insurance coverage
- (P) date of initial contact
- (Q) date of interview
- (R) signature and title of intake worker

(3) Each client's history shall be completed by a member of the program's treatment staff and shall include, but need not be limited to the following information:

- (A) presenting problem
- (B) history of substance abuse and problems
- (C) family and personal history
- (D) education and employment history
- (E) medical history
- (F) history of arrests and convictions
- (G) previous treatment history

(c) **Orientation**

(1) Each client admitted to a program shall receive an orientation in accordance with a written orientation policy and procedure.

(2) Such orientation shall include, but need not be limited to explaining in language understandable to each client:

- (i) the program's policies, goals and objectives;
- (ii) the services offered by the program and through referral to other service providers;
- (iii) the program's hours of operation;
- (iv) the fee policy and fee schedule;
- (v) the client's rights;
- (vi) the program's expectations of the client;

(vii) the protection and restrictions which derive from state and federal confidentiality law and regulations;

(viii) the program's rules and procedures and the consequences to the client of infractions of such rules; and,

(ix) the program's termination and discharge procedures

**(d) Assessment procedure**

(1) Each program shall have and utilize a written policy and procedure for assessing all clients admitted to the program. At a minimum the assessment shall include a written synthesis of information obtained during the intake procedure, which synthesis shall identify the client's strengths and the staff person's observations of the client's personality functioning and those situational factors which have contributed to the client's current dysfunction.

(2) The assessment shall be used as a guide to the formulation of the client's treatment plan.

**(e) Treatment plan**

(1) Each program, except detoxification programs shall, with the participation of the client, prepare a written individualized treatment plan for each client which shall address client needs of care within the context of community and client resources. Development of such plan shall begin upon admission.

(2) Each treatment plan shall be in writing and shall include at a minimum:

(A) a description of the client's identified problems to be addressed during treatment;

(B) goals which include a specific time for achievement

(C) methods of attainment by which such goals may be achieved;

(D) the name and title of the client's primary counselor;

(E) evidence that the client has participated in the formation of his own treatment plan, such as:

(i) the client's signature on the treatment plan;

(ii) a contract between the client and the program;

(iii) treatment goals identified by the client through notations on a checklist of possible goals or a narrative signed by the client and made a part of the treatment plan.

(3) Each client's treatment plan shall be reviewed periodically for completeness and appropriateness in accordance with a written standardized policy and procedure designed to ensure that the plan remains applicable to the changing needs of the client. The client's individual record shall contain written evidence of such periodic review, assessment of the client's progress and any revisions which have been made in the plan based on the required reviews. Treatment plans shall be reviewed no less frequently than:

(A) weekly for residential intensive programs;

(B) for residential intermediate and long term treatment and rehabilitation programs and day/evening programs, 30 days after preparation of a treatment plan, then every 60 days thereafter;

(C) for outpatient programs 30 days after preparation of a treatment plan for the first review, 60 days after the first review for the second review and 90 days thereafter; and,

(D) for methadone maintenance programs 30 days after preparation of the treatment plan, 90 days after the first review for the second review and every 6 months thereafter.

**(f) Aftercare**

Each treatment and rehabilitation program, which has an aftercare component, shall offer aftercare services to clients in accordance with a written aftercare plan.

The plan shall include, but need not be limited to:

- (1) a description of the objectives, policies and procedures of its aftercare services;
- (2) a description of the specific aftercare services available to clients; and,
- (3) policies and procedures for periodic review of aftercare services which are provided.

**(g) Discharge summary**

Each program shall prepare a written discharge summary for each client who completes a course of treatment or leaves the program. Such summary shall be prepared by the client's primary counselor and shall be recorded in the clients record and shall include but need not be limited to:

- (1) an evaluation of the client's progress toward the goals described in the client's treatment plan,
- (2) the reason for discharge and other information, if any, pertaining to the client's course of treatment,
- (3) a summary of all recommendations, if any, made to the client upon the clients leaving the program, and
- (4) a list of any referrals made to other organizations or service providers at the time the client leaves the program.

**(h) Referrals**

(1) Each program shall have and utilize a written policy and procedure for client referrals as part of a comprehensive network of care, which shall include, but need not be limited to:

- (A) a procedure for referral and monitoring of persons on a waiting list for admission to the program;
- (B) procedures for referral of clients between specific components of the awardee's program; and,
- (C) current information on, and referral to, self-help groups.

(2) Each program shall maintain a list of referral sources and resources which is periodically updated.

**(i) Client record system**

(1) Each program shall use a standardized record keeping system and maintain an individualized record for each client admitted to the program which shall document the changing status, needs and activities of the client as treatment progresses and shall include, but need not be limited to:

- (A) all standardized statistical information as required by sections (b) of this regulation, and emergency information;
- (B) all parts of the client's individualized treatment plan as required by section (e) of this regulation;
- (C) all client assessments performed, including documentation of client problems and needs;

(D) the results of all physical, psychological, medical, laboratory and vocational examinations and tests shall be included with the signature and title of the person administering the test or performing the examination;

(E) all referrals to services deemed to be necessary to the client but not provided by admitting facility;

(F) progress notes, signed and dated by the originator and listing all events which have impacted the client's progress in attaining goals such notes shall be kept as follows:

- (i) daily for residential detoxification programs
- (ii) weekly for residential and day/evening programs

(iii) per counseling sessions for outpatient and methadone programs;

(G) a discharge summary for all clients who have left the program.

(2) Each program shall have and utilize a policy and procedures for maintaining the security of client records which shall be in conformity with the requirements of the federal confidentiality regulations, 42 CFR 2.17.

(3) Each program shall have and utilize a policy and procedure for closing and storing client records. The policy and procedure shall include, but need not be limited to the following provisions:

(A) the entire record shall be maintained for a period of at least five years after closure and shall be protected against loss, damage or breach of client confidentiality;

(B) after 5 years such records may be destroyed by shredding or burning; and,

(C) the policy shall specify under what circumstances a record is to be closed.

**(j) Provision of medical services and medication**

(1) Medical alcohol detoxification programs, residential programs and methadone programs shall ensure that each client shall have a complete medical history and physical examination.

(2) Methadone programs shall perform the following laboratory tests:

(A) complete blood count and differential

(B) serological test for syphilis

(C) routine and microscopic urinalysis

(D) routine screening for drugs

(E) Multi-phasic chemistry profile

(F) Tine test followed by a chest x-ray only if the skin test is positive

(G) Australian Antigen, EKG and biological tests for pregnancy if clinically indicated.

(3) Each program shall have and utilize a written policy and procedure for administration, storage and self-administration of all medications. All medications shall be marked, regularly inventoried and stored in a locked cabinet.

(4) Each program shall have a fully-equipped first aid kit on the premises at all times the program is in operation.

(5) When a client is referred from another program and there is no break in the treatment regimen, a physical examination as required by subsection (2) above need not be repeated by the program accepting the referral. A record of physical examination from the referring program shall be included in the intake information in the client's record.

**(k) Meals**

Residential programs and detoxification programs shall provide at least three nutritionally balanced meals for each client each day.

(Effective September 20, 1984)

**Sec. 17-226d-7. Treatment and rehabilitation program requirements for specific modalities**

**(a) Residential medical detoxification programs**

(1) Services provided

Each residential medical detoxification program shall provide the following services:

(A) medical management of the detoxification process from alcohol or drugs or both;

(B) medical and psycho-social assessments of the needs of each client admitted to the program;

(C) referral of all clients to ongoing treatment for whom the assessment has indicated the desirability of continuing participation in the treatment process; and,

(D) motivational counseling to encourage continuing client participation in the treatment process; and,

(E) knowledge about and access to self-help groups.

(2) Additional admission criteria

In addition to the requirements of section 17-226d-6 (a) each residential medical detoxification program shall require that each person admitted to the program shall:

(A) be an alcohol or drug dependent person who is intoxicated by drugs or alcohol at the time of admission;

(B) be at risk of experiencing serious medical complications without medical monitoring of the detoxification process; and,

(C) be likely to require the administration of medications or other services by medical personnel under the supervision of a licensed physician, in order to reduce or eliminate the effects of withdrawal from alcohol or drugs on the body.

(3) Hours of operation

Each residential medical detoxification program shall operate 24 hours per day, seven days a week. Each residential medical alcohol detoxification program shall accept for admission at all times, persons who meet the program admission criteria and for whom space is available.

(4) Length of stay

Clients may remain in residential medical detoxification programs no longer than 5 days for alcohol detoxification and 14 days for drug detoxification unless there is a statement signed by a physician in the client's record stating why it is necessary for the particular client to remain in the program for a longer period of time.

(5) Staffing

(A) Each residential medical detoxification program shall have a licensed physician on the staff or under contract who shall be responsible for supervising all medical services provided by the program. The program shall specify the physician's duties in writing and shall maintain written records of the number of hours and specific functions performed by the physician for the program.

(B) A minimum of one licensed nurse shall be on duty at all times.

(C) A minimum of one paid staff person shall be on duty at all times in addition to the nurse required by subsection (B).

(D) There shall be a client to staff ratio at all times no greater than one staff person on duty for each 10 clients in residence.

(6) Medical services

In addition to the requirements of section 17-226d-6 (j) each residential medical detoxification program shall provide the following medical services:

(A) Medical screening by a physician, nurse or physician's assistant at the time of admission for each client to exclude clients who have any serious injury or other medical condition requiring referral to a hospital; and,

(B) Each client admitted to a residential medical detoxification program shall be examined by a physician within 24 hours after admission unless the client was examined by a physician immediately before admission pursuant to the requirements of 17-226d-6 (j) (5) and orders were written by the examining physician.

(b) **Social-setting alcohol detoxification**

(1) Services provided

Each social-setting alcohol detoxification program shall provide the following services:

(A) counseling and other supportive non-medical services to clients who are experiencing physical withdrawal from alcohol;

(B) continual observation of clients during the withdrawal process;

(C) motivational counseling to encourage continuing client participation in the treatment process;

(D) referral to ongoing participation in the treatment process; and,

(E) knowledge about the access to self-help groups

(2) Additional admission criteria

In addition to admission criteria developed pursuant to the requirements of 17-226d-6 (a), each social-setting alcohol detoxification program shall formulate admission criteria which ensure that:

(A) Each client admitted to the program has been observed and evaluated by staff trained to determine whether the client is eligible for admission to a social-setting alcohol detoxification program.

(B) Clients shall not be admitted to the program who:

(i) are unconscious or have obvious life threatening medical conditions, such clients shall be sent directly to a hospital;

(ii) exhibit symptoms of dual addiction or psychotic behavior, or have had a heart attack within 6 months shall be referred to an appropriate medical facility.

(C) Clients who exhibit or state that they have any of the following symptoms shall be sent to a hospital emergency room for immediate screening and must have a written medical clearance, signed by a licensed physician before they can be admitted to the program:

(i) a blood alcohol level of .3 or greater;

(ii) severe abdominal pain;

(iii) irregularities in skin color;

(iv) chest pain, vomiting or passing blood; or,

(v) evidence of recent traumatic injury.

(3) Hours of operation

Each program shall operate 24 hours per day, 7 days per week and shall accept admissions at anytime.

(4) Length of stay

Clients may remain in a social-setting alcohol detoxification program no longer than 5 days unless there is a statement signed by a certified alcoholism counselor in the client record stating why it is necessary for the particular client to remain in the program for a longer period of time.

(5) Staffing

(A) All professional staff employed by the program shall be trained in first aid and cardiopulmonary resuscitation and shall have additional training from a physician to recognize the onset of medical problems associated with withdrawal from alcohol.

(B) There shall be at least two paid staff persons on duty at all times.

(C) There shall be a client to staff ratio at all times no greater than one staff person on duty for each 10 clients in residence.

(6) Medical care agreements

Each program shall have a written agreement with one or more licensed physicians to provide staff training as required by subsection (5) (A) of this section.

(c) **Residential programs**

(1) Residential programs shall provide residential accommodations and meals and one or more of the following services to clients:

(A) Intensive services shall at a minimum include:

(i) a short term program of up to 30 days duration;  
 (ii) daily group and/or individual counseling sessions, alcohol education, and knowledge about, and access to, self-help groups.

(B) Long term treatment and rehabilitation services shall at a minimum include:

(i) daily group and, or individual counseling;  
 (ii) a minimum of 20 hours per week of treatment which may include activities such as individual, group or family counseling, lectures, discussions or films;  
 (iii) knowledge about and access to self help groups.

(C) Intermediate services which shall, at a minimum include:

(i) a program of more than 30 days duration;  
 (ii) counseling on an individual and/or group basis at least 3 days per week;  
 (iii) introduction to self-help groups;  
 (iv) assistance in finding and retaining gainful employment or entering an educational or vocational training program;  
 (v) a minimum of 3 hours of counseling per week for each client for the first 30 days treatment and a minimum of one counseling session per week thereafter.

(2) Additional admission criteria

In addition to admission criteria developed pursuant to the requirements of 17-226d-6 (a), residential programs shall not admit:

(A) any person in need of detoxification from alcohol or drugs;  
 (B) any person who would be an appropriate candidate for outpatient or day/evening treatment.

(C) any person for intermediate services for whom gainful employment is not a reasonable expectation as determined by the initial assessment.

(3) Hours of operation

Each residential program shall operate seven days a week, 24 hours per day.

(4) Medical services

Each residential program shall arrange for the provision of medical services for illness or injury which occur during the course of the client's stay in the program. The program may provide such services through a staff physician or through a contract or contracts with licensed physicians, clinics or hospitals.

(5) Staffing

A paid staff person shall be physically present overnight and shall have ready access to back up clinical staff at each residential program.

(d) **Day/evening programs**

(1) Services offered

Each day/evening treatment program shall, at a minimum provide the following services to its clients:

(A) a short term non-residential program operating a minimum of 5 hours a day, 5 days a week if a daytime program or a minimum of 3 hours an evening 3 evenings a week if an evening program;

(B) a planned program of activities including substance abuse education and an introduction to the concept of self-help groups;

(C) daily individual, group or family counseling each day the program is in operation;

(D) a minimum of fifty percent of each client's time at the program shall be spent in individual, group or family counseling sessions and other activities such as lectures, discussions or films.

(e) **Outpatient programs**

(1) Services offered

Each program shall provide the following minimum services:

(A) individual, family or group counseling on an outpatient basis;

(B) a minimum of one counseling session per client per week except when the client record includes an explanation why less frequent counseling is appropriate, however, any client who receives less than one counseling session within a 30 day period shall be discharged from the program; and,

(C) knowledge about and access to self-help groups.

(2) Hours of operation

Each outpatient program shall operate at least 5 days a week, eight hours a day. Each program shall be open at least one evening a week or two hours a week outside of the hours of 9:00 a.m. to 5:00 p.m. to accommodate the needs of clients who work during the day.

(3) Medical services

Each outpatient program which dispenses prescription drugs as part of their planned treatment regimen shall:

(A) employ a medical director who shall be responsible for overseeing the administration of all drugs to clients;

(B) give physicals in accordance with the requirements of section 17-226d-6 (1) to all clients prior to the start of drug therapy.

(f) **Methadone programs**

(1) Except where this section imposes other or more stringent specific requirements, any program offering methadone maintenance or methadone detoxification shall abide by the Federal Methadone Regulations, 21 CFR 291, which are hereby incorporated by reference.

(2) Admission criteria

(A) No program shall admit any person to maintenance treatment who: is less than 18 years old unless the program has documented evidence that the person has made at least two attempts at drug free treatment.

(B) A program may establish admission criteria which is more stringent than the federal requirements with the prior written approval of the State Methadone Authority.

(3) Required documentation

In addition to the requirements of subsection (i) of section 17-226d-6 each methadone program shall record the following information in the client's record:

(A) all changes in the client's medication schedule;

(B) all changes in dosage;

(C) in any case where a replacement dosage of methadone must be dispensed to a client during a single day the reasons why such replacement dosage was dispensed shall be recorded in the client's record; and,

(D) at any time the program physician orders that a urine screening or other required laboratory tests not be given the reasons for the order shall be recorded and signed by the physician.

(4) Hours of operation

(A) Inpatient programs shall be open 24 hours per day, seven days a week.

(B) Outpatient detoxification programs shall be open seven days a week.

(C) Outpatient maintenance programs shall be open a minimum of six days a week.

(5) Physicals and laboratory examinations

(A) Each program shall ensure each client has a physical examination upon admission to the program and at least annually thereafter in accordance with the

requirements of section 17-226d-7 (j). The annual physical may be performed by the client's personal physician.

(B) When a client who has left the program seeks readmission less than 6 months after receiving a required physical, only a urine screening need be performed unless other tests as required by section 17-226d-6 (j) (2) are medically indicated.

(C) A client who seeks readmission more than six months after receiving a required physical shall receive a physical and all laboratory tests as required by subsection (A) of this section.

(6) Each program shall have and utilize a written procedure for dispensing methadone to clients which shall include but need not be limited to the following requirements:

(A) Subject to the exceptions listed in subsection (8) below, all methadone dispensed by the program shall be consumed on the program's premises in the presence of the program staff member who dispensed the drug.

(B) A written description of the circumstances under which a replacement dosage may be administered to a client.

(C) Whenever a program permits clients to have take home dosages of medication, the program shall warn clients of the dangers of accidental poisoning of children or other members of the client's household and shall advise clients as to the proper and safe storage of methadone in the client's home.

(D) All methadone dosages dispensed for off-premises consumption shall be dispensed in child-proof containers with a warning label.

(7) Counseling

Each methadone program shall provide a minimum of one counseling session per month for each client.

(8) Permissible off-premises consumption

Each program which allows off-premises consumption of methadone dispensed by the program shall do so in accordance with a written procedure which shall include but need not be limited to, whichever of the following circumstances are applicable to the program:

(A) Each program which operates six days a week may give each enrolled client one take-home dosage of medication each week.

(B) Each program which has a written policy and criteria permitting decreasing attendance may give any client who qualifies up to a 6 day supply of methadone no more frequently than every 7th day in accordance with the requirements of the Federal Methadone Regulations.

(C) When an enrolled client is so ill that he is unable to physically come to the program for his medication the program physician may:

(i) Authorize delivery of the medication to the client provided that either a licensed nurse or a licensed physician, accompanied by one other person employed by the program, delivers the medication.

(ii) Obtain the approval of the Federal Food and Drug Administration and the State Methadone Authority to permit a relative or other individual to pick up a single dose of medication and deliver it to the client.

(D) Holidays

(i) Each outpatient program regardless of its regular schedule may close for the holidays of Independence Day, Thanksgiving, Christmas Day and New Year's Day and may provide a single dose of take-home medication for each client enrolled in the program for each holiday.

(ii) Each outpatient maintenance program, regardless of its normal schedule may close for official state holidays other than those listed in subsection (i) above and may provide a single dose of take-home medication for each client enrolled in the program for each holiday provided the reason for the take-home dose is recorded in each client's record.

(E) Travel

(i) Each program which allows take-home medication to be dispensed for client travel shall have and utilize written criteria describing the circumstances under which such take-home doses for travel are permitted.

(ii) When a client requests take-home medication for travel which will last more than seven days but less than 15 days the program must obtain the prior written approval of the State Methadone Authority before dispensing the take-home medication.

(iii) When a client requests take-home medication for travel which will last 15 days or more the program must obtain the prior approval of both the Federal Food and Drug Administration and the State Methadone Authority before dispensing the take-home medication.

(9) Involuntary detoxification

(A) Each program shall have and utilize a written procedure for the detoxification of clients who have been expelled from the program, which procedure shall conform to the requirements of section 17-226d-11 (g).

(B) Detoxification of clients expelled from the program shall occur at the expelling program's facilities unless the client has been expelled for violent behavior or threats of violence, in which case the program is not obligated to provide detoxification, but may make a referral to another program.

(C) A program shall have no further responsibility to provide treatment to, or take any other action on behalf of, a client who has been expelled from the program and who has been offered the opportunity to contest the expulsion pursuant to the requirements of section 17-226d-11 (g) and who has rejected the program's arrangements for detoxification provided pursuant to subsections (A) and (B) of this section.

(Effective September 20, 1984)

### **Sec. 17-226d-8. Long term care and rehabilitation programs**

(a) **Hours of operation** — Each program shall operate 24 hours per day, seven days per week.

(b) **Admission criteria**

(1) Each program shall have and utilize written admission criteria which shall be available to service recipients, staff, the community and the Commission.

(2) No person shall be admitted to a program unless he meets the program's admission criteria and any person who is ineligible because he does not meet the admission criteria shall be referred elsewhere.

(3) The written admission criteria shall include, but need not be limited to consideration of the following factors:

(A) age

(B) sex

(C) physical health

(D) mental status

(E) previous treatment history

(F) history of alcohol abuse

(G) current use of alcohol

(4) No person may be admitted to the program who does not have a documented past and current history of multiple admissions to alcohol abuse or alcoholism treatment facilities.

(5) Program shall not exclude any service recipient from readmission who has had occasional lapses in sobriety so long as the service recipient is sober at the time of admission.

**(c) Intake procedure**

(1) Each program shall have and utilize a written intake procedure which shall include but need not be limited to:

(A) A procedure for making and accepting referrals pursuant to the requirements of section (g) of this regulation.

(B) A time limit within which initial assessment of service recipients admitted to the program will be completed.

(C) A procedure for determining whether or not the service recipient meets the program's admission criteria and is appropriate for the program.

(2) Each program shall, during the intake procedure, collect at least the following demographic information on a standardized form from each person seeking admission to the program:

(A) Name

(B) Home Address

(C) Telephone Number

(D) Date of Birth

(E) Sex

(F) Race/Ethnicity

(G) Marital and Family Status

(H) Employment Status and Employer

(I) Education

(J) Current Family Income

(K) Next of Kin

(L) Social Security Number

(M) Criminal Justice System Status

(N) Referral Source

(O) Insurance Coverage

(P) Date of Initial Contact

(Q) Date of Interview

(R) Signature and Title of Intake Worker

(3) Each service recipient history shall be completed by a member of the program's treatment staff and shall include, but need not be limited to the following information:

(A) presenting problem

(B) history of substance abuse and problems

(C) family and personal history

(D) education and employment history

(E) medical history

(F) history of arrests and convictions

(G) previous treatment history

**(d) Orientation**

(1) Each person admitted to a program shall receive an orientation in accordance with a written orientation policy and procedure.

(2) Such orientation shall include, but need not be limited to explaining in language understandable to each service recipient:

- (A) the program's philosophy, goals and objectives;
- (B) the services offered by the program;
- (C) the program's hours of operation;
- (D) the fee policy, fee schedule and that no person shall be denied services because of his inability to pay for such services;
- (E) service recipient's rights;
- (F) the program's expectations of the service recipient;
- (G) the protection and restrictions which derive from the federal confidentiality requirements;
- (H) the program's rules and procedures and the consequences of infractions of such rules; and,
- (I) the program's termination and discharge procedures.

(e) **Assessment procedure**

(1) Each program shall have and utilize a written policy and procedure for assessing all persons admitted to the program. At a minimum the assessment shall include a written synthesis of information obtained during the intake procedure, which synthesis shall identify the service recipient's strengths and the staff person's observations of the service recipient's personality functioning and those situational factors which have contributed to the service recipient's current dysfunction.

(2) The assessment shall be used as a guide to the formulation of the service recipient's service plan.

(f) **Service plan**

(1) Each program shall prepare an individualized, written plan which states the service recipient's problems and describes the services to be provided by the program to address the problems related to, or resulting from, the service recipient's alcoholism.

(2) Each service plan shall be reviewed periodically for completeness and appropriateness in accordance with a written standardized policy and procedure designed to ensure that the plan remains applicable to the changing needs of the service recipient. The service recipient's records shall contain written evidence of such periodic review, assessment of the service recipient's progress and any revisions that have been made in the plan as a result of the review.

(g) **Referrals**

(1) Each program shall have and utilize a written policy and procedure for service recipient referrals as part of a comprehensive network of care. Such policy shall include, but need not be limited to:

- (A) a description of the circumstances or conditions under which a referral shall be made, accepted or rejected;
- (B) procedures for referral of service recipients between specific components of the awardee's program; and,
- (C) current information on, and referrals to, self-help groups.

(h) **Service recipient records**

(1) Each program shall use a standardized record-keeping system and shall maintain an individualized record for each service recipient admitted to the program which shall document the changing status, needs and activities of the service recipient. Such record shall include, but need not be limited to:

- (A) all standardized statistical information as required by section (c) of this regulation and emergency information;

(B) all parts of the service recipient's individualized service plan as required by section (f) of this regulation;

(C) all assessments of the service recipient performed by program staff, including documentation of the service recipient's problems and needs;

(D) the results of all physical, psychological, medical, laboratory and vocational examinations and tests including the signature and title of the person who administered the test or performed the examination;

(E) a weekly summary of the service recipient's activities as listed in the service plan; and,

(F) a discharge summary for each service recipient who has left the program.

(2) All active records shall be kept in locked files in a secured room.

(3) Each program shall have and utilize a policy and procedure for closing and storing service recipient records. The policy and procedure shall include, but need not be limited to the following provisions:

(A) the entire record shall be maintained for a period of at least five years after closure and shall be protected against loss, damage, or breach of confidentiality;

(B) after five years such records may be destroyed by shredding or burning; and,

(C) the policy shall specify under what circumstances a record is to be closed.

**(i) Medical services and medication**

(1) Each program shall ensure that each person admitted to the program shall have a complete medical history and physical examination.

(2) Each program shall have and utilize a written policy and procedure for administering, storing and self administration of all medications. All medications shall be marked, regularly inventoried and stored in a locked cabinet.

(3) Each program shall have a fully equipped first aid kit on the premises at all times the program is in operation.

(4) When a service recipient is referred from another program and there is no break in the treatment regimen, a physical examination as required by subsection (1) above need not be repeated by the program accepting the referral. A record of the physical examination from the referring program shall be included in the intake information recorded in the service recipient's record.

**(j) Staffing**

At least one paid member of the program's staff shall be on duty during the night.

**(k) Meals**

Each program shall provide at least three nutritionally balanced meals for each service recipient each day.

(Effective September 20, 1984)

**Sec. 17-226d-9. Shelters**

**(a) Screening**

(1) Each program shall have and utilize a written screening procedure which shall include, but need not be limited to:

(A) a process whereby all persons entering the program are screened for obvious signs of illness or injury and those exhibiting such signs are referred to a medical facility;

(B) a requirement that all persons entering the program shall surrender any weapons, alcoholic beverages and drugs in their possession;

(C) all screening for entrance to a program with sleeping accommodations shall be conducted during regularly scheduled hours;

(D) information including but not necessarily limited to the following shall be obtained from each person entering the program:

(i) Shelters shall obtain information on each service recipient's age, race and sex; and,

(ii) Shelters shall also keep a record of all referrals made or accepted by the program.

Such information shall be submitted quarterly to the Commission in the time, manner and form required by the Commission.

(E) all persons entering the program shall be informed of program rules and procedures and the possible consequences of infractions of such rules.

(2) No person shall be permitted to enter the program's facilities who has not been screened in accordance with the program's screening procedure.

**(b) Referrals**

(1) Each program shall maintain a list of referral sources and resources which is periodically updated.

(2) Each program shall have and utilize a procedure for referring to an appropriate facility any person who expresses an interest in obtaining treatment for alcohol or drug abuse and shall have available current information on self-help groups for substance abusers.

(3) Each program shall have a written procedure for accepting into the program any person who has been initially refused admittance because of illness or injury and referred to a medical facility as required by subsection (a) (1) (A) of this regulation. Such procedure shall include, but need not be limited to:

(A) a requirement that the person have a written medical clearance before the person may be permitted to enter the program;

(B) medical clearances shall be recorded by the program in a log as required by section (c) of this regulation.

**(c) Logs**

Each program shall maintain a written log which shall include, but need not be limited to:

(1) a record of all significant events which occur during the program's daily operations;

(2) a record of the names of any persons permanently or temporarily denied access to the program's facilities and the reasons for the denial of access; and,

(3) a copy of all medical clearances received pursuant to the requirements of subsection (b) (3) of this regulation.

**(d) Provision of medical services**

(1) Each program shall have and utilize a written policy and procedure for storing and self-administration of all medications which shall include a provision that all medication be marked and stored in a locked cabinet.

(2) Each program shall have a fully equipped first aid kit on the premises at all times the program is in operation.

**(e) Program schedule**

Each program shall have and utilize a written procedure for the provision of program services which includes a schedule of standard times for:

(1) screening persons for admission;

(2) serving meals, if meals are offered by the program;

(3) bathing or showering, in programs with sleeping accommodations; and,

(4) lights out, if the program provides sleeping accommodations.

**(f) Staffing**

(1) Each program shall have and utilize written policies and procedures for training program staff which shall include, but need not be limited to:

(A) training in knowledge of, and sensitivity to, the problems of substance abuse and addiction; and,

(B) training in first aid and cardiopulmonary resuscitation.

(2) Each program shall have at least the following minimum staffing:

(A) one paid staff member on duty at all times the program is in operation, all other positions may be filled by trained volunteers;

(B) one paid staff member on duty overnight for each 25 service recipients for programs which provide sleeping accommodations; and

(C) two paid staff members on duty during screening and mealtimes in programs with sleeping accommodations;

(g) **Security**

Each shelter offering sleeping accommodations shall have a policy and procedures dealing with security. Such policy and procedures shall include but need not be limited to:

(1) provisions for ensuring persons entering the program do not have access to weapons, alcoholic beverages or drugs while at the program's facilities;

(2) provisions for the protection of service recipients and staff during the screening process; and

(3) provisions for the protection of service recipients and their property while they are sleeping.

(Effective September 20, 1984)

**Sec. 17-226d-10. Employee assistance, community awareness, prevention and intervention programs**

(a) **Employee assistance programs**

(1) Each Employee Assistance program shall at a minimum have and utilize the following written materials:

(A) A detailed written description of all services which the program is able to provide to local business and industry in the geographical area served by the program.

(B) A written fee structure for all services which the program offers.

(C) A written sample contract for the program's services.

(D) A written description of the program's marketing strategy which identifies specific program objectives and describes how the program will meet these objectives.

(E) A written plan for record keeping and program evaluation which at a minimum measures the achievement of program objectives.

(2) Each Employee Assistance program shall document the services it provides through:

(A) Written summaries of its marketing activities which indicate how the activities relate to its marketing strategy;

(B) Copies of all contracts which the program has executed with business and industry; and,

(C) A written outline of the training sessions conducted with managers and supervisors employed by businesses and industries which have contracted for the program's services.

(b) **Community awareness programs**

(1) Each Community Awareness program shall be composed of three component services:

(A) Public Information Services through such activities as health fairs, distribution of informational pamphlets, film or book-lending libraries, public service announcements and speaker's bureaus; by which the program shall attempt to increase community awareness of a broad range of issues related to substance abuse.

(B) Educational Services through formal, structured presentations during which the program shall attempt to impart specific knowledge related to substance abuse to an identified target audience; and,

(C) Referral Services through which the program shall provide assistance in locating appropriate services for persons with service needs related to substance abuse;

(2) Each Community Awareness program shall prepare a written annual plan which shall include a description of the program and of the specific activities it intends to engage in, the staff who will participate in such activities and the relationship of each activity to the program's goals and objectives.

(3) Each Community Awareness program shall document the services it provides through the following means:

(A) Written summaries of any activities undertaken by the program including copies of any printed material, press releases and such other material as may demonstrate the nature and scope of services.

(B) Written description of any educational presentations made by program staff including the date on which the presentation was made, the place where it was made, the audience to which it was directed, an estimate of the number of participants and a brief summary of the content of the presentation.

(C) A log of all referrals made by the program.

(c) **Prevention**

(1) Each Prevention program shall prepare a written annual plan which shall include:

(A) a description of the program's goals and objectives.

(B) a description of the target population the program intends to serve.

(C) a description of the activities the program intends to engage in and their relationship to the program's goals and objectives.

(D) a list of the staff and a description of the tasks they will fulfill.

(E) a description of the procedures the program will use for evaluating its activities.

(2) Each Prevention program shall have a written policy and procedure for referrals of service recipients as part of a comprehensive continuum of care. Such policy shall include maintaining a list of referral sources which is periodically updated.

(3) Each Prevention program shall document the services it provides in each of the following ways which is compatible with the services it offers:

(A) written material used for recruitment of service recipients,

(B) written summaries of demographic data if such data is obtained from persons who have received program services,

(C) copies of curricula or training materials used by the program,

(D) pre and post course test results or service recipient evaluations of training sessions given by the program,

(E) summaries of training or educational activities, and

(F) training or educational activity schedules, and attendance lists if such lists are customarily obtained during such activities.

(d) **Intervention programs**

(1) Each Intervention Program shall prepare a written annual plan which shall include:

- (A) a description of the program's goals and objectives,
  - (B) a description of the activities the program intends to engage in and their relationship to the program's goals and objectives,
  - (C) a list of the staff and a description of the tasks they will fulfill, and
  - (D) a description of the procedures the program will use for evaluating its activities.
- (2) Each Intervention program shall have written criteria and procedures for recruitment and screening of service recipients. Such criteria shall include:
- (A) a description of the target population from which the program will attempt to recruit service recipients,
  - (B) a description of how the program will attempt to recruit such persons,
  - (C) samples of any materials used by the program in its recruitment efforts, and
  - (D) a written selection procedure which shall include a description of the criteria used to screen and select individuals who will most closely match the program's goals.
- (3) Referrals
- (A) Each Intervention program shall have and utilize a written policy and procedure for referrals of service recipients as part of a comprehensive continuum of care. Such policy shall include, but need not be limited to:
- (i) A description of the circumstances or conditions under which a referral shall be made.
  - (ii) A description of the circumstances and conditions under which members of a service recipient's immediate family may be referred to other organizations or service providers.
  - (iii) A procedure by which persons inappropriate for the services of an intervention program are referred to other services which can better meet their service needs.
- (B) Each Intervention program shall maintain a list of referral sources and resources which is periodically updated.
- (C) Each Intervention program shall maintain a written log of all referrals made by the program.
- (4) Each Intervention program shall document the services it provides through one or more of the following ways which is compatible with services it offers:
- (A) Written material used for recruitment or selection of service recipients;
  - (B) Written summaries or demographic data obtained from persons who have received program services;
  - (C) The program's log of referrals;
  - (D) A record shall be kept for each service recipient who receives short-term counseling or crisis intervention. Such record shall include but need not be limited to:
    - (i) demographic information including but not necessarily limited to: name, home address, telephone number, date of birth, sex, race/ethnicity, marital and family status, employment status, employer and education;
    - (ii) a description of the immediate problem which resulted in the Intervention services being sought;
    - (iii) a counselor's assessment of the service recipient's needs;
    - (iv) a summary of counseling sessions and the dates on which they occurred;
    - (v) the date on which the service recipient's relationship with the program ended and the resolution of the immediate problem which required the short-term counseling; and,
    - (vi) a confidentiality form signed by the service recipient and a release of information form signed by the service recipient if information concerning the service recipient was released by the program.

(E) Summaries of hotline activities including a log of calls received by the program.

(5) Each person who receives services from an Intervention program shall receive a brief orientation to the program in accordance with a written orientation policy and procedure.

The orientation shall include but need not be limited to explaining in language understandable to the service recipient:

(A) The program's approach to services, goals and objectives;

(B) The services offered by the program and through referral by other service providers;

(C) The program's hours of operation;

(D) The fee policy, fee schedule and the fact that no person shall be denied services because of his inability to pay for such services;

(E) The program's expectations of the service recipient;

(F) The protections and restrictions which derive from state and federal confidentiality requirements; and,

(G) The program's rules and procedures and the consequences of infractions of such rules.

(6) Each Intervention program shall have and utilize a written policy and procedure for obtaining an assessment and history of all persons who receive counseling from the program to determine whether the service recipient meets the program's criteria for such counseling service.

(7) Each service recipient who receives more than two sessions of counseling is deemed to be receiving treatment and the awardee must comply with the requirements of Section 17-226d-6 in providing such services.

(Effective September 20, 1984)

### **Sec. 17-226d-11. Service recipient's rights**

All service recipients receiving alcohol or drug abuse-related services from any program funded by the Commission shall be accorded the following minimum rights by such programs in addition to any other rights they might have under state or federal law or regulations.

#### **(a) Notice of rights and requirements**

(1) The program shall notify all service recipients to whom it provides services of all rights, responsibilities and program rules relating to the service recipient's participation in the program, including but not necessarily limited to those rights listed in this section, and the service recipient's right to have all records, correspondence and conversations relating to his treatment kept confidential. The program shall also notify all service recipients of changes in program rules as they occur.

#### **(b) Voluntary participation**

(1) Programs shall not use coercion or force to induce any person to enter, accept or remain in treatment, except that programs may accept for treatment any person who is brought to, transferred to, or committed to, the program under the authority of any Connecticut statute, including but not limited to those statutes authorizing protective custody, emergency treatment or involuntary commitment of alcoholics, involuntary commitment of drug addicts and the treatment for alcohol or drug abuse of persons in the custody of the Commissioner of Corrections.

(2) Persons admitted to a program shall not be forced to accept or participate in any type of treatment or counseling against the person's will, however a program may refuse to continue serving any person who refuses to participate or accept treatment.

(3) At the request of the service recipient or any member of the service recipient's immediate family, the full range of alternative treatments shall be described and programs or individuals identified, who can supply those alternatives which the admitting program does not offer.

**(c) Informed consent**

(1) The risks, side effects and potential benefits of all treatment offered to the service recipient and the various steps and activities involved in the treatment process shall be explained to the service recipient.

(2) Service recipients shall, if physically and mentally able to do so, give written consent before any treatment is begun. When such consent cannot be given because of the service recipient's physical or mental state, a written explanation for the lack of written consent shall be placed in the service recipient's records.

(3) If a program serves a target population whose primary language is not English, any required material shall be written in the target population's language of literacy.

(4) Whenever a program admits a service recipient who is illiterate, all required written materials shall be explained to the service recipient and a notation shall be placed in the service recipient's file explaining exactly how the required information was given to the service recipient, when and by whom.

(5) The risks, benefits and nature of any innovative, experimental, unusual or hazardous treatment or medication shall be fully explained to the service recipient, and the service recipient's written consent to the treatment obtained, before any such treatment is begun.

**(d) Physical restraint policy**

(1) A medical detoxification program may use physical restraint against a service recipient only to prevent the service recipient from harming himself or others, only after all other alternatives have been exhausted and only in accordance with a written policy for the use of physical restraint which shall include requirements for frequent observations by staff of any person in physical restraint and a written record of each such observation. No other type of program may utilize physical restraint.

(2) Before physical restraint may be used on any service recipient the medical director must give written authorization. Such written authorization, and an explanation of the reasons such restraint was necessary, shall be recorded in the service recipient's record.

(3) Physical restraint shall be discontinued as soon as it is determined by the medical director that the service recipient is no longer an immediate danger to himself or others.

**(e) Use of service recipient labor**

Programs which utilize the labor of service recipients shall ensure that all such labor shall be performed voluntarily in safe working conditions. Programs shall compensate service recipients at the prevailing wage rate for the work performed or shall obtain a written waiver from the service recipient which states the reasons why the work is being performed without compensation.

**(f) Visitors, mail and telephone policies**

(1) Residential treatment programs shall permit service recipients to receive visitors, make and receive telephone calls and send and receive mail at reasonable times and subject to reasonable program rules and regulations. Such program rules and regulations shall be in writing and shall be explained to all service recipients upon admission to the program.

(2) The program shall designate specific areas as places where service recipients shall meet with visitors. All visitors shall be informed of the programs rules relating to their conduct during visits.

(3) The program shall inform service recipients in advance when visitors are expected and all visits shall be conducted so as to cause minimal interruption of normal activities.

(4) When visitors or telephone or mail communications are contraindicated by the service recipient's condition, the service recipient's record shall indicate the reasons for the restrictions and that an explanation of the restrictions has been given to the service recipient.

(g) **Involuntary discharge**

(1) Each treatment program shall have a written involuntary discharge policy which shall include a requirement that all service recipients shall be informed upon admission of program rules and regulations, violation of which is grounds for involuntary discharge from the program, and shall sign a statement indicating that the service recipient understands the rules. Such statements shall be maintained in each service recipient's record.

(2) When a program has decided to discharge a service recipient for cause, a written statement from the program shall be mailed to the service recipient's home address or hand delivered. The notice shall contain detailed information justifying the discharge and informing the service recipient of his right to request a review of the discharge.

(3) If a service recipient who has been involuntarily discharged from a program requests a review within the time allowed by the program for such request, the program will provide such review. At a minimum the review shall include:

(A) An opportunity for the service recipient to meet with a person or persons designated by the awardee to present his reasons why the decision to discharge him should be reversed.

(B) The person or persons with whom the service recipient meets shall have the authority to reverse the decision to discharge and to reinstate the service recipient in the program.

(4) A timely request for a review by the service recipient shall have the effect of staying the discharge until after the reviewer makes a decision, except that a discharge shall become effective immediately if the reasons for the discharge include physical violence or the threat of physical violence when there is reason to believe such threat indicates a genuine possibility of actual physical violence directed against another service recipient or a program staff member.

(Effective September 20, 1984)

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## Regional Mental Health Boards

### Sec. 17-226l-1. Definitions

As used in these regulations:

(a) "Funds from local sources" means all cash or in-kind resources available except those derived from state or federal sources, and includes but is not limited to resources from local governmental units, private contributions, foundation grants, catchment area councils, and other private or public organizations;

(b) "Department" means the department of mental health; 90 Washington Street, Hartford, CT 06115;

(c) "Commissioner" means the commissioner of mental health;

(d) "Board" means regional mental health board as defined in § 17-226j of the general statutes;

(e) "Fiscal year" means July 1 to June 30;

(f) "Council" means catchment area council as defined in § 17-226j of the general statutes;

(g) "Regional director" means regional mental health director as defined in § 17-226g of the general statutes.

(Effective April 3, 1978)

### Sec. 17-226l-2. Evidence of incorporation; combined application

(a) Any board which applies for state funds must provide the commissioner with a certified copy of its Certificate of Incorporation prior to or with its application for funds.

(b) Any two or more adjoining boards may apply for state funds in combination. Each board individually in any such combination must meet the requirements set forth in these regulations in order for the combined boards to receive state funds.

(Effective April 3, 1978)

### Sec. 17-226l-3. List of directors

Any board which applies for state funds shall submit a list of its directors to the commissioner at the time of its application. The directors shall be identified as to profession, place of employment, residence and council membership.

(Effective April 3, 1978)

### Sec. 17-226l-4. Board meetings; consultations

It shall be a requirement for the receipt of state funds that each board meet regularly not less than four times a year. Timely notice of all meetings of the board shall be provided to the regional director and the commissioner. The regional director may attend each meeting of the board. Copies of the minutes of all meetings must be submitted to the regional director and the commissioner within thirty (30) days after said meetings. In addition, the board shall consult with the regional director at any time the board or the regional director feels it is necessary or appropriate.

(Effective April 3, 1978)

### Sec. 17-226l-5. Application for state funds

Any board which applies to the commissioner for funds to carry out the provisions of § 17-226l of the general statutes must include in its application the following information with respect to the proposed utilization of said funds:

(a) A summary of personnel to be paid by said board, including, (1) each person's name, if known, (2) position, (3) hours to be worked, (4) the total cost of each

position, and (5) the portions of such cost to be provided from funds from local sources and from state funds;

(b) Estimates of other costs of said board including, (1) rent, (2) heat, (3) light, (4) janitorial/maintenance, (5) telephone, (6) dues and subscriptions, (7) travel, (8) office supplies, (9) equipment rental and maintenance, and (10) any other expected expenses.

In addition, said application must include an estimate of the value and form of the funds from local sources as defined in Section 1 of these regulations to be collected during the period of time for which the application for state funds is made.

(Effective April 3, 1978)

#### **Sec. 17-226l-6. Funds from local sources**

Any board receiving state funds shall provide funds from local sources, as defined in Section 1 of these regulations, in an amount equal to at least five (5%) per cent of the amount received from the state during each fiscal year. Said funds from local sources shall be budgeted by the regional mental health board in such a manner so as to provide partial funding for necessary staff expenses. If at any time the commissioner determines that said board has not provided a sufficient amount of funds from local sources, he (she) shall suspend all state funding of said board until arrangements are made for the supply of additional funds from local sources.

(Effective April 3, 1978)

#### **Sec. 17-226l-7. Accounting; records**

(a) Any board which receives funds from the commissioner during any fiscal year shall account to the commissioner within sixty (60) days after the end of said fiscal year as to the manner in which said funds were utilized. Such accounting shall include but not be limited to the following information: (1) a summary of paid personnel of said board, including (a) each person's name, (b) position, (c) hours worked, (d) the total amount expended by the board to each person, and (e) the portions of such expenditures provided from funds from local services and state funds; (2) a summary of other costs of the board including (a) rent, (b) heat, (c) light, (d) janitorial/maintenance, (e) insurance, (f) telephone, (g) dues and subscriptions, (h) travel, (i) office supplies, (j) equipment rental and maintenance, and (k) any other expenses, including the percentage of such costs provided from state funds.

(b) The financial records of each such board shall be available for inspection by the department of mental health or other appropriate state agency and must be maintained for a period of at least three (3) years.

(Effective April 3, 1978)

#### **Sec. 17-226l-8. Annual reporting**

Each board shall annually review and evaluate the system of mental health services provided to residents of its region, and make known its findings and recommendations to the regional director, the commissioner and all council members in its region. The boards shall prepare and make available such additional reports, studies or evaluations as the commissioner or regional director may from time to time request. Said annual report must be submitted within sixty (60) days after the end of each fiscal year. Each such report shall include a comprehensive plan and priority ranking for the establishment or expansion of mental health services within its region.

(Effective April 3, 1978)

**Sec. 17-226l-9. Unexpended funds**

In the event that any board which receives state funds during any fiscal year does not expend said funds or incur liability for the expenditure of said funds prior to the end of the fiscal year, the board shall return said unexpended state funds to the department.

(Effective April 3, 1978)



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## **Licensure of Hospitals for Mentally Ill Persons**

### **Secs. 17-227-1—17-227-14.**

Repealed, October 16, 1975.

### **Sec. 17-227-14a. Definitions**

As used in sections 17-227-14a to 17-227-14m, inclusive:

A. “Applicant” means any person, firm, corporation or organization applying for a license or renewal of a license under this section;

B. “Certificate of need” means approval of capital expenditures or functions or services from the commission of hospitals and health care (sections 19-73a to 19-73t of the general statutes);

C. “Chief administrative officer” means the individual in charge of the overall management of the hospital;

D. “Clinical staff” means that group of professional and paraprofessional personnel of the hospital which is directly involved in the care and treatment programs;

E. “Department” means the department of mental health, 90 Washington Street, Hartford, Connecticut 06115;

F. “Emergency service” means an immediately available service to meet the psychiatric and/or medical needs of individuals who either present themselves or who develop such need for help;

G. “Hospital” means a psychiatric facility which primarily offers medically directed inpatient services for the diagnosis, treatment, care, protection and rehabilitation, as indicated, of individuals admitted with psychiatric disorders.

H. “License” means the certificate issued by the department that signifies compliance with these regulations and other applicable law and authorizes the applicant to conduct a hospital for mental illness;

I. “Licensee” means any person, firm, corporation or organization licensed to conduct a hospital under these regulations;

J. “Organizational chart” means a description of the successive delegations of functional authority and assignments of responsibility, listing all position categories and number of budgeted full-time equivalents;

K. “Policies” means written statements which define the basic philosophies and instructions required by the staff of the hospital in order for them to participate effectively in the operation of the hospital;

L. “Population to be served” means the group toward which the hospital directs its services; such groups may be geographical, client type, disability or functional level delineated;

M. “Professional” means an individual who, by custom, training, education or experience, is considered a member of one of the helping professions, e.g., physician, nurse, social worker, psychologist, who is qualified by specific training and experience in mental health care and treatment;

N. “Paraprofessional” means an individual who, through experience, inservice training or formal educational, or all three, functions in the hospital under a number of different job titles, such as mental health worker, psychiatric technician, psychiatric aide, psychiatric assistant, etc.;

O. “Staff” means those professional and paraprofessional individuals who are directly involved in the hospital’s programs, and includes any volunteer workers;

P. “Statement of ownership” means a written statement as to the actual legal owners of the hospital;

Q. “Treatment” means services related to the reduction of disability or discomfort, amelioration of signs and symptoms and changes in specified physical, mental or social functioning.

(Effective April 18, 1978)

**Sec. 17-227-14b. Licensure**

A. **License required; penalty:** every person, firm, corporation or organization conducting a hospital for mental illness must have a current and valid license issued by the department. Any person, firm, corporation or organization conducting a hospital for mental illness contrary to the provisions of section 17-227 shall be liable for a fine of not more than one thousand dollars or imprisoned not more than six months or both.

B. **Initial application:** (1) a person, firm, corporation or organization which desires to conduct a hospital for mental illness shall make written application for a license to the department on forms provided by the department.

(2) Such applicant shall furnish with the application the following:

- (a) Documentation of compliance with local zoning ordinances;
- (b) Documentation of compliance with local building codes;
- (c) The local fire marshall’s certificate of inspection of the hospital certifying compliance with the fire code;
- (d) A statement of ownership;
- (e) A curren organizational chart;
- (f) An application fee as required by section 17-227, payable to the state treasurer;
- (g) Documentation of approval of the commission on hospitals and health care (where appropriate);
- (h) Such other material as the department may reasonably request.

(3) The hospital shall be investigated by department personnel after receipt of the application in order to determine compliance with these regulations and applicable state laws.

C. **Issuance of license:** once compliance has been determined, the department shall issue a license to the applicant for the conducting of a hospital for mental illness. The license shall specify the location of the hospital, the name of the licensee, the name of the chief administrative officer and any limitations placed on the hospital. All licenses shall terminate annually on the 31st of December. The license shall be posted in a conspicuous place in the hospital.

D. **Changes in licenses:** licenses issued under this section are not transferable. If the licensee wishes to change the location or the hospital, or change the chief administrative officer, or if the ownership of the hospital changes, written application must be made to the department for permission to make such change. Such application shall be acted upon within ten days from the date of its filing.

E. **Renewal of license:** (1) each licensee wishing to continue conducting a hospital for mental illness shall make written application for renewal of the license to the department on forms provided by the department on or before each November 30th.

(2) Such licensee shall furnish with the application the following:

- (a) The local fire marshall’s certificate of annual inspection of the facility certifying compliance with the fire code;
- (b) A statement of ownership;
- (c) A current organizational chart;
- (d) An application fee as required by section 17-227, payable to the state treasurer;

(e) Documentation of approval of the commission on hospitals and health care (where appropriate);

(f) such other material as the department may reasonably request.

**F. Limitation, suspension or revocation of licenses:** a license issued under these regulations may be limited, suspended or revoked after due notice and hearing by the department upon proof that the licensed hospital is being improperly conducted or for the violation of any of the applicable provisions of section 17-227, or for the violation of these regulations. Such hearing shall be conducted in accordance with the administrative procedures act, sections 4-168, et seq.

**G. Miscellaneous:** (1) each applicant shall receive a copy of these regulations upon request for application forms;

(2) Department personnel shall have the right to enter and inspect a licensed hospital at any reasonable time.

**H. Effect of Accreditation:** (1) except as provided in subsection (2) of this section; if

(a) A Hospital for mental illness is accredited by the joint commission on accreditation of hospitals as a psychiatric hospital, and

(b) Such hospital authorizes the commission to release to the department (on a confidential basis) upon request a copy of the most current accreditation survey of such hospital made by such commission, then, such hospital shall be deemed to meet the requirements of these regulations; provided

(c) That such hospital provides the department with any and all documentation which the department deems is necessary for determination of compliance with applicable state and local law.

(2) Notwithstanding any other provision of these regulations, if the department finds following an inspection made pursuant to § 17-227-14b-G(2) that an accredited hospital has significant deficiencies, such hospital shall not be deemed as meeting the requirements of these regulations under this section.

(3) Any hospital for mental illness which is deemed under this section as meeting the requirements of these regulations must make application for a license to the department in accordance with subsections 17-227-14b-A, -B(1) and -B(2). Renewals of such licenses shall be in accordance with subsection 17-227-14b-E.

(Effective april 18, 1978)

### **Sec. 17-227-14c. Management**

A. There shall be full disclosure of psychiatric facility ownership and control.

B. A sound system of responsible accounting shall be maintained which produces information reflecting the facility's fiscal experience and its current financial posture.

C. The Chief Administrative Officer shall be the individual in charge of the overall management of the psychiatric hospital. He shall be a physician registered under the laws of this state who is a member of The American Board of Psychiatry and Neurology, or a physician registered under the laws of this state who has had at least three years' full time medical experience in an institution for the care and treatment of mentally ill persons, or a person holding a degree in hospital administration with broad experience in the field.

D. The management shall be cognizant of all pertinent state and federal statutes, laws, regulations, and Public Acts, and shall take all necessary steps to conform to all such legislation.

(Effective April 18, 1978)

**Sec. 17-227-14d. Environment**

A. There shall be appropriate and adequate space and equipment for all services to be provided effectively and efficiently in pleasant and functional surroundings, readily accessible to the patients of the hospital.

B. The physical plant shall meet and maintain all the standards of current federal, state and local zoning, building, fire and safety codes and standards.

C. There shall be appropriate and adequate space and equipment for any and all social, educational, rehabilitating, and recreational activities which the hospital may provide.

D. The environment of the hospital shall contribute to establishing and enhancing a positive self-image for the patient, and preserving his human dignity.

E. There shall be clearly delineated and written policies and procedures concerning effective relationships between staff and patients, between staff members, and between patients which shall contribute to the development of therapeutic interpersonal relationships for the patient.

F. The physical plant shall provide facilities for the physical separation of patients, for emotional, behavioral and/or medical reasons. The written procedures, policies and practices of such isolation shall be within the limits set forth by Sec. 17-206e of the Connecticut General Statutes.

G. The buildings, equipment and surroundings shall be kept clean and in good repair at all times and the management and operation of the hospital shall be such as reasonable to provide a healthy, comfortable and safe environment for the patients.

(Effective April 18, 1978)

**Sec. 17-227-14e. Safety**

A. The hospital shall be structurally constituted, equipped, operated and maintained so as to sustain its safe and sanitary characteristics and to prevent or minimize all health hazards in the facility for the protection of patients, personnel and visitors.

B. The hospital shall have written plans for the proper and timely care of casualties arising from both external and internal disasters, and shall periodically rehearse these plans.

C. The hospital shall have a written plan providing emergency services or arranging for the provision of such services to meet the needs of the patients and the facility.

(Effective April 18, 1978)

**Sec. 17-227-14f. Medical staff**

A. There shall be a medical staff consisting of at least one physician licensed in Connecticut and specializing in psychiatry, and said staff shall establish bylaws that are designed to ensure the achievement and maintenance of high standards of professional ethical practice.

B. The medical staff shall assure the patients' rights to physical and psychiatric examinations and treatment according to a specialized treatment plan as guaranteed under Section 17-206c and 17-206f of the Connecticut General Statutes.

(Effective April 18, 1978)

**Sec. 17-227-14g. Nursing**

(A) All hospitals providing inpatient care shall have an organized nursing service.

(B) The nursing service shall have a current, written organizational chart.

(C) Written nursing care policies and procedures shall be developed to provide the nursing staff with acceptable methods of meeting its responsibilities and achieving projected nursing care goals.

(D) The service shall be under the direction of a duly qualified registered nurse, and shall have a sufficient number of adequately trained personnel to meet the needs of the patients.

(1) Each hospital shall employ as Director of Nursing Services a nurse, registered in Connecticut, experienced in the care of the mentally ill patients and in the administration of psychiatric nursing services, who shall be responsible for the supervision and assignment of nursing personnel.

(2) There shall be on duty at all times at least one nurse, registered in Connecticut, who shall have had training and experience in the care of mentally ill patients.

(Effective April 18, 1978)

#### **Sec. 17-227-14h. Pharmacy**

A. The scope of pharmaceutical services shall be consistent with the medication needs of the patient and shall include a program for the control and accountability of drug products throughout the hospital which are consistent with all applicable state and federal legislation and regulations.

B. Pharmaceutical services shall be directed by a qualified registered pharmacist, and shall be staffed by a sufficient number of appropriately qualified personnel.

C. Written policies and procedures which govern the safe ordering, dispensing and administration of drugs which are consistent with all federal and state legislation and regulations shall be developed.

D. There shall be adequate equipment, supplies, and information resources provided for the safe and efficient functioning of the pharmaceutical service.

(Effective April 18, 1978)

#### **Sec. 17-227-14i. Personnel**

A. There shall be employed a sufficient number of appropriately qualified clinical staff and necessary supporting personnel to provide satisfactory care and treatment of its patients.

B. Each hospital shall establish and maintain sound personnel recruitment and selection policies.

C. There shall be a written policy assuring equal opportunity in hiring and employment practices for all personnel without regard to race, color, religion, sex or national origin, which adheres to all federal, state and local legislation concerned with nondiscriminatory practices.

(Effective April 18, 1978)

#### **Sec. 17-227-14j. Component services**

A. The chief administrative officer shall assure that the functions of the hospital are organized through appropriate departmentalization of services.

B. Every hospital shall have a written plan describing the organization of those services which the hospital offers, or the arrangements for the provision of such services to meet the needs of the patients.

C. Each service shall be guided by written current policies and procedures which are readily available to all appropriate personnel.

D. Each collaborating, recognized service shall be supervised by an individual whose qualifications shall be specified in the personnel policies.

(Effective April 18, 1978)

#### **Sec. 17-227-14k. Support services**

A. Each hospital shall have a written plan describing the organization of laboratory, pathology, radiology, nuclear medicine, or arrangements for the provision of such services.

(1) Each shall have sufficient personnel, equipment, supplies, and suitable environmental conditions to perform the required volume of work with optimal accuracy, precision, efficiency and safety.

(2) There shall be written policies and procedures that govern each services' activities.

B. Each hospital shall have an organized pastoral service, or shall have a written plan describing the arrangements for the provision of such services, to meet the needs of patients.

C. Each hospital shall have a written plan describing the organization of housekeeping, dietary, laundry, maintenance, and central service departments, or the arrangements for the provision of such services, to meet the needs of the hospital.

(1) There shall be written policies and procedures that govern each services' activities.

(2) The service shall be directed by a qualified person and staffed by adequate personnel to carry out its functions.

(3) There shall be adequate space, equipment and supplies to provide an efficient, safe and sanitary operation of each service.

(Effective April 18, 1978)

#### **Sec. 17-227-14l. Patient rights**

A. Each hospital shall comply with the provisions of the Patient's Bill of Rights (Sections 17-206a to 17-206k, inclusive, of the Connecticut General Statutes).

B. Admission and treatment of patients shall be conducted without regard to race, color, or national origin.

C. The hospital shall give each patient, upon admission, a written copy of the Patient's Bill of Rights in the language of the patient's understanding.

D. Each hospital should make provision for adequate personnel to assist patients who are members of national origin minorities with language problems.

(Effective April 18, 1978)

#### **Sec. 17-227-14m. Patient records**

A. A single, compiled, written record for each patient shall be kept.

B. All records shall be confidential, current and accurate.

C. The hospital shall maintain a system of identification and filing to facilitate the prompt location of a patient's record.

D. The patient record service shall be adequately directed, staffed and equipped to facilitate the accurate processing, indexing and filing of all patient records.

(Effective April 18, 1978)

### **Unusual Incidents**

#### **Sec. 17-227-15. Definitions**

As used in this section and in Section 17-227-16:

(a) "Department" means the department of mental health;

(b) "Employee" means an employee of the facility;

(c) "Facility" means a facility licensed by the department in accordance with section 17-227 of the general statutes;

(d) "Guest" means a person, other than a patient or employee, who is on the premises of a facility;

(e) "Patient" means a person who is being treated or who is a resident at a facility as defined in this section;

(f) “Serious injury” means an injury which results in the medical or surgical hospitalization of the injured person as an inpatient;

(g) “Unusual incident” means:

- (1) The death of a patient from other than natural causes;
  - (2) The death of an employee from whatever cause, while on duty;
  - (3) The death of a guest from whatever cause;
  - (4) A serious injury to a patient;
  - (5) A serious injury to an employee while on duty;
  - (6) A serious injury to a guest;
  - (7) The escape or elopement of a patient;
  - (8) A fire, theft or other occurrence which causes property damage or loss in the amount of \$100.00 or more;
  - (9) A criminal act by a patient or a criminal act by any person against a patient.
- (Effective April 27, 1977)

### **Sec. 17-227-16. Reporting unusual incidents**

Within twenty-four (24) hours of its discovery, the person in charge of the facility or his designed shall notify the department at the office of the Commissioner of the occurrence of any unusual incident as defined in these regulations. In each instance the person in charge of the facility or his designee shall also report the incident to the proper local authorities. The facility shall conduct its own investigation of the incident and make a written report thereof, a copy of which shall be sent to the department. Said written report shall contain a full description of the unusual incident, together with any other findings and any action taken by the facility or local authorities as a result of the incident.

(Effective April 27, 1977)

### **Secs. 17-227-17—17-227-20. Reserved**

## **Licensure of Psychiatric Clinics and Outpatient Services for Adults**

### **Secs. 17-227-21—17-227-25.**

Repealed, May 23, 1986.

### **Secs. 17-227-26—17-227-29. Reserved**

## **Licensing of Institutions which Provide Care and Treatment for Alcohol-Dependent Persons**

### **Secs. 17-227-30—17-227-44.**

Repealed, February 2, 1988.

## **Licensing of Intermediate Treatment Facilities for Adults**

### **Secs. 17-227-45—17-227-49.**

Repealed, May 23, 1986.

### **Sec. 17-227-50. Reserved**

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Repealed, August 2, 1994.

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Transferred, May 21, 1992.

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**Administration of the General Assistance Program**

**Secs. 17-273-1—17-273-10. Reserved**

**Sec. 17-273-11. Relatives legally liable for support**

(a) The following relations of a recipient of General Assistance shall be legally liable for the support of such recipient to the extent such relative has been found able to provide such support by the local welfare official.

(1) Husband or wife.

(2) Parent of child under 18 years of age. An adoptive parent assumes all the rights and responsibilities of a natural parent.

(Effective February 4, 1985)



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## Hearings for General Assistance Recipients

### Sec. 17-292d-1. Hearings

(a) **Notice of action.** In cases of intended action to reduce, suspend or terminate General Assistance Financial and/or Medical Aid, the local welfare official shall give written notice by means of a Notice of Action for General Assistance which shall be mailed or given at least ten working days before the date of proposed action except as otherwise provided hereinafter. The Notice of Action for General Assistance shall clearly state:

(1) the reasons and authority for the decision to reduce, suspend, or terminate assistance;

(2) when applicable, the computation made to arrive at the decision to reduce, suspend, or terminate assistance;

(3) that if the recipient disagrees with the decision for any reason, the recipient has a right to a hearing which she/he can exercise by signing and returning the form provided. A self-addressed envelope shall be provided.

(b) **Request for hearing.** Any applicant or recipient of General Assistance who is aggrieved by any overt action or failure to act by the local welfare official may request and shall be granted an opportunity to be heard upon receipt of such request by the local welfare official, provided such request is made within the ten working day period. A hearing may be requested either by the recipient or, if an authorization is signed by the recipient, by his authorized representative.

(1) Hearing requests shall be written, except for illiterate persons, who may orally request hearings.

(c) **Continuation of benefits pending a hearing.** If the town official receives a written request for a hearing before the date of proposed action, benefits to the recipient shall continue without reduction, suspension or termination until a hearing is held and the recipient is provided with a written notice of the decision.

A town is not required to give a recipient a ten working days advance Notice of Action only in the following situations:

(1) The recipient has made a written request for discontinuance of assistance.

(2) Termination is based on the fact that assistance has been granted:

(A) by the State Department of Income Maintenance, or

(B) under the provisions of a federal program and the federal benefit payment has actually been received by the recipient.

(3) The local welfare official has actual notice that the recipient:

(A) is dead,

(B) is institutionalized in a state-operated facility, or

(C) has left the town or state.

(4) Mailed correspondence to the recipient is returned marked addressee unknown.

(5) If a change in state law required the proposed action or if there is no dispute related to the facts in the situation or to the judgment that a correct application of these regulations had been made.

In the situations listed above, the Notice of Action need only be mailed or given to a recipient prior to the effective date of the proposed action, and a hearing need not be held before such effective date.

Except for situations as described above, the local welfare official shall not withhold assistance without initiating pretermination procedures.

Withholding assistance in any other circumstances constitutes a termination or suspension of assistance which is subject to the pretermination requirements.

(d) **Scheduling of hearing—postponement.** The local welfare official shall schedule pretermination hearings to take place no later than seven working days from the date of the town's receipt of such request. Recipients must be notified in writing of the time and date that the pretermination hearing will take place. A pretermination hearing shall be rescheduled one time upon request by the appellant or his representative, or by mutual agreement.

(e) **Oral notice to an illiterate person.** The local welfare official must provide oral notice by reading the decision to reduce, suspend or terminate assistance to each recipient known to be illiterate whenever the recipient is physically present in the office either in order to receive the decision; or having received the decision, to have it read.

(f) **Requirements as to hearings.** In addition to the foregoing provisions, the local welfare official must:

(1) Provide the recipient with an opportunity:

(A) prior to the hearing, upon giving one working day's notice, to examine all the documents regarding his/her case;

(B) to be represented by any person of his/her choice;

(C) at the hearing, to offer evidence on his/her behalf and to cross-examine (question) the local welfare official or anyone else whose testimony was used in making the decision;

(D) to tape or stenographically record the hearing. The city or town has no obligation to provide the recording equipment or stenographer.

(2) Provide a hearing officer to conduct the hearing who:

(A) did not participate in the initial decision to reduce, suspend, or terminate;

(B) conducts the hearing in an informal manner;

(C) evaluates all of the facts and evidence presented;

(D) makes a decision based only on evidence presented at the hearing and what is officially noted.

(E) renders a decision within three calendar days after the hearing.

(3) Mail or hand to each recipient for whom a hearing is held, a written decision on the hearing within three calendar days of the date on which the decision is rendered. Said decision shall be based on the evidence presented and shall state the reason(s) for such decision, the evidence, the authority upon which the decision was based, and the name of the hearing officer making the hearing decision.

(4) Retain a copy of each notice and hearing decision for a period of not less than three years, and, in addition, shall retain a copy of any tape or transcript, if made, for a period of not less than four months.

(5) If the original decision is upheld, assistance is reduced, suspended, or terminated. The recipient shall be advised that he is responsible for repayment of all assistance rendered beyond the date eligibility ceased and that procedures for the collection of an overpayment will be executed.

(g) For applicants who have been denied General Assistance, the local welfare official shall:

(1) Provide to each applicant found ineligible for benefits, a Notice of Action for General Assistance. The Notice of Action for General Assistance shall clearly state:

(A) the reason(s) for the decision;

(B) the authority upon which such decision is based;

(C) when applicable, the computation made to arrive at the decision;

(D) that if the applicant disagrees with the decision for any reason, the applicant has a right to a hearing which she/he can exercise by signing and returning the form provided.

(2) Provide oral notice by reading the decision to deny General Assistance to each applicant known to be illiterate whenever the applicant is physically present in the office either in order to receive the decision; or, having received the decision, to have it read.

(3) Provide a hearing to all applicants who request one in writing within ten working days of the date of the town's notice to deny the application. A hearing may be requested by an applicant's authorized representative if an authorization signed by the applicant is provided.

(A) Illiterate applicants may orally request a hearing.

(4) Provide the opportunity for the denied applicant to have a hearing at the time he is given the decision if he does not wish to be represented by counsel nor to have witnesses and requests an immediate hearing. If not, the applicant will be granted the hearing within three (3) working days of the town's receipt of the applicant's request for a hearing. The applicant may waive his or her right to a hearing in writing at any time prior to the hearing.

(5) Provide the applicant with the opportunity:

(A) prior to the hearing, upon giving one day's notice, to examine all documents regarding his/her case;

(B) to be represented by any person of his/her choice;

(C) at the hearing, to offer evidence of his/her behalf and to cross-examine (question) the local welfare official or anyone else whose testimony was used in making the decision;

(D) to tape or stenographically record the hearing. The city or town has no obligation to provide the recording equipment or stenographer.

(6) Provide a hearing officer to conduct the hearing who:

(A) did not participate in the initial decision to deny the application;

(B) conducts the hearing in an informal manner;

(C) evaluates all of the facts and evidence presented;

(D) makes a decision based only on evidence presented at the hearing and what is officially noted.

(E) renders a decision within three calendar days after the hearing.

(7) Mail or hand to each applicant for whom a hearing is held, a written decision on the hearing within three (3) working days of the date on which the decision is rendered. Said decision shall be based on evidence presented and shall state the reason(s) for such decision, the evidence, the General Assistance regulation page(s) and section(s) number(s) upon which the decision was based, and the name of the hearing officer making the hearing decision.

(8) Retain a copy of each notice and hearing decision for a period of not less than three years. Retain a copy of any tape or transcript if made for a period of not less than four months.

(h) If the decision of the local welfare official is upheld at the hearing, the local welfare official may take the intended action even though the appellant appeals the hearing decision at the State Fair Hearing level.

(i) Any applicant or recipient who is aggrieved by a hearing decision rendered at the local level may request a Fair Hearing at the State level within ten working days of receipt of the decision. Persons requesting a Fair Hearing shall make such request in writing to:

State of Connecticut  
Department of Income Maintenance  
Fair Hearing Section  
117 Main Street Extension  
Middletown, Connecticut 06457

The request shall include the fact that the applicant/recipient is appealing a decision made by a local welfare official regarding General Assistance.

The Fair Hearing shall be held within fifteen working days of such request, and a decision shall be rendered not later than fifteen working days after such hearing.

The local welfare official shall implement the decision of the Fair Hearing officer within the compliance time set forth within the decision.

(Effective June 2, 1986)

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## **Cost Related Reimbursement System for Long-Term Care Facilities**

### **DESCRIPTION OF ORGANIZATION**

#### **Sec. 17-311-1. Description**

The commissioner of income maintenance (hereinafter referred to as the commissioner) is empowered and described in 17-311, General Statutes of Connecticut, revised to 1981 (hereinafter referred to as G.S.).

(Effective March 17, 1983)

#### **Sec. 17-311-2. Functions**

The commissioner has the duty of establishing annually the cost of services for which payment is to be made to facilities receiving appropriations granted by the General Assembly as set forth in 17-312 G.S. through 17-314 G.S.

(Effective March 17, 1983)

#### **Sec. 17-311-3. Official address**

All communications should be addressed to the Commissioner of Income Maintenance, 110 Bartholomew Avenue, Hartford, Connecticut 06115, unless otherwise specified.

(Effective March 17, 1983)

#### **Sec. 17-311-4. Public information**

The public may inspect the regulations, decisions, and public records of the commissioner at his office in Hartford. Requests should be submitted in writing to the commissioner at the above-stated official address.

(Effective March 17, 1983)

#### **Sec. 17-311-5. Signature of documents**

The duly authorized and official documents of the commissioner including but not limited to the commissioner's orders, notices, and communications, shall be signed by the commissioner or his authorized representative.

(Effective March 17, 1983)

#### **Secs. 17-311-6—17-311-10. Reserved**

### **RULES OF PRACTICE**

#### **ARTICLE 1**

#### **GENERAL PROVISIONS**

##### **Part 1**

#### **Scope and Construction of Rules**

#### **Sec. 17-311-11. Scope of procedures**

These rules govern practice and procedure before the commissioner under the applicable laws of the State of Connecticut except as otherwise provided by statute.

(Effective March 17, 1983)

#### **Sec. 17-311-12. Definitions**

The definitions provided by 4-166 and 17-311 G.S. shall govern the interpretation and application of these rules. In addition thereto and except as otherwise required by the context:

(a) “Commissioner” means the commissioner or his designated representative.

(b) “Hearing” means that portion of the commissioner’s proceedings in the disposition of matters delegated to his jurisdiction by law wherein an opportunity for presentation of evidence and argument occurs, which is preceded by due notice and which includes both an opportunity to present to the commissioner such written and oral testimony and argument as the commissioner deems appropriate and an opportunity to examine and cross-examine any witness giving testimony therein. Any such hearing shall be conducted as a public hearing.

(c) “Contested case” means a proceeding in the commissioner’s disposition of matters delegated to his jurisdiction by law in which the legal rights, duties, or privileges of a party are determined by the commissioner after an opportunity for a hearing. The definition stated in 4-166(2) G.S. shall further define this term.

(d) “Party” means each person named or admitted by the commissioner as a party to a contested case, whose legal rights, duties, or privileges will be determined by the commissioner by the final decision therein.

(e) “Intervenor” means each person admitted as a participant in a contested case who is not designated a party.

(f) “Person” means any individual, partnership, corporation, association, governmental subdivision, or public or private organization of any character to which these rules of practice may apply where appropriate to the context of the regulations herein set forth.

(g) “Petitioner” and “applicant” mean any person who has filed a petition or application requesting action by the commissioner.

(h) “Related parties” means persons or organizations related through marriage, ability to control, ownership, family or business association.

(i) “Levels of care” means chronic and convalescent hospitals, rest homes with nursing supervision, and homes for the aged.

(Effective December 19, 1984)

### **Sec. 17-311-13. Waiver of rules**

Where good cause appears, the commissioner may permit deviation from these rules, except where precluded by statute.

(Effective March 17, 1983)

### **Sec. 17-311-14. Construction and amendment**

These rules shall be so construed by the commissioner as to secure just and expeditious determination of the issues presented hereunder. Amendments and additions to these rules may be adopted by the commissioner by being duly promulgated as regulations in accordance with Chapter 54 of the General Statutes.

(Effective March 17, 1983)

### **Sec. 17-311-15. Computation of time**

Computation of any period of time referred to in these rules begins with the first day following that on which the act which initiates such period of time occurs and ends on the last day of the period so computed. This last day of that period is to be included unless it is a day on which the State offices are closed, in which event the period shall run until the end of the next following business day. When such a period of time, with the intervening Saturdays, Sundays, and legal holidays counted, is five (5) days or less, the said Saturdays, Sundays and legal holidays shall be excluded from the computation; otherwise, such days shall be included in the computation.

(Effective March 17, 1983)

**Sec. 17-311-16. Extensions of time**

At the discretion of the commissioner for good cause shown, any time limit prescribed or allowed by these rules may be extended. All requests for extensions shall be made before the expiration of the period originally prescribed or as previously extended.

(Effective March 17, 1983)

**Sec. 17-311-17. Effect of filing, public records**

(a) The filing with the commissioner of any application, request for advisory ruling, petition, or request of any nature whatsoever shall not relieve any person of the obligation to comply with any statute or with any regulation or order of the commissioner.

(b) Any request, petition, or application filed for the purpose of securing from the commissioner any final decision or other action authorized by law shall be part of the public records of the commissioner as defined by statute.

(Effective March 17, 1983)

**Sec. 17-311-18. Consolidation of proceedings**

Proceedings involving related questions of law or fact may be consolidated by the commissioner.

(Effective March 17, 1983)

**Sec. 17-311-19. Rules of conduct**

Where applicable, the canons of professional ethics and the canons of judicial ethics adopted and approved by the judges of the Superior Court govern the conduct of the Commissioner; the state employees serving the commissioner, and all attorneys, agents, representatives, and any other persons who shall appear before the commissioner in any hearing, meeting, contested case or other proceeding.

(Effective March 17, 1983)

**Sec. 17-311-20. Ex parte communication**

Unless required for the disposition of matters ex parte authorized by law, the commissioner shall not communicate directly or indirectly with any party or intervenor concerning any issue of fact or law involved in any contested case that has been commenced under these rules, except upon notice and opportunity for all parties to participate. The commissioner may communicate with and may have the aid and advice of such persons as are assigned to assist him in any contested case. In a contested case, this rule shall not be construed to preclude such routine communications as are necessary to permit the commissioner and/or such persons as are assigned to assist him to investigate facts and to conduct the informal conferences allowed by these rules of practice at any time before, during, and after the hearing thereof.

(Effective March 17, 1983)

**Part 2****Formal Requirements****Sec. 17-311-21. Principal office**

The principal office of the commissioner is located at 110 Bartholomew Avenue, Hartford, Connecticut. The office of the commissioner is open from 8:30 a.m. to 4:30 p.m. each weekday except Saturdays, Sundays and legal holidays.

(Effective March 17, 1983)

**Sec. 17-311-22. Date of filing**

All orders, decisions, findings of fact, requests, correspondence, motions, petitions and any other documents governed by these rules shall be deemed to have been issued or received on the date on which they are issued or received by the commissioner at his principal office, except as may hereinafter be provided.

(Effective March 17, 1983)

**Sec. 17-311-23. Signatures**

Every request, application, notice, motion, petition, brief, and memorandum addressed to the commissioner shall be signed in behalf of the person filing.

(Effective March 17, 1983)

**Sec. 17-311-24. Identification of communications to the commissioner**

Communications should embrace only one matter and should contain the name and address of the sender and an appropriate file reference to the subject of the communication. When the subject matter pertains to a proceeding pending before the commissioner, the title of the proceeding and the docket number should be given. Failure to observe this rule may result in rejection and return of the communication to the sender by the commissioner.

(Effective March 17, 1983)

**Sec. 17-311-25. Formal requirements as to copies of documents and other papers filed in proceedings**

In addition to the original, there shall also be filed three (3) copies for the use of the commissioner, unless the filing of a greater or lesser number of such copies is directed by the commissioner.

(Effective March 17, 1983)

**Sec. 17-311-26. Service**

(a) **General rule.** Service of all documents and other papers filed in all proceedings, including but not limited to motions, petitions, applications, notices, briefs, and exhibits shall be by personal delivery or by first class mail, except as hereinafter provided.

(b) **On whom served.** All documents and other papers shall be served by the person filing the same on every party in the proceeding and all such additional persons as the commissioner shall direct.

(c) **Service by the commissioner.** A copy of any document or other paper served by the commissioner, showing the addresses to which the document or other paper was mailed, shall be placed in the commissioner's files and shall thereafter be prima facie evidence of the fact and date of such service.

(d) **Service of written notice.** Written notice of all orders, decisions or authorizations issued by the commissioner shall be given to the party affected thereby or to such other person as the commissioner may deem appropriate by personal service upon such person or by first class mail.

(Effective March 17, 1983)

**ARTICLE 2**

**CONTESTED CASES**

**Part 1**

**Parties, Intervention and Participation**

**Sec. 17-311-27. Designation of parties**

(a) In issuing the notice of hearing, the commissioner will designate as parties any persons known to the commissioner whose legal rights, duties, or privileges

are being determined in the contested case and any person whose participation as a party is then deemed by the commissioner to be necessary to the proper disposition of such proceeding subject to such person complying with 4-177a G.S.

(b) Subsequent to the issuance of the notice of hearing, no other person before the commissioner other than the petitioner and, in self-pay rate hearings, the self-pay patients affected by the self-pay rate determination at issue shall have standing as a party within the definition of 4-166 (8) G.S. except upon the express order of the commissioner.

(c) The commissioner will designate all self-pay patients or, in the case of incompetent self-pay patients, their guardians or conservators as parties of record, because self-pay rate hearings involve what rates self-pay patients pay to their nursing homes.

(d) At the commencement of a self-pay rate hearing, the nursing home shall submit for the record a written list of the names and addresses of all of its present and past self-pay patients and their guardians or conservators who are affected by the self-pay rate years which are the subject of such hearing. Failure of the nursing home to submit such written list shall constitute cause for a default of the facility at the self-pay rate hearing. The commissioner or his designated hearing officer or presiding officer shall have the discretion not to default a facility which inadvertently made a minor or technical error in its list and is willing to correct such minor or technical error if possible.

(Effective March 28, 1990)

#### **Sec. 17-311-28. Participation by persons other than parties**

(a) **Permission to participate.** At any time prior to the commencement of oral testimony in any hearing on a contested case, any person may request that the commissioner permit that person to participate in the hearing. Any person not a party that is so permitted to participate in the hearing will be identified as an intervenor for the purposes of these regulations and will participate in those portions of the contested case that the commissioner shall expressly authorize.

(b) **Status of a non-party that has been admitted to participate.** No grant or leave to participate in the hearing as an intervenor or in any other manner shall be deemed to be an admission by the commissioner that the person he has permitted to participate is a party in interest that may be aggrieved by any final decision, order, or ruling of the commissioner unless such grant of leave to participate expressly so states. An intervenor is a party of record for the limited purposes described in 4-183 G.S.

(Effective March 17, 1983)

#### **Sec. 17-311-29. Representation of parties and intervenors**

Each person authorized to participate in a contested case as a party or as an intervenor shall file a written notice of appearance with the commissioner. Such appearance may be filed in behalf of parties and intervenors by an attorney, an agent, or other duly authorized representative subject to the rules hereinabove stated. The filing of a written appearance may be excused in behalf of the commissioner.

(Effective March 17, 1983)

### **Part 2**

#### **Hearings**

#### **Sec. 17-311-30. Commencement of contested case**

When a hearing is required by law as to any person, the contested case shall be deemed to commence on the date of issuance of the agency determination which

is the subject of the filing of the request, application, or petition for purposes of 4-174 to 4-183 G.S.

(Effective March 28, 1990)

### **Sec. 17-311-31. Place of hearings**

All hearings of the commissioner shall be held at Hartford at the office of the commissioner, unless a different place is designated by statute or by direction of the commissioner.

(Effective March 17, 1983)

### **Sec. 17-311-32. Notice of hearings**

(a) **Persons notified.** Except when the commissioner shall otherwise direct, the commissioner shall give written notice of a hearing in any pending matter to all persons designated as parties, to all persons who have been permitted to participate as intervenors, to all persons otherwise required by statute to be notified, and to such other persons as have filed with the commissioner their written request for notice of hearing in the particular matter. Written notice shall be given to such additional persons as the commissioner shall direct. The commissioner may give such public notice of the hearing as the commissioner shall deem appropriate.

(b) **Contents of notice.** Notice of a hearing shall include but shall not be limited to the following: (1) a statement of the time, place, and nature of the hearing; (2) a statement of the legal authority under which the hearing is to be held and the identification of statutes and/or regulations that are involved; (3) a short and plain statement of fact describing the purpose of the hearing.

(Effective March 28, 1990)

### **Sec. 17-311-33. General provisions**

(a) **Purpose of hearing.** The purpose of any hearing the commissioner conducts under Chapter 54 G.S. shall be to provide to all parties an opportunity to present evidence and argument on all issues to be considered by the commissioner.

(b) **Order of presentation.** In hearings on requests, applications, and petitions, the party that shall open and close the presentation of any part of the matter shall be the person making the request, the applicant, or the petitioner.

(c) **Limiting number of witnesses.** To avoid unnecessary cumulative evidence, the commissioner may limit the number of witnesses or the time for testimony upon a particular issue in the course of any hearing.

(d) **The commissioner may permit any party to offer testimony in written form.** Such written testimony shall be received in evidence with the same force and effect as though it were stated orally by the witness who has given evidence, provided that each such witness shall be present at the hearing at which testimony is offered, shall adopt the written testimony under oath, and shall be made available for cross-examination as directed by the commissioner. Prior to its admission, such written testimony shall be subject to objections by parties.

(Effective March 17, 1983)

### **Sec. 17-311-34. Witnesses and testimony**

The commissioner, his designated hearing officer and/or his designated presiding officer may administer oaths, take testimony under oath relative to the case, subpoena witnesses and require the production of records, physical evidence, papers and documents to any hearings held in the case pursuant to 4-177b G.S.

(Effective March 28, 1990)

**Sec. 17-311-35. Rules of evidence**

The following rules of evidence shall be followed in the admission of testimony and exhibits in all hearings held under Chapter 54 G.S.

(a) **General.** Any oral or documentary evidence may be received; but the commissioner shall, as a matter of policy, exclude irrelevant, immaterial, or unduly repetitious evidence. The commissioner shall give effect to the rules of privilege recognized by law in Connecticut where appropriate to the conduct of the hearing. Subject to these requirements any testimony may be received in written form as herein provided.

(b) **Documentary evidence, copies.** Documentary evidence should be submitted in original form, but may be received in the form of copies or excerpts at the discretion of the commissioner. Upon request by any party an opportunity shall be granted to compare the copy with the original if available, which shall be produced for this purpose by the person offering such copy as evidence.

(c) **Cross-examination.** Cross-examination may be conducted as the commissioner shall find to be required for a full and true disclosure of the facts.

(d) **Facts noticed, committee records.** The commissioner may take administrative notice of judicially cognizable facts, including the records and the prior decisions and orders of the commissioner and the former committee on state payments. Any exhibit admitted as evidence by the commissioner in a prior hearing may be offered as evidence in a subsequent hearing and admitted as an exhibit therein; but the commissioner shall not deem such exhibit to be cognizable in whole or in part for this purpose and shall not consider any facts set forth therein unless such exhibit is duly admitted as evidence in the matter then being heard.

(e) **Facts noticed, scope and procedure.** The commissioner may take administrative notice of generally recognized technical or scientific facts within the commissioner's specialized knowledge. Parties shall be afforded an opportunity to contest the material so noticed by being notified before or during the hearing, or by an appropriate reference in preliminary reports or otherwise of the material noticed. The commissioner shall nevertheless employ the commissioner's experience, technical competence, and specialized knowledge in evaluating the evidence presented at the hearing for the purpose of making his finding of facts and arriving at a final decision.

(Effective March 17, 1983)

**Sec. 17-311-36. Filing of added exhibits and testimony**

Upon order of the commissioner before, during, or after the hearing any party shall prepare and file added exhibits and written testimony. Such added exhibits and testimony shall be deemed to be an offer of evidence and shall be subject to such comment, reply, and contest as due process shall require.

(Effective March 17, 1983)

**Sec. 17-311-37. Uncontested disposition of request, application or petition**

Unless precluded by law, any request, application, or petition may be resolved by stipulation, agreed settlement, consent-order or default, subject to the order of the commissioner. Upon such disposition a copy of the order of the commissioner shall be served on each party.

(Effective March 17, 1983)

**Sec. 17-311-38. Delegations of powers to hearing officers or presiding officers**

(a) As provided in 17-2 G.S., the commissioner may delegate the power and authority to any deputy, assistant, investigator or supervisor to serve as hearing

officer or presiding officer at a contested case hearing and to render final decision in said contested case.

(b) The commissioner may delegate the power and authority to any person to serve as hearing officer or presiding officer at a contested case hearing and to recommend a proposed decision to the commissioner with compliance with 4-179 G.S. when required by said statute.

(Effective March 28, 1990)

**Sec. 17-311-39. Record in a contested case**

The record in a contested case shall include: (1) written notice related to the case; (2) all petitions, pleadings, motions and intermediate rulings; (3) evidence received or considered; (4) questions and offers of proof, objections and rulings thereon; (5) the official transcript, if any, of proceedings relating to the case, or, if not transcribed, any recording or stenographic record of the proceedings; (6) proposed final decisions and exceptions thereto, where the hearing officer or presiding officer has not been delegated the authority to render final decision directly, and (7) the final decision.

(Effective March 28, 1990)

**Sec. 17-311-40. Final decision in a contested case**

All decisions and orders of the commissioner concluding a contested case shall be in writing. The commissioner will serve a copy of his final decision on each party in the manner required by these rules of practice and by Chapter 54 G.S.

(Effective March 17, 1983)

**ARTICLE 3**

**MISCELLANEOUS PROCEEDINGS**

**Part 1**

**Petitions Concerning Adoption of Regulations**

**Sec. 17-311-41. General rule**

These rules set forth the procedure to be followed by the commissioner in the disposition of a petition concerning the promulgation, amendment, or repeal of regulations.

(Effective March 17, 1983)

**Sec. 17-311-42. Form of petition**

Any person may at any time petition the commissioner to promulgate, amend, or repeal any regulation. The petition shall conform to the rules hereinabove stated, where applicable, and shall set forth clearly and concisely the text of the proposed regulation, amendment, or repeal. Such petition shall also state the facts and arguments that favor the action it proposes by including such data, facts, and arguments in the petition or in a brief annexed thereto. The petition shall be addressed to the commissioner and sent by mail or delivered in person during normal business hours. The petition shall be signed by the petitioner and shall furnish the address of the petitioner and the name and address of the petitioner's attorney, if applicable.

(Effective March 17, 1983)

**Sec. 17-311-43. Procedure after petition filed**

(a) **Decision on petition.** Upon receipt of the petition, the commissioner shall within thirty (30) days determine whether to deny the petition or to initiate regulation-making proceedings in accordance with law.

(b) **Procedure on denial.** If the commissioner denies the petition, the commissioner shall give the petitioner notice in writing, stating the reasons for the denial. (Effective March 17, 1983)

## Part 2

### Requests for Declaratory Rulings

#### Sec. 17-311-44. General

These rules set forth the procedure to be followed by the commissioner in the disposition of a request for declaratory rulings as to the validity of any regulation, or the applicability to specified circumstances of a provision of the General Statutes, a regulation, or a final decision on a matter within the jurisdiction of the commissioner.

Such a ruling of the commissioner disposing of a petition for a declaratory ruling shall have the same status as any decision or order of the commissioner in a contested case.

(Effective March 28, 1990)

#### Sec. 17-311-45. Form of petition for declaratory ruling

(a) Any person may petition the commissioner, or the commissioner may on his own motion initiate a proceeding, for a declaratory ruling as to the validity of any regulation, or the applicability to specified circumstances of a provision of the General Statutes, a regulation, or a final decision on a matter within the agency, provided that a petition to contest any regulation on the ground of non-compliance with the procedural requirements of Chapter 54 G.S. may only be filed within two years from the effective date of the regulation. Such petition shall be addressed to the commissioner and be sent by mail or delivered in person during normal business hours. Petitioner must file with the commissioner an original and five (5) copies of the petition.

(b) If the commissioner determines that a declaratory ruling will not be rendered, the commissioner shall within sixty (60) days thereafter notify the person so inquiring that the petition has been denied and furnish a statement of the reasons on which the commissioner relied in so deciding.

(c) A petition for declaratory ruling shall contain the following sections in the order indicated here:

(1) A statement of the questions being presented for a ruling, expressed in the terms and circumstances of the specific request but without unnecessary detail. This statement shall identify the statute, regulation or final decision which is the basis for the petition and shall identify the particular aspects thereof and special circumstances to which the question of validity or applicability is directed.

(2) A statement of the facts material to the consideration of the questions presented.

(3) A statement of the position of the practitioner with respect to the questions being presented.

(4) An argument amplifying the reasons relied upon for the petitioner's position, including any appropriate legal citations, must be included with the petition or be in an attached brief.

(5) A signature by the petitioner or legal representative, his address, telephone number and facsimile machine telephone number, if any, of the petitioner and legal representative, if applicable.

(d) The date of filing of any petition shall be the date the petition is received by the commissioner in the form prescribed by this regulation. Only complete petitions filed in conformance with this section will be considered by the commissioner.

(Effective March 28, 1990)

**Sec. 17-311-46. Procedure after petition for declaratory ruling filed**

(a) Within thirty days after receipt of a petition for a declaratory ruling, the commissioner shall give notice of the petition to all persons to whom notice is required by any provision of law and to all persons who have requested notice of declaratory ruling petitions on the subject matter of the petition.

(b) If the commissioner deems a hearing necessary or helpful in determining any issue concerning the request for declaratory ruling, the commissioner may schedule such hearing and give such notice thereof as shall be appropriate.

(c) Within forty-five calendar days of the submission of the complete petition for a declaratory ruling, persons wishing to be admitted to the proceeding as parties or intervenors shall file a petition with the commissioner. Such persons, in submitting their position and evidence in the declaratory ruling proceeding, shall comply with the other provisions of these regulations concerning the form, content and filing procedures for a petition. If the commissioner conducts a hearing, the commissioner or his designated hearing officer or presiding officer has the discretion to limit the participation of intervenors in such hearing, including the rights to inspect and copy records, to introduce evidence and to cross-examine, so as to promote the orderly conduct of the proceedings.

(d) Within sixty days after receipt of a petition for a declaratory ruling, the commissioner in writing shall: (1) issue a ruling declaring the validity of a regulation or the applicability of the provision of the General Statutes, the regulation, or the final decision in question to the specified circumstances, (2) order the matter set for specified proceedings, (3) agree to issue a declaratory ruling by a specified date, (4) decide not to issue a declaratory ruling and initiate regulation-making proceedings, under Section 4-168, on the subject, or (5) decide not to issue a declaratory ruling, stating the reasons for his action.

(e) A copy of all rulings issued and any actions taken under this section shall be promptly delivered to the petitioner and other parties personally or by United States mail, certified or registered, postage prepaid, return receipt requested.

(f) If the agency conducts a hearing in a proceeding for declaratory ruling, the provisions of subsection (b) of 4-177c, G.S., 4-178 G.S. and 4-179 G.S. shall apply to the hearing, except that if the commissioner delegates to the presiding officer or hearing officer the power to render final decision directly, he or she may do so.

(g) If the commissioner renders a declaratory ruling, a copy of the ruling shall be sent personally or by United States mail, certified or registered, postage prepaid, return receipt requested to the person requesting it and to that person's attorney, if applicable, and to any other person who has filed a written request for a copy with the commissioner.

(h) If the commissioner does not issue a declaratory ruling within one hundred eighty days after the filing of a petition therefor, the commissioner shall be deemed to have decided not to issue such ruling.

(i) Any time requirement in this section may be extended with the agreement of the petitioner.

(j) The commissioner shall keep a record of the proceeding as provided in 4-177 G.S.

(Effective March 28, 1990)

### Part 3

#### Miscellaneous Provisions

##### **Sec. 17-311-47. Commissioner investigations**

The commissioner may at any time institute investigations for such purpose as may be authorized by law, including but not limited to investigations of the submission of any false or misleading fiscal information or data which may lead to suspension of payments pursuant to 17-311(c) G.S.

(Effective March 17, 1983)

##### **Sec. 17-311-48. Procedures**

The rules of notice, practice, and procedure set forth in Article 2 govern any hearing held in the course of such an investigation.

(Effective March 17, 1983)

##### **Sec. 17-311-49. Reserved**

### ARTICLE 4

#### COST RELATED REIMBURSEMENT SYSTEM

##### **Sec. 17-311-50. Annual report used for submission of cost data**

Pursuant to sec. 17-311 of the General Statutes, the committee on state payments, (hereinafter referred to as "committee") approved, effective August 17, 1976, a cost report form designated the "Annual Report of Long-term Care Facilities" (hereinafter referred to as "annual report"). Such report shall be used to provide the commissioner with detailed cost information concerning the services provided by each certified and licensed long-term care facility for persons aided or cared for by the state.

The required completed annual report must be received by the commissioner no later than December 31 of each year for the cost year ending September 30 of that year, if a facility wishes to receive payment for persons aided or cared for by the state. Such report shall include the original and one clear copy. All documents must bear the original signatures of the administrator, owner and independent public accountant.

Failure to submit the annual report in a complete and timely manner shall result in the commissioner not promulgating an individual cost-related rate for such facility for the next rate year beginning July 1. Instead, for such delinquent facilities, the commissioner may authorize a rate comparable to the lowest rate paid to a facility for the same level of care.

(Effective March 17, 1983)

##### **Sec. 17-311-51. Type of system used in promulgating rates; prospective rates; cost year; rate year; retroactive rate adjustment**

Effective July 1, 1976, the system for determining per diem rates of payment to long-term care facilities in the state of Connecticut shall be an individual cost-related prospective rate system derived from cost information provided by each facility in the annual report, required by the commissioner, for each cost year ending September 30 which precedes the rate year beginning July 1 of the succeeding year. The first cost reporting period for which this cost-related system shall be effective shall be October 1, 1974 through September 30, 1975, with the rate determined

pursuant to this system to be effective for the period July 1, 1976 through June 30, 1977:

(a) In the event that the rate determined on the basis of the cost period October 1, 1974 through September 30, 1975 is less than the amount paid to a provider pursuant to the interim rate adopted by the committee on November 5, 1975 and re-enacted on August 17, 1976, no retroactive adjustment shall be made in favor of the state so as to require a repayment by a provider for the period prior to April 1, 1977.

(b) In the event that the rate determined on the basis of the cost period October 1, 1974 through September 30, 1975 exceeds the amount paid to a provider pursuant to the interim rate adopted by the committee on November 5, 1975 and re-enacted on August 17, 1976, the commissioner shall make a retroactive adjustment in favor of the provider and shall make payments to the provider from July 1, 1976 to the date of the determination of the new rate pursuant to this system.

(Effective March 17, 1983)

**Sec. 17-311-52. Computation of per diem reimbursement rates**

Per diem reimbursement rates shall be calculated for each level of care, e.g., chronic and convalescent hospital, rest home with nursing supervision and home for the aged, based upon:

(a) Allowable routine costs related to the provision of patient care as set forth in subchapter 18, part A of title 42 of the U.S. Code, section 1393 et seq. and the regulations promulgated thereunder (hereinafter referred to as medicare statutes and regulations) except as modified by these regulations and the Connecticut state plan approved by the United States department of health and human services.

(b) The allowable salary limits pursuant to the following schedule:

(1) For 1986

**Administrators'**

<i>Number of Beds</i>		<i>Add per Bed</i>	
<i>Within Level of Care</i>	<i>Base</i>	<i>Increment</i>	<i>Maximum</i>

**Homes for the Aged and**

**Other Community Group Homes**

1-60	\$20,000	92	\$25,530
61-120	25,530	101	31,590
121-over	31,590	80	36,465

**Rest Home With Nursing Supervision**

1-30	\$20,000	108	\$23,253
31-60	23,253	236	30,333
61-120	30,333	110	36,933
112-180	36,933	112	43,653
181-over	43,653	110	50,254

**Chronic and Convalescent Hospital and Multi-level Facilities**

1-60	\$21,537	\$238	\$35,817
61-120	35,817	176	46,379
121-180	46,379	133	54,359
181-over	54,359	112	61,078

**Assistant Administrators**

For facilities of over 99 certified beds, one assistant administrator (in addition to the administrator) may be allowed for each 100 beds at a salary of up to a maximum of 70% of the allowable salary paid to the administrator.

**Director of Nurses**

<i>Number of Beds</i>	<i>Base</i>	<i>Add per Bed</i>	
		<i>Increment</i>	<i>Maximum</i>
1-60	\$15,042	\$166	\$25,002
61-120	25,002	125	32,502
121-180	32,502	93	38,082
181-over	38,082	77	42,733

**Dietitians**

<i>Number of Beds</i>	<i>Code Requirements</i>	<i>Rate of Pay</i>
60 and under	8 hours per month	B.S. Degree only \$17.78 per hour B.S. Degree and ADA and RD \$19.71–23.71 per hour
61-90	16 hours per month	As Above
91-120	24 hours per month	As Above
121-150	32 hours per month	As Above
151-180	48 hours per month	As Above
181-210	64 hours per month	As Above
211 or more	Full Time Dietitian	As Above

**Physicians**

\$56.52 – \$80.91 per hour

**All other Professional/Technical Personnel Related to the Owner(s)**

Salary for full-time work \$17,633

(2) The allowable salary limits for ensuing years shall be determined by applying the percentage increase or decrease of the forecasted implicit price deflator for the gross national product for the appropriate period to the allowable salary limits for the preceding cost year, except that commencing with the rate year beginning July 1, 1983 salaries for directors of nursing unrelated to the owner(s) shall no longer be subject to such limitations and commencing with the rate year beginning July 1, 1986 salaries for other professional/technical personnel unrelated to the owner(s) shall no longer be subject to such limitations but rather must meet the general standard of being reasonable, necessary and directly related to patient care.

(3) Salaries for proprietors or in the case of non-profit facilities persons who exercise the equivalent of proprietorship or management functions and their relatives who claim to provide some or all of the functions required to operate the facility efficiently shall be supported by timekeeping records and other related documentation. For a proprietor or relative licensed by the Connecticut Department of Health Services as the administrator, compensation shall be allowed in accordance with the allowable administrative salary limits referred in the preceding paragraph. For proprietors or in the case of non-profit facilities persons who exercise the equivalent of proprietorship or management functions and their relatives who are not so licensed, allowable compensation for managerial administrative functions shall be limited to 70% of the allowable salary paid to the administrator. The salary allowed for a proprietor or relative shall not exceed the allowable salary limits based on a 40 hour work week.

(c) A separate inflation cost limitation for each of the following cost centers; dietary, laundry, housekeeping and routine nursing care; excluding routine nursing care for non-medical facilities such as homes for the aged.

Each inflation cost limitation shall be the sum of;

(1) Allowable costs per patient day for the prior year for the cost center without consideration of the prior year inflation control disallowance or cost efficiency adjustment, adjusted by the implicit price deflator for the gross national product published in "Economic Indicators" prepared for the joint economic committee by the council of economic advisors for the current cost year divided by the implicit price deflator for the gross national product for the prior cost year.

(2) The portion of real wage growth allowance per patient day for the prior year applicable to the cost center computed in accordance with subsection 16 below.

(3) Significant increases in operating costs of the cost center resulting from the implementation of new standards of care of staff specifically mandated by the Connecticut Department of Health Services and/or the certification requirements of the federal government.

(4) Significant increases in operating costs of the cost center resulting from capital renovation, expansion or replacement required for compliance with new state or federal standards for patient care referred to in (c) above.

(d) An efficiency limitation per patient day established at 160 percent of the median for all allowable costs except those property costs covered by the application of the fair rental value system. The efficiency limitation shall be determined by calculating such costs per patient day for each provider segregated by chronic and convalescent hospitals and homes for the aged. This efficiency limitation shall be cost controlling after application of subsection 3 above and any other disallowances prescribed by these regulations. This efficiency limitation shall decrease by five percentage points per year for each of the next two years. This efficiency limitation shall remain at 150 percent of the median thereafter.

In no event shall the efficiency limitations per patient day computed pursuant to this subsection be less than the allowable operating expense per patient day for the preceding cost year.

This subsection constitutes an overall cap which a facility's allowable costs for reimbursement purposes cannot exceed. All other subsections of the cost related reimbursement system regulations, including but not limited to Section 17-311-57, shall be construed to be subject to this subsection.

(e) For chronic and convalescent hospitals and rest homes with nursing supervision excluding intermediate care facilities for the mentally retarded, a separate cost efficiency adjustment for each of the four cost centers; dietary, laundry, housekeeping and routine nursing care; and for homes for the aged, a separate cost efficiency adjustment for each of the three cost centers; dietary, laundry and housekeeping.

For chronic and convalescent hospital and rest home with nursing supervision excluding intermediate care facilities for the mentally retarded, for the dietary, laundry and housekeeping cost centers, the cost efficiency adjustments shall be 10% of the excess of the 80th percentile of allowable costs per certified bed of all facilities for the cost center for the applicable level of care multiplied by the certified beds of the facility for the level of care, provided such excess exists for at least two cost centers for the applicable level of care and provided such excess is at least \$1,000 for the applicable cost center. For chronic and convalescent hospitals and rest home with nursing supervision, excluding intermediate care facilities for the mentally retarded, for routine nursing cost center, the cost efficiency adjustment shall be 10% of the excess of the 90th percentile of allowable costs per certified bed of all facilities for the cost center for the applicable level of care multiplied by the certified beds of the facility for the level of care over the allowable expense of the facility for the cost center, provided such excess exists for at least two cost centers for the

applicable level of care and provided such excess is at least \$1,000 for the routine nursing cost center.

For homes for the aged, for dietary, laundry and housekeeping cost centers, the cost efficiency adjustment shall be 10% of the excess of the 80th percentile of allowable costs per certified bed of all homes for the aged for the cost center multiplied by the certified beds of the facilities' home for the aged over the allowable expense of the facilities' home for the aged for the cost center, provided such excess is at least \$1,000 for the applicable cost center.

After a facility has received a cost efficiency adjustment for a cost center of a level of care for two years in a row, that is, beginning with the third year, the cost efficiency adjustment shall be increased to 20% of the excess described above.

**(f) An allowance for property costs based upon a fair rental value system.**

(1) The fair rental value allowance shall be in lieu of interest on mortgages, other property financing costs, depreciation on buildings and non-movable equipment and rental charges (except for leases entered into between unrelated parties prior to December 20, 1976). The allowance shall be computed in the same manner whether the facility is owned or leased (except as provided in subsection c) and whether the facility is operated by an individual owner, partners, or a corporation.

(2) The fair rental value allowance consists of rental allowance of the use of land, buildings and non-movable equipment related to patient care.

(a) The annual fair rental value allowance for the use of land shall be determined by multiplying the base value of the land by a rate of return which is equal to one-third of the medicare rate of return for the cost year, but not more than four percent nor less than two and one-half percent per annum. The base value of the land of a facility first used as a long term care facility after September 30, 1954, shall be the actual cost of the land consisting of the purchase price and the cost of grading, filling and site preparation. For those facilities first used as a long term care facility before October 1, 1954, the base value of the land shall be the actual cost of the land adjusted from the date of acquisition to cost year 1974. The base value in any case shall not vary because of changes in ownership except as provided in section 17-311-57(1), financial arrangements of an owner, or whether the land is owned or leased.

(b) Real property other than land consists of:

- buildings and building improvements;
- all equipment attached to buildings and considered to be real property as distinguished from personal property; and
- land improvements, including parking lots, driveways, sidewalks, sewage systems, walls and pump houses.

The fair rental value allowance is calculated to yield a constant amount each year in lieu of interest and depreciation costs, such allowance for the use of real property other than land shall be determined by amortizing the base value of such property over its remaining useful life and applying a rate of return on the unamortized base value.

The annual rate of return shall be calculated for proprietary facilities on the basis of medicare rates of return as set forth in 42 C.F.R., Section 405.429, and 5/8th of such rates for nonprofit (voluntary and governmental) facilities. The applicable rate of return shall remain constant for each property item for a period of ten years. Thereafter each subsequent ten years, the rate of return shall be adjusted based upon the preceding five year average of the medicare rate of return.

For proprietary facilities, the applicable rate of return for real property other than land, first used for a long term care facility after September 30, 1974 or acquired by new owners between October 1, 1974 and December 20, 1976, shall be the medicare rate of return for the cost year when first used for a long term care facility or acquired by new owners, respectively. The applicable rate of return for all other real property other than land shall be based on the cost year that such property was first used for a long term care facility as follows:

- Cost Year 1974 — 1974 medicare rate of return;
- Cost Year 1973 — average of 1973 and 1974 medicare rates of return;
- Cost Year 1972 — average of 1972, 1973 and 1974 medicare rates of return;
- Cost Year 1971 — average of 1971, 1972, 1973 and 1974 medicare rates of return;
- Cost Years Prior to 1971 — average of 1970, 1971, 1972, 1973, and 1974 medicare rates of return.

For nonprofit (voluntary and governmental) facilities, constructed or acquired after the effective date of this amendment to the regulations, the applicable rate of return utilized in calculating the fair rental value shall be the same rate of return as that used for proprietary facilities.

The base value of real property other than land first used for a long term care facility after September 30, 1974 and December 20, 1976, shall be the actual cost of the property. The base value of all other real property other than land shall be the undepreciated book value of the property as of October 1, 1974; that is, the cost less the accumulated depreciation, from the date of acquisition, allowable under medicare statutes and regulations.

In any situation where book values are incomplete or questionable and therefore may not reflect the value on the date of acquisition, the commissioner may disallow any claim for such unsupported amount or may in his discretion establish a value based on property values of comparable facilities.

A facility transferred to a new owner after December 20, 1976 retains the same base values as existed for the previous owner except as provided in section 17-311-57 (1).

The remaining useful life of buildings first used as a long term care facility after September 30, 1974, or acquired by new owners between October 1, 1974 and December 20, 1976, shall be thirty years. The remaining useful life of all other buildings except those acquired by new owners after December 20, 1976 shall be thirty years minus the number of years between October 1, 1974 and the date of building construction, reconstruction sufficient to extend its useful life to thirty years, or acquisition, whichever is later. The remaining useful life of buildings acquired by new owners after December 20, 1976 shall be the same as if the buildings had not changed ownership after December 20, 1976, except as provided in section 17-311-57 (1).

The remaining useful life of real property other than buildings shall be determined as described herein for buildings with the exception that for such property whose estimated useful life is less than thirty years, such estimated useful life shall be used in all calculations instead of thirty years.

For purposes of reimbursement, a minimum residual value is established for real property other than land at 10% of the cost of such property. The allowance for the use of such property shall not be less than the amount determined by applying the appropriate medicare rate of return to the minimum residual value.

(3) A facility which has entered into a lease with an unrelated party prior to December 20, 1976 may petition the state to recognize the arms-length relationship of the parties and the process and procedure leading to the terms and conditions of an existing lease when the terms and conditions were arrived at through arms-length negotiations with unrelated parties. Any provider who is such a lessee must provide full detailed information, including copies of such leases and proof of arms-length relationship. In addition, a formal written letter requesting the recognition of such an arrangement must be included in the annual report transmitted to the commissioner each year for which such consideration is desired.

Upon acceptance of satisfactory proof of an arms-length relationship and upon review of the terms of said lease for reasonableness, the commissioner may accept the continuation of the rental or lease agreement and may decide not to impose the rules and regulations applicable under the fair rental value system until the lease expires.

**(g) Management service fees.**

Management fees paid to related parties shall be recognized only to the extent of the actual cost to the related party of providing necessary services related to patient care.

Fees paid to outside organizations for management services shall be allowed for inclusion in the computation of the per diem reimbursement rate provided that such costs are paid under arms-length arrangements to unrelated parties and are approved by the commissioner.

Requests for approval shall be submitted annually by the provider to the commissioner at least three months in advance of entering into arrangements for outside management services. Such requests shall be reviewed as to their reasonableness in relation to the size of the facility and the complexity of its operating structure, and as to their necessity for the effective administration of the facility's operations. The granting of approval will provide the basis for recognition of the costs of the requested management services in the cost year in which they are incurred and inclusion in the rate to be effective July 1 of the following year.

(h) Allowances for membership in professional associations whose function is to improve the competence of administrators and professional staff serving patients up to a maximum of \$24.00 per bed for the cost year ending September 30, 1986. For the cost years ending September 30, 1987, September 30, 1988, and September 30, 1989, increases in such dues paid by providers to professional associations in excess of \$24.00 per bed will be recognized as an allowable cost to the extent that such percentage increase in such association dues does not exceed the percentage increase in the implicit price deflator for the gross national product (GNP) as determined in subsection (c) (1) of this regulation. As a condition precedent for professional dues to be recognized as allowable costs, the professional association must file with the department not later than March 31 of each year an annual report for the fiscal year ending December 31 of the prior year setting forth all revenues received and all expenses incurred during such fiscal year.

**(i) Exclusion of unallowable costs.**

All costs included in the computation of the per diem reimbursement rate must be reasonable and directly related to the provision of services necessary for patient care. In addition to those costs specifically disallowed pursuant to the medicare statutes and regulations as modified by these regulations, items to be excluded from the calculation of the rate shall include but not be limited to:

- (1) duplications of functions or services.

(2) expenditures made for the protection, enhancement, or promotion of a provider's interests.

(3) educational expenditures to colleges or universities for tuition and related costs for owners or employees.

(4) directors' fees.

(5) expenditures made for the personal comfort, convenience or transportation of owners or employees.

(6) travel for purposes of attending conferences or seminars outside of the continental United States. Other out-of-state travel to attend bona fide professional seminars must be limited to no more than one representative from the participating facility and the total dollars expended must meet the medicare definition of reasonableness.

(7) outpatient services, day care services and meals-on-wheels.

(8) costs of residences which are not certified as long term care facilities.

(9) bad debts.

(10) advertising except for help wanted ads.

(11) Expenditures made for salaries, fringe benefits or any type of reimbursement to or for any person who is convicted in any state or federal court of a crime involving fraud in the medicare program or medicaid program or aid to families with dependent children program or state supplement to the federal supplemental security income program or any federal or state energy assistance program or general assistance program and is under a resultant termination or suspension from participation in any of said programs. If such termination or suspension results from a conviction pursuant to Connecticut General Statutes Section 17-83k, such termination or suspension shall be effective with the date of conviction notwithstanding the plea entered prior to conviction.

Costs to be excluded from per diem reimbursement rate determination pursuant to the above should be specifically identified in the appropriate section of the annual report.

(j) Exclusion of costs of legal, accounting and consultant services, and related costs incurred in connection with rehearings, arbitration or judicial proceedings pertaining to the reimbursement rates approved by the commissioner, except that such costs shall be recognized as allowable if the commissioner, the arbitration panel or the court concludes that the facility's request for reimbursement rate adjustment constitutes a valid claim. In such situations, the reasonable aggregate amount of legal, accounting and consultant services, and related costs to be allowed shall be determined by the commissioner.

**(k) Disallowance of interest expense except as noted below.**

For proprietary facilities, all interest expense on any form of indebtedness shall not be allowed as reimbursable expense, since proprietary facilities are allowed a fair rental allowance for the use of land, buildings, and non-movable equipment and a return on equity pursuant to subsection 12 below for the use of all other assets related to the provision of current patient care.

For non-profit facilities, only interest expense required to obtain necessary working capital shall be allowed as a reimbursable expense, all other interest expense shall be disallowed, since non-profit facilities are allowed a fair rental allowance for the use of land, buildings, and non-movable equipment.

The disallowance of interest expense described in the two preceding paragraphs does not preclude capitalization of interest during the period of construction of a new facility or an addition to an existing facility and the inclusion of such capitalized interest in the cost of construction.

**(l) Return on equity.**

Proprietary facilities shall be allowed a return on equity which is determined by multiplying the medicare rate of return for the cost year by the average current equity for the cost year and the average non-current equity for the cost year. For facilities which submit an annual report for less than a full year of operation, the return on equity will be adjusted in proportion to the length of the annual report period.

Current equity shall be equal to current assets which are related to current patient care minus current liabilities which are not interest bearing and are not owed to owners or related parties.

Non-current equity shall be equal to non-current assets which are related to current patient care and are not subject to the fair rental value system minus non-current liabilities which are not interest bearing and are not owed to owners or related parties. For some facilities, non-current equity consists of only movable equipment net of depreciation, because other non-current assets are either unrelated to patient care or subject to the fair rental value system, and all non-current liabilities are either interest bearing or are owed to owners or related parties.

For purposes of this section, equity shall not include assets which are not related to current patient care, such as, but not limited to, investments, loans to owners or related parties, marketable securities, cash in excess of average monthly operating requirements (computed by dividing twelve into the annual operating costs related to patient care exclusive of inflation and efficiency adjustments and non-cash items such as, but not limited to, depreciation and amortization), construction-in-progress and monies available for the completion of construction, real property held for future use and goodwill which was not purchased or which was purchased after December 20, 1976. Also, equity shall not include assets which are subject to the fair rental value system, such as, but not limited to, land, buildings, and non-movable equipment since facilities are allowed a fair rental value allowance for the use of such assets.

Since interest is not a reimbursable expense, equity is not reduced by interest-bearing liabilities so that facilities may receive a return on such indebtedness. Also, equity is not reduced by loans from owners or related parties so that facilities receive a return on such indebtedness. The basis for calculating return on equity does not vary whether the facility is fully funded by owners' capital or funded in whole or in part by debt.

All inclusions in, and exclusions from, equity cited in the medicare statutes and regulations which are not discussed above shall be recognized and given full effect in the calculation of equity.

As a minimum, a proprietary facility shall be allowed a return on equity in an amount sufficient to meet the cost of borrowing for working capital needs provided that the working capital loan is one which:

- (1) has a due date no greater than 12 months.
- (2) is payable to a bank or recognized finance company which makes such loans to the general public and is an unrelated entity, and
- (3) is necessary and proper for the current operation and maintenance of the facility as measured by average monthly cash requirements, and is not used for acquisition of fixed assets or for unallowable and non-patient related expenditures.

**(m) A limitation of the total allowable costs for each level of care of non-profit long term care facilities.**

For non-profit facilities, the aggregate total allowable costs shall not exceed the costs submitted by the provider plus efficiency adjustments, less unallowable costs exclusive of those not required under applicable federal regulations, e.g., inflation and efficiency limitations, salary controls, and the effect of the fair rental value system.

**(n) Computation of per diem reimbursement rates for each level of care.**

For rate determination purposes, no sub-classifications within levels of care shall be allowed.

**(o) The total costs as adjusted by the procedures referred to above divided by the minimum allowable patient days for the applicable cost year.**

A patient day is the unit of measurement for lodging provided and services rendered to one inpatient between the census-taking hour on two successive days. In computing patient days, the day of admission shall be counted but the day of discharge shall not. In computing patient days, reserve bed days shall be counted.

For purposes of computing minimum allowable patient days, utilization of a facility's certified beds shall be determined at a minimum of 90% of capacity, except for new facilities and facilities which are certified for additional beds which may be permitted a lower occupancy rate for the first three months of operation after the effective date of licensure.

**(p) An adjustment in the rate for the time lag between the cost period and the rate period.**

This adjustment shall be the gross national product (GNP) deflator percentage increase or decrease for the eighteen-month time lag from the cost year ending September 30 to the twelve months ending March 31 of the succeeding rate year. This factor shall be computed annually on or about April 15 preceding computation of annual rates to be effective the following July 1. Because the GNP deflator used in the initial rate calculation is estimated in part, when official quarterly rates are finalized, the rate shall be adjusted, if the absolute difference is more than 5% of the factor and commencing with the July 1, 1984 to June 30, 1985 rate year, if the absolute difference is more than 3 percentage points, with the final adjustment to be made based upon the data available on December 31 following the close of the rate year.

**(q) An allowance for real wage growth.**

Such allowance shall be predicated upon a factor determined by using a ten-year moving average of the changes in non-manufacturing real wages in Connecticut reported by Chase Econometric Associates, Inc. The ten-year moving average shall extend through the end of the calendar year covered by the annual report used for the determination of the per diem reimbursement rate. The real wage growth allowance is limited to wages paid excluding fringe benefits and applies only to employees paid on an hourly rate basis (excluding salaried employees). Reasonable costs mandated by collective bargaining agreements between the employer and other agreements between the employer and the employees shall be allowed to the extent that such costs are reasonable.

**(r) Separate reimbursement for minimum wage increases.**

Beginning with the effective date of any legislative action which increases the minimum wage rate for labor, the commissioner shall pay long term care facilities the portion of the resulting increase in wage costs for employees thus affected applicable to medicaid patients and supplemental security income recipients. For this purpose, each provider may submit cost data identifying the wage increase on a quarterly basis in the manner prescribed on such forms provided by the department.

**(s) Specified limitations on per diem rates.**

(1) per diem rates for facilities caring for recipients under the medicaid program and/or the supplemental security income program shall not exceed the rate of payment for self-pay persons, or the general ceiling for payment for medicare.

(2) per diem rates for homes for the aged and community residences for the mentally retarded shall not be less than the rate determined pursuant to section 17-311-54.

(t) **Related party principle**

42 C.F.R. Sec. 405.427 is incorporated by reference as a minimum standard and hereby made a part of this regulation.

(u) **Adjustment of rates to provide payment for increased reasonable costs or expenditures necessitated by changes in law.**

(1) If changes in federal or state laws, regulations or standards related to the provision of patient care adopted subsequent to June 30, 1985, results in increased costs or expenditures, the commissioner shall adjust rates and provide payment for any such increased reasonable costs or expenditures within a reasonable period of time retroactive to the date of enforcement. Nothing in this subsection shall be construed to require the department of income maintenance to adjust rates and provide payment for any increases in costs resulting from an inspection of a facility by the department of health services.

(2) Any facility which believes itself qualified for rate adjustment pursuant to subsection (1) above must petition the department of income maintenance on forms to be prescribed by the Department specifying the change in federal or state law, regulation or standard adopted subsequent to June 30, 1985, the exact amount of the increased reasonable cost or expenditure incurred to comply with such change in law, and the exact identity of the added staffing, goods or services utilized to come into compliance.

(v) **Nursing Pool Costs.**

(1) For the cost reporting year commencing October 1, 1985, and for subsequent cost reporting years, facilities shall report the cost of using the services of any nursing pool employee by separating said cost into two categories, the portion of the cost equal to the wages of the employee for whom the nursing pool employee is substituting shall be considered a nursing cost and any cost in excess of such wages shall be further divided so that seventy-five percent of the excess cost shall be considered an administrative or general cost and twenty-five percent of the excess cost shall be considered a nursing cost, provided if the total nursing pool costs of a facility for any cost years are equal to or exceed fifteen percent of the total nursing expenditures of the facility for such cost year, no portion of nursing pool costs in excess of fifteen percent shall be classified as administrative or general costs.

(2) Any facility which believes subsection (1) above to be applicable to it must complete the pertinent section of the annual report prescribed by the Department. Failure to complete said section shall result in all nursing expenditures being classified as nursing costs.

(w) **Providers concerning which payment checks are issued directly to patients or residents.**

Concerning all providers whose patients or residents receive payment checks directly from the department (i.e., the beneficiary-resident receives the payment check rather than the provider-vendor), the department is authorized to include as a factor in setting an annual rate any past unallowable costs which resulted in past overpayments so as to recover such past overpayments.

(Effective June 2, 1986)

**Sec. 17-311-53. Desk review and field audits**

(a) The per diem rate of payment established pursuant to section 17-311-50 et seq. shall be determined by desk review of the submitted annual report which shall subsequently be verified and authenticated by field audit procedures which are approved by the United States Department of Health and Human Services. Facilities shall generally be audited on a biennial basis. This audit cycle may be changed based upon audit experience. A recomputation of rate, based upon field audit adjustments or otherwise, shall be made retroactive to the applicable period. Such retroactive recomputation replaces the originally determined annual Medicaid per diem rate and shall not be construed to constitute a new annual Medicaid per diem rate so as to require the public hearing mandated by Connecticut General Statutes, section 17-314.

(b) Whenever the Commissioner of Income Maintenance renders a rate decision, whether based upon a field audit or otherwise, which decision results in the facility being indebted to the Department of Income Maintenance for past Medicaid overpayments, the department shall recoup said Medicaid overpayments as soon as possible from the department's monthly Medicaid payments to the facility. If the facility submits a rehearing request in compliance with Connecticut General Statutes, section 17-311 (b), the department shall afford the facility a rehearing as soon as practicable after commencement of recoupment of past Medicaid overpayments. Said rehearing request shall not automatically stay the recoupment, which may be stayed in the discretion of the commissioner.

(c) In a recoupment situation, the Department of Income Maintenance shall determine a recoupment schedule of amounts to be recouped from the facility's monthly Medicaid payments after consideration of the following factors:

- (1) The amount of the indebtedness;
- (2) The objective of completion of total recoupment of past Medicaid overpayments as soon as possible;
- (3) The cash flow of the facility; and
- (4) Any other factors brought to the attention of the department by the facility relative to the provider's ability to function after recoupment.

(d) Whenever a facility has received past Medicaid overpayments, the department may recoup the amount of such Medicaid overpayments from the monthly Medicaid payments to the facility regardless of any intervening change in ownership.

(e) A facility may give the commissioner notice of a proposed change in ownership (to include the names and addresses of the proposed buyers) at least nine (9) months before said change in ownership. The department shall then conduct a field audit of the facility and notify both the facility and the prospective buyers of the existence of any indebtedness to the department resulting from past Medicaid overpayments. Following the conclusion of such field audit the department shall determine the recoupment schedule and commence recoupment in accordance with such schedule unless the department, in its discretion agrees to wait until the consummation of the sale. At the time of the consummation of such sale, the seller shall pay in full to the department the total amount of such indebtedness. Failure of the seller to repay at that time will subject the buyer to recoupment as set forth in subsection (d).

(f) If a facility owes money to the department, the department may offset against such indebtedness any liability of the department to another provider which is owned or controlled by the same person or persons who owned or controlled the first facility at the time the indebtedness to the department was incurred. In the case of

the same person or persons owning or controlling two or more facilities but separately incorporating them, whether the person or persons own or control such corporations shall be an issue of fact. Where common ownership or control is found, this subsection shall apply notwithstanding the form of business organization utilized by such persons, e.g. separate corporations, limited partnerships, etc. Findings of common ownership or control does not necessarily require 51% or more ownership or evidence of actual past exercise of control but rather only requires the potential or ability to directly or indirectly exercise influence or control. When the commissioner renders a decision to act pursuant to this subsection, an aggrieved provider which desires to contest the finding of common ownership or control may, within ten days of such decision by the commissioner, obtain, by written request to the commissioner, and administrative hearing within the department on the issue of whether common ownership or control exists. At such an administrative hearing pursuant to this subsection, the department shall have the burden of proof on said issue. For purposes of this subsection only, when an aggrieved provider submits a timely request for administrative hearing as aforesaid, an automatic stay of offset against payments to the second facility pursuant to this subsection shall enter and remain in effect until the department issues its administrative final decision concluding the aforesaid administrative hearing on the issue of whether common ownership or control exists.

(Effective June 2, 1986)

#### **Sec. 17-311-54. Optional rate determination**

Homes for the aged and community residences for the mentally retarded shall have the option of complying with section 17-311-50 of the regulations which requires the annual reports and cost data be provided for individual rate determination for each facility or acceptance of the per diem rate determined as explained below. The election to have an individual rate computed shall necessitate the filing of the annual report.

The rate for the year beginning July 1, 1982 for homes for the aged and community residences for the mentally retarded which do not elect to have an individual per diem rate computed shall be predicated on the rate authorized for providers with 10 or less beds for the prior rate year adjusted prospectively by multiplying it by the quotient derived by dividing the GNP deflator for the upcoming rate year by the GNP deflator for the prior rate year. Thereafter the rate for such facilities shall be computed by multiplying the rate for the prior year by the quotient derived by dividing the GNP deflator for the upcoming rate year by the GNP deflator for the prior rate year.

(Effective March 17, 1983)

#### **Sec. 17-311-55. Interim rates**

Newly constructed facilities shall receive an interim per diem rate of payment for each level of care computed on the basis of budgetary data (from CHHCFD-4 new 6/75) submitted to the commissioner.

Newly acquired facilities shall receive an interim per diem rate of payment for each level of care based on the existing rate adjusted to reflect any changes in property values pursuant to section 17-311-57(1). In the event that substantive changes in operation have been affected by the new owners materially changing operating costs, additional adjustments to the existing rates may be made to the extent such changes in operations and related costs are specifically identified and documented by the facility.

An interim per diem rate may be authorized for a facility which has undergone changes in level of care or significant changes in licensed bed capacity mandated

or approved by the department of health services and the commission on hospitals and health care.

An interim per diem rate may be revised by the commissioner at any time based on additional information which may become available to him. The interim rate shall remain in effect until the first of the following occurs:

(a) a per diem rate is computed on the basis of an annual report for a full cost year in which the facility achieved ninety percent (90%) occupancy of its certified beds; or

(b) a per diem rate is computed on the basis of the facility's second annual report for a full cost year.

Interim rates shall be replaced by revised per diem rates computed on the basis of actual costs which are allowable as defined in these regulations, and minimum allowable patient days (ninety percent utilization except as provided in section 17-311-52(15) for the period in which the interim rates were in effect. Proper retroactive adjustments, in favor of the provider or the state, shall be made to all amounts paid on the basis of interim rates.

(Effective March 17, 1983)

### **Sec. 17-311-56. Record maintenance and retention**

Through June 30, 2004, each facility shall maintain all supporting records for the ten (10) most recent cost years without regard to change in ownership. Beginning July 1, 2004, each facility shall maintain all supporting records for the seven (7) most recent cost years without regard to change in ownership. At the discretion of the commissioner, any facility which fails to comply with such requirements may be paid at the lowest rate paid to another facility for the same level of care, or the commissioner may disallow those costs for which appropriate documentation has not been maintained. All facilities shall be required to maintain their books of account on the accrual method of accounting and accurate time records shall be maintained for all persons paid salaries or wages. This section does not affect the independent requirement that any medical records must be maintained for the length of time specified in section 19-13-D8t(o) of the Regulations of Connecticut State Agencies.

(Effective March 17, 1983; amended March 1, 2002)

### **Sec. 17-311-57. Hardship appeals**

The commissioner shall consider requests for rate revisions due to hardship for any of the following reasons:

(a) A sale of a facility is contemplated because of the death of the principal owner of a facility, or the principal owner is unable to conduct any business activities due to documented health disability or to advanced age i.e., not less than 65 years. For purposes of these regulations, a principal owner is defined as an individual proprietor or the individual(s) owning the controlling equity in a partnership or corporation.

For those sales which result from the factors mentioned in the preceding paragraph, the property basis used in the application of the fair rental value system, may under certain circumstances be increased as a result of a sale of equity interest in a facility. Sales of partial interests and sales to individuals who are partners or shareholders with the seller in the facility subject to sale or any other long term care facility generally will not provide a basis for property valuation adjustment.

To enable the state to consider a claim for an adjustment in the property basis, the seller must petition the commissioner setting forth all of the pertinent facts of such sale. The commissioner shall examine the transaction and may consider factors

such as the following in reaching a decision as to whether and in what amount the property basis may be adjusted.

- (1) the reasonableness of the selling price.
- (2) the arms-length relationships between the buyer, seller and mortgage lender.
- (3) the cost of the property recorded by the seller and the effect thereon of inflationary cost increases as measured by recognized price indices such as the dodge building cost index and the implicit price deflator for the gross national product.
- (4) the extent to which depreciation and amortization of the assets covered by the sale needs to be adjusted to reflect the inflationary cost increases determined pursuant to (3) above.
- (5) the degree of financing by the seller in relation to the total selling price of the property.

Based on consideration of the foregoing and any other factors as the commissioner deems pertinent, the commissioner may decide that an adjustment in property basis is appropriate, equitable and does not prejudice the interests of the state.

No portion of the purchase price of any facility shall be recognized as purchased goodwill includable in the base for computation of return on equity.

In computing the fair rental value allowance for the revised value of the property, the remaining useful life of the property shall be the greater of:

- (1) the remaining useful life of the principal buildings purchased; or
- (2) longest term of any mortgage on the property.

Once the sale is effectuated, the commissioner must be notified whether the buyer or seller shall be held financially liable for future assets or the liabilities due to rate adjustments not known at the time of the sale. Failure to submit this information at the time of the sale may result in the commissioner not promulgating an interim rate for the new owner.

(b) A facility is unable to meet its debt service obligations to banks and other recognized financing institutions because of the insufficiency of the property fair rental value allowance included in the per diem reimbursement rate. If an adjustment in the rate is requested on this basis, the provider must petition the commissioner for an adjustment and set forth all the pertinent facts for the commissioner's consideration. The commissioner shall examine the following and such other factors as he deems appropriate in reaching a decision as to whether and in what amount the per diem rate may be adjusted.

(1) the financial status of the facility must be considered exclusive of any transactions which are not recognized as allowable for rate computation under these regulations.

(2) The mortgage terms and amount must be reasonable in relation to the useful life and carrying amount of the property of the facility used for patient care, provided that the proceeds of refinancing are devoted to patient care.

(3) The mortgage transactions must have been entered into prior to December 20, 1976.

(c) (1) The commissioner receives an affidavit executed by the appropriate official of the facility swearing that the facility had filed for hardship relief pursuant to Emergency Regulation 17-311-82 (e) dated July 6, 1982. In this event the commissioner shall continue the payments authorized pursuant to the Emergency Regulation through June 30, 1983. In the event that the commissioner learns through audit or by notification of the trustees of the pension plan or otherwise that the money so provided has not been used to make the promised contributions to the pension plan

the facility agrees to the automatic recoupment of the amount paid out by the commissioner pursuant to this subsection without a hearing; or

(2) The commissioner receives an affidavit executed by the appropriate official of the facility swearing that:

(A) The facility has entered into a legally enforceable agreement with its employees and less than twelve (12) months of the pension costs thereof were reflected in the current medicaid rate.

(B) The terms of the agreement include a provision that the facility must make payments to a qualified pension plan governed by ERISA.

(C) The actual payment of the contribution to the pension plan threatens the economic viability of the facility.

(D) Any funds received as a result of the increase in the rate granted by the commissioner as a result of the operation of this subsection will go exclusively toward the payment of the contribution to the qualified pension plan, and

(E) In the event that the commissioner learns through audit or by notification of the trustees of the pension plan or otherwise that the funds so provided have not been used to make the promised contributions to the pension plan the facility agrees to the automatic recoupment of the amount paid out by the commissioner pursuant to this subsection without a hearing.

(3) Upon examination of the above information and consideration of any other factors which he deems pertinent, the commissioner may grant an increase to the current medicaid rate which is the lesser of:

(A) The projected costs of the actual contribution to the pension plan to be incurred for the current medicaid rate year divided by estimated actual and imputed patient days for the medicaid rate year or,

(B) the dollar amount, for the portion of the current medicaid year for which contribution to the pension plan are made, produced by multiplying the facility's projected gross wages by the percentage listed in the most recent Chamber of Commerce of the United States study entitled Employee Benefits for "Pension plan premium and pension payments not covered by insurance-type plan (net)" for hospitals in the chart listing "Employee Benefits as Percent of Payroll," divided by estimated actual and imputed patient days for the current medicaid rate year. The commissioner may, if he deems appropriate, increase the percentage listed therein by the Implicit Price Deflator for the Gross National Product for the period since the study. This subsection shall not be construed to authorize any immediate reimbursement of pension costs which are already reimbursed in the facility's existing medicaid rate.

(C) in the event that the Annual Report of Long Term Care Facility reflects only part of the first year of pension costs, the facility may apply for hardship relief for the unreported portion of said pension costs pursuant to this subsection.

In the event that the Annual Report of Long Term Care Facility reflects twelve (12) months pension costs, the facility shall be ineligible for hardship rate relief pursuant to this subsection.

(4) A facility or a portion of a facility (provided that no portion of a facility will be considered for hardship relief unless it is maintained as a distinct part with fifteen beds or more or unless approved by the Department for 10 to 14 beds under the provisions of subsection (4) (a) (4)) is either providing or proposing to provide care for traumatic brain injury (hereinafter TBI) patients who require extensive care but not acute general hospital care as defined below and seeks a separate TBI rate.

**(a) Availability of hardship rate relief for facilities serving traumatically brain injured patients**

A chronic and convalescent nursing facility, or a distinct part of a facility, either providing or proposing to provide care for TBI patients who require extensive care but not acute general hospital care may be granted hardship rate relief, at the discretion of the Commissioner of Income Maintenance (provided that no portion of a facility will be considered for hardship relief unless it is maintained as a distinct part with fifteen beds or more or unless approved by the Department for 10 to 14 beds under the provisions of subsection (4) (a) (4)), if such a facility demonstrates that it would suffer financial hardship if not granted rate relief and if the facility meets the requirements for the granting of TBI hardship relief.

For purposes of this Section TBI is any combination of focal and diffuse central nervous system dysfunction, both immediate and delayed, occurring at the brain stem level and above, which results from the interaction of any single or repetitive external force and the body.

In determining whether to grant in whole or part or to deny the request for hardship rate relief for a TBI facility, the Commissioner may consider factors including, but not limited to, the following:

(1) The hardship caused by not having a separate TBI rate calculated for the facility. Each applicant shall file all financial records which the Commissioner, in his discretion, deems necessary to enable the Commissioner to determine if a financial hardship exists or will exist absent the granting of TBI hardship rate relief.

(2) Cost. Each applicant shall file all necessary budgetary data to enable the Commissioner to determine how much the proposed services will cost in excess of the current costs of the facility.

(3) Program Services to be Provided. Each applicant must provide a detailed proposal setting forth specifically what program services will be provided, the quantity of such services, personnel qualifications (specifying the nature of the training and experience of each person providing program services) and the level or levels of TBI patient, using the "Rancho" Scale of Levels of Cognitive Functioning, developed by the Adult Head Trauma Service of Rancho Los Amigos Hospital (hereinafter the "Rancho" scale) for which the services will be appropriate. The proposal must demonstrate that the program requirements set forth in Subsection (c) below will be met and how they will be met.

(4) The Size of the Proposed Unit. Unless granted an exception as provided for below, no unit can be considered for hardship relief unless it is a free standing facility or a distinct part of an existing facility with said distinct part made up of at least fifteen (15) beds. Units with fewer than fifteen (15) beds, but made up of at least ten (10) beds may be approved when it can be shown that the unit will not be more costly than comparable units of fifteen (15) beds or more and that the operation of a larger unit would not be in the best interest of the patients.

(5) Proposed timetable for occupancy of a TBI Unit by TBI patients. Applicant must submit a schedule which details by month, the number of TBI patients and the number of geriatric patients by source of payor that will occupy the distinct part unit. The period of time for which this schedule must be produced is from the date that the first TBI patient is admitted to the date that the unit is fully occupied by TBI patients.

(6) Geographical Location.

(7) The experience of the provider in caring for TBI patients and the experience of the personnel proposed to be utilized in providing the care to the TBI patients.

(8) The number of beds for which TBI hardship relief has already been granted in the same general geographical area.

(9) Any other factors which the Commissioner deems appropriate to consider.

In order to permit the Commissioner to consider an application for TBI hardship rate relief, the applicant shall submit an affidavit sworn to under oath which includes:

(A) the items listed in 1 through 6 above and any other information requested by the Commissioner,

(B) a statement that any funds received as a result of the operation of this subsection will be spent exclusively on the TBI patients and

(C) a statement that in the event that the Commissioner learns through audit or otherwise that the funds so provided have not been used on the TBI patients, the facility agrees to the automatic recoupment of the amount paid out by the Commissioner pursuant to this subsection prior to a hearing.

**(b) Effect of granting hardship relief**

The Commissioner, at his discretion, may grant in whole or in part an application for hardship rate relief upon terms he deems appropriate, equitable and in the best interest of the State or he may deny an application for hardship rate relief. If TBI hardship rate relief is granted, the efficiency limitation set forth in Section 17-311-52 (4), which controls allowable costs at 150 percent of the median of chronic and convalescent nursing facilities, and the inflation cost limitation provided for in Section 17-311-52 (3) shall not apply to the TBI facility or the TBI portion of the facility.

(1) In the event that the Commissioner grants hardship rate relief, an interim TBI rate will be established. In computing the interim rate, the Department will determine the total cost of the TBI unit and deduct the expected revenue from the other patients who will occupy this unit as determined by the cost proposal and the schedule of occupancy required above. The expected revenue to be deducted will be computed by multiplying the number of days in the TBI unit occupied by non-TBI patients by the prevailing Connecticut Medicaid rate. The resultant amount will be divided by the estimated TBI days and the quotient derived therefrom will be the interim TBI rate. The interim rate will be replaced annually or may be replaced at any time by the Commissioner at his discretion when new information is made available to the Department. Revised interim TBI rates will be determined by dividing the reasonable costs of caring for TBI patients as reported in the Annual Report of Long-Term Care Facility by the number of actual TBI days. Interim TBI rates will be replaced by per diem rates computed on the basis of the reasonable costs incurred in caring for TBI patients for the period in which the interim rates were in effect. The Annual Report of Long-Term Care Facility for the appropriate year ending September 30 will be utilized to report the necessary data and must be filed annually by December 31. Proper retroactive adjustments in favor of the provider or the State shall be made to all amounts paid on an interim basis.

After a period of not more than three years from the effective date of these regulations, the Department will analyze the costs incurred in caring for TBI patients and determine what limitations, if any, will be placed on subsequent TBI rates.

(2) For purposes of calculating a separate TBI rate, whether interim or final, a facility that has been granted a special TBI rate for a distinct part shall allocate its costs to the distinct part as if the distinct part were licensed as a separate level of care.

(3) The purpose of granting TBI hardship rate relief is to provide care to TBI patients. Therefore, any funds received as a result of the operation of this subsection must be spent exclusively for care of the TBI patients and in the event that the

Commissioner learns through audit or otherwise that the funds so provided have not been used on the TBI patients, the facility agrees to the automatic recoupment of the amount paid out by the Commissioner pursuant to this subsection prior to a hearing.

(c) **Availability of hardship TBI rate relief**

(1) In order to be considered for hardship TBI rate relief, a chronic and convalescent nursing facility applying for such rate relief must comply with applicable state licensure and federal skilled nursing certification requirements for the provision of nursing home care. In addition, the facility must demonstrate:

(A) that the facility has been granted approval by the Commission on Hospitals and Health Care, pursuant to the provisions of Connecticut General Statutes Section 19a-154, to devote the facility, or distinct part of the facility, to providing services on behalf of traumatically brain injured patients. The extent of any hardship rate relief granted pursuant to this section will be limited to any conditions contained in any ruling of the Commission, including any order limiting the number of beds which may be devoted to the care of traumatically brain injured patients. In order to be considered for hardship rate relief, any distinct part of a facility must contain at least 15 beds devoted to the care of TBI patients, unless approved by the Department for 10 to 14 beds under the provisions of subsection (4) (a) (4).

(B) that the facility has adopted policies, and is prepared to implement its policies, governing the provision of nursing care, related medical care including physician services, and rehabilitative services, which reflect awareness of and provision for meeting the special medical and rehabilitative needs of TBI patients. Where TBI hardship rate relief is requested for a distinct part of the facility, the facility must adopt and implement separate policies for the distinct part serving TBI patients. The medical records of the facility must reflect that patient care is being provided TBI patients in accordance with the facility's patient care policies.

(C) that the facility's policies reflect awareness of modern practices of rehabilitative medicine, including the provision of rehabilitative services through an interdisciplinary process. Interdisciplinary teams must be staffed to properly assess and plan for the needs of each individual patient, including at a minimum, a physician, a nurse experienced in providing rehabilitative nursing and skilled nursing services, and a physical therapist, occupational therapist and/or a speech therapist or other professionals depending on the needs of the TBI patient. Notwithstanding the requirement that rehabilitative services be provided through an interdisciplinary process, the facility is obligated to comply with state licensure and federal certification requirements that require that rehabilitative services be provided pursuant to a physician's order.

(D) that the facility's policies grant priority for admission wherever practicable to TBI patients who require extensive nursing or rehabilitative services or to TBI patients who are difficult to place in nursing facilities. For purposes of this regulation, the TBI patients requiring extensive nursing or rehabilitative services means patients requiring the provision of at least two skilled nursing or rehabilitative (physical therapy, occupational therapy, speech therapy) services daily. Daily means seven days a week for skilled nursing services and five days a week for rehabilitation services. TBI patients who are difficult to place in nursing facilities include patients in coma, patients on ventilators and patients exhibiting behavioral disturbances. Any admission policy adopted by a facility serving TBI patients must refer to the "Rancho" scale in describing the type of TBI patients who may be admitted to the facility, or distinct part of a facility, granted TBI hardship rate relief.

(E) that the facility adopt and implement policies requiring that TBI patients be provided cognitive remediation service by occupational therapists, speech pathologists or consulting psychologists, as determined by the interdisciplinary team and pursuant to a physician's order.

(F) that the facility adopt and implement policies requiring that comatose TBI patients receive coma arousal services in conformity with current professional opinion pursuant to a determination of the interdisciplinary team and a physician's order. The facility must furthermore adopt and implement policies requiring and demonstrating how comatose patients will be protected from harm from others, including behaviorally active clients.

(G) that the facility has adopted and implements discharge policies which provide for the discharge of TBI patients from the facility, or distinct part of the facility, when the TBI patient no longer requires the intensity of skilled nursing or rehabilitative services which required the granting of hardship rate relief to the facility. The required discharge policies may allow for transfer of the patient from a distinct part of the facility (granted hardship rate relief under this section) to a bed in the facility that is not subject to the rate relief granted by this section. Any discharge of a TBI patient must comply with the applicable state licensure and federal certification requirements.

(H) that the facility has adopted and implements policies which require that the TBI patient's rehabilitative progress be periodically monitored and objectively assessed. The rehabilitation plan must be amended as necessary. The facility's policies must provide that failure of the TBI patient to make reasonable progress in his rehabilitation plan shall be grounds for his discharge from the facility, or a distinct part of the facility granted hardship rate relief, unless the patient requires intense skilled nursing care or presents major behavioral disturbances which preclude his discharge from the facility. The TBI patient may be readmitted to the facility if he subsequently shows progress in rehabilitation such that the provision of intensive rehabilitative services is indicated.

(I) that the facility has made arrangements with physicians experienced in providing care to TBI patients, e.g., specialists in rehabilitation medicine or physical medicine, to provide for the medical and rehabilitative needs of TBI patients. In addition, the facility must demonstrate that it has arrangements with specialty consulting physicians, depending on the needs of the patients, e.g., neurosurgeons, neurologists, pulmonary disease specialists, urologists and infectious disease specialists.

(J) that the facility has retained sufficient rehabilitative professionals, i.e., physical therapists, occupational therapists, and speech therapists, to meet the rehabilitative needs of the TBI patients. Physical therapists, occupational therapists and speech therapists must have prior experience working with TBI patients or working with patients with similar treatment needs.

(K) that sufficient and appropriate space outside of the patient's bedroom, is available to conduct rehabilitative services.

(L) that the facility has arranged for the provision of consulting psychological services for TBI patients. As an exception to the Departmental policies that otherwise applies to the provision of psychological services on behalf of skilled and intermediate care facility residents, the psychological services required by this subsection may be provided at the facility; however, the cost of such psychological services must be reported on the facility's annual cost report and Title XIX reimbursement for the cost of such services must be claimed exclusively through the facility's per

diem rate instead of by a direct charge by the psychologist to the Department for ancillary psychological services.

(2) A chronic and convalescent nursing facility that is dually certified as both a skilled nursing and intermediate care facility may apply for hardship rate relief for TBI patients requiring intermediate care services. In order for hardship rate relief to apply to TBI patients requiring intermediate care services, the facility must demonstrate:

(A) that the facility complies with applicable state licensure and federal intermediate care certification requirements.

(B) that the facility has adopted and implements policies that reflect awareness of any provision for meeting the needs of TBI patients requiring the intermediate care facility level of services through the use of community services, depending on the needs of such patients. Referrals to such providers as the Division of Vocational Rehabilitation of the Department of Education for vocational rehabilitation services, to community sheltered workshops, to community-based rehabilitation clinics or to community-based day treatment programs must be made depending on the patient's need for such services. The facility must assist the TBI patient in seeking reimbursement for the cost of community services through any available source of payment.

(C) that the facility has adopted and implements admission and discharge policies which provide for the discharge of, or the refusal to admit TBI patients requiring the intermediate care facility level of services unless the TBI intermediate care patient requires the intensity of staff services available as a result of the granting of hardship rate relief to the facility, either because of behavioral disturbances or the need for intense but not skilled rehabilitative services. TBI patients requiring daily rehabilitative services should properly be classified as in need of skilled nursing facility services.

**(d) Maintenance of TBI hardship rate relief**

(1) As provided in these regulations, the granting of hardship rate relief is discretionary with the Commissioner of Income Maintenance. The Commissioner of Income Maintenance may not exercise his discretion unless the facility, at a minimum, fulfills the requirements of subsection (c) above. Once hardship rate relief is granted, the efficiency limitation of Section 17-311-52 (4) and the inflation cost limitation contained in 17-311-52 (3) shall not apply to the TBI facility or the TBI portion of the facility, provided that the Commissioner does not exercise his discretion by revoking the TBI hardship rate relief granted pursuant to this regulation.

(2) The Commissioner may exercise his discretion and revoke any TBI hardship rate relief for any reason which he deems appropriate, including but not limited to, his finding that the granting of hardship rate relief is not equitable or in the best interests of the State. Noncompliance with applicable state licensure or federal certification requirements shall be cause to revoke TBI hardship rate relief, provided that the facility has had an opportunity to correct said deficiencies and has not done so to the satisfaction of the Commissioner. The retention by the facility of its license or its federal medical certification will not constitute a reason not to revoke hardship rate relief under this section if the Commissioner finds that the facility contains deficiencies which have not been corrected. Noncompliance with the requirements of subsection (c) pertaining to specialized TBI care shall also be cause for the Commissioner to revoke hardship TBI rate relief. Violation of the nondiscrimination provisions set forth in subsection (f) below shall be cause to revoke TBI hardship rate relief. Use of the funds received pursuant to this TBI hardship rate relief provision, other than on the TBI patients shall be cause to revoke TBI hardship rate

relief. This list of causes for revocation is not intended to be all inclusive of reasons for revocation.

Any such revocation of hardship relief shall be effective upon whatever date the Commissioner deems appropriate, equitable and in the best interest of the State.

In revoking TBI hardship rate relief, the Commissioner may rely on any information he deems reliable including but not limited to, findings by the health inspection agency pertaining to state licensure or federal certification and findings of the patient review teams of the Department of Income Maintenance.

(3) The Commissioner shall notify the facility of the denial or revocation of TBI hardship rate relief and the effective date of any revocation. If the facility submits a request for a hearing in compliance with section 17-311 (b) of the Connecticut General Statutes, the Department shall afford the facility a hearing as soon as practicable. Said hearing request shall not automatically stay a revocation, and/or any recoupment, which may be stayed in the discretion of the Commissioner.

(4) Given the discretionary nature of both the granting and the revocation of TBI hardship rate relief and the nature of the relief modifying the rate reimbursement system applied to the other long term care facilities throughout the state, the Commissioner's exercise of discretion modifying, denying or revoking TBI hardship rate relief may be overturned only when the facility has shown by clear and convincing evidence that the Commissioner's decision is arbitrary, capricious or a clearly unwarranted exercise of discretion.

**(e) Prior authorization requirements**

(1) Any TBI recipient of medical assistance under Part IV of Chapter 302 of the General Statutes must receive the prior authorization of the Department of Income Maintenance prior to his admission to a facility, or distinct part of a facility, granted hardship rate relief under this section. Any individual who was not eligible for medical assistance at the time of admission to such a facility but who subsequently becomes eligible for medical assistance, must receive the prior authorization for such care before a request is made for payment for the cost of such care. Unless prior authorization has been granted, medical assistance for the cost of care provided by the facility will not be paid by the Department of Income Maintenance.

(2) In order to be granted prior authorization for Title XIX payment for the cost of skilled nursing facility services, the TBI applicant must establish not only that he is eligible for the level of care requested but also establish that he requires the intensity of skilled nursing or rehabilitative services required for facilities granted hardship rate relief under this section.

(3) TBI patients requiring intermediate care facility services generally do not require the intensity of services made available by the granting of TBI hardship rate relief. A TBI recipient of medical assistance requiring intermediate care services, who requests prior authorization for Title XIX payment for the cost of care provided by the facility must demonstrate that the required services could not otherwise be provided to the applicant and that the intensity of nursing (including direct care) or rehabilitative services required by the applicant justifies placement in a facility granted TBI hardship rate relief.

(4) Any prior authorization for the cost of care provided by a facility granted hardship rate relief will be limited to no more than six months. Subsequent prior authorizations may be granted for succeeding six month periods provided that the TBI patient demonstrates that he continues to require the intensity of services provided by the facility granted TBI hardship rate relief under this section and that the TBI patient demonstrates sufficient progress to warrant continued placement in a facility granted TBI hardship rate relief.

(5) Prior authorization may be granted for no more than 30 days for Administratively Necessary Days in accordance with the provisions of subsection (f) below.

**(f) Administratively necessary days**

Administratively Necessary Days are TBI unit days reimbursed by Medicaid for services to a Title XIX eligible patient and to a patient who will eventually be determined eligible. A patient qualifying for ANDs does not require TBI level-of-care. Instead, the patient requires medical services at the skilled nursing or intermediate level-of-care. The patient is forced to remain in the TBI unit because the appropriate medical level-of-care placement in the skilled nursing or intermediate care facility is not available.

If given prior authorization in accordance with subsection (e) above, TBI ANDs will be paid at the TBI rate for up to a maximum of thirty (30) days when the following procedures and conditions are met:

(1) The Medicaid patient is no longer at the acute care level of service but is at a skilled nursing level-of-care or at an intermediate level-of-care;

(2) Discharge to a skilled nursing or intermediate level-of-care bed is impossible due to the unavailability of a bed;

(3) The patient's timely discharge and placement to an appropriate skilled nursing or intermediate care bed is planned and arranged by the facility. Clear evidence of this active and continuous transfer or discharge process is documented in the patient's hospital medical record.

**(g) Nondiscrimination**

Any facility applying for TBI hardship rate relief or to which TBI hardship rate relief has been granted which receives payments pursuant to the Connecticut Title XIX program must abide by the requirements of Section 19a-533 and 19a-550 of the Connecticut General Statutes and the regulations promulgated thereunder with respect to admission and continuation of stay in the TBI facility or the distinct part of the facility. Violation of said provisions shall be grounds not only for the sanctions imposed therein, but the Commissioner, on this basis alone or in conjunction with other reasons, may modify, deny or revoke TBI hardship relief.

**(h) Advisory committee**

The Commissioner shall establish an advisory committee of at least a neuropsychiatrist, a rehabilitation nurse with TBI experience, a psychiatrist and a consumer advocate, who shall provide advice and recommendation to the Department in the following areas:

(1) Upon review of the application as specified in this section, the granting or denial of rate relief to the applicant who has applied to the commissioner for rate relief in order to provide services to TBI patients.

(2) The consideration of regulatory or procedural changes which would improve the services provided to TBI patients under this section.

(3) As brought to the committee's attention by the Department, medical opinion about the appropriateness of admission or continued stay of a TBI patient in a bed which has been granted rate relief under this section.

**(i) Other provisions**

Except as specifically provided in this hardship provision, all other State and Federal statutes and regulations concerning long term care facilities apply to TBI units and patients.

(Effective March 3, 1987)

**Sec. 17-311-58.**

Repealed, March 17, 1983.

**Sec. 17-311-58a. Calculated rates**

The rates that were calculated and paid for the rate year commencing July 1, 1983, and calculated and to be paid for the rate year commencing July 1, 1984, which were calculated, based on the skilled nursing facility and intermediate care facility levels of care designations, shall be deemed to have been set based on the State licensure levels of chronic and convalescent home and rest home with nursing supervision, respectively.

(Effective December 19, 1984)

**Sec. 17-311-59.**

Repealed, March 17, 1983.

**Sec. 17-311-59a. Facility beds licensed as**

All facility beds licensed as chronic and convalescent nursing home beds by the Connecticut Department of Health Services (“DHS”) pursuant to Sections 19a-493 of the Connecticut General Statutes and 19-13-D8t of the Regulations of Connecticut State Agencies and certified by DHS and HCFA pursuant to the Medicaid program (Title XIX) solely as skilled nursing facility beds prior to the effective date of this regulation, which subsequent to the effective date of this regulation receive an additional or dual certification as intermediate care beds, shall continue to be reimbursed by the DIM pursuant to the provisions of the regulations formerly applicable to skilled nursing facility beds.

(Effective December 19, 1984)

**Sec. 17-311-60.**

Repealed, March 17, 1983.

**Cost Related Reimbursement System for Long-Term Care Facilities**

**Sec. 17-311-60a. Definitions**

The following terms are defined pursuant to Section 17-314 (b), of the Connecticut General Statutes.

(a) “Other allowable services” are defined as those services provided by the types of providers listed below to the extent that the cost of said services are not included in the calculation of the per diem rate of the facility.

- (1) Physicians
- (2) Dentists
- (3) Other practitioners (e.g., podiatrists, and optometrists)
- (4) Laboratories
- (5) Pharmacies
- (6) Physical therapists, speech therapists and occupational therapists
- (7) Providers of transportation to other medical services
- (8) Other medical services except for nursing facility and inpatient hospital care

(b) “Out-of-state per patient day Medicaid rate” is defined as that rate paid by the other state for routine patient care plus any additional amounts paid for by the other state.

(c) A “state” is defined as any state, commonwealth, territory, district or other governmental entity participating in the Medicaid program.

(Effective December 5, 1986)

**Sec. 17-311-61.**

Repealed, March 17, 1983.

**Sec. 17-311-61a. Rate adjustments for charges in excess of reasonable and necessary costs for other allowable services**

Pursuant to Section 17-314 (c):

(a) No facility shall accept payment for other allowable services, as defined in Section 17-311-60a, provided by the facility in excess of the rate set by the Commissioner of the Department of Income Maintenance pursuant to paragraph (c) below.

(b) Any facility which accepts payment over the reasonable and necessary costs as determined in accordance with subsection (c) below for other allowable services from any state, as defined in Section 17-311-60a, shall be subject to recovery actions as defined in Connecticut General Statutes 17-314 (d) and subsection (d) below.

(c) Reasonable and necessary costs per patient day for other allowable services, which services are defined in Section 17-311-60a, shall be calculated by multiplying the statewide average costs for other allowable services for Connecticut Medicaid patients for the cost year October 1 through September 30 preceding the rate year by the implicit price deflator for the gross national product for the current cost year divided by the implicit price deflator for the gross national product for the prior cost year and dividing by the number of Connecticut Medicaid patient days. The Commissioner shall notify the facility of the reasonable and necessary costs, per patient day, for other allowable services annually effective July 1.

(d) Any amount received for other allowable services in excess of the reasonable and necessary costs of the other allowable services provided by the facility shall be deducted from the allowable costs of the facility for routine care, as defined in Section 17-311-50 *et seq.*, of the Regulations of Connecticut State Agencies, as follows:

From the facility's out-of-state Medicaid rates shall be deducted the facility's Connecticut Medicaid per diem rate and the statewide average cost per patient day for other allowable services as determined pursuant to subsection (c) above. The result of the computation shall be multiplied by the out-of-state patient days and the product derived therefrom shall be deducted from the facility's allowable costs as defined in Section 17-311-50 *et seq.*, of the Regulations of Connecticut State Agencies.

(e) The facility shall provide the Department with the following information annually with the Annual Report of Long-Term Care Facility:

(1) The out-of-state Medicaid rate(s) applicable to the cost period and the corresponding out-of-state Medicaid patient days by month; and

(2) The Connecticut Medicaid rate(s) applicable to the cost period and the corresponding Connecticut Medicaid patient days by month.

(f) In the event that any facility fails to provide the information requested in (e) of this section, the Commissioner shall make the computation set forth in (d) of this subsection based upon the revenue and patient day sections of the Annual Report of Long Term Care Facility submitted by the facility for the appropriate cost period.

(Effective December 5, 1986)

**Sec. 17-311-62.**

Repealed, March 17, 1983.

**Sec. 17-311-62a. Rate adjustments for facilities subject to the provisions of section 17-314 (e) of the Connecticut general statutes**

(a) "Available beds" are defined as the average number of beds occupied by medical assistance patients from this State and the average number of beds that are empty. Available beds are determined as follows:

Multiply certified beds reported in Annual Report of Long Term Care Facility by 365. Subtract from this product the total patient days reported in the Annual Report. To this number add the patient days for Connecticut Medicaid patients. Dividing this sum by 365 will result in the available beds.

(b) "Required number" is defined as the average number of beds occupied by medical assistance patients from this State during the period October 1, 1980 through September 30, 1981 and is determined by dividing the number of Medicaid patient days reported in the Annual Report of Long Term Care Facility for the cost year 1981 by three hundred sixty-five.

(c) Any facility subject to the provisions of Section 17-314 (e) of the Connecticut General Statutes, which as of the effective date of these regulations has less beds available to medical assistance patients from this State than the required number shall petition the Department stating the number of beds available in the facility as of the effective date of the regulations.

(d) If at any time after the effective date of these regulations said facility has fewer available beds than the required number, such facility shall actively solicit Connecticut Medicaid patients for admission by advising out-placement directors at referring hospitals of available vacancies and by accepting referrals of Connecticut Medicaid patients from the Department.

(e) If the average number of available beds in any such facility for the cost year falls below the required number, the provisions of subsections (c) and (d) of Section 17-314 and the regulations promulgated pursuant thereto shall apply. The excess amount shall be determined by multiplying the number of available beds less than the required number by the amount received for other allowable services in excess of the rate approved by the Commissioner and multiplying this product by 365. This amount shall be deducted from the allowable costs establishing rates for the rate period covered by the Annual Report in which the available beds were less than the required number.

(Effective December 5, 1986)

**Secs. 17-311-63—17-311-90.**

Repealed, March 17, 1983.

**Secs. 17-311-91—17-311-100. Reserved**

**Part IV**

**Relating to Rules of Practice for the Arbitration of Items of Aggrievement on Rates Determined Pursuant to Section 17-311 through Section 17-314**

**Sec. 17-311-101. Objective of proceedings**

The objective of the rehearing and arbitration proceedings of Sec. 17-311 is to provide a means for the expeditious disposition of disputes relating to rates established by the commissioner for any provider pursuant to his authority under Sec. 17-312 to 17-314 inclusive and the regulations promulgated thereunder.

(Effective June 2, 1986)

**Sec. 17-311-102. Designation of tribunal**

The arbitration tribunal established according to the procedures set forth in Section 17-311 and the regulations promulgated thereunder, to adjudicate the above disputes, shall be termed the "arbitration tribunal."

(Effective June 2, 1986)

**Sec. 17-311-103. Administration**

The administration of the arbitration proceedings shall be conducted jointly by the office of the chief court administrator and the clerk of the superior court of the judicial district wherein the state referee who is to serve as an arbitrator has his office and chambers. Requests for arbitration, all correspondence and any other papers or process necessary or proper for the initiation of continuation of an arbitration under these regulations and for any court action therewith or for the entry of judgment on an award made thereunder shall be served, in addition to the commissioner and the provider, on the chief court administrator, the state referee participating as the third arbitrator, and the office of the clerk of the superior court for the judicial district where the state referee has his chambers. All papers, process or notices to the commissioner shall be mailed to by certified mail or served upon the commissioner at 110 Bartholomew Avenue, Hartford, Connecticut.

(Effective June 2, 1986)

**I. Rehearings****Sec. 17-311-104. Rehearing procedure**

Any provider to which payments are made by the commissioner pursuant to Sec. 17-312 to 17-314 inclusive, which is aggrieved by any decision of the commissioner, may, within ten days after written notice thereof from the Committee, obtain, by written request to the commissioner, a rehearing on all items of aggrievement. The request for a rehearing shall be accompanied by a detailed statement outlining the items of aggrievement. The commissioner shall, upon the receipt of all papers and documents necessary to determine and evaluate said request, conduct such a rehearing as soon as practicable after the receipt of the same.

(Effective June 2, 1986)

**Sec. 17-311-105. Conduct of rehearing**

The rehearing shall be deemed a contested case, which means a proceeding in the commissioner's disposition of matters delegated to his jurisdiction by law, in which the legal rights, duties or privileges of the party are determined by the commissioner after an opportunity for a hearing. The definition stated in Section 4-166 (2) of the General Statutes shall further define this term, and all other regulations of the commissioner as appear in the commissioner's description of organization and rules of practice, i.e. Sec. 17-311-27 et seq. shall govern the rehearing procedure. Pursuant to the authority vested in him by Section 17-2, the commissioner may delegate to any deputy, assistant, investigator or supervisor the power to serve as hearing officer or presiding officer and to issue directly the final decision of the department containing findings of fact, conclusions of law and an order. In the alternative, the commissioner may himself preside at the rehearing and issue directly final decision. In the alternative, the commissioner may designate any person to serve as hearing officer or presiding officer and then to submit a proposal for decision to the commissioner pursuant to section 4-179. At such rehearing official notice may be taken of any records maintained in the files of the department, and

the hearing officer or presiding officer is authorized to have the assistance of members or representatives of the agency including but not limited to legal and accounting advisors.

(Effective March 28, 1990)

**Sec. 17-311-106. The decision on rehearing**

The commissioner shall render his decision in writing, in accordance with the contested case provisions of Chapter 54 of the General Statutes and regulations referred to above within ninety days of close of the proceedings, or after thirty days after the receipt of any data the close of the rehearing, the subsequent submission of a late file, the subsequent submission of a memorandum of law, or the receipt of the hearing transcript, whichever is later.

(Effective June 2, 1986)

**II. Arbitration Proceedings**

**Sec. 17-311-107. Commencement of arbitration**

In the event that items of aggrievement are not resolved at the rehearing to the satisfaction of both the commissioner and the provider, then said items shall be submitted to binding arbitration to an arbitration board consisting of one member appointed by the provider, one member appointed by the commissioner, and one member appointed by the chief court administrator from among the retired judges of said court, which retired judge shall be compensated for his services on such board in the same manner as a state referee is compensated for his services under Sec. 52-434.

(Effective June 2, 1986)

**Sec. 17-311-108. Institution of arbitration**

Proceedings for arbitration shall be instituted by filing a request for arbitration in the form of a pleading as prescribed by applicable provisions of the Connecticut Practice Book and the Connecticut General Statutes within thirty days after the mailing of the notice of the final decision of the commissioner with respect to the rehearing. Copies of the request for arbitration shall be sent to the chief court administrator, and to the commissioner at the address provided for in these regulations and in the rules of practice of the commissioner.

(Effective June 2, 1986)

**Sec. 17-311-109. Position paper of party requesting arbitration; filing of record; memorandum in response**

The provider requesting arbitration shall file together with its request for arbitration a memorandum setting forth its position and contentions concerning each of the items of aggrievement which have not been resolved in a satisfactory manner by the decision on the rehearing. Within thirty (30) days of the receipt of such position paper and memorandum, the commissioner shall file the original or a certified copy of the entire record of the rehearing appealed from, which shall include the department's findings of fact and conclusions of law, separately stated. By stipulation of all parties to such appeal proceedings, the record may be shortened. The arbitration board may require or permit subsequent corrections or additions to the record. Within thirty days of the filing of the record, the department shall file its memorandum in response.

(Effective June 2, 1986)

**Sec. 17-311-110. Appointment of arbitrators by the parties**

Each of the parties shall file the name of the person which the provider and the commissioner has designated as the arbitrator. Each of the parties will file together with the name of the arbitrator a request to the chief court administrator for the designation of a state referee as the third arbitrator. The chief court administrator shall appoint from a panel of referees designated by the chief court administrator one arbitrator to serve as the third member of the panel, provided that the appointment shall be made no later than thirty days from the receipt of a copy of the request for arbitration as described above.

(Effective June 2, 1986)

**Sec. 17-311-111. Appointment of arbitrator; qualifications**

The chief court administrator may appoint one or more state referees as permanent arbitrators to serve in the arbitration of disputes referred to arbitration panels in accordance with the procedure set forth herein. The provider and the commissioner shall be required to name persons as their choice for their representative arbitrator who have had knowledge of the matters which are the subject of the arbitration issues. The commissioner may not serve as arbitrator.

(Effective June 2, 1986)

**Sec. 17-311-112. Scope of review**

The arbitration board shall confine itself to a review of the record. The arbitration board shall not substitute its judgment for that of the department as to the weight of the evidence on questions of fact. The arbitration board may affirm the decision of the department or remand the case to the department to reopen the rehearing. The arbitration board may reverse the department's rehearing decision and remand it to the department for a new rehearing if substantial rights of the provider have been prejudiced because the administrative findings, inferences, conclusions, or decisions are: 1. In violation of constitutional or statutory provisions; 2. In excess of the statutory authority of the agency; 3. Made upon unlawful procedure; 4. Affected by other error of law; 5. Clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; 6. Arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

(Effective June 2, 1986)

**Sec. 17-311-113. Oral argument; time and place; adjournment**

The arbitrators shall appoint a time and place for oral argument based on the record and notify the parties thereof and, on application of either party and for good cause shown, shall postpone the time of the oral argument. They may also adjourn the oral argument, from time to time, as may be necessary, but no postponement or adjournment shall extend the time, if any, fixed in the arbitration agreement or by these rules for rendering the review of the record decision.

(Effective June 2, 1986)

**Sec. 17-311-114. Stay of department rehearing decision pending arbitration board's review of the record**

The institution of the arbitration proceeding pursuant to these regulations shall not of itself stay enforcement of the department's rehearing decision. The department, or the arbitration board, may order a stay upon appropriate terms in its discretion.

(Effective June 2, 1986)

**Sec. 17-311-115. Representation by counsel**

Either party may be represented in the arbitration proceeding by counsel or by other authorized representatives.

(Effective June 2, 1986)

**Sec. 17-311-116. Stenographic record**

Whenever a stenographic record is requested by one or more parties, the arbitration panel will arrange for a stenographer. The total cost of the transcript shall be paid by the requesting party.

(Effective June 2, 1986)

**Sec. 17-311-117. Attendance at hearings**

Persons having a direct interest in the arbitration, including representatives of certified collective bargaining agents at the institution are entitled to attend and observe arbitration proceedings.

(Effective June 2, 1986)

**Sec. 17-311-118. Majority decision**

All decisions of the arbitrators shall be by majority vote.

(Effective June 2, 1986)

**Sec. 17-311-119. Subsequent court proceedings**

The provisions of section 52-417 through section 52-424, inclusive, are herewith incorporated by reference as if fully set forth for the purpose of governing any judicial proceedings subsequent to the entry of the final decision based upon review of the rehearing record by the arbitration board.

(Effective June 2, 1986)

**Sec. 17-311-120. Aggrieved provider's choice of remedy to contest Sec. 17-311 (b) final administrative rate rehearing decision**

As an alternative remedy to the arbitration process set forth in Sec. 17-311-107 to Sec. 17-311-119 supra, a provider aggrieved by a final decision of the commissioner pursuant to a rate rehearing conducted pursuant to the provisions of Sec. 17-311 (b) as a contested case in accordance with the provisions of Sec. 4-177 et seq. of the Connecticut General Statutes may pursue its administrative appeal in the Connecticut Superior Court pursuant to the provisions of Sec. 4-183 Conn. Gen. Stat. The provider will not be required to pursue the arbitration process included herein as a remedy available within the agency for the purposes of exhaustion of administrative remedies but may proceed, subsequent to the final rate rehearing decision pursuant to Sec. 17-311 (b) to the superior court. The filing of an administrative appeal without the pursuit of the arbitration process available herein shall not be the ground of objection to said administrative appeal by the department. When a provider elects to invoke this subsection and bring a Sec. 4-183 appeal of Sec. 17-311 (b) rate rehearing final decision directly to the Connecticut superior court, the provider waives any right to simultaneously or subsequently initiate the aforesaid arbitration process to appeal said Sec. 17-311 (b) rate rehearing final decision. Likewise, when the provider elects to initiate the aforesaid arbitration process to appeal a Sec. 17-311 (b) rate rehearing final decision, the provider waives any right to simultaneously or subsequently bring a Sec. 4-183 appeal of said Sec. 17-311 (b) rate rehearing final decision.

(Effective June 2, 1986)

**Secs. 17-311-121—17-311-126.**

Repealed, June 2, 1986.

**Secs. 17-311-127—17-311-159. Reserved****Self-pay Charges for Patients in Long-Term Care Health Facilities****Sec. 17-311-160. Maximum allowable charges to self-pay patients**

(a) Effective July 1, 1980, and annually thereafter, the Commissioner of Income Maintenance (hereinafter referred to as Commissioner) shall authorize the maximum allowable charges to self-pay patients (hereinafter referred to as self-pay charges) for routine services as defined in Section 17-311-161 below in private and semi-private accommodations of licensed chronic and convalescent hospitals, rest homes with nursing supervision and licensed homes for the aged, as defined in Section 19-576 of the general statutes (hereinafter referred to as facilities). The self-pay charges shall be determined on the basis of the cost related reimbursement system used for determining per diem rates of payment to long-term care facilities in the State of Connecticut as set forth in Section 17-311-50 through Section 17-311-57 of these regulations, (hereinafter referred to as State rates), except as prescribed by the regulations below.

(b) Notwithstanding section 17-311-161 below, self-pay charges authorized by the commissioner may not be less than the state rates established for each facility. Therefore, a facility must increase its self-pay charge to the state rate or the state rate shall be lowered to the self-pay charge.

(c) Self-pay charges determined pursuant to the regulations herein shall be deemed to constitute reimbursement for all reasonable costs related to patient care plus a profit or an operating surplus and a fair rate of return on invested capital or equity. Therefore, no request for an increase, except as provided in section 17-311-167 shall be heard by the commissioner.

(d) No facility may charge its self-pay patients more than permitted by emergency regulation 17-311-159 until the July 1, 1980 self-pay charges become effective.

(Effective March 17, 1983)

**Sec. 17-311-161. Self-pay charges for routine services**

Self-pay charges for routine services shall be established for each facility individually and for each level of care provided by such facility in accordance with the following method:

(a) Routine services means the per diem charge by a nursing home for services and items includable in the facility's state rate calculated for purposes of Section 17-311-161 (b) (1) and shall include but not be limited to room accommodations, nursing care rendered by non-private duty nursing personnel, food, institutional laundry services, housekeeping services, services related to the use and maintenance of real property, social and recreation services, and all other allied and customary services offered pursuant to an express or implied agreement between the provider and the patient. Routine services shall not include those services defined below as ancillary services. Other than by charging up to the maximum allowable self-pay rates determined by the commissioner, under no circumstances shall a facility impose any additional charge upon any of its self-pay patients for any routine services.

(b) The Commissioner shall determine once during the period no less than thirty nor more than ninety days prior to the effective date of each new rate year the statewide median medicaid or public assistance rate for patients cared for by the

State of Connecticut at each level of care, e.g., chronic and convalescent hospital, rest home with nursing supervision, and homes for the aged. Once such median for a new rate year is computed, it shall not be subsequently recomputed. The self-pay charge that may be imposed by each facility for routine services for each level of care shall be computed by adding:

- (1) The facility's state rate as calculated for the purposes of these regulations, and
- (2) The amount derived by applying the specific percentages of the statewide median state rate for each level of care (expressed in dollars and cents rounded to the nearest whole cent), as set forth in the schedule below:

<u>Room Accommodations</u>	<u>Percentage to be applied to Statewide Median State Rate</u>
Private (one patient in a room)	50%
Semi-Private (two patients in a room)	25%
Semi-Private (three or more patients in a room)	12%

Except that the commissioner has the discretion to promulgate a self-pay rate to be charged to a patient who at the patient's request enters into a contract with a facility for special accommodations larger than the facility's private (one patient to a room) accommodation.

(c) The self-pay charges for those facilities which charge a uniform single rate for a given level of care regardless of room accommodation shall be determined using a weighted bed average as follows: multiply the maximum allowable self-pay charges as computed in accordance with subsection (b) above by the number of beds in each class of room accommodation, and divide the total of these products by the total number of licensed beds available for use in the level of care.

(d) For purposes of determining self-pay charges the provisions of section 17-311-52(4) and 17-311-52(13) shall not apply.

(e) The calculation of self-pay charges shall be predicated upon the provision of all services including those necessary to provide an adequate level of quality of care. If the commissioner finds after a formal administrative hearing that a facility has not provided an adequate level of quality of care;

(1) The Commissioner shall not include in the state rates any cost efficiency adjustment pursuant to section 17-311-52 in the computation of the self-pay charges.

(2) Self-pay charges shall not be greater than self-pay charges for the previous rate year except as required by section 17-311-160 above.

The commissioner has the discretion to refer quality of care complaints and issues to the department of health services for investigation and either appropriate action by said agency or recommendations to the department of income maintenance.

(f) For the purposes of computing self-pay charges for the rate year beginning July 1, 1980, for those facilities which do not have a state rate, the dollar amounts used in subsection (b) (2) above shall be added to the facility's existing legal self-pay charge for each type of accommodation and level of care. In subsequent years, the facility shall file an annual report pursuant to section 17-311-168 and state rates shall be computed in accordance with the cost related reimbursement system as the basis for computing the self-pay charges.

(g) In the event that the increase permitted pursuant to subsection (b) above, is less than 104% of the previously approved self-pay charge, the self-pay charge may be increased to 104% of the previously approved self-pay charge, except as provided in section 17-311-163.

(h) In no event shall the self-pay charge computed pursuant to subsection (b) above be permitted to exceed 124% of the previously approved self-pay charge except as required by section 17-311-160 (b).

(i) For purposes of computing a facility's maximum allowable self-pay charges only, the commissioner shall include as a factor in such computations past self-pay rate adjustments in favor of the provider resulting from field audit adjustments or adjustments pursuant to Sec. 17-311-52 (p) (Gross National Product deflator adjustments) which constituted uncollectable retroactive self-pay rate increases due to the thirty day notice of self-pay rate increase requirement of Conn. Gen. Stat. Sec. 17-314a. This subsection shall apply to all such field audit adjustments in favor of the provider and Sec. 17-311-52 (p) adjustments in favor of the provider for periods subsequent to the effective date of this subsection.

(Effective June 2, 1986)

### **Sec. 17-311-162. Self-pay charges for ancillary services**

(a) Ancillary services means those charges to patients which are directly identifiable as customary medical services rendered to individual patients, and furnished at the direction of a physician because of specific medical need and are either not reusable or represent a cost for each preparation (e.g., physical therapy, speech therapy, catheters, colostomy bags, prosthetic devices, and all other similar services or devices), provided that with respect to services, such services are rendered by employees of the Facility. Services rendered by outside consultants or independent contractors who establish and determine the charges to the patient for such services, and to which charges the facility does not add a mark-up for overhead or profit, shall not be considered ancillary services for the purposes of this regulation. Ancillary services shall not be construed to include any good or service for which the department reimburses a facility in the medicaid rate for the care of Title XIX patients.

(b) Effective July 1, 1980, self-pay charges for ancillary services shall be the ancillary charges in effect on December 1, 1979 increased by the percentage factor used in section 17-311-161 (b) for semi-private 2-bed room accommodations. Thereafter, for each ensuing rate year, self-pay charges for ancillary services shall be the prior year's self-pay charges for ancillary services increased by the percentage factor used in section 17-311-161 (b) for semi-private 2-bed room accommodations. Each self-pay patient shall receive an itemized statement of the ancillary services for which the patient is charged. Effective with the rate year commencing July 1, 1986, self-pay charges for ancillary services shall be the ancillary charges in effect on July 1, 1985 increased by the percentage factor by which the facility's self-pay rates for semi-private 2-bed room accommodations increased from the preceding rate year. Thereafter, for each ensuing rate year, self-pay charges for ancillary charges shall be the ancillary charges in effect on June 30 of the preceding rate year increased by the percentage factor by which the facility's self-pay rates for semi-private 2-bed room accommodations increased from the preceding rate year.

(Effective June 2, 1986)

### **Sec. 17-311-163. Unauthorized charges to self-pay patients**

(a) Any facility which is found by the commissioner to have overcharged its self-pay patients, is issued a demand by the commissioner pursuant to subsection (c), and fails to rectify its violation upon demand by the commissioner, shall not be permitted any increase pursuant to Section 17-311-161 of these regulations.

(b) Any facility which charges a self-pay patient or the self-pay patient's legal guardian or conservator an amount greater than that permitted by the commissioner

shall either refund the excess amount paid or credit the account of the self-pay patient for the excess amount paid. In the event that the full amount of the overcharge cannot be returned to the patient through the use of the credit, the remaining amount of the overcharge shall be refunded to the patient, the patient's legal guardian or conservator, of his/her estate.

(c) If the Commissioner is notified that a facility has failed to meet the obligations of subsection (b), he shall cause the matter to be investigated for verification of the overcharges. If an overcharge is found to have been made, he shall make demand upon the facility in writing by certified mail demanding that the facility comply with the requirements of subsection (b). If after thirty-one (31) days, the facility has not complied with the demand made by the Commissioner of Income Maintenance, the matter shall be referred to the Office of the attorney general for enforcement of the rate determination pursuant to subsection (e) of section 17-314a of the Connecticut General Statutes.

(Effective June 2, 1986)

### **Sec. 17-311-164. Field audit and other rate adjustments**

(a) Every facility for which self-pay charges are established may be audited as deemed necessary by the commissioner. Therefore, each facility shall maintain all supporting expenditure records up-to-date and available for review for a minimum period of ten years from date of previous audit, regardless whether the facility has changed ownership or not.

(b) In the event that a recomputation of a facility's state rate due to field audits or otherwise requires a change in a state rate which has served as the basis for a prior computation of the facility's self-pay charges, the self-pay charges shall be recomputed. However the recomputation shall only be implemented retroactively if it constitutes a downward self-pay rate adjustment. Increases in self-pay rate may only be implemented after all self-pay patients in the facility have been given notice of the rate increase, as determined by the commissioner, at least thirty days prior to the effective date of such rate increase. The facility shall be required to make appropriate refund as provided in section 17-311-163 (b).

(Effective June 2, 1986)

### **Sec. 17-311-165. Hearings**

(a) Prior to the setting of the self-pay charges on July 1 each year, the Commissioner shall hold public hearings at various locations around the state after first giving notice as provided hereinafter. The Commissioner shall publish a notice of the hearing in the Connecticut Law Journal, mail a notice to the Commissioner on Aging and the Commissioner of Health Services and to all facilities for which he established rates pursuant to Section 17-314a, announcing the date, time, place and purpose of the hearing. Each facility shall post such notice in a place conspicuous to the patients within the facility and each facility shall provide copies of the notice immediately to the residents of the facility or to their legal guardians or conservators.

(b) At the public hearing, in addition to any matters relevant to rate setting, the commissioner shall receive any complaint of alleged overcharges of self-pay patients, or violations of state or federal law which allegedly occurred within the past twelve months relating to the quality of patient care provided by a facility. A transcript of the hearing shall be made and a copy shall be given to the commissioner of the department of health services or his designee for appropriate review and/or investigation by that department.

(Effective June 2, 1986)

**Sec. 17-311-166. Notification and hearings**

(a) The commissioner shall send a notice by mail to each facility, informing the facility of the commissioner's decision with respect to the self-pay charges approved, and the percentage of increase approved for self-pay charges for ancillary services for the prospective fiscal year beginning July 1st. Immediately upon receipt of the self-pay charges decision, each facility shall provide a written notice of the decision to any self-pay patient affected, or to his guardian or conservator. Any facility, self-pay patient, or the guardian or conservator of a self-pay patient, aggrieved by the decision with respect to the self-pay charges, may obtain by request in writing to the commissioner, a hearing with respect to the self-pay charges decision, provided that such written request is made not later than ten (10) days after the date that the written notice of the decision is provided by the commissioner to the facility.

(b) Notices shall be sent by the facility by regular mail, postage prepaid, to the last known address of the self-pay patient, guardian, or conservator, and the facility shall certify to the commissioner the date upon which the notices were mailed to the self-pay patients.

(c) Notices sent by the facility to self-pay patients, guardians, or conservators regarding the self-pay charges established by the commissioner must contain the following information:

(1) The self-pay charge established by the commissioner for the level of care and type of room occupied by the patient.

(2) The date of the decision by the commissioner.

(3) The manner in which the patient, guardian or conservator may contest the self-pay charge, i.e., by mailing to the commissioner a written request for a hearing within ten days of the date of the decision by the commissioner.

(4) The address of the commissioner.

(d) Upon the receipt of a request for a hearing with respect to the self-pay charges, the Commissioner shall schedule a hearing in accordance with the provisions of sections 4-177 to 4-181, inclusive, and in accordance with section 17-311-27 through 17-311-40 of the rules of practice of the Commissioner. The hearing shall be held as soon as practicable after the receipt of such request by the Commissioner. The Commissioner shall provide notice to the facility of the date, time and place of the self-pay rate hearing. The facility must provide written notice, postage prepaid, of such date, time and place of the self-pay hearing to the last known address of any self-pay patient affected or to his guardian or conservator. The facility must also conspicuously post such notice on its premises. Failure of the facility to provide such notice to its self-pay patients shall constitute cause for a default of the facility at the self-pay rate hearing.

(e) The Commissioner shall proceed with reasonable dispatch to conclude the hearing pending before him with respect to the establishment of the self-pay charges and shall render final decision not later than ninety days following the close of the hearing, the filing of the briefs, the filing of late file exhibits, or the receipt by the department of the hearing transcript, whichever last occurs.

(f) Pursuant to any hearing with respect to self-pay charges requested by a patient, guardian, or conservator, the facility, pending receipt of the commissioner's final decision, shall be permitted to charge and collect any amounts equal to or less than the self-pay charges established by the commissioner. If the present self-pay charge is greater than the self-pay charge established by the commissioner for the prior fiscal year, the facility shall escrow 20% of the difference, of the aggrieved patient's charges.

(g) Any final decision rendered by the commissioner pursuant to any hearing with respect to establishing self-pay charges requested by a patient, guardian or conservator, shall apply to all other similarly situated self-pay patients.

(Effective June 2, 1986)

### **Sec. 17-311-167. Requests for increases in self-pay charges**

(a) In the event of any unforeseen or material change in circumstances, a facility may submit an application for an increase in the self-pay charges established by the commissioner pursuant to the procedure set forth in section 17-311-160 through 17-311-163, supra, by making application for permission to impose charges to self-pay patients in excess of the authorized self-pay charges. Such application must clearly set forth that the application is made pursuant to subsection 1 (c) of Public Act 79-182.

(b) In reviewing and evaluating a facility's request for permission to impose self-pay charges in excess of those authorized by the commissioner pursuant to section 17-311-160, et seq. supra, whenever applicable the commissioner shall consider, but not be limited to, the following:

(1) The cost impact of compliance with any statute, regulation, ordinance, or tax, lawfully promulgated or imposed by any federal, state or local governmental authority having jurisdiction over the operations of the facility, including but not limited to increases in local real estate taxes and changes in the public health code mandated by the Connecticut department of health services;

(2) Changes in the level of care provided by the facility;

(3) The cost of substantial additions, renovations, and improvements to real property not included in the cost year base data used to establish the facility's self-pay charges;

(4) Unforeseen changes in the general economy significantly affecting the system under which the state rates were determined as the basis for establishing the self-pay charges;

(5) In the case of a facility where self-pay charges were determined pursuant to section 17-311-161 (e) above, evidence from the department of health services establishing that the conditions which led to the imposition of the provisions of section 17-311-161 (e) have been remedied.

(c) The considerations set forth in subsection (b), above, shall be used by the commissioner whenever applicable to determine a facility's need for a self-pay charge in excess of the self-pay charges established annually by the commissioner, and shall not be applicable to a facility's request for an increase in its state rates.

(d) In addition to the requirements herein above stated, each rate application shall, if required by the commissioner, contain either in the statement of application or as exhibits annexed thereto and accompanying the application, data such as, but not limited to, the following:

(1) The date on which each proposed charge would become effective.

(2) The levels of care or accommodations to which each proposed charge would apply.

(3) Statements of financial operations for the prior fiscal year, the current year, and the budgeted year at the present and at the proposed charges.

(4) A schedule of existing charges in effect prior to the date of application showing actual revenues and numbers of patients and other users of the facility, categorized by rates, by classification of patient and by other appropriate classification for the periods covered by the prior year and by the current year. The schedule will show such revenues at the existing charges and budgeted at the proposed charges.

(5) Statement of the proposed increased charges or changes which will result in increased self-pay charges which the applicant proposed to make effective. Such statement shall also set forth the proposed charge structure with reasonable clarity and with appropriate rate classifications, where applicable.

(6) Actual and budgeted expenses with supporting detail set forth by the accounts affected.

(e) The applicant may file as prefiled testimony and as exhibits any data which it offers the commissioner as proof in support for the proposed rate application. Such evidence shall not be incorporated in any of the prescribed components but shall be presented separately as annexed materials and received as offers of proof to the extent such evidence is relevant to the applicant's case.

(f) The commissioner may decide on such an application with or without a hearing in accordance with section 1 (c) of Public Act 79-182.

(Effective May 15, 1980)

### **Sec. 17-311-168. Requirements for filing annual reports**

(a) All facilities having 10 or more beds must file the annual report utilized by the commissioner of income maintenance in determining rates pursuant to section 17-314 of the general statutes. This annual report must be filled out completely and filed with the commissioner no later than the 31st day of December of each year.

(b) Any facility which fails to file the annual report will not be granted an increase in its previously approved self-pay charges.

(Effective May 15, 1980)

### **Sec. 17-311-169. Self-pay charges for newly constructed or acquired facilities**

(a) Self-pay charges for newly constructed or acquired facilities shall be established in accordance with section 17-311-161 on the basis of the State rates for such facilities determined in accordance with section 17-311-55 of the regulations governing state agencies. Any facility which does not serve state patients must nevertheless provide the Commissioner with the necessary data to determine state rates, so that the state rates can be used as the basis for determining self-pay charges.

(b) At such time as the state rates for a facility are changed, the self-pay charges shall also be redetermined in accordance with section 17-311-161.

(Effective March 17, 1983)

## **Nursing Home Discrimination Against Applicants for Admission**

### **Secs. 17-311-170—17-311-199. Reserved**

### **Sec. 17-311-200. Definitions**

For purposes of the enforcement of Section 19a-533 of the General Statutes of Connecticut, and as implemented by Sections 17-311-200 through 17-311-209 of the Regulations of Connecticut State Agencies, the following definitions shall apply:

(a) "nursing home" means any chronic disease hospital, chronic and convalescent facility or any rest home with nursing supervision, as defined by section 19a-521, which has a provider agreement with the Department of Income Maintenance to provide services to recipients of medical assistance pursuant to Part IV of chapter 302 of the Connecticut General Statutes and to accept reimbursement for the cost of such services pursuant to said program, or which receives payment from the state for rendering care to indigent persons.

(b) “indigent person” means any person who is eligible for or who is receiving medical assistance benefits from the state or general assistance benefits from a town;

(c) “applicant for admission” means any person who either himself or through any representative, including but not limited to his guardian, conservator, family member, physician, social worker or discharge planner, indicates a desire to the nursing home to be admitted into such nursing home.

Such indication of desire for admission to the nursing home may be communicated to the facility by a person or his representative in person, by mail or by telephone. Nursing homes may not restrict applicant for admission status to those persons who have personally visited the facility, completed and signed application forms, submitted medical, social or financial information, or in any other way not expressly permitted by this section.

(d) “dated list of applications” shall constitute an inquiry list, i.e. a chronological dated list indicating in order the name of each person who indicated a desire to the nursing home to be admitted into such nursing home as indicated in subsection (c) above.

(e) “waiting list” shall constitute a chronological list of persons who have substantially completed and returned to the nursing home the written application for admission. The names of such persons shall appear on the waiting list in the order in which such persons return their substantially completed applications to the facility.

(Effective October 1, 1988)

#### **Sec. 17-311-201. Prohibition of discrimination against indigent applicants**

A nursing home which receives payment from the state for rendering care to indigent persons shall be prohibited from discriminating against indigent persons who apply for admission to such facility on the basis of source of payment.

(Effective October 1, 1988)

#### **Sec. 17-311-202. Admission in order of application of all applicants**

A nursing home which receives payment from the state for rendering care to indigent persons shall admit all applicants for admission to such facility (i.e. indigents, Self-Pay, Medicare, V.A., etc.) in the order in which such applicants appear on the waiting list, unless a statute or regulation otherwise provides.

(Effective October 1, 1988)

#### **Sec. 17-311-203. Provision of receipts**

Each nursing home shall provide a receipt to all applicants for admission as defined *supra*. Nursing homes shall ask all applicants whether they desire to receive a receipt and be placed on the dated list of applicants at such time as the applicant indicates a desire to be admitted into such nursing home. Receipts shall be provided to applicants stating the date and time of the aforesaid initial contact of the nursing home by the applicant or his representative. Each receipt shall be consecutively numbered and shall state the name and address of the applicant for admission and the date and time of such application. Receipts shall be provided immediately to a person or his representative who personally appeared at the facility or mailed within two business days to a person or his representative who applied to the facility by mail or by telephone. Facilities may require that requests for receipts and the issuance thereof be effected during normal business hours, provided that such requirement is applied to all applicants for admission in a non-discriminatory manner.

(Effective October 1, 1988)

**Sec. 17-311-204. Maintenance of dated list of applications**

When a person indicates a desire to be admitted into a nursing home, his name shall be placed immediately on the facility's dated list of applications. Such dated list of applications shall be in a bound volume and shall be in the chronological order in which persons contacted the facility and indicated a desire to be admitted with the date and time of initial contact indicated by the person's name.

(Effective October 1, 1988)

**Sec. 17-311-205. Mailing of written application to persons on dated list of applications**

(a) Within two (2) business days after such initial contact, the facility shall mail its written application form to such person or his representative. At the beginning of the front page of such written application the following wording shall appear in capital letters in bold face type and/or underlined:

**YOU HAVE CONTACTED THIS NURSING HOME AND INDICATED A DESIRE TO BE ADMITTED AS A PATIENT TO THIS FACILITY. BECAUSE OF THIS, YOU HAVE ALREADY BEEN ISSUED A RECEIPT INDICATING THE DATE AND TIME OF YOUR INITIAL REQUEST AND YOUR NAME HAS BEEN PLACED ON OUR DATED LIST OF APPLICATIONS OR INQUIRY LIST.**

**PLEASE FIND ENCLOSED THIS FACILITY'S WRITTEN APPLICATION FORM. AS SOON AS YOU SUBSTANTIALLY COMPLETE AND RETURN THE FORM TO THE FACILITY, YOUR NAME WILL BE PLACED ON OUR WAITING LIST FOR ADMISSION TO THE FACILITY. YOUR NAME WILL ONLY BE PLACED ON OUR WAITING LIST AFTER YOU SUBSTANTIALLY COMPLETE AND RETURN THIS WRITTEN APPLICATION FORM TO US.**

(b) In determining whether a returned written application is "substantially complete," a nursing home may not reject as incomplete a written application when said facility has accepted as "substantially complete" other written applications which are equal to or lesser than the rejected written application in their completeness.

(Effective October 1, 1988)

**Sec. 17-311-206. Maintenance of a waiting list**

(a) Each nursing home shall maintain a "waiting list for admission" which shall constitute a single, bound volume of the names of persons who have substantially completed and returned to the facility the written application form. Looseleaf binders, or any other volume which is subject to additions, deletions or other changes, shall not constitute compliance with this requirement. Once an applicant's name is placed on the waiting list for admission, said name may not be removed until such person has been admitted to the nursing home, such person expires, or such person or his representative gives the nursing home written notice of the withdrawal of the application, or pursuant to subsection (b) of this section.

An offer to admit an applicant on a specific day which is refused by the applicant shall not justify the deletion of the applicant's name from the waiting list. Whenever a nursing home passes over the name of an applicant on its waiting list and admits

another, a dated notation must be made on the waiting list indicating why such applicant was not admitted and supporting documentation of the reason must be maintained and readily available.

Nursing homes shall inform an applicant for admission of his/her place on the waiting list whenever the applicant requests such information during normal business hours.

(b) If a nursing home desires to remove an applicant's name from its waiting list who is unresponsive to facility telephone calls and letters, the nursing home may no sooner than 120 days after initial placement of the person's name on its waiting list inquire by letter to such applicant as to whether or not he desires continuation of his name on the waiting list. If such applicant does not respond to such letter and at least an additional 120 days pass, the facility may send a second such letter. If such applicant still does not respond and at least an additional 30 days pass, the facility may remove such applicant's name from its waiting list.

(Effective October 1, 1988)

### **Sec. 17-311-207. Daily logs**

Each nursing home shall maintain a "daily log" in a single bound volume for each calendar year which must be completed on a daily basis by indicating, for each day, the number of applications for admission, the number of indigent persons applying for admission, the number of vacancies, the number of persons admitted to the facility and the number of indigent persons admitted to the facility, and the number of individuals readmitted to the nursing home after a period of hospitalization. Daily logs for the last three calendar years shall be maintained in a single location in the nursing home. Looseleaf binders, or any other volume which is subject to additions, deletions or other changes, shall not constitute compliance with this requirement.

(Effective October 1, 1988)

### **Sec. 17-311-208. Enforcement of statute regardless of intervening change in ownership**

Since, as per Conn. Gen. Stat. § 19a-533 (d) statutory rate sanctions apply to the rate year resulting from the cost report for the twelve month fiscal year during which violations of the statute took place, Conn. Gen. Stat. § 19a-533 rate sanctions are part of the rate history of a nursing home into which a buyer steps. Therefore, such rate sanctions shall be implemented regardless of any intervening change in ownership.

(Effective October 1, 1988)

### **Sec. 17-311-209. Admissions**

(a) Nursing homes may not discriminate against indigent persons and shall admit all applicants for admission in the order in which the names of such applicants appear on the waiting list, except as otherwise provided by statute or these regulations.

(b) A facility may admit applicants other than in the order in which their names appear on the waiting list, provided that the following exceptions are uniformly and consistently applied without regard to source of payment, only if:

(1) An applicant has yet to provide medical, social or financial information requisite to determine the individual's eligibility for admission provided that the nursing home had previously notified the applicant what specific medical, social and financial information was required and can document such notification. In such case, a dated notation must be made on the waiting list.

(2) An applicant for admission fails to meet the applicable level of care requirements contained in the Public Health Code, Reg. Ct. St. Ag. § 19-13-D8T (d) (1) (A), and/or the applicant requires care or services without which the patient is at risk which the facility is unable to provide as certified by its Medical Director in accordance with Reg. Ct. St. Ag. § 19-13-D8T (h) (2) (D) and 19-13-D8T (i) (4) (D) (iii). It shall constitute unlawful discrimination forbidden by this section, however, if a nursing home fails to properly and consistently apply the applicable level of care requirements or if it improperly determines that the applicant requires care or services beyond its capability as set forth *supra*, having the effect of denying admission of an indigent person to the nursing home.

(3) A person had previously been a resident of a nursing home who was absent from the nursing home for a reason of hospitalization and is entitled to priority admission as per Conn. Gen. Stat. § 19a-537. Any person so admitted shall have a notation to that effect made on the daily log.

(4) Transfers of patients from one level of care to another within a facility licensed to offer more than one level of care, i.e., chronic disease hospital, chronic and convalescent nursing home, rest home with nursing supervision, home for the aged, are not subject to the provisions of Conn. Gen. Stat. § 19a-533 or these regulations, provided that such intrafacility transfers are for bona fide medical reasons.

(5) The nursing home admits a patient who has been determined by an appropriate state agency to be in need of protective services and is referred to the facility for admission by an appropriate state agency pursuant to the provisions of Conn. Gen. Stat. § 46a-14 *et seq.*

(6) Due to decertification or license revocation of another facility or some other public health reason, the Commissioner of Health Services or his representative refers a patient to the facility.

(7) The nursing home has been granted permission by the Connecticut Commission on Hospitals and Health Care to withdraw from the Medicaid program by terminating its provider agreement pursuant to the provisions of Conn. Gen. Stat. § 19a-154. In order to be excused from the admission requirements of this section, the facility must comply with the terms and conditions of any order entered by the Commission allowing a withdrawal from the program by appropriate discharge and transfer of all Medicaid patients provided that any withdrawal from the Medicaid program must be accomplished within (3) months of the order granting permission to withdraw, unless the order of the Commission allows the facility more than three months to withdraw from the program, except that if the Medical Director of the nursing home certifies that specific Medicaid patient(s) would suffer serious harm as a result of a discharge or transfer, the Department of Income Maintenance, may, if it concurs with the determination of the facility's Medical Director, enter into a limited provider agreement with the facility covering only such patients—which will otherwise excuse the facility from complying with the admission requirements of this section.

(8) The applicant (A) has entered into a continuing care contract in accordance with Conn. Gen. Stat. § 17-535 and regulations promulgated thereunder, and is a resident of a continuing care facility that provides for care to be given by the nursing home; or (B) resides in a residential facility for the elderly that offers meals, and some combination of housekeeping, emergency medical call systems and other social supports, and two or more health-related benefits in addition to shelter and is controlled, owned or operated by the owner or operator of a nursing home which is located on the same or an adjacent site or in the immediate geographic proximity.

Health-related benefits include priority access to the nursing home without regard to source of payment, health care provided by a nursing home or by a home-health agency as defined in Conn. Gen. Stat. § 19a-490, or the services of any licensed health professional on a regular, ongoing basis, either on staff or on contract.

(9) A designated number of beds set aside for respite care with a maximum stay of 30 consecutive days with such applicants admitted in the order in which their names appear on the waiting list;

(10) A designated number of beds set aside for short term rehabilitation with a 90 day maximum stay with such applicants admitted in the order in which their names appear on the waiting list;

(11) A designated number of beds set aside for the terminally ill with applicants in such condition accepted in the order in which their names appear on the waiting list;

(12) A designated number of beds in a specialized unit (e.g. Alzheimer's Unit, TBI Unit) and applicants with that condition accepted in the order in which their names appear on the waiting list;

(13) A spouse of the applicant is a patient in the nursing home;

(14) The applicant was discharged from the nursing home to the community within fifteen days of his/her request for readmission;

(15) A municipally owned and operated facility with residency requirement with resident applicants admitted in the order in which their names appear on the waiting list;

(16) The facility offers any of the following specialized medical treatments: nasogastric tubes with pump, respiratory therapy with or without a ventilator or other specialized tracheostomy care, intravenous therapy including hyperalimentation, Clinitron-type beds, Hubbard-type tanks, provided that patients in need of the treatment(s) are admitted in the order in which their names appear on the waiting list. A facility offering any such treatment shall designate a maximum number of beds for which such treatments will be offered;

(17) The facility is owned or operated by a religious organization exempt from taxation for federal income tax purposes which exists to provide long term care to members of its religion provided that all applicants who are members of such religion are admitted in their order of application without regard to their source of payment and without regard to any other factor including but not limited to either their own or their families' past financial contributions and/or volunteer efforts to such religion and/or its related organizations.

(18) The facility is owned, operated by or affiliated with a fraternal organization exempt from taxation for federal income tax purposes which exists to provide long term care to members of its fraternal organization provided that all applicants who are members of such fraternal organization are admitted in the order of application without regard to their source of payment and without regard to any other factor including but not limited to either their own or their families' past financial contributions and/or volunteer efforts to such fraternal organization and/or its related organizations.

(19) The facility is owned or operated by a non-stock, non-profit corporation exempt from taxation for federal income tax purposes which (1) provides now and provided in its original charter or certificate of incorporation that it is established for the benefit of the municipality in which it is located, and (2) receives financial assistance through grants or donations from the municipality in which it is located and/or the residents thereof, provided that all applicants who are residents of such municipality are admitted in the order of application without regard to their source

of payment and without regard to any other factor including but not limited to either their own or their families' past financial contributions and/or volunteer efforts to such facility and/or its related organizations.

(20) The nursing home has entered into a contract or contracts with a hospital or hospitals pursuant to which patients to be discharged from the hospital are given priority in admission to no more than fifteen percent of the nursing home's beds as such beds become vacant, with said fifteen percent limitation referring to all such contracts combined. Such contracts may only be entered into when the municipality in which the nursing home is located is within forty (40) miles of the hospital. Such agreements shall provide that patients shall be referred by the hospital to the nursing home in the order in which such patients are medically ready for discharge without regard to their source of payment. Once a nursing home admits a patient pursuant to this subsection, it may not accept any payment in excess of the Title XIX Medicaid rate in the case of a Medicaid patient and it may not accept any payment in excess of the facility's applicable maximum allowable self-pay rate in the case of a private-pay patient. Whenever a nursing home has a vacant bed and the hospital does not have a patient to be referred pursuant to this subsection, the nursing home must immediately fill such vacancy from its waiting list for admission, provided that if the hospital has identified a patient whose discharge will be completed within four working days, the nursing home may hold the bed for this period under arrangement with the hospital.

(Effective March 28, 1990)



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**Title XIX Payments to Hospitals, Including Principles of  
Hospital Cost Reimbursement and Rates of Payment  
for Administratively Necessary Days**

**Sec. 17-312-101. Principles to be used in computing rates**

The principles of hospital cost reimbursement to be used in computing rates pursuant to Section 17-312 (a), (b) and (c) shall be those set forth in Title XVIII of the Social Security Act as amended by Public Law 97-248 i.e., "Medicare" principles as they existed for retrospective reasonable cost reimbursement.

(Effective March 7, 1986)

**Sec. 17-312-102. General reimbursement policy**

The Department of Income Maintenance (hereinafter the Department) will reimburse inpatient acute care services in accordance with rules set forth herein.

**Definitions.**

- (a) "Admissions" means the same volume of treatment defined as discharges.
- (b) "Discharge" means any patient who was discharged at a date subsequent to the date admitted to the hospital for treatment as an inpatient, except that it shall also mean such patient admitted and discharged on the same day where such patient:
  - (1) died, or
  - (2) left against medical advice.
- (c) "Final adjusted target rate" means the total allowable cost per discharge including routine and ancillary costs as set forth in the Medicare Principles of Reimbursement net of excludable costs which are defined in Section 17-312-105 (d) of the regulations.
- (d) "Fiscal year" means the hospital fiscal year commencing on October 1 and ending on September 30.
- (e) "Hospital" means a hospital included within the definition of health care facilities or institutions under section 19a-145 of the General Statutes and licensed as a short-term general hospital by the Department of Health Services but shall not include a short-term children's general hospital. A hospital included within the definition of health care facilities or institutions under said section but licensed as a mental health facility shall be included within the definition of hospital under this subsection at such time as such hospital is covered by the Medicare prospective payment system.
- (f) "Medicaid" refers to medical assistance provided pursuant to chapters 302 and 308 of the General Statutes and Title XIX of the Social Security Act.
- (g) "Medicare" refers to Title XVIII of the Social Security Act and to the regulations established pursuant to Title XVIII.
- (h) "Medicare Principles of Reimbursement" refers to Title 42 of the Code of Federal Regulations (CFR), subchapter B, Part 405, subpart D and, as may hereafter be amended.
- (i) "Rate year" means the fiscal year beginning October 1, for which the hospital's Medicaid reimbursement level is being established.
- (j) "Prior year" means the most recently completed fiscal year.
- (k) "TEFRA allowed amounts" means the amounts allowable under the Federal Tax Equity and Fiscal Responsibility Act of 1983.
- (l) "TEFRA base year" means the hospital's fiscal year ending in calendar year 1982.
- (m) "Rate Period" means the fiscal year that an interim per diem rate is determined.

(n) “Interim Per Diem Rate” means the rate as calculated pursuant to Section 17-312-103 (a).

(Effective January 19, 1988)

**Sec. 17-312-103. Medicaid interim per diem rate**

**(a) Interim Rate Computation**

The Department will reimburse inpatient acute care services based on an interim per diem rate subject to cost settlement per Section 17-312-104 (b) of these regulations.

(b) The interim rate is calculated for each hospital as follows:

The target amount per discharge from the most recently filed cost report will be increased by the estimated TEFRA update factors from the cost report period to the interim rate period. The product will be the rate period estimated target amount per discharge.

The Department will divide the estimated target amount per discharge by the average length of stay as calculated from the most recently filed cost report to determine an interim per diem rate of payment. To this quotient will be added the estimated per diem costs of those items excludable from the TEFRA calculation as defined in Section 17-312-105 (d) of these regulations. The sum of this calculation is the Medicaid interim per diem rate.

**(c) Information and Notification**

**Information Requirements**

All hospitals must provide adequate cost data annually based on financial and statistical records for the year ending September 30. The hospital must submit a cost report each year on forms prescribed by the Department. The Department requires that these reports be completed and filed within 60 days after issuance. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting. If the filing is not done on a timely basis, the Department may withhold payment to the provider.

(Effective January 19, 1988)

**Sec. 17-312-104. Determination of TEFRA reimbursement level**

**(a) TEFRA Payment Methodology**

The Department will determine Medicaid allowable inpatient costs pursuant to TEFRA principles of reimbursement. The components of Medicaid allowable inpatient cost will be determined in the following manner:

**(1) Computation of Target Rates**

**(A) Base Costs for Computing Target Rates**

Target rates will be based on the provider’s fiscal year ending during the calendar year 1982. The Department will use the appropriate cost and statistical data from the provider’s TEFRA base year. The Department will calculate the total Medicaid allowable inpatient cost by applying Medicare Principles of Reimbursement in effect at that time. The Medicaid allowable inpatient cost is divided by the number of Medicaid discharges to produce the TEFRA base year operating cost per discharge. Hospital based physicians, capital, direct medical education, malpractice and kidney acquisition costs, as determined by using Medicare principles of reimbursement, will be excluded from this calculation. The methodology for computing the TEFRA Base Year Operating Cost per Discharge (BPOR) is defined as:

$$\text{BPOR} = \text{OC} / \text{D}$$

where: OC=Total Title XIX Inpatient Operating Cost for the TEFRA base year net of excludable cost (Form HCFA-2552, Worksheet D-1, Part II, line 56).  
D=Medicaid discharges for the hospital’s TEFRA base year.

**(B) Annual Adjustment Factor**

To compute the TEFRA allowed amount, the Department will continue to use the update factor used by Medicare to revise the yearly rates for nonparticipating PPS hospitals and units. The update factor is published annually in the Federal Register.

**(C) Computation of Hospital Target Rates**

The hospital specific final target rate will be calculated by multiplying the TEFRA Base Year Operating Cost per Discharge by the accumulated update factor from the TEFRA base year to the cost report.

**(2) Determination of Allowable Costs for the Cost Report Year**

Once the Department determines the costs which are allowable pursuant to the Medicare principles of reimbursement, the Department determines which costs are applicable to the Medicaid program. Ancillary costs are determined by a ratio of total cost to total charges factor. This ratio is applied to Medicaid charges for the various ancillary cost centers. Routine costs are determined by computing the cost per day. This amount is multiplied by the total number of Medicaid days. The total allowable cost including routine and ancillary costs net of excludable costs is then compared to the final target amount. The total allowable costs are divided by the Medicaid discharges to determine the allowable cost per discharge.

If the hospital's allowable costs per discharge is greater than their hospital specific final target rate then the Department will not consider as Medicaid allowable inpatient costs any costs above the hospital specific final target rate.

If the hospital's allowable costs per discharge is less than their hospital specific final target rate, the Department will consider the Medicaid allowable inpatient costs to be allowable costs per discharge plus (a) 50% of the difference between the allowable costs per discharge and the hospital specific final target rate, or (b) 5% of the hospital specific final target rate, whichever is less.

**(3) Determination of Total TEFRA Allowable Payments**

Total TEFRA allowable payments for the year will be based on total allowable costs, as defined to be the sum of:

(A) allowable Title XIX costs for malpractice, hospital based physicians, capital, medical education, and kidney acquisition, as set forth in Section 17-312-105 (d) and

(B) allowable inpatient routine and ancillary costs, and

(C) the allowable incentive as defined in Section 17-312-104 (2) of these regulations.

**(b) Allowed Payments under TEFRA for the Medicaid Program—Cost Settlement**

The total allowed payment under TEFRA will be the sum of all allowable costs as determined above for each hospital. The total allowed costs will be compared to the interim payments made by the Department plus other payments made on behalf of Title XIX recipients, and the amount owed to the State or to the hospital pursuant to cost settlement will be paid.

(Effective January 19, 1988)

**Sec. 17-312-105. Other related information****(a) Rebasing**

After the implementation year, the Commissioner may in his sole discretion, select a new base period using actual cost data from more recent years for prospectively determining the target rate in the event that he determines that to do so is appropriate, equitable and does not prejudice the interests of the State.

**(b) Allowable and Nonallowable Costs**

Allowable costs, nonallowable costs, and reasonableness of costs will be based on Medicare principles of reimbursement as defined in Section 17-312-102.

(c) **Reporting Year**

For the purpose of determining payment rates, the reporting year is the hospital's fiscal year.

(d) **Excludable costs**

The Department will reimburse hospitals for hospital based physicians, capital, direct medical education, malpractice, and kidney acquisition costs attributable to Medicaid based on Medicare principles of reimbursement.

(e) **Change of Ownership Resulting From a Sale or Lease**

When a sale or lease occurs, the provider's target rate basis will remain the same as before the transaction.

(f) **Retention of Records**

Each hospital will maintain financial and statistical records of the period covered by such cost reports for a period of not less than ten years following the date of submittal of the cost report to the Department. These records must be accurate and in sufficient detail to substantiate the cost data reported. The provider will make such records or copies thereof available upon demand to the Department, or its representatives.

(g) **Audits**

(1) Desk Audit

Each cost report will be subjected to a review to ensure completeness, appropriateness and accuracy.

(2) Field Audit

Field audits will be performed on a timetable determined by the Department. The purpose of the field audit of the facility's financial and statistical records is to verify that the data submitted on the cost report is accurate, complete and reasonable. The field audits are conducted in conformity with Medicare regulations and are of sufficient scope to determine that only proper items of cost applicable to the services furnished were included in the provider's calculation of its costs and to determine whether the expense attributable to such proper items of cost were accurately determined to be reasonable. Any item not supported by adequate documentation or which is found to be unallowable will be disallowed by field audit. Proper adjustments to future payments will be made to recover amounts determined by field audit to be overpayments.

(h) Whenever a Medicare cost report is reopened, the result of the reopening will be applied to the Medicaid cost report.

(i) Notwithstanding any of the above provisions, any requirements mandated by changes in Federal law applicable to the Medicaid program shall be hereby incorporated into these regulations and shall supersede any contrary provision of these regulations.

(Effective January 19, 1988)

**Sec. 17-312-106. Free-standing chronic disease hospitals with over 50% medicaid patient days**

(a) **Commission Rate Order.** A chronic disease hospital having more than an average of 50% of its inpatient days paid for by the Department may seek to obtain an adjustment of reimbursement from the Department. In order to be considered it shall submit, within thirty (30) days of the issuance of a final uncontested order by the Commission on Hospitals and Health Care (Commission) a copy of such rate

order together with a schedule of the hospital's rates and charges as filed with the Commission in compliance with such rate order.

(b) **All-Inclusive Rate.** The Commissioner may establish, based upon consideration of the Commission rate order and upon documents submitted to the Department by the hospital, and the cost elements set forth in Section 17-312 (c) of the General Statutes, and any other information the Commissioner deems appropriate, an annualized interim all-inclusive per diem rate including routine services and ancillary services, to be paid by the Department to the hospital effective with the date authorized by the Commission.

(c) **Year-end Settlement.** Each chronic disease hospital reimbursed in accordance with this section shall submit to the Department, within sixty (60) days following the end of the hospital's fiscal year, a verified complete statement of actual utilization of hospital routine and ancillary services by patients paid for by the Department. Services may be paid for based upon consideration of the rates approved by the Commission for said services and the cost elements set forth in Section 17-312 (c) of the General Statutes. Any amount owed to the Department or owing to the provider will be calculated by comparing actual routine and ancillary services utilized during the period to the interim all-inclusive per diem rate. Within sixty (60) days of receipt of the data submitted by the hospital, the Commissioner shall determine, based upon the data and upon such reviews of it as he shall deem necessary, the amount owed either by the Department to the hospital or by the hospital to the Department and shall forward to the hospital a statement reflecting that determination. That amount shall be paid within sixty (60) days of the hospital's receipt of the statement of balance owed.

(Effective April 19, 1988)

### **Sec. 17-312-107. Disproportionate share adjustment**

For purposes of this regulation, the following definitions apply:

(a) **Definitions**

(1) "Medicaid inpatient utilization"—For a hospital, the total number of its Medicaid inpatient days including newborn in a cost reporting period, divided by the total number of the hospital's inpatient days including newborn in that same period.

(2) "Low-income utilization rate"—For a hospital, the sum (expressed as a percentage) of the fraction, calculated as follows:

(A) Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from State and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient services (including the amount of such cash subsidies) in the same cost reporting period; and,

(B) The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for Medical assistance under an approved Medicaid State plan) that is, reductions in charges given to other third-party payers, such as HMOs, Medicare or Blue Cross.

(b) Effective for the fiscal year ending September 30, 1989 and subsequent fiscal years hospitals which meet at least one of the following criteria shall be eligible for a disproportionate share adjustment.

(1) A Medicaid inpatient utilization rate at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State.

(2) A low-income inpatient utilization rate exceeding 25 percent.

(c) If the hospital meets one of the criteria in subsection (b), it must also have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under the State Medicaid plan.

(d) The Department shall determine from available Medicaid cost reports which hospitals meet the criteria of subsection (b) (1). Hospitals that believe they meet the criteria of subsection (b) (2) must file with the Department by August 1st of each year their calculation that the low-income inpatient utilization rate exceeded 25 percent for the most recently completed fiscal year.

(e) In calculating interim rates pursuant to section 17-312-103 of these regulations, hospitals that qualify for a disproportionate share adjustment shall have its estimated TEFRA target amount increased by the available Medicare disproportionate share adjustment percentage as determined by the Medicare fiscal intermediary.

(f) A hospital that received an adjustment as a disproportionate share hospital in its interim per diem rate shall receive in its final target rate calculated pursuant to Section 17-312-104 of these regulations the same adjustment percentage as set forth in subsection (e) above.

(Effective June 26, 1989)

### **Secs. 17-312-108—17-312-200. Reserved**

#### **Sec. 17-312-201. Non-required acute hospital care**

For hospital patients who no longer require acute hospital care, the Department will only pay for those patients who qualify for Medicaid certified Skilled Nursing Facility or Intermediate Care Facility services at the rate established pursuant to Section 17-312-101 and specified below in Section 17-312-202 and 17-312-203.

(Effective March 7, 1986)

#### **Sec. 17-312-202. Interim rate of payment to hospitals**

As an interim rate of payment to hospitals, prior to cost settlement, the Department will pay: (1) for the first seven days of hospital care for patients who no longer require acute care, a rate which is equal to fifty percent (50%) of the hospital's interim non-intensive care per diem rate; (2) for the eighth through fourteenth day of such care a rate which is equal to seventy-five percent (75%) of the hospital's interim non-intensive care per diem rate; and (3) for days of such care after the fourteenth day a rate equal to one hundred percent (100%) of the hospital's interim non-intensive care per diem rate.

(Effective March 7, 1986)

#### **Sec. 17-312-203. Rate of payment to hospitals for cost settlement purposes**

As a rate of payment to hospitals for cost settlement purposes, the Department will pay: (1) for the first seven days of hospital care for patients who no longer require acute care, a rate which is equal to fifty percent (50%) of the hospitals non-intensive care per diem rate; (2) for the eighth through fourteenth day of such care,

a rate which is equal to seventy-five percent (75%) of the hospital's non-intensive care unit per diem rate; and (3) for days of such care after the fourteenth day, a rate equal to one hundred percent (100%) of the hospital's non-intensive care unit per diem rate.

(Effective March 7, 1986)



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## **Establishment of Rates for Community Living Arrangements Licensed by the Department of Mental Retardation**

### **Sec. 17-313b-1. Definitions**

As used in Sections 17-313b-1 to 17-313b-17, inclusive:

(1) “Commissioner” means the Commissioner of Income Maintenance or his designated representative.

(2) “Commissioner of Mental Retardation” means said commissioner or his designated representative.

(3) “Audited consolidated operational report” means the annual cost and performance reporting document, which consists of forms provided by the Department of Mental Retardation, and submitted by all organizations operating community living arrangements or community living arrangements and day services.

(4) “Operational plan” means the document, which consists of forms provided by the Department of Mental Retardation, and submitted by all organizations operating community living arrangements for use in establishing rates for the following contract year.

(5) “Community living arrangement” means any residence operated by an organization for mentally retarded persons and licensed pursuant to Section 19a-467 G.S. other than a community training home, group residence, habilitative nursing facility, or residential school. A facility certified to participate in the Medicaid program as an intermediate care facility for the mentally retarded shall not be considered a community living arrangement for purposes of establishing rates pursuant to these regulations.

(6) “Community Training Home” means a residence licensed as such by the Department of Mental Retardation pursuant to Section 19a-467 G.S.

(7) “Region” means Department of Mental Retardation region of the state.

(8) “Primary Region” means that Department of Mental Retardation Region in which an organization has its highest number of community living arrangement placements.

(9) “Day Services” means the range of non-residential services provided to persons by organizations which receive funding from the state including, but not limited to, community work services, adult day treatment, supported employment and elderly enrichment.

(10) “Organization” means any business entity which operates community living arrangements and/or day services for mentally retarded persons.

(11) “Client” means a mentally retarded person who receives services funded, or partially funded by the Department of Mental Retardation.

(12) “Contract Year” means the period of July 1 through June 30.

(13) “Contract” means the written agreement between the Department of Mental Retardation and an organization to provide services during the contract year.

(14) “Residential Client Needs Assessment” means documents which present a composite assessment of individual client needs for each community living arrangement to assist in establishing the basic staffing pattern required in the residence. The forms and assessment are provided by the Department of Mental Retardation.

(15) “Newly Licensed Community Living Arrangement” means any community living arrangement operated by an organization that has been licensed for less than twelve (12) months and which has not had a rate established pursuant to Sec. 17-313b-8.

(16) “Line Item” means the categories of expenditures, administrative and general, direct service staff compensation, direct service costs other than direct service staff compensation, and room and board costs, used in the rate setting process established by these regulations.

(17) “Line Item Cost Settlement” means the cost settlement process for the expenditure categories recognized in these regulations.

(18) “Multi-Unit Structure” means any residential building in which more than one unit is leased or offered for lease.

(19) “Related Parties” means persons or organizations related through marriage, ability to control, ownership, family or business association. Past exercise or influence or control need not be shown, only the potential or ability to directly or indirectly exercise influence or control.

(Effective June 24, 1988)

### **Sec. 17-313b-2. Filing of operational plan**

Each private organization operating community living arrangements (CLA) shall annually file an operational plan with the primary regional office of the Department of Mental Retardation.

(1) The operational plan shall be filed no later than the first business day following April 1 of each year for use in negotiating and establishing rates for the subsequent contract year July 1 through June 30.

(2) A residential client needs assessment, which includes needs of each client residing in a community living arrangement, serves as the basis for the cost elements in the operational plan.

(3) Forms and specific expense and revenue categories shall be provided by the Department of Mental Retardation in order to assure that all data supplied by the filing organizations is consistent in form and content to facilitate comparison statewide.

(Effective March 22, 1990)

### **Sec. 17-313b-3. Filing of audited consolidated operational report (ACOR)**

Each private organization operating community living arrangements or community living arrangements and day services shall annually file an audited consolidated operational report with the primary regional office of the Department of Mental Retardation.

(1) The ACOR shall be filed no later than the first business day following October 15 for the contract year July 1 through June 30.

(2) The ACOR shall provide actual audited costs, revenues, and client data for the preceding contract year July 1 through June 30.

(3) Forms and specific expense and revenue categories shall be provided by the Department of Mental Retardation in order to assure that all data supplied by the filing organizations is consistent in format and content to facilitate comparison statewide.

(4) The ACOR shall be completed in accordance with generally accepted accounting principles and audited in accordance with generally accepted auditing standards. Audited financial statements, notes to same and the auditor’s opinion letter shall accompany the ACOR filing.

(5) Whenever costs are incurred between related parties, allowable cost shall be defined as and limited to the cost to the related party. Findings of relatedness may be made in the absence of majority stock ownership of the related parties in respective organizations. The related party principle applies to any transaction between a provider and a related party, including but not limited to one time or multiple transactions involving services or supplies and one time sales or lease of the facility

itself. Related party transactions must be identified as such in the ACOR and the unallowable portion excluded in the appropriate section of the ACOR.

(Effective June 24, 1988)

**Sec. 17-313b-4. Consequences for failure to file on or before dates specified in these regulations**

(1) For each day that the ACOR is not filed, following the dates specified in these regulations, a penalty of one half of one percent (.50%) of the current monthly payment attributable to administrative and general expenses shall be assessed from the total monthly payment for expenses for the first thirty days; three-quarters of one percent (.75%) for the second thirty days and one percent (1.0%) beyond sixty days. This penalty shall result in a reduction in payment for the month following the calculation of the penalty.

(2) The Commissioner of Mental Retardation may waive imposition of the penalty if he deems that extraordinary circumstances prevented the timely filing of the ACOR. The waiver shall be granted according to terms and for a period of time established by the Commissioner of Mental Retardation. An organization must request a waiver, in writing, prior to the filing dates specified in these regulations.

(Effective March 22, 1990)

**Sec. 17-313b-5. Computation of per diem room and board reimbursement rates for community living arrangements owned or leased by the licensee excluding units leased in multi-unit structures**

The system for determining per diem rates for room and board payment by the Department of Income Maintenance for persons eligible pursuant to Chapter 302, Part III, G.S., who are residents of community living arrangements which are owned or leased by the licensee, excluding units leased in multi-unit structures which is computed in accordance with Sec. 17-313b-6, shall be an individual historical cost related prospective rate system derived from the documents filed pursuant to Secs. 17-313b-2 and -3, per diem room and board reimbursement rates shall be promulgated annually, effective July 1, based upon costs reported in the ACOR filed the preceding October.

Per diem room and board reimbursement rates for community living arrangements owned or leased by the licensee, excluding units leased in multi-unit structures, shall be calculated based upon:

(1) An amount of property costs based upon a fair rental value system.

(i) The fair rental value amount shall be in lieu of interest on mortgages, other property financing costs, depreciation on buildings and non-movable equipment and rental charges. The amount shall be computed in the same manner whether the living arrangement is owned or leased or whether the community living arrangement is operated by an individual owner/partnership or a corporation.

(ii) The fair rental value amount consists of a rental amount for use of land, buildings and non-movable equipment related to resident care.

(A) The annual fair rental value amount for the use of land shall be determined by multiplying the base value of the land by a rate of return which is equal to one-third of the Medicare rate of return for the contract year but not more than four percent nor less than two and one-half percent per annum.

(B) Real property other than land consists of:

(1) Buildings and building improvements;

(2) All equipment attached to buildings and considered to be real property as distinguished from personal property; and

(3) Land improvements, including parking lots, driveways, sidewalks, sewerage systems, walls and pump houses.

The fair rental value amount is calculated to yield a constant amount each year in lieu of interest and depreciation costs. Such amount for the use of real property other than land shall be determined by amortizing the base value of such property over its remaining useful life and applying a rate of return on the unamortized base value. The base value of all real property other than land shall be the actual cost of the property less the accumulated depreciation from the date of acquisition to the date of first use as a licensed residence for persons with mental retardation. The remaining useful life is thirty years from the date of first use as a community living arrangement for mentally retarded persons. The annual rate of return shall be calculated in accordance with the procedures specified in Section 17-311-52-(f) (2) (b) of the Regulations of Connecticut State Agencies as amended, except for the factor which is applied to the medicare rate of return which shall be 1.5, not 1.0.

In any situation where book values are incomplete or questionable and therefore may not reflect the value on the date of acquisition. The commissioner may disallow any claim for such unsupported amount or may in his discretion establish a value based on property values of comparable properties and/or residences.

Upon a change of ownership of a community living arrangement the commissioner, in consultation with the Commissioner of Mental Retardation, may modify the base values of the property for the new owner if deemed in the best interest of the clients residing in the community living arrangement and is appropriate, equitable and does not prejudice the interests of the state.

For purposes of reimbursement, a minimum residual value is established for real property other than land at 10% of the cost of such property. The amount for the use of such property shall not be less than the amount determined by applying the appropriate Medicare rate of return to the minimum residual value.

(iii) In the event of an unforeseen or material change in allowable property costs, which are not reflected in the cost base, the community living arrangement may submit a request, in writing, to the Commissioner for an increase to reflect such change in the fair rental value amount.

Based on the consideration of the date presented and any other factors as the Commissioner deems pertinent, the Commissioner may decide that an adjustment in property basis is in the best interest of the clients residing in the community living arrangement and is appropriate, equitable, and does not prejudice the interest of the state.

(2) An amount for the reasonable cost of dietary, laundry, maintenance, housekeeping, transportation, utilities, fuel, property-related insurance, and property taxes.

(3) An amount for the reasonable cost of moveable equipment based upon depreciation and interest according to generally accepted accounting principles.

(4) An amount for reasonable interest expense required to obtain necessary working capital.

(5) Grants, gifts, fundraising, or endowment income specifically designated for payment of operating costs included in the room and board rate, based on actual cost or fair rental computations, shall be offset against those costs.

(6) Computation of a per diem reimbursement rate based upon the total cost as adjusted by the procedures referred to above divided by minimum allowable resident days or resident days whichever is greater for the applicable cost year.

A resident day is the unit of measurement for room and board provided and client-based services rendered to one client between the census taking hour on two successive days. In computing resident days, the first day of residence shall be counted but the last day of residence shall not. In computing resident days, reserve bed days for which payment is received shall be counted.

For purposes of computing minimum allowable resident days, utilization of a community living arrangement's licensed beds shall be determined at a minimum of 90% of capacity (excluding beds designated for respite care), except for newly licensed community living arrangements and existing community living arrangements which are licensed to serve additional clients which may be permitted a lower occupancy rate for the first three months of operation after the effective date of licensure. Minimum allowable resident days for beds designated for respite care shall be determined at a minimum of 50% capacity.

In the event that a bed designated for respite care is not suitable for full-time use for such purpose, the organization may request, in writing, a waiver of the 50% minimum occupancy for such bed in the affected community living arrangement. Based on consideration of the information presented and any other factors as the commissioner deems pertinent, the commissioner may grant a waiver. If such waiver is granted, actual respite days of care for the bed for which payment is received will be used in the computation of the community living arrangement's per diem reimbursement rate.

(7) An adjustment in the rate, for costs other than the property costs included in the fair rental value computation, for the time lag between the preceding contract year and the succeeding contract year.

This adjustment shall be the gross national product (GNP) deflator percentage increase or decrease for the twenty-four month time lag from the contract year ending the preceding June 30 to June 30 of the succeeding contract year. The GNP deflator is the implicit price deflator for the gross national product published in the "Economic Indicators" prepared for the Joint Economic Committee by the Council of Economic Advisors.

(8) Cost limitation.

For all community living arrangements, the aggregate total allowable costs shall not exceed the costs submitted by the organization, less unallowable costs.

(9) A statutory limitation on per diem rates.

Per diem rates paid by the state for care of persons eligible for assistance under the provisions of Chapter 302, Part III of the General Statutes shall not exceed the rate of payment for similar services to the general public.

(Effective June 24, 1988)

**Sec. 17-313b-6. Computation of per diem room and board reimbursement rates for community living arrangements in leased units in multi-unit structures**

Per diem reimbursement rates for room and board provided by a community living arrangement in a leased unit of a multi-unit structure shall be based upon:

(1) A reasonable rent based on an arms-length transaction between unrelated parties reviewed by the commissioner.

(2) An amount for the reasonable cost of dietary, laundry, maintenance, housekeeping, transportation, utilities, fuel, property-related insurance, and property taxes.

(3) An amount for the reasonable cost of moveable equipment based upon depreciation and interest according to generally accepted accounting principles.

(4) An amount for reasonable interest expense required to obtain necessary working capital.

(5) Grants, gifts, fundraising, or endowment income specifically designated for payment of operating costs included in the room and board rate, based on actual cost or fair rental computations, shall be offset against those costs.

(6) Computation of a per diem reimbursement rate based upon the total cost as adjusted by the procedures referred to above divided by minimum allowable resident days or resident days whichever is greater for the applicable cost year.

A resident day is the unit of measurement for room and board provided and client-based services rendered to one client between the census-taking hour on two successive days. In computing resident days, the first day of residence shall be counted but the last day of residence shall not. In computing resident days, reserve bed days for which payment is received shall be counted.

For purposes of computing minimum allowable resident days, utilization of a community living arrangement's licensed beds shall be determined at a minimum of 90% of capacity (excluding beds designated for respite care), except for newly licensed community living arrangements and existing CLA's which are licensed to serve additional clients which may be permitted a lower occupancy rate for the first three months of operation after the effective date of licensure, minimum allowable resident days for beds designated for respite care shall be determined at a minimum of 50% capacity.

In the event that a bed designated for respite care is not suitable for full-time use for such purpose, the organization may request, in writing, a waiver of the 50% minimum occupancy for such bed in the affected community living arrangement. Based on consideration of the information presented and any other factors as the commissioner deems pertinent, the commissioner may grant a waiver. If such a waiver is granted, actual respite days of care for the bed for which payment is received will be used in the computation of the community living arrangement's per diem reimbursement rate.

(Effective June 24, 1988)

#### **Sec. 17-313b-7. Per diem room and board reimbursement rates for community training homes payable by the department of social services**

The per diem room and board reimbursement rate for community training homes which is paid by the Department of Social Services shall be the rate computed pursuant to Section 17-311-54 of the Regulations of Connecticut State Agencies.

(Effective March 28, 1996)

#### **Sec. 17-313b-8. Client-based service rate determination process**

The client-based service rate is for payment of costs for the provision of services for eligible persons in community living arrangements whose admission into the CLA is authorized by the Department of Mental Retardation pursuant to 17a-228 of the Connecticut General Statutes and regulations promulgated thereunder. Residential client needs assessments serve to establish basic staffing patterns used in the annual negotiation of this rate.

##### **(1) Cost settlement**

(i) An organization will not be reimbursed for costs in excess of the sum of the negotiated rates for all community living arrangements operated by the organization, unless such reimbursement is otherwise authorized pursuant to these regulations. The ACOR will serve as the basis for review of actual expenditures for the preceding contract year. There shall be a bottom line cost settlement for costs at or below the

sum total of the negotiated rates for the preceding contract year. Cost settlement decisions shall be made within approximately 120 days of the filing of the ACOR for the preceding contract year. Such decisions shall be effected through the adjustment of current payments for the three months after cost settlement decisions are made or shall be reimbursed entirely to the Department of Mental Retardation for community living arrangements which cease operation.

(ii) Cost settlement occurs when actual expenditures are below the sum total of the established rates for all community living arrangements operated by the organization for the preceding contract year. For all allowable expenditures made pursuant to such contract with the department of mental retardation by an organization in compliance with performance requirements thereof, 50% of the difference between such actual expenditures made and the amount received by the organization from the department of mental retardation per such contract shall be reimbursed to the department of mental retardation.

(iii) Reductions may be made to the negotiated rate for community living arrangements to the extent they fall below 85% of the total available occupancy for the preceding contract year, for reasons other than the failure of the Department of Mental Retardation to place clients, if the organization fails to adequately justify the reduced occupancy rate. For purposes of this section occupancy is the actual client days in residence based on attendance records. Total available occupancy is the number of clients for whom the rate was established times 365. The occupancy rate is established by dividing actual client days in residence by the total available occupancy. Reductions made pursuant to this section shall be reflected in the bottom line cost settlement.

(iv) Grants, gifts, fundraising or endowment income, and expenditures from such income, shall be reported in the ACOR. To the extent such income is specifically designated for operating costs included in the client-based service rate the expenditures from such income shall be deducted from the total operating costs which serve as the basis for negotiating the next year's rate. If an organization demonstrated that such income is not available for the succeeding contract year there will be no deduction and the overpayment shall be recovered through the line item cost settlement.

Grants, gifts, fundraising, or endowment income not specifically designated but used for payment of operating costs reported in the ACOR shall be deducted from the total operating costs which serve as the basis for negotiating the next year's rate.

(v) For the 1992 contract year only, an organization may elect the cost settlement methodology in effect immediately prior to the effective date of these regulations. Such election shall be made at the time of submission of the organization's 1992 contract year ACOR.

(2) The client-based service rate for each community living arrangement includes:

(1) Salary, wage and benefit costs for administrative and general and direct service personnel; and

(2) Non-salary costs which are not included in the per diem room and board reimbursement rate as specified in Sec. 17a-313b-6 of these regulations. Nothing in this section shall be construed to require the Department of Mental Retardation to pay for costs which were disallowed in the calculation of the room and board rate.

(3) Administrative costs will be reviewed for reasonableness as a percentage of direct service and total operating costs based on statewide averages. Administrative costs are necessary to manage and operate community living arrangements but are not assignable to the cost of services rendered to an individual client.

(4) Staff development and training costs for new employees and ongoing direct service staff, a component of non-salary costs reimbursable under this rate, will be negotiated based on core development and training modules specified by the Department of Mental Retardation and other training negotiated and agreed to by the department and the organization.

(5) Analyses of the operation plan, ACOR, and other relevant information relating to management, financial and programmatic performance will be used in the rate negotiation process.

(6) Inadequate management, financial and programmatic performance may result in a contract term of less than twelve months.

(7) Client-based service rates are established prospectively and payments will be made retrospectively each month for costs incurred during the preceding month.

(8) The annual appropriation to the Department of Mental Retardation of funds for community living arrangements, and the allocation of these funds to the respective Department of Mental Retardation regions, shall be taken into account in establishing client-based service rates. In no event shall the Department of Mental Retardation be required to make payments in excess of funds appropriated for this purpose and allocated to the regions.

(9) When negotiations between the organization and the DMR result in agreed upon client-based service rates for the community living arrangements operated by an organization, the Commissioner of Mental Retardation shall certify these rates and shall issue rates in accordance with such certification. If negotiations fail to result in agreed-upon client-based service rates by the first business day following May 15, the Commissioner of Mental Retardation shall certify his department's last best offer and shall issue rates in accordance with such certification.

(10) Newly licensed community living arrangements, for which client-based service rates are established pursuant to this section, shall be fully reimbursed in accordance with the negotiated rate for the first 60 days after the first client is in residence. After 60 days there shall be a proportional adjustment, reflected in the line item cost settlement for each day the community living arrangement is not fully occupied unless the organization provides adequate justification for the reduced occupancy.

(Effective September 28, 1994)

**Sec. 17-313-9. Establishment of comprehensive payment levels and computation of residential service rates paid by the department of mental retardation for community training homes**

**(a) Definitions**

As used in this section:

(1) "Client assessment documents" means documents which represent a composite assessment of individual client needs to assist in establishing the appropriate level of supervision. The forms and assessment are provided by the Department of Mental Retardation.

(2) "Department" means the Department of Mental Retardation.

(3) "Personal need allowance" means income which is available to a resident which may not be used for payment of room, board or service.

(4) "Ongoing comprehensive support" means twenty-four hour supervision with periodic special interventions required due to complex medical or behavioral needs of the resident(s).

(b) (1) Three comprehensive payment levels are established for mentally retarded persons, who are eligible for funding pursuant to section 17a-228 G.S., and the

regulations promulgated thereunder, who reside in community training homes. A comprehensive payment level is established by the department in accordance with a client's need for supervision as indicated in client assessment documents. The comprehensive payment level per resident per month for the period July 1, 1993 through June 30, 1994 are as follows:

<u>Level of Supervision</u>	<u>Payment Level per Resident Per Month</u>
Less than 24 hour supervision	\$ 876.68
24 hour supervision	1,112.33
Ongoing comprehensive	1,419.85

(2) On July 1, 1994 and for each subsequent year commencing July 1, the payment level for each level of supervision will be adjusted by the percentage increase or decrease in legislative appropriations for existing community training homes from the prior year to the present year.

(3) On July 1, 1995 and for each subsequent year commencing July 1, the comprehensive payment level for each level of supervision shall be adjusted by the amount of increase or decrease in the monthly total of the rate established pursuant to Section 17-313b-7 of these regulations.

(c) The comprehensive payment levels set forth in subsection (b) of this section represent the total amount received for room, board and services provided to a resident of a community training home. These payment levels are composed of the monthly total of the rate pursuant to section 17-313b-7 of these regulations and a residential service rate paid by the department. The residential service rate is the difference between the established comprehensive payment level and the monthly total of the rate established pursuant to section 17-313b-7 of these regulations.

(d) A resident of a community training home who is not a recipient of the state supplement program administered by the Department of Social Services may retain, from whatever source, an amount equal to the unearned income disregard plus personal need allowance received by an individual receiving state supplement who lives in a community training home. To the extent that the income of such resident is insufficient to provide this amount, the residential service rate shall be increased by an amount sufficient to equal it.

(e) Special support payments, by the Department of Mental Retardation, may be negotiated between the community training home provider and the appropriate regional director of the department of mental retardation. Special support payments will be in addition to the applicable payment level, and any other payments established pursuant to subsection (b) of this section, for additional necessary expenses related to special needs of a client which are not reimbursed through the applicable comprehensive payment level. Any request for special support payments must be supported by client assessment documents prepared or approved by a client's request for special support payments must be supported by client assessment documents prepared or approved by a client's assessment documents prepared or approved by a client's interdisciplinary team. Additional expenses which may require special support payments are those relating to:

- (1) Professional services;
  - (2) Unusual necessary transportation;
  - (3) Unusual and recurring personal care needs; and
  - (4) Unusual property damage attributable to client behavior.
- (Effective March 28, 1996)

**Sec. 17-313b-10. Interim room and board and client-based service rate determination process for newly licensed community living arrangements**

Newly licensed community living arrangements shall file an operational plan with the appropriate Department of Mental Retardation regional director.

(1) The Department of Mental Retardation shall negotiate the cost elements which will serve as the basis for an interim client-based service rate and the Department of Income Maintenance shall establish an interim room and board rate.

(2) The interim rates established pursuant to this section will serve as the basis for the one-time, start-up funding provided by the Department of Mental Retardation pursuant to Sec. 19-483b-3 of the Regulations of State Agencies.

(3) Newly licensed community living arrangements shall be reimbursed at 100 percent of the negotiated rate for the first 60 days after the first client is in residence. There shall be a proportional adjustment, reflected in the line item cost settlement, for each day after 60 days for which the community living arrangement is not fully occupied, unless the organization provides adequate justification for the reduced occupancy.

This proportional adjustment will be calculated in accordance with Section 17-313b-8 (1) (iii) of these regulations, except that the first 60 days shall not be included in the calculation.

(4) Interim rates shall remain in effect until a room and board rate is established pursuant to Section 17-313b-5 or Section 17-313b-6 of these regulations based upon a 12 month ACOR ending June 30th and a client-based service rate is established pursuant to Section 17-313b-8 of these regulations based upon a 12 month ACOR ending June 30th.

These interim per diem rates may be revised by the commissioner at any time based on additional information which may become available to him.

(5) Interim room and board rates shall be replaced by revised rates computed on the basis of actual per diem costs which are allowable as defined in Section 17-313b-5 or Section 17-313b-6 of these regulations for the period in which the interim rates were in effect. Proper retroactive adjustments, in favor of the community living arrangement or the state shall be made to all amounts paid on the basis of interim rates.

(Effective June 24, 1988)

**Sec. 17-313b-11. Amortization of start-up costs not paid by the Department of Mental Retardation through start-up funding**

Costs that are normally identified under generally accepted accounting principles as organizational expenses and/or costs which are to be capitalized shall be excluded from costs proposed to the Department of Mental Retardation for start-up funding under Section 19-483a G.S. and applicable regulations. Any such excluded costs shall be amortized over a reasonable period of not less than thirty-six (36) months beginning with the month during which the first client is in residence and shall be reimbursed in the service portion of the rate.

(Effective June 24, 1988)

**Sec. 17-313b-12. Interim contract year adjustment of client-based service rate**

Organizations are not to exceed cost elements included in their negotiated rate without prior written authorization from the appropriate Department of Mental Retardation regional director.

An organization may only request negotiation on an adjusted client-based service rate when a new client enters the community living arrangement whose needs, as

documented in a residential client needs assessment, will cause a significant variation in the existing client-based service rate or in an emergency situation.

(Effective June 24, 1988)

**Sec. 17-313b-13. Phase-in of client-based service rate system**

Three separate rate setting systems shall exist to establish service rates for the contract year July 1, 1987 through June 30, 1988. For succeeding contract years, all existing community living arrangements shall have client-based service rates established in accordance with Sec. 17-313b-8 of these regulations. After June 30, 1988, all newly licensed community living arrangements will have an initial rate established in accordance with Sec. 17-313b-10 of these regulations.

(1) All organizations shall file an unaudited consolidated operational report on or before the date established by an emergency regulation for the period July 1, 1985 through June 30, 1986. For any organization which failed to comply with the provisions of Section 17-313b-2 of the emergency regulations, effective July 9, 1987, the commissioner may authorize rates comparable to the lowest rate paid to a community living arrangement for the same level of care.

(2) Pilot organizations, selected on a voluntary basis from a region designated by the Commissioner of Mental Retardation, shall file operational plans on or before dates agreed upon by such organizations and the Department of Mental Retardation, for the contract year July 1, 1987 through June 30, 1988.

(i) Room and board reimbursement rates shall be established for the community living arrangements operated by the pilot organizations, in accordance with Sec. 17-313b-5 or Sec. 17-313b-6 of these regulations, whichever is applicable for the contract year July 1, 1987 through June 30, 1988.

(ii) Client-based service rates shall be negotiated and established for the community living arrangements operated by the pilot organizations in accordance with Sec. 17-313b-8 of these regulations, for the contract year July 1, 1987 through June 30, 1988, and shall supercede any previously established rates for the pilot organizations.

(3) Existing community living arrangements operated by non-pilot organizations shall have rates established for the contract year July 1, 1987 through June 30, 1988 based upon the unaudited consolidated operational report.

(i) Room and board reimbursement rates shall be established for the community living arrangements operated by the non-pilot organizations, in accordance with Sec. 17-313b-5 or Sec. 17-313b-6 of these regulations, whichever is applicable.

(ii) Per diem service reimbursement rates for community living arrangements licensed for four or more beds, excluding beds designated for staff and/or respite care, shall be calculated based upon:

(a) An amount for direct care staff, administrative and clerical staff and/or services, transportation of residents and staff, and such other expenses necessary to maintain the licensure of the facility in accordance with the regulations of the Department of Mental Retardation, adjusted by the Gross National Product (GNP) deflator percentage increase or decrease for the eighteen month time lag from the cost year to the rate year; plus

(b) A cost efficiency adjustment of 25% of the difference between the allowable cost per resident day in the cost year and the service rate promulgated pursuant to subsection (3) (iii) infra of these regulations for the group home's licensed level of care for the rate year ending June 30 following the close of the cost year. In no event shall such cost efficiency adjustment be made if the allowable cost per resident day as defined in these regulations in the cost year exceeds 90% of the amount for the applicable level of care in subsection (3) (iii) infra; plus

(c) Computation of a per diem reimbursement rate based upon the total costs as adjusted by the procedures referred to above divided by the minimum allowable resident days for the applicable cost year.

A resident day is the unit of measurement for lodging provided and services rendered to one inpatient between the census-taking hour on two successive days. In computing resident days, the day of admission shall be counted but the day of discharge shall not. In computing resident days, reserve bed days for which payment is received shall be counted.

For purposes of computing minimum allowable resident days, utilization of a facility's licensed beds shall be determined at a minimum of 90% of capacity (excluding beds designated for respite care), except for new facilities and facilities which are licensed for additional beds which may be permitted a lower occupancy rate for the first three months of operation after the effective day of licensure. Minimum allowable resident days for beds designated for respite care shall be determined at a minimum of 50% of capacity.

(iii) Per diem service rates for existing community living arrangements, licensed for three or fewer beds, excluding beds designated for staff and/or respite care, operated by non-pilot organizations shall be a flat rate based on the aggregate level of care provided in the community living arrangement as indicated in the license issued by the Department of Mental Retardation. Such rates shall also be the maximum amount paid per day for all community living arrangements at each level of care.

The per diem rates for the level of care as determined by the Department of Mental Retardation at the time of licensure, for the contract year ending June 30, 1988 are as follows:

<i>Licensed Level Of Care</i>	<i>Amount Per Resident Per Day</i>
1	\$ 19.93
2	\$ 42.67
3	\$ 54.35
4	\$ 68.59
5	\$ 89.83

The Commissioner of Income Maintenance may, upon the written request of the Commissioner of Mental Retardation, grant an exemption from the per diem service rate for the level of care 5 if the Commissioner of Mental Retardation determines that the per diem service rate would jeopardize an appropriate placement. The per diem service rate established in excess of level of care 5 shall be programmatically and fiscally justified by the Commissioner of Mental Retardation.

If a community living arrangement is licensed to serve clients at more than one disability level, a weighted average amount payable to such community living arrangement shall be computed as follows. The Department of Mental Retardation shall designate the number of beds licensed at each level of care in the community living arrangement. The rate for a community living arrangement shall be determined by summing for each level of care within the community living arrangement the product of the number of beds at each level times the amount specified in this subsection for each level, or the amount granted in an exemption pursuant to this section, updated to the current contract year, and dividing said sum by the total number of licensed beds in the community living arrangement. The commissioner, with the approval of the Commissioner of Mental Retardation, may grant an exemption from the limitations of this section, if such exemption is necessary to accommo-

date residential direct service staff compensation adjustments approved by the Commissioner of the Department of Mental Retardation. Any such exemptions shall be programmatically and fiscally justified by the Commissioner of the Department of Mental Retardation.

A community living arrangement which does not achieve 90 percent occupancy in the first 90 days of operation may petition the Commissioner for a service rate which exceeds the amount specified in this subsection based on the hardship which such limitation would otherwise cause. Such petition must set forth the pertinent factors relating to such hardship, including such detailed cost data as may be required to document the facts of the case and the reasons for the failure to attain the aforementioned occupancy level. Based on the consideration of the foregoing and any other factors as the commissioner deems pertinent, the commissioner, with the approval of the Commissioner of the Department of Mental Retardation, may grant an exemption of not more than ninety days from the limitations of this section.

(4) New community living arrangements operated by non-pilot organizations which receive initial funding through state fiscal year 1987–1988 appropriations, shall have rates established in accordance with the following:

(i) Room and board reimbursement rates shall be established for new community living arrangements which receive initial funding through state fiscal year 1987–1988 appropriations, operated by non-pilot organizations, in accordance with Sec. 17-313b-5 or Sec. 17-313b-6 of these regulations, whichever is applicable.

(ii) Service rates for these community living arrangements shall be established in accordance with the following modified level of care system. The per diem service rates for the modified level of care as determined by the Department of Mental Retardation at the time of licensure for the contract year ending June 30, 1988, are as follows:

<i>Licensed Level of Care (Level of Supervision)</i>	<i>Amount Per Resident Day</i>
1 and 2 (assisted)	\$42.67
3 and 4 (moderate supervised)	\$68.59
5 (ongoing comprehensive)	\$89.83

The Commissioner of Income Maintenance may, upon the written request of the Commissioner of Mental Retardation, grant an exemption from the per diem service rate for the level of care 5 if the Commissioner of Mental Retardation determines that the per diem service rate would jeopardize an appropriate placement. The per diem service rate established in excess of level of care 5 shall be programmatically and fiscally justified by the Commissioner of Mental Retardation.

If a community living arrangement is licensed to serve clients at more than one disability level, a weighted average amount payable to such community living arrangement shall be computed as follows. The Department of Mental Retardation shall designate the number of beds licensed at each level of care in the community living arrangement. The rate for a community living arrangement shall be determined by summing for each level of care within the community living arrangement the product of the number of beds at each level times the amount specified in this subsection for each level, or the amount granted in an exemption pursuant to this section, updated to the current contract year, and dividing said sum by the total

number of licensed beds in the community living arrangement. The Commissioner, with the approval of the Commissioner of Mental Retardation, may grant an exemption from the limitations of this section, if such exemption is necessary to accommodate residential direct service staff compensation adjustments approved by the Commissioner of the Department of Mental Retardation. Any such exemptions shall be programmatically and fiscally justified by the Commissioner of the Department of Mental Retardation.

A community living arrangement which does not achieve 90 percent occupancy in the first 90 days of operation may petition the commissioner for a service rate which exceeds the amount specified in this subsection based on the hardship which such limitation would otherwise cause. Such petition must set forth in pertinent factors relating to such hardship, including such detailed cost data as may be required to document the facts of the case and the reasons for the failure to attain the aforementioned occupancy level. Based on the consideration of the foregoing and any other factors as the commissioner deems pertinent, the commissioner, with the approval of the Commissioner of the Department of Mental Retardation, may grant an exemption of not more than ninety days from the limitations of this section.

(5) Rates will only be established in accordance with this section for the contract year July 1, 1987 through June 30, 1988. Thereafter, rates shall be established in accordance with the remaining sections of these regulations.

(Effective June 24, 1988)

#### **Sec. 17-313b-14. Record maintenance and retention**

Each organization shall maintain all supporting accounting and business records and records relating to the provision of service which shall be available for review at a place and time determined by the Department of Mental Retardation or the Department of Income Maintenance for a minimum period of ten (10) years without regard for changes in ownership. The Commissioner may disallow those costs for which appropriate documentation has not been maintained. All organizations shall be required to maintain their books of account on the accrual method of accounting, and accurate time records shall be maintained for all persons paid salaries or wages.

(Effective June 24, 1988)

#### **Sec. 17-313b-15. Audits**

The Departments of Income Maintenance and Mental Retardation shall have the right to audit all supporting accounting and business records and all records relating to the provision of services to clients funded by the respective departments in community living arrangements.

(Effective June 24, 1988)

#### **Sec. 17-313b-16. Other reporting requirements**

Each organization which has filed an initial operational plan negotiated client-based service rate(s) and has had room and board rate(s) established under that plan shall file subsequent mid-year operational report summaries on forms provided by the Department of Mental Retardation. Mid-year reports shall be used for ongoing assessment of management, financial and programmatic performance.

(Effective March 22, 1990)

#### **Sec. 17-313b-17. Temporary service supplement**

An organization may apply to the Commissioner of Mental Retardation for a temporary service supplement to the established client-based service rate for any

community living arrangement. A temporary service supplement shall be available only for payment for time-bounded, client-specific, outcome-oriented resources to be used during periods of unanticipated client stress and transition. The need for a temporary service supplement must be documented and approved by the interdisciplinary team for the specific client. The Commissioner of Mental Retardation shall certify the need for and amount of the supplement to the commissioner who shall authorize payment of the supplement from funds appropriated to the Department of Mental Retardation. In no event shall a temporary service supplement be paid for longer than eighteen (18) months.

(Effective June 24, 1988)

**Sec. 17-313b-18. Hearings**

Any organization which is aggrieved by any rate decision pursuant to these regulations by the Commissioner of Income Maintenance or the Commissioner of Mental Retardation may, within ten days after written notice thereof from the commissioner issuing the decision obtain by written request from the commissioner issuing the decision a hearing on all items of aggrievement. Hearings and all subsequent appeals therefrom before the Commissioner of Income Maintenance shall be conducted in accordance with the procedures specified in Section 17-311 (b) G.S., and Sections 17-311-1 through 17-311-40 of the Regulations of Connecticut State Agencies. Hearings and all subsequent appeals therefrom before the Commissioner of Mental Retardation shall be conducted in accordance with the procedures specified in Sections 19-570-1 through 19-570-60 of the Regulations of Connecticut State Agencies. The Commissioners may request the participation of others when appropriate.

(Effective March 22, 1990)



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## **Organization of Department of Children and Youth Services**

### **Sec. 17-411-1. Commissioner's office**

The Department of Children and Youth Services operates under the direction of the Commissioner of Children and Youth Services who is appointed by the Governor. The Commissioner is advised with respect to formulating Departmental policy by a statewide Advisory Council whose members are appointed by the Governor. Two Deputy Commissioners assist the Commissioner in administering Department operations—the Deputy Commissioner for Program Services, and the Deputy Commissioner for Administrative and Support Services. The Commissioner has direct responsibility for the supervision of the Department's School District and the Division of Research, Planning and Evaluation. The Deputy Commissioner for Program Services has responsibility for the Division of Children's and Protective Services, the Division of Institutions and Facilities, the Division of Preventive and Community Services, and the Division of Treatment Services. The Deputy Commissioner for Administrative and Support Services has responsibility for the Division of Personnel, the Division of Fiscal Affairs, the Division of Data Processing, and the Division of Policy and Licensing.

(Effective July 3, 1978)

### **Sec. 17-411-2. Division of children's and protective services**

This Division administers the children's and protective services program under a Purchase of Service Agreement with the Department of Social Services. The Division operates through five regional areas, each headed by an Assistant Regional Coordinator who is advised with respect to formulating regional policy by a Regional Advisory Board whose members are appointed by the Commissioner of Children and Youth Services. The Division provides protective services to children and their families reported to be abused and/or neglected. It provides supervision and placement services to children committed to the guardianship of the Commissioner as neglected and uncared for under Section 17-62 of the General Statutes and to children included in the non-committed treatment program which provides, at the discretion of the Commissioner, financial assistance and social services to assist parents in securing required placements for children out of their own home for residential treatment purposes. The services provided by the Division include placement and supervision of children in foster homes and other facilities and financial assistance and social services to unwed mothers.

(Effective July 3, 1978)

### **Sec. 17-411-3. Division of institutions and facilities**

This Division is responsible for the operation of the various child caring institutions and facilities operated by the Department including the following mental health facilities: Adolescent Drug Rehabilitation Unit, Meriden; Bridgeport Children's Center, Bridgeport; Connecticut Valley Hospital—Adolescent Unit Middletown; Connecticut Valley Hospital—Children's Unit (RiverView), Middletown, Fairfield Hills Adolescent Unit, Newtown; High Meadows, Hamden; Norwich Hospital—Adolescent Unit, Norwich, State Receiving and Study Home, Warehouse Point; Undercliff Mental Health Center, Meriden. This Division is also responsible for the operation of Long Lane School in Middletown for the care and rehabilitation of children committed to the Commissioner as adjudicated delinquents under Sections 17-68 and 17-69 of the General Statutes. The Division also administers an aftercare

program which provides services and counseling to delinquent or pre-delinquent children in residing in the community and also administers a group home care program. The Division carries responsibility for the coordination of private child caring institutions and facilities to provide services for children included in the Department programs.

(Effective July 3, 1978)

**Sec. 17-411-4. Division of preventive and community services**

This Division focuses on encouraging the development of community resources and services to meet the needs of children and includes the youth services programs and Department contracts for services provided by grants-in-aid programs in the community for child guidance clinics, day treatment centers and various demonstration programs.

(Effective July 3, 1978)

**Sec. 17-411-5. Division of treatment services**

This Division is responsible for developing and monitoring the treatment plans for children serviced by the Department, staff training and development, operation of Interstate Compacts related to the placement of children in Connecticut from other states and for children going from Connecticut to be placed in other states and provides administrative hearings to protect the rights of children included in the Department's programs.

(Effective July 3, 1978)

**Sec. 17-411-6. The division of personnel**

The Division of Personnel which is headed by a Personnel Administrator has responsibility for all personnel management activities including staff recruitment, classification and compensation as well as employee relations and collective bargaining.

(Effective July 3, 1978)

**Sec. 17-411-7. Division of fiscal affairs**

This Division, headed by a Chief Fiscal Officer, has responsibility for Department financial, business, accounting and budget functions.

(Effective July 3, 1978)

**Sec. 17-411-8. Division of data processing**

The Division of Data Processing is headed by a Chief of Data Processing and is responsible for the development, utilization and coordination of the Department's Data computer processing system and procedures.

(Effective July 3, 1978)

**Sec. 17-411-9. Division of policy and licensing**

This Division is headed by a Director and includes responsibility for the coordination and development of Departmental regulations, policies and operational procedures as well as for the relicensing of the child caring institutions and placement agencies licensed by the Department.

(Effective July 3, 1978)

**Sec. 17-411-10. The department school district**

The Department operates its own school district which is headed by a Superintendent of Schools and includes in the school district the children residing in the institutions and facilities operated by the Department.

(Effective July 3, 1978)

**Sec. 17-411-11. Division of research planning and evaluation**

This Division is headed by a Director and carries the responsibility for planning and program development, research and evaluation, to provide a basis to monitor and evaluate the operations of the programs within the Department.

(Effective July 3, 1978)

**Sec. 17-411-12. Public information and request**

The public may obtain information or make submissions or requests concerning the operations of the Department of Children and Youth Services by communication by telephone or mail to the appropriate Division, Regional Office, institution or facility. In the event that required information cannot be obtained in this manner, communication should be addressed to the Office of the Commissioner.

(Effective July 3, 1978)

**Sec. 17-411-13. Obtaining regulations, policy, etc.**

Copies of regulations and other written statements of policy or interpretations formulated, adopted or used by the Department of Children and Youth Services in the discharge of its functions, all forms and instructions used by the Department and all final orders, decisions and opinions of the Department are maintained in the Office of the Commissioner and will be available for public inspection upon reasonable request made to the Commissioner and at such reasonable time as may be determined by the Commissioner. The subject matter available does not include material deemed to be privileged or confidential.

(Effective July 3, 1978)

**Sec. 17-411-14. Request for declaratory ruling**

The Department of Children and Youth Services will accept a request for declaratory ruling as to the applicability of any statute or regulation administered by the Department in the following form:

- (a) A request stating the factual background of the issue must be in writing;
- (b) The request shall be signed by the person seeking such ruling and shall include his address for purposes of reply;
- (c) The request shall state clearly the question of applicability upon which it seeks ruling;
- (d) The request shall state the position of the person seeking such ruling with respect to the question of applicability;
- (e) The request may include an argument in support of the position of the person seeking such ruling with such legal citation as may be appropriate;
- (f) The Department of Children and Youth Services reserves to itself the option of refusing a declaratory ruling in the event that the request requesting such ruling does not state a sufficient basis to show that the person seeking such ruling has standing or is otherwise entitled to such a ruling.

(Effective July 3, 1978)

**Sec. 17-411-15. Request for regulation**

The Department of Children and Youth Services will accept a request for the promulgation, amendment, or repeal of a regulation of the Department in the following form:

- (a) Request must be in writing;
- (b) The request shall be signed by the person making such request and shall include his address for purposes of reply;

(c) The request shall clearly state the language to be promulgated, amended, or repealed. The same request may include matter to be promulgated as well as matter to be amended or matter to be repealed;

(d) The request may include a statement of facts and arguments in support thereof.  
(Effective July 3, 1978)

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**Placement of Children and Youth on Aftercare**

**Secs. 17-415a-1—17-415a-11.**

Transferred, February 1, 1994.

<i>Former Number</i>	<i>New Number</i>
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17-415a-2	17a-7-2
17-415a-3	17a-7-3
17-415a-4	17a-7-4
17-415a-5	17a-7-5
17-415a-6	17a-7-6
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## Employee Personnel Files

### Secs. 17-415 (g)-1—17-415 (g)-5.

Repealed, April 27, 1987.

## Personal Data

### Sec. 17-415 (g)-6. Definitions

The following definitions shall apply to these regulations.

(a) “Attorney” means an attorney at law empowered by a person to assert the confidentiality of or right of access to personal data under the Personal Data Act, Conn. General Statute § 4-190.

(b) “Authorized representative” means a parent, or guardian or conservator, other than an attorney, appointed to act on behalf of a person and empowered by such person to assert the confidentiality of or right of access to personal data under the Personal Data Act, Conn. General Statute § 4-190.

(c) “Automated personal data system” means a personal data system in which data is stored, in whole or part, in a computer or in computer accessible files.

(d) Category of personal data means the classifications of personal information set forth in the Personal Data Act, Conn. Gen. Stat. § 4-190 (9).

(e) Child/youth means any person under eighteen years of age, except as otherwise specified, or any person under twenty one years of age who is in full-time attendance in a secondary school, a technical school, a college or a state accredited job training program.

(f) “Computer accessible files” means any personal data which is stored on-line or off-line, which can be identified by use of electronic means, including but not limited to microfilm and microfilm devices, which includes but is not limited to magnetic tape, magnetic film, magnetic disks, magnetic drums, internal memory utilized by any processing device, including computers or telecommunications control units, punched cards, optically scannable paper or film.

(g) Department/Agency means the Department of Children and Youth Services.

(h) “Maintain” means collect, maintain, use or disseminate.

(i) “Manual personal data system” means a personal data system other than an automated personal data system.

(j) Other Data means any other information which because of name, identifying number, mark or description can be readily associated with a particular person.

(k) “Person” means an individual of any age concerning whom personal data is maintained in a personal data system, or a person’s attorney or authorized representative.

(l) “Personal data” means any information about a person’s education, finances, medical or emotional condition or history, employment or business history, family or personal relationships, reputation or character which because of name, identifying number, mark or description can be readily associated with a particular person. “Personal data” shall not be construed to make available to a person any record described in subdivision (3) of the subsection (b) of Conn. General Statute § 1-19.

(m) “Personal data system” means a collection of records containing personal data.

(n) “Record” means any collection of personal data, defined in subsection (9) of Conn. General Statute § 4-190, which is collected, maintained or disseminated. (Effective April 27, 1987)

**Sec. 17-415 (g)-7. General nature and purpose of personal data systems**

**(a) Division of Children and Protective Services Records**

(1) The Division of Children and Protective Services system directory is located in the office of the Division Director at 170 Sigourney Street, Hartford, Conn.

(2) Records are maintained in manual form.

(3) The purpose of the system is to record and document division activities in responding to complaints of child abuse/neglect and in providing services to children and their families.

(4) Division personal data records are the responsibility of the Division Director, 170 Sigourney Street, Hartford, Connecticut. All requests for disclosure or amendment to these records should be submitted to the appropriate Regional Director as listed below, if known, or if not known, to the Division Director.

Region I, Regional Director, 1115 Main St., Bridgeport, CT

Region II, Regional Director, 2105 State St., Hamden, CT

Region III, Regional Director, 331 Main St., Norwich, CT

Region IV, Regional Director, 1049 Asylum Ave., Hartford, CT

Region V, Regional Director, 414 Meadow St., Waterbury, CT

(5) Routine sources of data may include children and families, (clients), reporters of child abuse/neglect, medical personnel, educators, social workers, and other mental health professional staff persons, foster and adoptive parents.

(6) Personal data are collected and maintained and used under authority of Sections 17-32 et seq. and 17-410 et seq. of the Connecticut General Statutes.

(7) Records are used by Division Staff to reflect treatment plans, services, and payments to or on behalf of children/families included within the programs operated by the Division.

**(b) The Division of Treatment Standards and Assurance Records**

(1) The Division of Treatment Standards and Assurance personal data records are located at 170 Sigourney St., Hartford, Conn.

(2) Records are maintained in manual form.

(3) The purpose of the system is to document activities pertaining to (A) conducting Administrative Hearings as requested by clients, licensees, or vendors, (B) administering three compacts between Connecticut and other states covering appropriate placement, supervision and return of children and youth across state lines, (C) determining the timeliness and quality of department treatment planning and service delivery.

(4) Division personal data records are the responsibility of the Division Director, 170 Sigourney Street, Hartford, Conn. All requests for disclosure or amendment to these records should be submitted to the Division Director.

(5) Routine sources of data may include—children/youth, parents/family and significant other adults, and other state interstate compact administering agencies.

(6) Personal data are collected and maintained under authority of Section 17-32 et seq. and 17-410 et seq. of the Conn. General Statutes.

(7) Records are used by Division Staff to reflect case information pertaining to administrative hearings, compliance with interstate compacts pertaining to the placement and return of children across state lines, and quality assurance monitoring of Department treatment planning and service delivery.

**(c) Division of Personnel Records**

(1) The Division of Personnel system directory is located in the office of the Personnel Administrator at 170 Sigourney Street, Hartford, Conn.

(2) Records are maintained in both manual and automated form.

(3) The purpose of the system is to provide data necessary for personnel/payroll management activities and/or as required by Federal and State Law.

(4) Division personal data records are the responsibility of the Personnel Administrator, 170 Sigourney Street, Hartford, Conn. All requests for disclosure or amendment to these records should be submitted to the Personnel Administrator.

(5) Routine sources of data may include applicants for employment, employees, previous employees, references provided by applicants and other state agencies.

(6) Personal data are collected and maintained and used under authority of Sections 4-193 et seq. of the Connecticut General Statute.

(7) Records are used by Division Staff and other administrative/supervisory staff as required to record and document the performance of personnel management activities within the Department.

**(d) Division of Fiscal Services Records**

(1) The Division of Fiscal Services system directory is located in the office of the Chief Fiscal Officer at 170 Sigourney Street, Hartford, Conn.

(2) Records are maintained in both manual and automated form.

(3) The purpose of the system is to maintain vendor payment records, reimbursement for employee travel expenses and reflect activities required to secure federal and state payments for department operated programs.

(4) Division personal data records are the responsibility of the Chief Fiscal Officer, 170 Sigourney Street, Hartford, Conn. All requests for disclosure or amendment to these records should be submitted to the Chief Fiscal Officer.

(5) Routine sources of data may include vendors, employees, other state and federal agencies.

(6) Personal data are collected and maintained and used under authority of Sections 17-32 et seq. and 17-410 et seq. of the Connecticut General Statutes.

(7) Records are used by Division Staff to reflect Department receipt of federal/state funding and Department payments to vendors for services provided to or on behalf of children/families.

**(e) Division of Licensing Records**

(1) The Division of Licensing system directory is located in the office of the Division Director at 170 Sigourney Street, Hartford, Conn.

(2) Records are maintained in both manual and automated form.

(3) The purpose of the system is to record and document division activities related to the licensing/relicensing of child-caring facilities and child placing agencies, and the Adoption Resource Exchange.

(4) Division personal data records are the responsibility of the Division Director. All requests for disclosure or amendment to these records should be submitted to the Division Director.

(5) Routine sources of data may include applicants for licensing, relicenses, references, other state and federal agencies.

(6) Personal data are collected and maintained and used under authority of Sections 17-32 et seq. and 17-410 et seq. of the Connecticut General Statutes.

(7) Records are used by Division and other Department Staff to reflect activities related to assessing and determining the initial and continued compliance with licensing requirements by child-caring facilities and child-placing agencies.

**(f) Unified School District II Records**

(1) The Unified School District II system directory is located in the office of the School District Superintendent at 170 Sigourney Street, Hartford, Connecticut.

(2) Records are maintained in manual form.

(3) The purpose of the system is to maintain educational records of students served through the District and to document and record the School District's administrative functions.

(4) School District personal data records are the responsibility of the Superintendent, Unified School District II, 170 Sigourney Street, Hartford, Conn. All requests for disclosure or amendment to these records should be submitted to the Superintendent.

(5) Routine sources of data may include students, parents/guardians, teachers, private and other public education agencies.

(6) Personal Data are collected and maintained and used under authority of Section 17-441 of the Connecticut General Statutes.

(7) Records are used by the Unified School District Staff to reflect educational programs and services provided to students enrolled in the School District.

**(g) Division of Research and Evaluation—Emergency Shelter Records**

(1) The Division of Research and Evaluation—Emergency Shelter system—is located in the office of the Division Director at 170 Sigourney, Hartford, Conn.

(2) Records are maintained in automated form.

(3) The purpose of the system is to record and document referrals, admissions and services provided to children/youth by emergency shelters.

(4) Division personal data records are the responsibility of the Division Director, 170 Sigourney Street, Hartford, Conn. All requests for disclosure or amendment to these records should be submitted to the Division Director.

(5) Routine sources of data may include emergency shelter staff persons.

(6) Personal data are collected and maintained and used under authority of Section 17-48 et seq. of the Connecticut General Statutes.

(7) Records are used by Division Staff to monitor and evaluate the services provided to children/youth by emergency shelters.

**(h) Division of Data Processing Records**

(1) The Division of Data Processing system directory is located in the office of the Division Director at 170 Sigourney Street, Hartford, Conn.

(2) Records are maintained in automated form.

(3) The purpose of the system is to collect, store, and disseminate information pertaining to children and families serviced by the department and vendors of services purchased by the department.

(4) Division personal data records are the responsibility of the Division Director, 170 Sigourney Street, Hartford, Conn.

(5) Routine sources of data may include department social workers and vendors of services purchased by the department.

(6) Personal data are collected and maintained and used under authority of Sections 17-32 et seq. and 17-410 et seq. of the Connecticut General Statutes.

(7) Records are used by Division and other Department Staff to maintain and update the information pertaining to services and payments provided to or on behalf of children/families included within the programs operated by the Department.

**(i) Henry D. Altobello Children and Youth Center Records**

(1) The Henry D. Altobello Children and Youth Center system is located in the office of the Superintendent at Undercliff Road, Meriden, CT.

(2) Records are maintained in manual form.

(3) The purpose of the system is to document the diagnosis, treatment planning, treatment process and response of the child.

(4) Personal data records are the responsibility of the Superintendent, Undercliff Road, Meriden, CT. All requests for disclosure or amendment to these records should be submitted to the Superintendent.

(5) Routine sources of data may include examination and observation; interview of the child, parent or other adult caretakers; and information provided by medical personnel, educators, social workers, mental health and other professionals.

(6) Personal data are collected, maintained and used under authority of Sections 17-32 et seq. and 17-410 et seq. of the Connecticut General Statutes.

(7) Records are used by the Henry D. Altobello Children and Youth Center Staff to reflect treatment planning and services provided to children as well as to the parents/families or other caretaker of such children.

**(j) Greater Bridgeport Children's Services Center Records**

(1) The Greater Bridgeport Children's Services Center System is located in the office of the Director at 1450 Barnum Road, Bridgeport, CT.

(2) Records are maintained in manual form.

(3) The purpose of the system is to document the diagnosis, treatment planning, treatment process and response of the child and/or family in treatment.

(4) Personal data records are the responsibility of the Director, 1450 Barnum Road, Bridgeport, CT. All requests for disclosure or amendment to these records should be submitted to the Director.

(5) Routine sources of data may include examination and observation; interview of the child, parent or other adult caretakers; and information provided by medical personnel, educators, social workers, mental health and other professionals.

(6) Personal data are collected, maintained and used under authority of Sections 17-32 et seq. and 17-410 et seq. of the Connecticut General Statutes.

(7) Records are used by the Greater Bridgeport Children's Services Center Staff to reflect treatment planning and services provided to children as well as to the parents/families or other caretaker of such children.

**(k) High Meadows Records**

(1) The High Meadows system is located in the office of the Superintendent at 825 Hartford Turnpike, Hamden, CT.

(2) Records are maintained in manual form.

(3) The purpose of the system is to document the diagnosis, treatment planning, treatment process and response of the child.

(4) Personal Data records are the responsibility of the Superintendent, 825 Hartford Turnpike, Hamden, CT. All requests for disclosure or amendment to these records should be submitted to the Superintendent.

(5) Routine sources of data may include examination and observation; interview of the child, parent or other adult caretakers; and information provided by medical personnel, educators, social workers, mental health and other professionals.

(6) Personal data are collected, maintained and used under authority of Sections 17-32 et seq. and 17-410 et seq. of the Connecticut General Statutes.

(7) Records are used by High Meadows Staff to reflect treatment planning and services provided to children as well as to the parents/families or other caretaker of such children.

**(l) Housatonic Adolescent Hospital Records**

(1) The Housatonic Adolescent Hospital system is located in the office of the Superintendent, Box W, Newtown, CT.

(2) Records are maintained in manual form.

(3) The purpose of the system is to document the diagnosis, treatment planning, treatment process and response of the child.

(4) Personal Data records are the responsibility of the Superintendent, Box W, Newtown, CT. All requests for disclosure or amendment to these records should be submitted to the Superintendent.

(5) Routine sources of data may include examination and observation; interview of the child, parent or other adult caretakers; and information provided by medical personnel, educators, social workers, mental health and other professionals.

(6) Personal data are collected, maintained and used under authority of Sections 17-32 et seq. and 17-410 et seq. of the Connecticut General Statutes.

(7) Records are used by Housatonic Adolescent Hospital Staff to reflect treatment planning and services provided to children as well as to the parents/families or other caretaker of such children.

(m) **Long Lane School Records**

(1) The Long Lane School system is located in the office of the Superintendent, Long Lane, Middletown, CT.

(2) Records are maintained in manual form.

(3) The purpose of the system is to document the assessment, treatment planning, treatment process and response of the child.

(4) Personal Data records are the responsibility of the Superintendent, Long Lane, Middletown, CT. All requests for disclosure or amendment to these records should be submitted to the Superintendent.

(5) Routine sources of data may include examination and observation; interview of the child, parent or other adult caretakers, and information provided by medical personnel, educators, social workers, mental health and other professionals.

(6) Personal data are collected, maintained and used under authority of Sections 17-32 et seq. and 17-410 et seq. of the Connecticut General Statutes.

(7) Records are used by Long Lane Staff to reflect treatment planning and services provided to children as well as to the parents/families or other caretaker of such children.

(n) **RiverView Hospital Records**

(1) The RiverView Hospital system is located in the office of the Superintendent, River Road, Middletown, CT.

(2) Records are maintained in manual form.

(3) The purpose of the system is to document the diagnosis, treatment planning, treatment process and response of the child.

(4) Personal data records are the responsibility of the Superintendent, River Road, Middletown, CT. All requests for disclosure or amendment to these records should be submitted to the Superintendent.

(5) Routine sources of data may include examination and observation; interview of the child, parent or other adult caretakers; and information provided by medical personnel, educators, social workers, mental health and other professionals.

(6) Personal data are collected, maintained and used under authority of Sections 17-32 et seq. and 17-410 et seq. of the Connecticut General Statutes.

(7) Records are used by RiverView Staff to reflect treatment planning and services provided to children as well as to the parents/families or other caretaker of such children.

(o) **State Receiving Home Records.**

(1) The State Receiving Home system is located in the office of the Superintendent, 36 Gardner St., Warehouse Point, CT.

(2) Records are maintained in manual form.

(3) The purpose of the system is to document the diagnosis, treatment planning, treatment process and response of the child.

(4) Personal data records are the responsibility of the Superintendent, 36 Gardner St., Warehouse Point, CT. All requests for disclosure or amendment to these records should be submitted to the Superintendent.

(5) Routine sources of data may include examination and observation; interview of the child, parent or other adult caretakers; and information provided by medical personnel, educators, social workers, mental health and other professionals.

(6) Personal data are collected, maintained and used under authority of Sections 17-32 et seq. and 17-410 et seq. of the Connecticut General Statutes.

(7) Records are used by the State Receiving Home Staff to reflect treatment planning and services provided to children as well as to the parents/families or other caretaker of such children.

(p) **Wilderness School Records**

(1) The Wilderness School personal data records are maintained at the school in Tunxis State Forest, East Hartland, Connecticut.

(2) Records are maintained in manual form.

(3) The purpose of the system is to document the admission and participation of children/youth in the wilderness experience summer program and the year-round follow-up programs for participants who have returned to their communities.

(4) Wilderness School personal data records are the responsibility of the School Director, Tunxis State Forest, East Hartland, CT. All requests for disclosure or amendment to these records should be submitted to the Superintendent.

(5) Routine sources of data may include child/youth, family and other significant adult persons, court personnel, school personnel, and other youth service agencies.

(6) Personal data are collected, maintained and used under authority of 17-410 et seq. of the Connecticut General Statutes.

(7) Records are used by the Wilderness School Staff to reflect services provided to participants in the school programs and to parents/families or other caretaker of such children.

(Effective April 27, 1987)

**Sec. 17-415 (g)-8. Categories of personal data**

The following categories of personal data may be maintained:

(a) **Division of Children and Protective Services records**

(1) Personal data records may include social and family history, education, financial, medical, emotional condition, personal relationships, reputation or character description, treatment plans and placement planning and services.

(2) Categories of other data may include social security numbers, case numbers, control systems and correspondence.

(3) Records are maintained pertaining to children and families serviced by the Division of Children and Protective Services.

(b) **Division of Treatment Standards and Assurance Records**

(1) Personal data records may include social and family history, education, financial, medical, emotional condition, personal relationships, reputation or character description, treatment plans and placement planning and services.

(2) Categories of other data may include social security numbers, case numbers, control systems, correspondence and survey reports.

(3) Records are maintained which may pertain to children/youth, child-caring facilities, child placing agencies, and vendors of services purchased by the department.

**(c) Division of Personnel Records**

(1) Personal data records may include employment history, salary records, education, mental/emotional condition or history, and references.

(2) Categories of other data may include social security numbers, employee numbers, and addresses.

(3) Records are maintained pertaining to department applicants for employment and employees.

**(d) Division of Fiscal Services Records**

(1) Personal data records may include financial payments, vendor names and addresses, children's income and assets, requests for and receipt of federal and state payments to the department.

(2) Categories of other data may include social security numbers and case numbers.

(3) Records are maintained pertaining to payments made on behalf of children/families involved in Department programs and reimbursements secured by the Department.

**(e) Division of Licensing Records**

(1) Personal data records may include social and family history, education, financial, medical, emotional condition, personal relationships, reputation or character description, photo listing of children free for adoption and listing of families seeking to adopt a child.

(2) Categories of other data may include controls, correspondence and reports.

(3) Records are maintained pertaining to child care facilities, child placing agencies licensed by the Department and to reflect the operation of the Adoption Resource Exchange.

**(f) Unified School District II Records**

(1) Personal data records may include social and family history, education, financial, medical, emotional condition.

(2) Categories of other data may include program and case identification numbers.

(3) Records are maintained pertaining to students serviced by the Unified School District II.

**(g) Division of Research and Evaluation—Emergency Shelter Records**

(1) Personal data records may include name, age, sex of applicant/resident of emergency shelter, prior and planned future living arrangements, dates of admission and discharge, and reasons for admission.

(2) Categories of other data may include social security numbers, case numbers, correspondence and monitoring reports.

(3) Records are maintained pertaining to youth in need of emergency shelter services.

**(h) Division of Data Processing Records**

(1) Personal data records may include social and family history, education, financial, emotional condition, personal relationships.

(2) Categories of other data may include social security and case numbers.

(3) Records are maintained pertaining to children and families serviced by the Department and vendors of services purchased by the Department.

**(i) Henry D. Altobello Children and Youth Center Records**

(1) Personal data records may include medical and emotional condition and history, family and personal relationships, character, finances, education and work history.

(2) Categories of other data may include social security and case numbers.

(3) Records are maintained in the name of the child/patient but may contain information about family members and/or other significant adult persons.

**(j) Greater Bridgeport Children's Services Center Records**

(1) Personal data records may include medical and emotional condition and history, family and personal relationships, character, finances, education and work history.

(2) Categories of other data may include social security and case numbers.

(3) Records are maintained in the name of the child/patient but may contain information about family members and/or other significant adult persons.

**(k) High Meadows Records**

(1) Personal data records may include medical and emotional condition and history, family and personal relationships, character, finances, education and work history.

(2) Categories of other data may include social security and case numbers.

(3) Records are maintained in the name of the child/patient but may contain information about family members and/or other significant adult persons.

**(l) Housatonic Adolescent Hospital Records**

(1) Personal data records may include medical and emotional condition and history, family and personal relationships, character, finances, education and work history.

(2) Categories of other data may include social security and case numbers.

(3) Records are maintained in the name of the child/patient but may contain information about family members and/or other significant adult persons.

**(m) Long Lane School Records**

(1) Personal data records may include medical and emotional condition and history, family and personal relationships, character, finances, education and work history.

(2) Categories of other data may include social security and case numbers.

(3) Records are maintained in the name of the child but may contain information about family members and/or other significant adult persons.

**(n) RiverView Hospital Records**

(1) Personal data records may include medical and emotional condition and history, family and personal relationships, character, finances, education and work history.

(2) Categories of other data may include social security and case numbers.

(3) Records are maintained in the name of the child/patient but may contain information about family members and/or other significant adult persons.

**(o) State Receiving Home Records**

(1) Personal data records may include medical and emotional condition and history, family and personal relationships, character, finances, education and work history.

(2) Categories of other data may include social security and case numbers.

(3) Records are maintained in the name of the child but may contain information about family members and/or other significant adult persons.

**(p) Wilderness School Records**

(1) Personal data records may include education, financial, medical, emotional history, family and personal relationships, and information pertaining to child/youth

participation in programs while at Wilderness School and in other programs upon return to the community.

(2) Categories of other data may include social security and case numbers.

(3) Records are maintained pertaining to youth who are/or have participated in school programs.

(Effective April 27, 1987)

**Sec. 17-415 (g)-9. Maintenance of personal data**

(a) Personal data will not be maintained unless relevant and necessary to accomplish the lawful purposes of the agency. Where the agency finds irrelevant or unnecessary public records in its possession, the agency shall dispose of the records in accordance with its records retention schedule and with the approval of the Public Records Administrator as per Conn. Gen. Stat. § 11-8a. or, if the records are not disposable under the records retention schedule, request permission from the Public Records Administrator to dispose of the records under Conn. Gen. Stat. § 11-8a.

(b) The agency will collect and maintain all records with accurateness and completeness.

(c) Insofar as it is consistent with the needs and mission of the agency, the agency, wherever practical, shall collect personal data directly from the persons to whom a record pertains.

(d) Agency employees involved in the operations of the agency's personal data systems will be informed of the provisions of: (i) the Personal Data Act; (ii) the agency's regulations adopted pursuant to § 4-196; (iii) the Freedom of Information Act and (iv) any other state or federal statute or regulations concerning maintenance or disclosure of personal data kept by the agency.

(e) All agency employees shall take reasonable precautions to protect personal data under their custody from the danger of fire, theft, flood, natural disaster and other physical threats.

(f) The agency shall incorporate by reference the provisions of the Personal Data Act and regulations promulgated thereunder in all contracts, agreements or licenses for the operation of personal data system or for research, evaluation and reporting of personal data for the agency or on its behalf.

(g) The department shall have an independent obligation to insure that personal data requested from any other agency is properly maintained.

(h) Only agency employees who have a specific need to review personal data records for lawful purposes of the agency will be entitled to access to such records under the Personal Data Act.

(i) The agency will keep a written up-to-date list of individuals entitled to access to each of the agency's personal data system.

(j) The agency will insure against unnecessary duplication of personal data records. In the event it is necessary to send personal data records through interdepartmental mail, such records will be sent in envelopes or boxes sealed and marked "confidential."

(k) The agency will insure that all records in manual personal data systems are kept under lock and key and, to the greatest extent practical, are kept in controlled access areas.

(l) With Respect To Automated Personal Data Systems

(1) The agency shall, to the greatest extent practical, locate automated equipment and records in a limited access area:

(2) To the greatest extent practical, the agency shall require visitors to such area to sign a visitor's log and permit access to said area on a bona-fide need-to-enter basis only.

(3) The agency, to the greatest extent practical, will insure that regular access to automated equipment is limited to the operations personnel.

(4) The agency shall utilize appropriate access control mechanisms to prevent disclosure of personal data to unauthorized individuals.

(m) Records for each personal data system are maintained in accordance with schedules prepared by the Connecticut State Library, Department of Public Records Administration and records retention schedules approved by the Public Records Administrator as authorized by Section 11-8a of the C.G.S. Retention schedules are on file at the Central Office of the Department of Children and Youth Services and may be examined during normal working hours.

(Effective April 27, 1987)

### **Sec. 17-415 (g)-10. Disclosure of personal data**

(a) Within four business days of receipt of a written request therefore, the agency shall mail or deliver to the requesting individual a written response in plain language, informing him/her as to whether or not the agency maintains personal data on that individual, the category and location of the personal data maintained on that individual and procedures available to review the records.

(b) Except where nondisclosure is required or specifically permitted by law, the agency shall disclose to any person upon written request all personal data concerning that individual which is maintained by the agency. The procedures for disclosure shall be in accordance with Conn. Gen. Stat. §§ 1-15 through 1-21k. If the personal data is maintained in coded form, the agency shall transcribe the data into a commonly understandable form before the disclosure.

(c) The agency is responsible for verifying the identity of any person requesting access to his/her own personal data.

(d) The agency is responsible for ensuring that disclosure made pursuant to the Personal Data Act is conducted so as not to disclose any personal data concerning persons other than the person requesting the information.

(e) The agency may refuse to disclose to a person medical, psychiatric or psychological data on the person if the agency determines that such disclosure would be detrimental to that person. Additionally, the agency may refuse to disclose to a person personal data pertaining to that person if such nondisclosure is otherwise permitted or required by law.

(f) In any case where the agency refuses disclosure, it shall advise that person of his/her right to seek judicial relief pursuant to the Personal Data Act.

(g) If the agency refuses to disclose medical, psychiatric or psychological data to a person based on its determination that disclosure would be detrimental to that person and nondisclosure is not mandated by law, the agency shall, at the written request of such person, permit a qualified medical doctor to review the personal data contained in the person's record to determine if the personal data should be disclosed. If disclosure is recommended by the person's medical doctor, the agency shall disclose the personal data to such person; if non disclosure is recommended by such person's medical doctor, the agency shall not disclose the personal data and shall inform such person of the judicial relief provided under the Personal Data Act.

(h) The agency shall maintain a complete log of each person, individual, agency or organization who has obtained access or to whom disclosure has been made of

personal data under the Personal Data Act, together with the reason for each such disclosure or access. This log shall be maintained for not less than five years from the date of such disclosure or access or for the life of personal data record, whichever is longer.

(i) When an individual is asked to supply personal data to a state agency, including the agency, the agency shall disclose to that individual, upon request:

(1) The name of such agency and division within such agency requesting the personal data;

(2) The legal authority under which such agency is empowered to collect and maintain the personal data;

(3) The individual's rights pertaining to such records under the Personal Data Act and agency regulations;

(4) The known consequences arising from supplying or refusing to supply the requested personal data; and

(5) The proposed use to be made of the requested personal data.

(Effective April 27, 1987)

**Sec. 17-415 (g)-11. Contesting the content of personal data records**

(a) Any person who believes that the agency is maintaining inaccurate, incomplete or irrelevant personal data concerning him/her may file a written request with the agency for correction of said personal data;

(b) Within 30 days of receipt of such request, the agency shall give written notice to that person that it will make the requested correction, or if the correction is not to be made as submitted, the agency shall state the reason for its denial of such request and notify the person of his/her right to add his/her own statement to his/her personal data records.

(c) Following such denial by the agency, the person requesting such correction shall be permitted to add a statement to his or her personal data record setting forth what that person believes to be an accurate, complete and relevant version of the personal data in question. Such statements shall become a permanent part of the agency's personal data system and shall be disclosed to any individual, agency or organization to which the disputed personal data is disclosed.

(Effective April 27, 1987)

**Administration of Medication in Day Programs and Residential Facilities by Trained Persons**

**Secs. 17-415 (g)-12—17-415 (g)-16.**

Transferred, February 1, 1994.

<i>Former Number</i>	<i>New Number</i>
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17-415 (g)-13	17a-6 (g)-13
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Transferred, February 1, 1994.

<i>Former Number</i>	<i>New Number</i>
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Transferred, February 1, 1994.

<i>Former Number</i>	<i>New Number</i>
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Transferred, February 1, 1994.

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Transferred and amended, February 8, 1993.

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## Community Action Agencies

### Sec. 17-470-1. Definitions

(a) "Commissioner" means the Commissioner of Human Resources.

(b) "Community Action Agency" means a public or private nonprofit agency which has previously been designated by and authorized to accept funds from the Federal Community Services Administration (CSA) for Community Action Agencies under the Economic Opportunity Act of 1964 or a successor agency established pursuant to section 17-467 of the Connecticut General Statutes.

(c) "Community Action Program" means a community based and operated program which:

(1) Includes or is designated to include a sufficient number of projects or components to provide a range of services and activities having a measurable and potentially major impact on the causes of poverty in the community or those areas of the community where poverty is a particularly acute problem.

(2) Organizes and combines its component projects and activities in a manner appropriate to carry out the provisions of Chapter 311 of the Connecticut General Statutes and these regulations.

(3) Conforms to any other criteria the Commissioner may prescribe consistent with the provisions of Chapter 311 of the Connecticut General Statutes and these regulations.

(d) "Community" means a municipality or a county, or any combination thereof, or a neighborhood or other area, irrespective of boundaries or political subdivisions, which provides a suitable organizational base and possesses the commonality of interest and need for a community action program.

(e) "Delegate Agency/Sub-contractor" means an organization which is given all or a significant portion of the responsibility for carrying out a program by a Community Action Agency.

(Effective March 5, 1986)

### Sec. 17-470-2. Community action boards

(a) Each Community Action Agency shall administer its program through a community action board which shall consist of not more than fifty-one and not less than fifteen members and shall be so constituted that:

(1) One-third of the members of the board are elected public officials currently holding office, or their designees, except that if the number of elected officials reasonably available and willing to serve is less than one-third of the membership of the board, membership on the board of appointive public officials may be counted in meeting such one-third requirement.

(2) At least one-third of the members of the board are persons chosen in accordance with democratic selection procedures adequate to assure that they are representative of the poor in the area served; and

(3) The remainder of the members of the board are officials or members of business, industry, labor, religious, welfare, education or other major groups and interests in the community.

(b) Each member of the board selected to represent a specific geographical area within a community shall reside in the area he represents. No person selected under subdivision (2) or (3) of subsection (a) as a member of the board shall serve on such board for more than five consecutive years, or more than a total of ten years.

(c) The responsibilities of the board shall include but not be limited to the following:

- (1) Appointment of the Executive Director of the agency;
  - (2) Determination of major personnel, fiscal, and program policies;
  - (3) Determination of overall program plans and priorities, including the provisions for evaluating progress against performance;
  - (4) Final approval of all program proposals and budgets;
  - (5) Enforcement of compliance with all conditions of all grants;
  - (6) Determination of rules of procedure for the Board;
  - (7) Selection of officers and the Executive Committee of the Board.
- (Effective March 5, 1986)

**Sec. 17-470-3. Functions of community action agencies**

The functions of a community action agency shall, subject to the provisions of Chapter 311 of the Connecticut General Statutes and the approval of the commissioner of human resources, include, but not be limited to:

(a) Planning systematically for and evaluating the program, including actions to develop information as to the problems and causes of poverty in the community, to determine how much and how effectively assistance is being provided to deal with those problems and causes, and to establish priorities among projects, activities, and areas as needed for the best and most efficient use of resources;

(b) Encouraging agencies engaged in activities related to the community action program to plan for, secure and administer assistance available under Chapter 311 of the Connecticut General Statutes or from other sources on a common or cooperative basis; providing planning or technical assistance to those agencies; and generally, in cooperation with community agencies and officials, undertaking actions to improve existing efforts to attack poverty, such as improving day to day communications, closing the service gaps, focusing resources on the most needy, and providing additional opportunities to low-income individuals for regular employment or participation in the programs or activities for which those community action agencies and officials are responsible;

(c) Initiating and sponsoring projects responsive to needs of the poor which are not otherwise being met, with particular emphasis on providing central or common services that can be drawn upon by a variety of related programs, developing new approaches or new types of services that can be incorporated into other programs, and filling gaps pending the expansion or modification of those programs; providing technical assistance and other support needed to enable the poor and neighborhood groups to secure on their own behalf available assistance from public and private sources; and

(d) joining with and encouraging business, labor and other private groups and organizations to undertake, together with public officials and agencies, activities in support of the community action program which will result in the additional use of private resources and capabilities, with a view to such things as developing new employment opportunities, stimulating investment that will have a measurable impact in reducing poverty among residents of areas of concentrated poverty, and providing methods by which residents of those areas can work with private groups, firms and institutions in seeking solutions to problems of common concern.

(Effective March 5, 1986)

**Sec. 17-470-4. Authority of community action agencies**

A community action agency shall have authority to enter into contracts with private and public nonprofit agencies, to receive and administer funds received pursuant to Chapter 311 of the Connecticut General Statutes, to receive and adminis-

ter funds and contributions from private and local public sources which may be used in support of a community action program, and to receive and administer funds under any federal or state assistance program pursuant to which a public or private nonprofit agency, organized in accordance with this chapter could act as grantee, contractor or sponsor of projects appropriate for inclusion in a community action program. Community action agencies and limited purpose agencies previously funded by the Community Services Administration, subject to federal law or regulation, shall be given first priority in the allocation of federal funds under the Community Services Block Grant Act or of any subsequent federal funds that were previously designated as Community Services Administration funds. Such funds shall be distributed through an agreement between the commissioner and the community action agencies. The agreement will be based on criteria that include the percentage of population that is at or below 150% of the Federal Poverty Guideline established by the Office of Management and Budget in each Community Action Agency service district; the demography of each Community Action Agency service area; the availability of funds; and the discretion of the Commissioner. If such agreement is not reached by four weeks before the block grant plan is to be submitted to the general assembly pursuant to section 4-28b, the governor and the commissioner shall make the final decision on distribution. In the event the community services block grant is eliminated, each community action agency shall also be given due consideration, subject to the restrictions of applicable law or regulations, in the distribution of federal, state or municipal funds that are available to support antipov-erty programs that have been administered by that agency on or after July 1, 1981. A community action agency, subject to the approval of its governing board, shall have authority to transfer funds received and to delegate powers to other agencies.

(Effective March 5, 1986)

#### **Sec. 17-470-5. Fiscal accountability of a community action agency**

(a) The Community Action Agency will establish and will, for each approved program funded by the Commissioner, maintain in a bank or banks, which are members of the Federal Deposit Insurance Corporation, a separate and special fund which will be designated "Expenditures Account" with identifying number. The Community Action Agency will promptly deposit in such account all funds received pursuant to an approved program funded by the Commissioner.

(b) The Community Action Agency will, at or prior to opening any bank account, enter into an appropriate agreement with the bank in which such account is to be opened which makes effective certain rights of the Commissioner. An executed copy of the bank agreement must be submitted by the Community Action Agency to the Commissioner.

(c) The Commissioner may waive the requirements of Section 17-470-5 (a)-(b) herein in writing if he determines such waiver to be beneficial to the operation of the program based on previous administrative practice or a Community Action Agency is under the fiscal control of a municipality and not contrary to the best interests of the State.

(d) The Community Action Agency shall maintain books, records, documents, program and individual service records and other evidence of its accounting and billing procedures and practices, which sufficiently and properly reflect all direct and indirect costs of any nature incurred in the performance of this regulation. These records shall be subject at all reasonable times to monitoring, inspection, review or audit by authorized employees or agents of the Commissioner or the State or

interested Federal agencies. The Community Action Agency shall collect fiscal statistical data and submit fiscal statistical reports at times and in the manner prescribed by the Commissioner. The Community Action Agency will retain all such books, records, other financial and program and individual service documents concerning this regulation for a period of three (3) years after a completed audit.

(e) In the event the Commissioner has advanced funds to the Community Action Agency, the Community Action Agency shall at the end of the contract period, or earlier if the contract is terminated, pay back to the Commissioner, in full, any unexpended advanced funds; or such unexpended advanced funds may at the discretion of the Commissioner be carried over and used as part of the next advance if a new similar agreement with the Community Action Agency is executed. The same provisions will hold true with regard to any other monies owed to the Commissioner including audit exceptions. The Community Action Agency will remit to the Department of Human Resources that portion of such unexpended funds which is due and owing to the Department of Human Resources as determined by the Commissioner.

(f) Audits of programs administered by community action agencies, as defined in section 17-460, shall be conducted in a comprehensive fashion and the number of such audits conducted with respect to programs administered by a single community action agency shall be limited to the minimum required by state or federal law. Where permitted by Section 7-396a of the Connecticut General Statutes, a single independent audit shall be conducted on a yearly basis for each community action agency.

(Effective March 5, 1986)

#### **Sec. 17-470-6. Community participation**

Each Community Action Agency shall establish procedures to assure maximum feasible participation of neighborhood based organizations, residents of the community and members of the groups served to assist such agency in prioritizing, planning, conducting and evaluating components of the community action program. Agency priorities established under section 17-470-7 shall not be modified without substantial documentation of changed circumstances and, when practical, the approval of the parties involved in setting those priorities.

(Effective March 5, 1986)

#### **Sec. 17-470-7. Program priorities**

The priorities of a Community Action Program may include, but not be limited to, component projects designed to assist eligible participants, including the elderly poor, in attaining the following objectives:

- (1) To secure and retain meaningful employment;
- (2) To obtain adequate education;
- (3) To provide for education and care of young children;
- (4) To make better use of available income;
- (5) To provide and maintain adequate housing and a suitable living environment;
- (6) To provide information and education, and access to healthful nutrition;
- (7) To obtain services for the prevention of and rehabilitation from drug abuse and alcoholism;
- (8) To obtain emergency assistance to meet immediate and urgent individual and family needs, including the need for health services, nutritious food, housing, energy and unemployment-related assistance;
- (9) To remove obstacles and solve personal and family problems which block the achievement of self-sufficiency;

- (10) To achieve greater participation in the affairs of the community;
  - (11) To make more frequent and effective use of other programs related to the purposes of Chapter 311 of the Connecticut General Statutes; and
  - (12) To stimulate and take full advantage of capabilities for self-advancement.
- (Effective March 5, 1986)

#### **Sec. 17-470-8. Delegation of authority**

(a) Where consistent with sound and efficient management and subject to federal law and regulations and these regulations a Community Action Agency may delegate the administration of component projects to delegate agency/sub-contractors. When a Community Action Agency places responsibility for major policy determinations with respect to the character, funding, extent and administration of, and budgeting for, programs to be carried on in a particular geographic area within the community in subsidiary board, council, or similar agency, such board, council or agency shall be broadly representative of such area. The Community Action Agency shall be responsible to the Commissioner for ensuring that the delegate agency sub-contractor will comply with the terms and conditions of the regulation. The Community Action Agency will execute an agreement with the delegate agency/sub-contractor in the manner and form prescribed by the Commissioner. The Community Action Agency may require additional contract provisions to ensure compliance with applicable statutes, regulations or by-laws as it sees fit to impose.

(b) Representatives of community action agencies shall be recognized as knowledgeable on issues affecting low income, elderly and handicapped citizens for the purposes of sharing information with governmental bodies considering such issues.

(Effective March 5, 1986)

#### **Sec. 17-470-9. Process to revoke a community action agency designation**

A Community Action Agency shall lose its designation to serve a political subdivision, or a group of political subdivisions, only if the Commissioner finds after adequate notice, a written statement of reasons and a fair hearing held in the community served by the agency that such agency has materially failed to comply with Chapter 311 of the Connecticut General Statutes and these regulations. The procedure to revoke a Community Action Agency's designation is as follows:

(a) The Commissioner will inform the Executive Director of the Community Action Agency in writing if he has reason to believe that the Community Action Agency is in non-compliance with these regulations or Chapter 311 of the Connecticut General Statutes. The communication will advise the Community Action Agency on what course of action will be required to come into compliance.

(b) The Community Action Agency will have thirty (30) days to respond in writing to the requirements prescribed by the Commissioner.

(c) The failure or refusal of the Community Action Agency to come into compliance with the policy as prescribed by the Commissioner within thirty (30) days of the initial communication will result in a notice sent to the Chairman of the Board. This notice will inform the chairman that the Community Action Agency is not in compliance and will contain a written statement of the specific reasons for the Commissioner's finding of noncompliance, and will outline what specific course of action will be required to come into compliance.

(d) If a best effort by the Community Action Agency to come into compliance has not occurred within the second 30 day time period, the Commissioner will send a notice of his intent to hold a hearing. This letter will be sent to the executive

director and the chairman of the board by registered mail and will include the place and time for the hearing.

(e) The Commissioner's decision on the hearing will be provided within 30 days.

(f) If the decision of the Commissioner is adverse to the agency, the Commissioner may provide financial assistance to other public or private non profit agencies to aid them in establishing a community action agency in the area no longer served.

(Effective March 5, 1986)

**Sec. 17-470-10. Financial assistance**

The Commissioner may provide financial assistance to Community Action Agencies for planning, conducting, administering and evaluating Community Action Programs and component projects.

(Effective March 5, 1986)

**Sec. 17-470-11. Civil rights**

All Community Action Agencies, other agencies, contractors and boards thereof included in the provisions of this regulation, shall comply with federal, state and local civil rights laws.

(Effective March 5, 1986)

**Sec. 17-470-12. Administrative requirements**

To the extent that Community Action Agencies as defined in Section 17-470-1 of these regulations, are also Human Resources Development Agencies, as defined in Section 8-221 of the Connecticut General Statutes, further administrative requirements, including those governing provision of state financial assistance by the Commissioner are available at and may be obtained from the Office of the Commissioner of the Department of Human Resources.

(Effective March 5, 1986)

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## Opportunities Industrialization Center

### Sec. 17-478-1. Definitions

(a) “Commissioner” means the Commissioner of the State Department of Human Resources.

(b) “Department” means the Connecticut State Department of Human Resources.

(c) “Economically disadvantaged” means an individual whose income based on the total gross annual income, excluding assets, does not exceed 150% of the Federal Poverty Income Guidelines for the current year.

(d) “Opportunities Industrialization Center (OIC)” is an organization which provides a full range of comprehensive employment training programs that provide recruitment, counseling, remediation, motivational prejob training, vocational training, job development, job placement and other appropriate services enabling disadvantaged and under-skilled individuals to secure and retain employment at their maximum capacity. Such a center may be affiliate of the Opportunities Industrialization Centers of America, Incorporated or a community-based organization that provides comparable services.

(e) “Underemployed” means an individual working part-time but seeking full-time work; or working full-time but receiving wages below 150% of the Federal Poverty Income Guidelines established by the Commissioner of Human Resources, in cooperation with the Commissioners of Labor and Income Maintenance.

(f) “Unemployed” means an individual who is without a job, is available for work and is seeking full-time work.

(Effective November 20, 1986)

### Sec. 17-478-2. OIC boards

(a) Each Opportunities Industrialization Center shall administer its program through a board consisting of not more than fifty-one and not less than fifteen members who represent a cross-section of the community.

(b) The responsibilities of the board shall include, but not be limited to, the following:

(1) Appointment of the Executive Director of the agency;

(2) Determination of major personnel, fiscal, and program policies;

(3) Final approval of all program proposals and budgets;

(4) Enforcement of compliance with all conditions of all DHR grants;

(5) Determination of overall program plans and priorities, including the provisions for evaluating progress against performance;

(6) Determination of rules of procedure for the Board;

(7) Selection of officers and the Executive Committee of the Board.

(Effective November 20, 1986)

### Sec. 17-478-3. Eligibility

(a) An OIC may be eligible for program funding if at least 80% of the program participants are underemployed or unemployed. Such individuals may include those who have limited English-language proficiency or are displaced homemakers, school dropouts, teenage parents, handicapped older workers, veterans, offenders, alcoholics, or addicts.

(b) Priority shall be given to individuals who receive assistance from a town under Chapter 308 of the Connecticut General Statutes.

(Effective November 20, 1986)

**Sec. 17-478-4. Criteria for distribution of funds**

The criteria for distribution of funds shall include the following requirements:

(a) An OIC receiving State assistance shall submit a grant action request/program design and financing plan to their Board of Directors for approval.

(b) After the Board approves the plan, the OIC shall submit the grant action request/program design and financing plan to DHR for review and approval.

(c) An approved grant action request/program design and financing plan shall demonstrate that:

(1) The OIC has consulted with the Commissioners of Income Maintenance and Labor in the planning and operation of the program;

(2) The OIC involved residents in the region to be served by the program in the planning and operation of the program;

(3) The OIC involved the business community in the region to be served by the program in its development and operation;

(4) The OIC gave priority to persons who receive assistance from a town under chapter 308.

(d) The program receiving financial assistance shall have adequate internal administrative controls, accounting procedures, personnel standards, evaluation procedures, availability of inservice training and technical assistance programs and other policies as are necessary to promote the effective use of funds received under said sections.

(Effective November 20, 1986)

**Sec. 17-478-5. Limits of assistance**

(a) This is not an entitlement program.

(b) OIC allocations shall be based on the availability of State Funds and the availability of funding levels from other grant sources.

(c) DHR may also provide funding for the operation of an organization which provides research and development, management, staff salaries, and the recruitment of major sources of funding.

(d) DHR financial assistance to an OIC shall include, but not be limited to: rent, insurance, utilities and administrative salaries.

(e) An OIC shall have the authority to use DHR funds to pay for program expenses.

(f) Final funding allocations shall be determined by the Commissioner of Human Resources.

(Effective November 20, 1986)

**Sec. 17-478-6. Program priorities**

The priorities of a OIC may include, but not be limited to, the provision of the following services:

1. Recruitment
2. Counseling
3. Remediation
4. Motivational prejob training
5. Vocational training
6. Job development
7. Job placement

(Effective November 20, 1986)

**Sec. 17-478-7. Fiscal accountability of an opportunities industrialization center**

(a) An OIC shall deposit DHR funds in a bank or banks which are members of the Federal Deposit Insurance Corporation. The OIC Agency shall promptly deposit in a bank account all DHR funds received pursuant to an approved program funded by the Commissioner.

(b) The Commissioner may waive in writing the requirements of Section 17-478-7 (a) herein if he determines such waiver to be beneficial to the operation of the program based on previous administrative practice.

(c) The OIC shall maintain books, records, documents, program and individual service records and other evidence of its accounting and billing procedures and practices, which sufficiently and properly reflect all direct and indirect costs of any nature incurred in the performance of this regulation. These records shall be subject at all reasonable times to monitoring, inspection, review or audit by authorized employees or agents of the Commissioner or the State or interested Federal agencies. The OIC shall collect fiscal statistical data and submit fiscal statistical reports at times and in the manner prescribed by the Commissioner. The OIC will retain all such books, records, other financial and program and individual services documents concerning this regulation for a period of three (3) years after a completed audit.

(d) In the event the Commissioner has advanced funds to the OIC Agency, the OIC shall at the end of the contract period, or earlier if the contract is terminated, pay back to the Commissioner, in full, any unexpended advanced funds; or such unexpended advanced funds may at the discretion of the Commissioner be carried over and used as part of the next advance if a new similar agreement with the OIC is executed. The same provisions will hold true with regard to any other monies owed to the Commissioner including audit exceptions. The OIC will remit to the Department of Human Resources that portion of such unexpended funds which is due and owing to the Department of Human Resources as determined by the Commissioner.

(e) There shall be a single annual audit for each DHR funded program administered by an OIC prepared by a reputable firm of independent certified public accountants no later than six months after the end of the program year.

(Effective November 20, 1986)

**Sec. 17-478-8. Civil rights**

All Opportunities Industrialization Centers shall comply with Federal, State and local civil rights laws.

(Effective November 20, 1986)

**Sec. 17-478-9. Process to defund an opportunities industrialization center**

An Opportunities Industrialization Center shall be defunded only if the Commissioner finds after adequate notice, a written statement of reasons and a hearing held in the community served by the agency that such agency has materially failed to comply with Chapter 312 of the Connecticut General Statutes and these regulations. The procedure to defund an Opportunities Industrialization Center is as follows:

(a) The Commissioner will inform the Executive Director of the Opportunities Industrialization Center in writing if he has reason to believe that the Opportunities Industrialization Center is in non-compliance with these regulations or Chapter 312 of the Connecticut General Statutes. The communication will advise the Opportunities Industrialization Center on what course of action will be required to come into compliance.

(b) The Opportunities Industrialization Center will have thirty (30) days to respond in writing to the requirements prescribed by the Commissioner.

(c) The failure or refusal of the Opportunities Industrialization Center to come into compliance with the policy as prescribed by the Commissioner within thirty (30) days of the initial communication will result in a notice sent by the Commissioner to the Chairman of the Board. This notice will inform the chairman that the Opportunities Industrialization Center is not in compliance and will contain a written statement of the specific reasons for the Commissioner's finding of noncompliance, and will outline what specific course of action will be required to come into compliance.

(d) If a best effort by the Opportunities Industrialization Center to come into compliance has not occurred within the second 30 day time period, the Commissioner will send a notice of his intent to hold an administrative hearing. This letter will be sent to the executive director and the chairman of the board by registered mail and will include the place and time for the hearing.

(e) The Commissioner's decision on the hearing will be provided within 90 days.

(f) If the decision of the Commissioner is adverse to the agency, the Commissioner may provide financial assistance to other public or private nonprofit agencies to aid them in establishing an Opportunities Industrialization Center in the area no longer served.

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## Emergency Shelters

### Sec. 17-590-1. Definitions

As used in Sections 17-590-1 to 17-590-7 inclusive, as follows:

(a) “Applicant” means a public, or private organization or agency that has submitted an emergency shelter grant application to the Department of Human Resources.

(b) “Client” means any homeless individual eighteen (18) years of age or over, or homeless family, or emancipated minor, who is in need of and requests emergency shelter services.

(c) “Commissioner” means the Commissioner of the Department of Human Resources or a designee.

(d) “Dangerous weapon” means any instrument, article or substance which is capable of causing death or serious bodily injury.

(e) “Department” means the Department of Human Resources.

(f) “Emergency” means a situation in which immediate action must be taken to meet the needs of individuals or families who do not have sufficient resources to secure shelter.

(g) “Emergency Shelter” means housing in a single, accessible location, excluding residential treatment centers for drug and/or alcohol abuse, youth shelters, halfway houses and transitional living programs, that provides at a minimum, sleeping and bathroom facilities for homeless individuals and families in a facility that meets local building, health, fire, safety and handicapped persons access codes, and zoning requirements.

(h) “Emergency Shelter Services” means, but is not limited to, purchase of emergency shelter services in other than a central facility, and the social, health and related services that may be part of the individual emergency shelter program. It does not include residential treatment centers for drug and/or alcohol abuse, youth services, halfway houses and transitional living programs.

(i) “Grant Application” means a request for funds to develop and/or maintain an emergency shelter program and may include one or more of the following eligible expenses: minor facility renovation, administrative and program expenses, and/or purchase of emergency shelter services.

(j) “Operator” means the applicant, or designee of the applicant, who is responsible for the on-site management and operation of the emergency shelter, and/or the administration of emergency shelter services.

(k) “Physical assault” means a willful touching of a person by another person with intent to do harm with any instrument, article or substance, or any portion of the body, and shall include the attempted use of a dangerous weapon by one person against another.

(l) “Resident” means a person who receives any type of services from a shelter program which is a recipient of Department funding.

(m) “Threat” means a verbal or physical expression of an intent to harm, or otherwise cause bodily injury to another person or to damage property.

(Effective February 1, 1993)

### Sec. 17-590-2. Application process

(a) The Commissioner shall review and approve the operating policies of shelters receiving grants from the Department. The Department shall require an applicant or recipient to comply with the following requirements in order to receive funding for emergency shelter services:

(1) Demonstrate sufficient demand for emergency shelter services and/or emergency shelter services in a particular location.

(2) Demonstrate that the applicant has the administrative and managerial capability to establish and operate an emergency shelter facility and/or provide emergency services in a sensitive, humane and cost effective manner.

(3) Submit an application to the Commissioner that includes the following written information:

(A) table of organization and by-laws of governing body;

(B) written operating/admission policies;

(C) written grievance procedures;

(D) house rules;

(E) a description of program staffing (paid/volunteer) that indicates a minimum staff to client ratio of one staff member per 25 residents;

(F) goals and objectives of program;

(G) a description of the emergency shelter services which will be provided;

(H) a description of the physical facility as to: location; accessibility to transportation and health/social and related services; type and size of building; handicapped persons access; any available parking area; space allocation for shelter activities and capacity of shelter;

(I) evidence of conformity of the program and building to local zoning ordinances, local building codes and state fire and health regulations;

(J) schedule of the daily operation of the emergency shelter and services offered;

(K) completed Department budget forms that contain the fiscal information necessary for the Commissioner to authorize payments based on each shelter's capacity and the level of funding available from other sources; and

(L) if applicable, a report on the number of grievances filed pursuant to the shelter grievance procedure, the reasons for each grievance, and the disposition of each grievance.

(4) Submit operating policies that comply with Section 17-590-4 and Section 17-590-5.

(5) Submit grievance procedures that comply with Section 17-590-6 and Section 17-590-7.

(b) All grant requests may be accepted, rejected or modified at the discretion of the Commissioner. The decision of the Commissioner may not be appealed.

(c) The applicant will be notified in writing of the acceptance or rejection of the application within sixty (60) days. If an application is rejected, the applicant will be notified of the reason(s) for the rejection.

(Effective February 1, 1993)

### **Sec. 17-590-3. Financing and program review**

(a) The allocation of funds shall be by a contract that shall set forth the specific conditions under which the grant is awarded.

(b) Sections 17-590-1 through 17-590-7, inclusive comprise the minimum standards of eligibility for Department funding. Meeting the minimum requirements does not guarantee that an applicant or awardee will receive Department funding, nor that funding will be awarded in subsequent fiscal years.

(c) Grant funds must be utilized consistently with the grant award and grant funds are subject to recovery if not so utilized.

(d) The grantee shall submit periodic program and progress reports on Department forms as required by the Commissioner and shall maintain records of the use of the grievance procedure which are available to the Department for review upon request.

(e) The performance of each awardee shall be reviewed and evaluated at least annually by the Department. Such reviews and evaluations may be performed by examining the awardee's documents and reports, by site visits by Department staff, or by a combination of both document review and site visits. An awardee's performance shall be evaluated by a review of:

(1) its compliance with Sections 17-590-1 through 17-590-7, inclusive and the terms and conditions of its contract; and

(2) its financial reports to the Department and annual audit.

(f) If the Department determines that the awardee has failed to meet its obligations under subdivisions (1) and (2) above, it may place the awardee on probation or, when the failure is serious or repeated, terminate its contract.

(Effective February 1, 1993)

#### **Sec. 17-590-4. Operating policies of shelters**

##### **(a) Admissions policy:**

(1) The admissions policy shall reflect the goals and objectives of the program.

(2) There shall be no discrimination in the acceptance of clients, on the basis of race, religion, national origin, or sexual orientation and no rejections of clients on the basis of past conduct unconnected to the shelter or shelter program.

(3) It shall describe a process for screening all persons entering the shelter or its programs for obvious signs of illness or injury, including intoxication from drugs and/or alcohol, and a process for referring those exhibiting such signs to the proper facility.

(4) If it is the policy of the grantee to search an individual prior to admittance, said procedure must be so conducted that it does not unduly infringe upon the privacy rights of the individual.

(5) A confidential record shall be kept of all clients admitted, referrals made, and services offered and the number of individuals who are refused admittance and the reasons for refusal, except in the case of refusal because of insufficient beds, in which case a record of the number of people turned away will be maintained.

(6) A homeless individual or family as defined in accordance with subsection (b) of Section 17-590-1 shall not be denied access to a shelter due to the inability to pay a fee.

##### **(b) House rules:**

(1) The house rules shall be posted in a conspicuous location in a public area of the facility. Each client seeking admission to a shelter shall sign a form provided by the shelter indicating that they were advised of the house rules; the penalties of violating said rules; and they agree to abide by the posted house rules. This document shall be part of their case file. The rules shall be clear, explicit and administered fairly. They shall include the penalty for infringement of house rules. The penalty shall be clearly stated and evenly enforced. The house rules and their penalties shall be periodically reviewed by the shelter, with input from shelter residents. Copies of the shelter's house rules and any subsequent revision thereof shall be made available to staff and residents and be provided to the Department.

(2) House rules shall be reasonable, and shall address, at a minimum, the following:

(A) daily schedule;

(B) permitted length of stay and conditions under which extensions will be granted;

(C) resident fees/contributions;

(D) bed reservation or daily reapplication;

(E) bathing;

- (F) laundry facilities;
  - (G) meals (if served);
  - (H) safe storage of residents' food supplies;
  - (I) social, or other services offered;
  - (J) supervision and discipline of children;
  - (K) duties expected of residents;
  - (L) a description of policies covering violent or disruptive behavior;
  - (M) privacy and confidentiality;
  - (N) fire evacuation and safety procedures;
  - (O) use and handling of prescribed medication;
  - (P) use and/or possession of alcohol, drugs or weapons;
  - (Q) visits from people who are not residents of the shelter;
  - (R) access to telephones;
  - (S) arrangements for safekeeping of residents' financial interests and personal belongings;
  - (T) policies for group meetings of residents;
  - (U) provisions for mail distribution; and
  - (V) access to medical services.
- (c) **Grantees must ensure that residents:**
- (1) will not be suspended or expelled from the shelter or a shelter services unit except for good cause;
  - (2) will be afforded hearings on grievances in accordance with Sections 17-590-6 and 17-590-7;
  - (3) will be offered decent, safe, and sanitary shelter;
  - (4) will have shelter or shelter services matters pertaining to them kept confidential;
  - (5) will have access, directly or through their designated representatives, to their shelter or shelter services records;
  - (6) will be treated by staff with consideration, respect, and dignity and without physical or mental abuse; and
  - (7) will be entitled to equal application of shelter or shelter services rules.
- (Effective February 1, 1993)

### **Sec. 17-590-5. Expulsion and suspension of shelter residents**

- (a) All rules and policies of the shelter, including the shelter's grievance procedures, shall be posted in a conspicuous place and shelter residents shall be given a copy upon request. The shelter's grievance procedures shall include information on how to initiate the grievance process. If the infraction of a rule or procedure might lead to suspension or expulsion of residents, the notice of the rules and policies shall clearly warn residents of this and state the lengths of time of such possible suspensions or expulsions.
- (b) All rules and policies shall be written in plain language and translated for non-English speaking residents. If there is reason to believe the resident is illiterate, the rules and procedures shall be provided orally.
- (c) A resident shall not be expelled or suspended, except for good cause. Good cause includes, but is not limited to, the following kinds of events:
  - (1) violations, after a warning, of posted house rules which seriously or materially impede the operation of a shelter;
  - (2) behavior that poses a threat to the health or safety of other residents, shelter staff, or other people on the premises of the shelter, or to the physical property of

the residents or the shelter or anyone on the premises of the shelter. This may include the possession or use of illegal drugs or alcohol;

(3) violations, after a warning, of case plans or contracts, when the resident has committed him/herself in writing to follow such plan or contract;

(4) expiration of a defined length of stay, unless, according to the shelter's own rules, the resident qualifies for an extension;

(5) theft or destruction of property in or on the grounds of the shelter; or

(6) sexual harassment or sexual activity in violation of shelter rules.

(d) If a shelter resident violates a rule or policy that might lead to suspension or expulsion, except for cases in subsection (e) of Section 17-590-5 below:

(1) The resident shall receive written and oral notice of the infraction prior to suspension or expulsion. This notice shall state the consequences of having violated the rule or regulation; and

(2) The resident shall have an opportunity to request the review of this decision through the shelter grievance procedure prior to the suspension or expulsion. The notice in subdivision (1) of this subsection shall inform the resident of his or her rights to a grievance review and how to request a grievance review.

(e) In cases where the behavior of the resident poses a threat to the health or safety of other residents, shelter staff, or anyone on the grounds of the shelter, or to the physical property of the residents of the shelter or anyone on the premises of the shelter, the resident may be suspended or expelled without any prior warning, or the prior opportunity for a hearing under the shelter grievance procedure. A staff person who has decided to expel or suspend a resident shall, whenever possible, consult with an impartial staff person on whether the decision is appropriate.

(f) A resident may be suspended without prior warning or a prior opportunity for a hearing if he or she poses a threat to the health of other residents, shelter staff or anyone on the grounds of the shelter because the resident is reasonably believed to be infected with a disease that is easily spread through casual contact and/or by airborne means only if:

(1) contamination with the disease could cause serious health problems for others;

(2) the shelter does not have adequate means to isolate the infected residents; and

(3) the shelter, if possible, has attempted to place the resident in an alternative facility.

(g) Behavior that constitutes a threat to health and safety shall be defined by the shelter and shall include the following:

(1) possession, distribution, or use of illegal drugs or alcohol;

(2) possession of a dangerous weapon;

(3) physical violence or the threat of physical violence when there is reason to believe such a threat indicates a genuine possibility of actual physical violence directed at anyone in or on the grounds of the shelter; or

(4) arson or attempted arson.

(h) The shelter must clearly identify in the notice provided under subsection (a) of Section 17-590-5, the rules' infractions that lead to suspension or expulsion without prior notice or a prior hearing.

(i) The resident shall have an opportunity to have any decision to expel or suspend him or her reviewed under the shelter grievance procedure. The burden shall be on the shelter to show that the resident was in violation of the shelter rules. In the case of expulsion or suspension under Section 17-590-5 (e), the review may be conducted after expulsion or suspension.

(j) Any resident who is suspended or expelled shall, whenever possible, be given information on any other facilities available to him or her, and the name and phone number of the person to contact at any appropriate public agency.

(k) If the expelled or suspended resident was originally placed at the shelter by a state agency, that agency must be informed of the expulsion or suspension within one business day.

(Effective February 1, 1993)

### **Sec. 17-590-6. Shelter grievance procedures**

(a) Each shelter shall create a shelter grievance procedure. The shelter shall consult with residents of the shelter when creating the grievance procedure.

(b) The shelter grievance procedure shall be available to any resident who is aggrieved about any adverse action including, but not limited to, suspension or expulsion. The shelter grievance procedure shall also be available to an individual who has been initially refused admittance.

(c) The shelter grievance procedure shall contain the following minimum requirements:

(1) Unless an extension of time is agreed to by both parties, the grievance review shall take place within three (3) business days of the request for a review, except that, in the case of someone who is suspended or expelled without a prior opportunity for a hearing, the grievance review shall take place by the next business day if the resident is placed in an alternative facility pending the review, or within 24 hours of the suspension or expulsion if no other placement is available, or later if an extension of time is requested by the shelter resident;

(2) The grievance review shall be conducted by an impartial person who has the authority to modify, affirm or reverse the decision that is being grieved.

(3) The resident may be represented by any person of his or her choosing.

(4) The resident shall be allowed to review, confront, and refute any evidence relied upon in any decision relating to the grievance; by any appropriate means including, but not limited to, the use of witnesses.

(5) Any decision shall be in writing, shall be based on the evidence presented at the review, and shall explain the parties' rights to an appeal.

(d) An impartial person shall be any person, including an employee of the shelter, who did not take part in the decision or procedure which is being grieved.

(Effective February 1, 1993)

### **Sec. 17-590-7. Appeal panels**

(a) Any decision of a grievance review may be appealed to:

(1) a panel of three (3) people, consisting of a shelter resident or former resident, a shelter staff person or a member of the Board of Directors, and another person not employed by the shelter or receiving shelter services. The panel chairperson shall be the person not employed by the shelter or receiving shelter services; or

(2) an appeal panel consisting of one impartial person who is mutually agreeable to both parties.

(b) The shelter shall maintain a list of people in each of the above categories, to be updated as necessary, and shall select a person from each list for each grievance review. All panel members shall be impartial.

(c) The shelter shall ensure that panel members receive training about the grievance procedure, as appropriate.

(d) An appeal will take place within five (5) business days of the request for a hearing. Other than cases under Section 17-590-5 (e), a decision to suspend or expel will be stayed pending the appeal.

(e) The chairperson shall have overall administrative responsibility for conducting the appeal hearing. The chairperson will:

(1) instruct the other panel members on procedures prior to the hearing;

(2) ensure that the hearing is conducted in an orderly manner;

(3) afford all parties the opportunity to present information fully; and

(4) permit parties to question each other when it is appropriate to do so.

(f) A simple majority vote of the panel will be sufficient to render a decision.

(g) The decision of the panel to reverse, modify or affirm the decision of the shelter shall be sent in writing to all parties involved within ten (10) days of the hearing and will be binding.

(Effective February 1, 1993)



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## Fair Hearings

### Sec. 17-603-1. Definitions

As used in Sections 17-603-1 to 17-603-13, inclusive, as follows:

(a) “Account Review” means an informal hearing, conducted either in-person or based only on the case record, by the Bureau of Child Support Enforcement or the Support Enforcement Division of the Superior Court for the purpose of determining the appropriate distribution of child support collections.

(b) “Aggrieved Person” means an individual authorized by Section 17-603 of the Connecticut General Statutes to request a fair hearing.

(c) “Commissioner” means the Commissioner of the Department of Human Resources.

(d) “Conservator” means a person, a municipal or state official, or a private profit or nonprofit corporation, appointed by the probate court. For purposes of these regulations, a conservator shall have the same rights as an aggrieved person.

(e) “Department” means the Department of Human Resources.

(f) “Desk Review” means an administrative hearing conducted by a hearing officer for an aggrieved person who resides in another State and who is unable to attend the hearing. The Desk Review shall have the same force and effect as a fair hearing, but shall be limited to interstate child support cases that qualify for review under federal and state laws.

(g) “Hearing Officer” means an individual designated by the Commissioner to conduct a hearing in an agency proceeding. Such individual may be a staff employee of the agency.

(h) “Intervenor” means a person, other than a party, granted status as an intervenor by an agency in accordance with the provisions of subsection (d) of Section 4-176 of the Connecticut General Statutes or subsection (b) of Section 4-177a of the Connecticut General Statutes.

(i) “Notice of Action” means a written statement mailed to the aggrieved person which indicates that the Department or its duly authorized agents have taken or intend to take a specific action. Such action shall include, but not be limited to:

(1) the denial, discontinuance, suspension, termination or reduction of payment;

(2) the child support enforcement actions specified in Section 17-603-11 of these regulations; or

(3) the change in the manner or form of payment.

(j) “Notice of Hearing” means a written statement mailed to the aggrieved person from the Commissioner or the Commissioner’s duly authorized hearing officer giving the time and place of the fair hearing at least ten (10) days prior to the date of the fair hearing.

(k) “Party” means each person (A) whose legal rights, duties or privileges are required by statute to be determined by an agency proceeding and who is named or admitted as a party, (B) who is required by law to be a party in an agency proceeding or (C) who is granted status as a party under subsection (a) of Section 4-177a of the Connecticut General Statutes.

(l) “Person” means any individual, partnership, corporation, association, governmental subdivision, agency or public or private organization of any character, but does not include the agency conducting the proceeding.

(m) “Request for a Fair Hearing” means a written request in simple language signed by the aggrieved person that contains the reasons why the aggrieved person is seeking to have his case reviewed by the Department.

(Effective September 25, 1992)

**Sec. 17-603-2. Time limits**

(a) In all programs administered by the Department, the aggrieved person shall mail his request for a fair hearing within sixty (60) days of the date that the Department or its duly authorized agent renders its decision. The date that the notice of action is mailed shall be deemed the date the decision was rendered.

(b) In benefit programs where the Department has provided for a pre-termination hearing, the aggrieved person must request a fair hearing within ten (10) days of the mailing date of the Department's notice of action in order to prevent termination or reduction of benefits.

(c) Within ninety (90) days following the close of evidence, or the due date for the filing of briefs, whichever is later, the Commissioner or duly authorized hearing officer shall render a final decision based on all the evidence on the record and apply all pertinent provisions of law, regulations, and departmental policy. Such final decision shall supersede the decision made without a hearing, and shall be implemented within one hundred and twenty (120) days after the request of such hearing; however, the one hundred and twenty (120) day time period shall be extended by any period of continuance granted. The Department shall mail the aggrieved person a copy of the decision within one business day of its rendition.

(d) Where federal law or regulations govern the Department's programs and establish different time limits than this section, the time limits in the federal law or regulations shall prevail.

(e) In all other cases, the time limits described in Section 17-603-2 of these regulations shall take precedence over any conflicting or inconsistent state regulations pertaining to fair hearings conducted by the Department.

(Effective October 2, 1991)

**Sec. 17-603-3. Denial or dismissal**

(a) The Department shall deny a request for a fair hearing if the aggrieved person does not request the fair hearing within the time limits described in Section 17-603-2 of these regulations.

(b) The Department shall dismiss a request for a fair hearing if:

(1) the aggrieved person withdraws the request in writing; or

(2) the aggrieved person fails to appear at the scheduled hearing without good cause; or

(3) the matter is resolved to the satisfaction of the aggrieved person prior to the fair hearing.

(Effective October 2, 1991)

**Sec. 17-603-4. Notice of hearing**

(a) The Department shall notify the aggrieved person in writing at least ten (10) days in advance regarding the time, place, and nature of the fair hearing.

(b) The Department's notice of hearing shall:

(1) advise the aggrieved person of the name, address, and telephone number of the person to notify if the aggrieved person is unable to attend the fair hearing;

(2) state that the Department will dismiss the fair hearing if the aggrieved person fails to appear at the fair hearing without good cause;

(3) provide a statement of the legal authority and jurisdiction under which the fair hearing is held;

(4) provide a reference to the particular sections of the statutes and regulations involved;

(5) provide a short and plain statement of the matters asserted. If the agency or other party is unable to state the matters in detail at the time the notice is served, the initial notice may be limited to a statement of the issues involved. Thereafter, upon application, a more definite and detailed statement shall be furnished; and

(6) advise the aggrieved person of the right to be represented by counsel or another person.

(Effective October 2, 1991)

### **Sec. 17-603-5. Scheduling and location**

The Department shall schedule the fair hearing to be held:

(a) during normal working hours;

(b) within thirty (30) days from the date the Department receives the request for a fair hearing; however, a reasonable period of continuance may be granted for good cause; and

(c) at a reasonable location accessible to the aggrieved person. If the aggrieved person is disabled, the fair hearing may be held at such person's home if so requested.

(Effective October 2, 1991)

### **Sec. 17-603-6. Duties and powers of hearing officer**

(a) The Commissioner may designate a hearing officer to conduct the fair hearing provided that no individual who has personally carried out the function of an investigator may serve as a hearing officer in that case.

(b) The hearing officer may render the final decision on behalf of the Commissioner, or at the discretion of the Commissioner, the delegation of authority to the hearing officer may be limited to the conduct of the hearing and the presentation to the Commissioner of findings of fact, proposed conclusions of law and a proposed final decision in accordance with Section 4-179 of the Connecticut General Statutes. The final decision in such a case shall be made by the Commissioner in accordance with Connecticut General Statute Section 4-179.

(c) In addition to any other expressed or implied powers, the hearing officer shall have the authority to:

(1) schedule the fair hearing;

(2) require a representative from the Department or its authorized agents, the Family Division, or other cooperating agencies to attend the fair hearing, to submit a case summary prior to the fair hearing, and to provide necessary documents and case files at the fair hearing;

(3) require the Department and aggrieved person to submit a list of witnesses prior to the fair hearing;

(4) compel by subpoena, when deemed necessary, the attendance and testimony of witnesses, the production of records, physical evidence, documents and papers in accordance with Sections 4-177b and 17-603 of the Connecticut General Statutes;

(5) administer oaths or affirmations;

(6) separate and sequester witnesses;

(7) determine the issue(s) of the hearing;

(8) determine whether evidence is relevant and material to the issue(s);

(9) regulate the conduct and course of the fair hearing consistent with due process;

(10) maintain a fair hearing record that shall consist of all papers filed under the proceedings including a mechanical recording of the fair hearing; and

(11) render a final decision on behalf of the Commissioner.

(Effective October 2, 1991)

**Sec. 17-603-7. Agency proceedings on proposed final decisions**

(a) In contested cases where the Commissioner limits the delegation of authority to the hearing officer to render a proposed final decision in accordance with Section 4-179 of the Connecticut General Statutes, the following shall apply.

(1) As soon as possible, following the close of evidence or the due date for the filing of briefs, the hearing officer shall render a proposed final decision. A copy of the proposed final decision shall be served upon the agency and upon the parties by certified mail.

(2) A proposed final decision made under this section shall be in writing and contain a statement of the reasons for the decision and a finding of facts and conclusion of law on each issue of fact or law necessary to the decision.

(3) A party adversely affected by a proposed final decision may file exceptions, present briefs and petition the Commissioner for an opportunity to present oral arguments; provided that any such exceptions, briefs and petitions shall be filed by said party within ten (10) days of the mailing date of the proposed final decision. This subdivision shall apply only in cases where the Commissioner has not heard the matter or read the record.

(4) The Commissioner shall determine the amount of time for oral argument.

(5) The parties and the agency conducting the proceeding may waive, by written stipulation, compliance with subdivisions (1) through (4) inclusive of this section.

(b) The Commissioner shall render a final agency decision in accordance with Sections 17-604 and 4-179 of the Connecticut General Statutes and Section 17-603-2 (c) of these regulations.

(Effective October 2, 1991)

**Sec. 17-603-8. Rights of the aggrieved person**

The aggrieved person shall have the right to:

(a) in a contested case, each party and the agency conducting the proceeding shall be afforded the opportunity to inspect and copy relevant and material records, papers and documents not in the possession of the party or such agency, except as otherwise provided by federal law or any other provision of the general statutes and at a hearing, to respond, to cross-examine other parties, intervenors, and witnesses, and to present evidence and argument on all issues involved;

(b) present his case or have such case presented by legal counsel or authorized representative retained by the aggrieved person;

(c) such other rights as may be provided for in the Uniform Administrative Procedure Act.

(Effective October 2, 1991)

**Sec. 17-603-9. Fair hearing decision**

(a) The fair hearing decision shall be based exclusively on evidence admitted to the record, or officially noticed by the hearing officer.

(b) The fair hearing decision shall:

(1) summarize the facts; and

(2) identify the evidence and legal authority supporting the decision.

(Effective October 2, 1991)

**Sec. 17-603-10. Maintaining and reinstating benefits**

(a) The Department shall not terminate or reduce the aggrieved person's assistance benefits until the fair hearing decision is rendered, if the fair hearing has been

requested within the ten (10) day notice period as stated in subsection (b) of Section 17-603-2 of these regulations.

(b) If the fair hearing decision reinstates the aggrieved person's benefits, said benefits may be retroactive to the date of discontinuance.

(Effective October 2, 1991)

**Sec. 17-603-11. Special considerations for the child support enforcement program**

**(a) Prehearing Review by the Support Enforcement Division and Fair Hearing by the Department**

(1) An individual who has been mailed a notice of action concerning one or more of the following enforcement actions shall have the right to request a review by the Support Enforcement Division of the Superior Court:

(A) Withholding of a refund of federal income taxes in accordance with Section 52-362e-2 of the Regulations of Connecticut State Agencies.

(B) Placement of a lien in accordance with Section 52-362d-2 of the Regulations of Connecticut State Agencies.

(C) Reporting of an arrearage to a consumer reporting agency in accordance with Section 52-362d-3 of the Regulations of Connecticut State Agencies.

(D) Withholding of a refund of state income taxes in accordance with Section 52-362e-3 of the Regulations of Connecticut State Agencies.

(2) To obtain such a review, an aggrieved person shall request a review from the Support Enforcement Division within twenty (20) days of the mailing date of the notice of action.

(3) If the aggrieved person is dissatisfied with the review decision by the Support Enforcement Division, or the Support Enforcement Division has taken no action on the request within fifteen (15) days, the aggrieved person shall have the right to request a fair hearing.

(4) A fair hearing shall be requested within sixty (60) days from the mailing date of the notice of action, regardless of whether the Support Enforcement Division completed its review.

(5) Failure to request a review from the Support Enforcement Division shall not preclude the aggrieved person from requesting a fair hearing within sixty (60) days from the mailing date of the notice of action.

**(b) Appeals from Account Reviews**

Individuals who are aggrieved by an account review decision have the right to request a fair hearing in accordance with Section 17-603 of the Connecticut General Statutes and these regulations.

**(c) Defenses for the Child Support Enforcement Program**

Defenses that the aggrieved person may raise at a fair hearing concerning the withholding of state or federal income tax refunds, placement of liens, credit bureau reporting, and offset against money payable by the state include, but are not limited to, those defenses set out in Sections 52-362d-1 and 52-362e-1 of the Regulations of Connecticut State Agencies.

**(d) Rights of Custodial Relative(s) in Non-AFDC Cases**

(1) In non-AFDC cases only, a copy of the notice of hearing mailed to the aggrieved person, in accordance with Section 17-603-4 of these regulations, shall also be mailed to the custodial relative(s) at least ten (10) days prior to a scheduled hearing.

(2) The custodial relative(s) in non-AFDC cases only, who attends the fair hearing shall have the same rights as the aggrieved person, including, but not limited to:

legal representation, testimony, witnesses, exhibits, receipt of the decision and right to appeal.

(e) **Interstate Cases**

(1) In interstate cases where the obligor resides in another state, the obligor may request a desk review from this state or an administrative review from the state with the order upon which the enforcement action is based.

(2) Requests for an administrative review from the state with the order shall be made through the State of Connecticut. Within ten (10) days of receipt of such a request, the Department shall notify the state with the order of the request and provide all necessary information to that state.

(3) In a case where another state submits to the IRS a referral for offset on the basis of a Connecticut court order, and the other state transfers the case to Connecticut for administrative review, the hearing officer shall schedule the hearing and render a decision within forty-five (45) days from the receipt of the other state's request, unless:

- (A) the other state's request is incomplete; or
  - (B) the parties request and receive a continuance.
- (Effective June 1, 1993)

**Sec. 17-603-12. Reconsideration and modification of final decisions**

(a) Unless otherwise provided by law, a party in a contested case may, within fifteen (15) days after the personal delivery or mailing of the final decision, file with the agency a petition for reconsideration of the decision on the ground that:

- (1) an error of fact or law should be corrected;
- (2) new evidence has been discovered which materially affects the merits of the case and which for good reasons was not presented in the agency proceeding; or
- (3) other good cause for reconsideration has been shown.

Within twenty-five (25) days of the filing of the petition, the agency shall decide whether to reconsider the final decision. The failure of the agency to make that determination within twenty-five (25) days of such filing shall constitute a denial of the petition. Within forty (40) days of the personal delivery or mailing of the final decision, the agency, regardless of whether a petition for reconsideration has been filed, may decide to reconsider a final decision. If the agency decides to reconsider a final decision, pursuant to subdivisions (1), (2) or (3) of this subsection, the agency shall proceed in a reasonable time to conduct such additional proceedings as may be necessary to render a decision modifying, affirming or reversing the final decision. Any such additional proceedings shall be conducted in accordance with Sections 17-603 and 17-604 of the Connecticut General Statutes and these regulations.

(b) On a showing of changed conditions, the agency may reverse or modify the final decision, at any time, at the request of any person or on the agency's own motion. The procedure set forth in this subsection for contested cases shall be applicable to any proceedings in which such reversal or modification of any final decision is to be considered. The party or parties who were the subject of the original final decision, or their successors, if known, and intervenors in the original contested case, shall be notified of the proceeding and shall be given the opportunity to participate in the proceeding. Any decision to reverse or modify a final decision shall make provision for the rights or privileges of any person who has been shown to have relied on such final decision.

(c) The agency may, without further proceedings, modify a final decision to correct any clerical error. A person may appeal that modification under the provisions

of Section 4-183 of the Connecticut General Statutes or if an appeal is pending when the modification is made, may amend the appeal.

(Effective October 2, 1991)

**Sec. 17-603-13. Right to appeal**

(a) The aggrieved person or the custodial relative who attends the fair hearing shall have the right to appeal the fair hearing decision to the court of competent jurisdiction in accordance with Section 4-183 of the Connecticut General Statutes.

(b) The aggrieved person or the custodial relative who attends the fair hearing shall file his appeal within forty-five (45) days after the mailing date of the fair hearing decision and shall serve the Commissioner with a copy of the petition to appeal within forty-five (45) days from the mailing date, unless the Commissioner extends the time limits for good cause. However, in no event shall a petition for extension be considered or approved if filed later than ninety (90) days after the rendition of the fair hearing decision in accordance with Section 17-604(c) of the Connecticut General Statutes.

(Effective October 2, 1991)



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## An Assistive Technology Revolving Fund

### Sec. 17-606a-1. Program purpose

(a) In accordance with the requirements of Section 17-606a of the General Statutes of Connecticut, the purpose of this program is to make loans available to persons with disabilities at affordable rates and/or terms to acquire and/or maintain equipment designed to assist them to become independent (assistive equipment). Such loans shall assist people with a variety of disabilities to improve their quality of life, access employment opportunities and either become or continue to be productive members of the community.

(Effective July 13, 1993)

### Sec. 17-606a-2. Definitions

The following terms, as used in Section 17-606a-1 to Section 17-606a-11 inclusive, are defined as follows:

(a) “Applicant” means any individual who has signed and submitted an application for a loan.

(b) “Assistive equipment” means any device, implement or item, including vehicle and home modifications, which is used to increase, maintain, or improve the functional capabilities of individuals with disabilities and assist such individuals to improve their quality of life, access employment opportunities and/or become or continue to be productive members of the community.

(c) “Commissioner” means the Commissioner of The Department of Human Resources.

(d) “Compensation” means margin and/or fees customarily collected by lending institutions for the administration and servicing of loans.

(e) “Department” means the Department of Human Resources.

(f) “Disability” means any physical or mental impairment which substantially limits one or more major life activities as defined by the Rehabilitation Act of 1973, as amended.

(g) “Discretionary income” means the balance of income remaining after calculating the applicant’s total monthly income as specified on the application and subtracting therefrom the total of the applicant’s monthly expenses as specified on the application submitted.

(h) “Family” means a household consisting of the applicant or the applicant and one or more persons residing with the applicant including parent(s), a parent’s spouse, and their minor children who reside together, or the supervising relatives, a supervising relative’s spouse and their minor children who reside together; except that a foster child shall be considered a family of one.

(i) “Fiduciary agent” means any organization, entity or individual with which the Department of Human Resources establishes a contract to review loan applications, close loans and administer, service and document loans.

(j) “Income” means wages, interest, dividends, capital gains, retirement income, public and private assistance and disability payments, workers’ compensation, rents and other forms of remuneration or compensation.

(k) “Income group” means one of the following household groups, adjusted by family size and based on the appropriate Connecticut median income, as determined by the Commissioner on July 1 of each year: (1) households with incomes 25 percent or less of the Connecticut median income; (2) households with incomes more than twenty five percent but not more than 50 percent of the Connecticut median income; (3) households with incomes more than 50 percent but not more than 75 percent

of the Connecticut median income; (4) households with incomes more than 75 percent of Connecticut median income but not more than 100 percent of the Connecticut median income and (5) households with incomes more than one hundred percent of the area median income.

(l) "Independent Living Center" means an organization or non-profit agency, governed by a Board of Directors whose membership includes at least 51 percent persons with disabilities, and managed and staffed primarily by individuals with disabilities. Such centers provide at minimum peer counseling, advocacy, independent living skills training and information and referral services to individuals with disabilities.

(m) "Eligible Individual" means an individual with a disability, as defined in Section 17-606a-2(f), who shall benefit from assistive equipment.

(n) "Loan" means a loan from the Assistive Technology Loan Fund.

(o) "Loan Fund" means the Assistive Technology Loan Fund.

(p) "Peer counselor" means individuals with disabilities, knowledgeable in assistive technology, who provide guidance, advocacy, and information and referral to persons interested in exploring assistive technology options, including the Assistive Technology Revolving Fund.

(q) "Pre-approved loan" means a loan application which has received, from the peer counselor, a non-binding recommendation for funding pending verification of information and final approval by the fiduciary agent.

(Effective July 13, 1993)

### **Sec. 17-606a-3. Advisory committee**

An advisory committee shall provide oversight, consultation, and technical assistance to the Commissioner in the administration of loan funds. It shall also make recommendations to the Commissioner concerning appeals by individuals who have been denied loans or have loans in default. This committee shall be composed of peer counselors from each of Connecticut's Independent Living Centers, members from the Department of Human Resources Consumer Advisory Committee, an ex-officio member representing the fiduciary agent, ex-officio members with expertise in loan administration, preferably banking officers, and an ex-officio member from the Bureau of Rehabilitation Services. All members shall be appointed by the Commissioner.

(Effective July 13, 1993)

### **Sec. 17-606a-4. Public information**

The loan program shall be publicized by the Commissioner through press releases and contacts with private and public agencies throughout the state. Informational brochures shall be available at locations around the state; e.g., independent living centers, municipal offices for people with disabilities, the State Office of Protection and Advocacy for Persons with Disabilities, state agency regional offices that provide services to people with disabilities, local area offices on aging, special education resource centers, educational systems, advocacy and disability rights organizations, and other locations where consumers and their families might look for assistance and information about assistive equipment, including rehabilitation centers and hospitals.

(Effective July 13, 1993)

### **Sec. 17-606a-5. Application process**

(a) All persons with disabilities, needing assistive technology, shall be eligible to apply for a loan under this program. Individuals whose gross annual income

exceeds 100 percent of the median family income in Connecticut, as determined by the Commissioner on July 1 of each year, shall be required to apply for and be denied loans through other financial institutions, including banks, prior to initiation of a loan application under this program.

(b) Applications for loans shall be initiated through peer counselors designated by the Department, knowledgeable in the identification of appropriate assistive technology and resources, including this loan fund, in independent living centers or similar organizations which are located strategically across the state.

(1) Assistive Technology Plan

All completed applications for loan funds shall be based on an Individual Assistive Technology Plan jointly developed by the applicant and peer counselor. Evidence of the following shall be included in such plans:

(A) verification of an individual's disability through a descriptive narrative or other means;

(B) substantiation of the need for assistive technology;

(C) assistance in the identification of appropriate assistive devices and reputable vendors which can provide such equipment;

(D) identification of alternative avenues of funding to acquire the needed technology; and

(E) provisions for orientation and training after receipt of the assistive technology.

(2) Application Completion

Subsequent to the development of an Assistive Technology Plan, a formal loan application shall be completed. The peer counselors shall provide financial counseling services for prospective borrowers to ascertain the appropriate loan amount and the repayment terms which are necessary to prevent the loan from becoming a financial burden to the borrowers. The loan terms shall be determined as specified in Section 17-606a-6.

Sources of an applicant's income and other family income shall be clearly identified as to origin and amount. In addition, applicants whose gross annual income is greater than 100 percent of the family median income in Connecticut shall verify that they have been denied other available resources or funds. Upon completion of the application, a preliminary recommendation for approval or denial of the loan shall be made by the peer counselor. Such recommendation shall be based upon the amount of funds requested, the applicant's ability to pay predicated on available discretionary income as defined in Section 17-606a-2(g), and the term of the loan which is limited to the lesser of five years or the life of the equipment. Applicants shall be informed of the preliminary decision. In the case of loan denial, applicants shall be given the reasons for denial and informed of their right to appeal the decision to the Commissioner.

The application, peer counselor recommendation, and other necessary information shall be forwarded to a fiduciary agent which shall administer the loan fund.

(Effective July 13, 1993)

**Sec. 17-606a-6. Loan administration**

(a) Subsequent to a Request for Proposal, the Department shall contract with a fiduciary agent to review completed applications, review proposed loan terms and conditions, approve or deny loans, disburse loan proceeds, and collect installment payments.

(b) **Pre-Approved applications**

(1) Upon receipt of pre-approved applications:

(A) The fiduciary agent shall verify an applicant's come. Documentation verifying income shall be maintained and made available, as needed, for appeals by applicants or upon request by the Commissioner.

(B) The fiduciary agent shall ensure that a credit check is performed on the prospective borrower by an acceptable credit reporting agency and may charge the prospective borrower a fee to cover the cost of obtaining such report. Credit reliability shall be a factor in loan approval.

(2) Upon application approval, the fiduciary agent shall provide low-interest loans to individuals for approved assistive technology as specified in the assistive technology plan.

(3) All loans provided through the fiduciary agent shall comply with all applicable State and Federal Truth-In-Lending and Disclosure and Consumer Protection laws.

(4) Except as may be agreed to by the Commissioner, all forms used in the administration of the loan fund shall be those prescribed and/or approved by the Commissioner.

(5) All loans made though the fiduciary agent shall be made without regard to race, color, religious orientation, sexual orientation, or physical or mental disability.

(6) The interest rate for all loans under this program shall range from two percent annual percentage rate to the prime rate, as published daily in the business section of the Wall Street Journal. The interest rate shall be calculated using standard amortization tables.

(7) The maximum period of time for which each loan is written under this program shall be up to five years or the expected life of the assistive equipment, whichever is less.

(8) Each loan repayment schedule and/or interest rate shall be based upon the amount of funds requested, the individual's available discretionary income, as determined by the peer counselor and verified by the fiduciary agent, and the anticipated life of the equipment.

(9) Requests for interest rate reductions or term extensions shall be reviewed by the advisory committee and shall include copies of calculations and working papers to justify the need for approval of the request.

(10) There shall be no maximum or minimum loan amount. Such amounts shall be based on an individual's ability to pay as set forth in Section 17-606a-5 (b) (2).

(11) The fiduciary agent shall provide the borrower with notice of all loan decisions. Such notice shall outline the terms and conditions of the loan and shall state that the loan is being provided through a program administered by the Commissioner.

(12) If the borrower accepts the terms and conditions of the commitment letter, the fiduciary agent and the borrower shall then execute the required loan documents within five business days.

(13) All disbursements made under this program shall be made through an Administrative Bank Account which requires the signature of one authorized officer or employee of the fiduciary agent on all checks.

(14) All disbursements shall be issued with joint endorsement to the assistive equipment vendor and individual borrower.

(15) The fiduciary agent may receive compensation in exchange for administration of the loan program including receipt, processing and approval of loan applications, and disbursement of and collection of funds, including late fees. All such compensation may be included in the principal loan amount.

(16) All costs and/or fees, including those for legal expenses, placing of liens, recovery of equipment, or those related to loan default, shall be the responsibility of the borrower and may be added to the cost of the loan.

**(c) Denied Applications**

When the fiduciary agent receives a recommendation from a peer counselor to deny a loan or the fiduciary agent denies a loan and the loan applicant appeals that decision, the fiduciary agent shall, at the applicant's expense, secure a credit check and necessary income information which shall be forwarded to the advisory committee at its request.

If the fiduciary agent elects to review a denied application which has not been appealed by the loan applicant, the review shall be at the fiduciary agent's expense.  
(Effective July 13, 1993)

**Sec. 17-606a-7. Assistive equipment**

Listed below are examples of eligible items of assistive equipment. Other items may be considered upon request. Assistive equipment includes, but is not limited to, the following: wheelchairs; scooters; platform lifts; environmental control systems; elevators; home accessibility modifications (including ramps, bathrooms, kitchens); computer hardware and software (including voice output, braille screen output, screen text enlargement, and document scanners); alternative input devices; switches; augmentative communication devices; automobile/van modifications; artificial limbs; hearing aids; low vision aids; and document readers.

(Effective July 13, 1993)

**Sec. 17-606a-8. Default**

(a) A loan shall be delinquent when a scheduled payment is not made by the borrower or other breach of the loan agreement.

(b) Delinquent borrowers shall receive, at a minimum, 30 and 45 day past due notices from the fiduciary agent.

(c) A loan may be declared in default if payments have not been received by the fiduciary agent and the loan is not current within 60 days of notice of delinquency to the borrower.

(d) Collection efforts for loans declared in default shall be performed by the fiduciary agent or shall be assigned to the Department's Bureau of Collection. Associated expenses incurred by this process shall be included for collection from the borrower.

(e) The conditions and terms of delinquent loans may be renegotiated by the peer counselor, fiduciary agent and borrower.

(f) Any application may be denied if the applicant has a loan delinquency and/or default under this program.

(Effective July 13, 1993)

**Sec. 17-606a-9. Administrative review**

(a) Applicants shall have the right to administrative review of the denial, or term or interest rate of a loan under this program. The review shall be conducted by the advisory committee which shall render a decision within 30 days of receipt of the request for review.

(b) Any person aggrieved by the decision may request a hearing pursuant to Conn. Gen. Stat. 17-603.

(Effective July 13, 1993)

**Sec. 17-606a-10. Financial reporting**

(a) The fiduciary agent shall maintain complete and accurate books and records, insofar as they pertain to the loan fund, and they shall be set up and maintained in accordance with the latest procedures approved by the Commissioner.

(b) The fiduciary agent shall furnish the Commissioner with financial statements and other reports relating to the loan fund in such detail and at such times as the Commissioner may require.

(c) At any time during regular business hours, and as often as the Commissioner may require, the Commissioner or his representatives shall be entitled to full and free access to the accounts, records and books of the fiduciary agent relative to the loan fund, said permission to include the right to make or require the Contractor to provide excerpts, transcripts, or copies of such accounts, records and books.

(Effective July 13, 1993)

**Sec. 17-606a-11. Reporting requirements**

(a) The fiduciary agent shall submit to the Commissioner of Human Resources, beginning in 1993, and annually thereafter, before October thirty-first, a report, for the year ending the preceding September thirtieth, which includes an analysis, by income group, disability, and type of assistive technology, of those individuals served by the revolving loan fund.

(Effective July 13, 1993)

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## **Child Day Care Business Firm Tax Credits**

### **Sec. 17-615-1. Definitions**

As used in Sections 17-615-1 through 17-615-10, inclusive:

(a) “Business firm” means any business firm as defined in Section 17-613 of the Connecticut General Statutes.

(b) “Child day care” means the care that is provided to children of business firm employees by (1) registered or licensed child care providers, (2) providers giving day care in the child’s home, (3) or a relative giving day care in the relative’s home that has been approved by the Commissioner.

(c) “Child Day Care Center” means a program of supplementary care for related or unrelated children outside their homes on a regular basis for a part of the 24 hours in one or more days in the week.

(d) “Commissioner” means the Commissioner of the Department of Human Resources.

(e) “Department” means the Department of Human Resources.

(f) “Expenditure year” means the calendar year in which amounts are invested in programs operated or created pursuant to an application approved in accordance with Section 17-613 (b) of the Connecticut General Statutes or in which expenditures are paid or incurred in relation to facilities pursuant to an application approved in accordance with Section 17-613 (c) of the Connecticut General Statutes.

(g) “Low income employee” is an individual, employed by the business firm making an application, whose gross wage from the firm at the time of application does not exceed fifty percent (50%) of the median income for an individual as annually established by the United States Department of Health and Human Services for the State of Connecticut.

(h) “Subsidy” means a direct money payment made by a business firm to an employee for the payment of child day care expenses, or paid to a provider on behalf of particular employees.

(i) “Tax credit allocation” means the amount of tax credit allocated by the Department to a business firm whose application for the Child Day Care Business Firm Tax Credit Programs has been approved by the Commissioner.

(Effective October 2, 1991)

### **Sec. 17-615-2. Child day care tax credit program**

Any business firm which contributes or plans to contribute a subsidy for its employees’ child day care costs may apply for a tax credit allocation by submitting a written application on a form provided by the Department.

(Effective October 2, 1991)

### **Sec. 17-615-3. Program description**

The Child Day Care Tax Credit program provides financial assistance to business firms as a benefit for helping employees pay the cost of child care. Business firms may receive tax credits of fifty (50%) percent of the amount spent to subsidize employees’ child care costs during the tax year. The child care may be in any one of the following situations: licensed group day care home or center; registered family day care home; or care in the child’s home or in a relative’s home.

(Effective October 2, 1991)

### **Sec. 17-615-4. Business firm eligibility**

(a) Applications from business firms shall be submitted to the Commissioner after the October first preceding the expenditure year and on or before June first

of such expenditure year. The Commissioner shall approve or disapprove each application within sixty (60) days of receipt based on the information submitted, as well as the availability of funds.

(b) As part of the application approval process, the business firm shall be required to furnish the following for each employee receiving a subsidy:

- (1) The employee's name or identification number.
- (2) The name and address of the child day care providers expected to care for the children and an indication as to the type of child day care.
- (3) The amount to be subsidized for the employee's child day care expenses.
- (4) The yearly gross salary or wage of each employee.
- (5) The number of the employee's children expected to benefit from the subsidy.
- (6) The number of weeks during which it is expected that such children will be under the care of such providers.

(c) Applications submitted during any calendar month of the tax year shall be compared against all other applications received during that month. Preference shall be accorded to those applications that document the highest percentage of low income employees that are expected to benefit from a tax subsidy.

(d) In the event the allocation of funds for tax credits is not sufficient to finance all of the qualified applicants, priority shall be established first by the extent to which the tax credits will be used by low income employees and then by the date of the Department's receipt of the application.

(e) The applicant's principal place of business shall be furnished on the application.

(f) For those applications that are approved, the notification shall specify the maximum tax credit limit allocated to the business firm. A copy of such decision of approval shall be attached to the business firm's final tax return filed with the Department of Revenue Services.

(g) If an application is disapproved, the business firm shall be notified in writing of the reasons for the disapproval by the Commissioner.

(Effective October 2, 1991)

#### **Sec. 17-615-5. Allotment of tax credit**

(a) Any such business firm receiving a tax credit allocation shall, within thirty (30) days of the end of the expenditure year, submit a report of its actual expenditures in such year to the Commissioner.

(b) The amount of tax credit allowed under Section 17-613 (b) of the Connecticut General Statutes which is not exhausted in the expenditure year must be carried back to the five (5) preceding years (beginning with the earliest of such years) before any unexhausted balance can be carried forward to the five (5) succeeding years (beginning with the earliest of such years.)

(c) With respect to credits against the tax imposed under Chapter 212, any credit must be claimed on a quarterly tax return for a quarter ending in the expenditure year. With respect to credits against the tax imposed under Chapters 207, 210 or 211, any credit must be claimed on the annual tax return for the expenditure year. With respect to credits against the tax imposed under Chapter 208 or 209, any credit must be claimed on the annual tax return for the business firm's accounting period, for federal income tax purposes, with or within which the expenditure year ends.

(Effective October 2, 1991)

**Sec. 17-615-6. Child day care center tax credit program**

Any business firm that is planning to build a child day care center on or near the work site may apply for a tax credit allocation by submitting a written application on a form provided by the Department.

(Effective October 2, 1991)

**Sec. 17-615-7. Program description**

The Child Day Care Center Tax Credit program provides financial incentives to business firms for the establishment of facilities for child day care. Business firms may receive tax credits for planning, site preparation, construction, renovation or acquisition of child care facilities. Any equipment purchased or installed for permanent use within or adjacent to the facility (i.e., playground or kitchen equipment or appliances) may also be eligible for credit. The maximum tax credit shall be forty percent (40%) of expenditures, not to exceed \$20,000 per income year.

(Effective October 2, 1991)

**Sec. 17-615-8. Application approval process**

(a) Applications from business firms shall be submitted to the Commissioner after the October first preceding the expenditure year and on or before June first of the expenditure year. Applications shall be approved or rejected in writing by the Commissioner within sixty (60) days of receipt based on the information submitted, as well as the availability of funds.

(b) As part of the application approval process, business firms who are seeking a tax credit shall be required to indicate whether:

(1) the facility will be operated under a license from the state Department of Health Services.

(2) the facility will be operated by the applicant on a not-for-profit basis.

(3) any other firms will seek a tax credit for sharing the costs of establishing the facility. All such firms may seek a proportional share of the tax credit.

(c) The applicant's principal place of business shall be furnished on the application.

(d) For those applications that are approved, the notification shall specify the maximum tax credit allocated to the business firm. A copy of such decision of approval shall be attached to the business firm's tax return filed with the State Department of Revenue Services.

(e) If an application is disapproved, the business firm shall be notified in writing of the reasons for the disapproval by the Commissioner.

(Effective October 2, 1991)

**Sec. 17-615-9. Allotment of tax credit**

(a) If two (2) or more business firms are contributing to the cost of establishing a child care facility, each business firm shall submit a separate application that indicates its contribution to such cost in the expenditure year.

(b) Any such business firm receiving such allocation shall, within thirty (30) days of the end of the expenditure year, submit a report of its actual expenditures to the Department.

(c) The amount of tax credit allowed under Section 17-613 (c) of the Connecticut General Statutes which is not exhausted in the expenditure year must be carried back to the five (5) preceding years (beginning with the earliest of such years) before any unexhausted balance can be carried forward to the five (5) succeeding years (beginning with the earliest of such years).

(d) With respect to credits against the tax imposed under Chapter 212, any credit must be claimed on a quarterly tax return for a quarter ending in the expenditure year. With respect to credits against the tax imposed under Chapter 207, 210 or 211, any credit must be claimed on the annual tax return for the expenditure year. With respect to credits against the tax imposed under Chapter 208 or 209, any credit must be claimed on the annual tax return for the business firm's accounting period, for federal income tax purposes, with or within which the expenditure year ends.  
(Effective October 2, 1991)

**Sec. 17-615-10. Business firm ineligibility**

Business firms that regularly engage in the construction or operation of child day care facilities are not eligible to participate in the Child Day Care Center Tax Credit Program.

(Effective October 2, 1991)

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## Eviction Prevention

### Sec. 17-619-1. Purpose

The purpose of the Eviction Prevention Program (EPP), as created by Connecticut General Statutes Sections 17-619 et al, is to prevent homelessness among families whose income does not exceed 60% of the state median income and who are at risk of becoming homeless or in imminent danger of eviction or foreclosure.

(Effective October 1, 1993)

### Sec. 17-619-2. Definitions

For the purpose of Sections 17-619-1 through 17-619-16, inclusive, the following definitions shall apply:

(a) “Applicant” means any person who is eighteen or older or the head of a household who has requested eviction prevention services from a mediation agency under this regulation.

(b) “Arrearage” means money which is overdue and unpaid.

(c) “Desk review” means an informal hearing conducted by a mediation agency in response to a written appeal filed by an applicant.

(d) “Eviction” means the legal process used to terminate a person’s right to remain in his or her rental home.

(e) “Family” means any individual or related and unrelated individual(s) who live together and share living expenses, including a family of one.

(f) “Foreclosure” means a legal termination of all rights of the mortgagor or his or her grantee in the property covered by the mortgage.

(g) “Gross family income” means all income, from whatever source derived, including, but not limited to:

(1) Earned income such as compensation paid by an employer to an employee for personal services and includes wages, salaries, tips, commissions, bonuses, and earnings from self-employment or contractual agreements.

(2) Unearned cash income such as pensions, annuities, dividends, interest, rental income, estate or trust income, royalties, social security or supplemental security income, unemployment compensation, workers’ compensation, alimony, child support, and cash assistance from federal, state, or municipal assistance programs.

(h) “Imminent danger” means having received a threat to terminate the applicant’s right to remain in the home, including but not limited to, a notice to quit, a default notice threatening foreclosure, or court papers in support of an eviction or foreclosure.

(i) “Lease” means a rental agreement, either oral or written, authorizing a person to occupy a home for a certain length of time.

(j) “Mediation agency” means an entity under contract with the Department of Human Resources to mediate disputes between tenants and landlords or creditors and mortgagors-in-possession on behalf of the Department.

(k) “Mortgage” means a written instrument in which real estate is used as a security for repayment of a debtor obligation.

(l) “Net monthly income” means all gross monthly income minus mandatory deductions, including, but not limited to: federal income tax based upon all allowable exemptions; social security tax; retirement plan deductions; union dues or fees; group life insurance premiums; health insurance premiums for all legal dependents; and for self-employed individuals, all legitimate business expenses.

(Effective October 1, 1993)

**Sec. 17-619-3. Program description**

(a) The Eviction Prevention Program prevents homelessness through the intervention of trained community-based mediators who use assessment, mediation and, when necessary, rent bank resources, including grants and loans, to keep families in their homes.

(b) The Eviction Prevention Program benefits families by preventing homelessness, improving landlord-tenant relationships, establishing a credit record for families who utilize the loan component, and stabilizing potentially homeless families in permanent housing.

(c) No applicant shall be eligible for grants and/or loans from the rent bank without participation in the assessment and mediation program.

(d) No family shall receive grant assistance under the Eviction Prevention Program in excess of one thousand dollars, nor loan assistance in excess of \$1,200 more than once in any eighteen (18) month period beginning with the date of the mediated agreement.

(e) The Eviction Prevention Program is not an entitlement program. Assessment and mediation services, as well as rent bank resources, are contingent upon the availability of funds.

(Effective October 1, 1993)

**Sec. 17-619-4. Eligibility**

The Eviction Prevention Program is available to an applicant who meets the following criteria:

(a) resides in Connecticut;

(b) has a gross family income at or below 60% of the state median income adjusted for family size;

(c) is at risk of becoming homeless or is in imminent danger of eviction or foreclosure; and

(d) is not in default on any Eviction Prevention Program loan.

(Effective October 1, 1993)

**Sec. 17-619-5. Referrals for vendor payments**

Mediation agencies may refer to the appropriate regional office of the Department of Income Maintenance (DIM) any applicants for Eviction Prevention services who are recipients of Aid to Families with Dependent Children (AFDC) or the optional State Supplemental Income program, when the risk of eviction is due to nonpayment, for assistance with the vendoring of payments toward back rent or current rent.

(Effective October 1, 1993)

**Sec. 17-619-6. Procedures**

(a) Each mediation agency shall have and utilize a written intake procedure which shall include, but not be limited to:

(1) a procedure for making and accepting referrals; and

(2) a procedure for determining whether or not the family meets the program's admission criteria and is appropriate for the program.

(b) Each mediation agency shall, during the intake procedure, collect at least the following information on an application form from each family seeking admission to the program:

(1) name;

(2) home address;

(3) telephone number;

- (4) date of birth;
  - (5) family status;
  - (6) income source(s);
  - (7) current family income (of all household members);
  - (8) amount of arrearage or delinquency;
  - (9) reason(s) for arrearage or delinquency;
  - (10) social security number;
  - (11) referral source;
  - (12) date of initial contact;
  - (13) date of interview;
  - (14) signature and title of intake worker; and
  - (15) applicant's signature.
- (Effective October 1, 1993)

**Sec. 17-619-7. Income verification**

(a) All applicants shall be required to document gross family income for the previous four (4) weeks or for the previous six (6) calendar months, if self-employed.

(b) All applicants have the option of having their eligibility determination documented based on gross family income for the previous 52 weeks from the date of application if they believe that it more accurately reflects gross annual family income.

(c) Participating mediation agencies shall require an applicant to substantiate gross family income by furnishing one or more of the following:

- (1) self-employment worksheet;
- (2) wage stubs;
- (3) a letter from an employer, customer, or other source of income;
- (4) a Certificate for Disclosure of Gross Wages, Salary or Commission;
- (5) federal income tax returns;
- (6) state income tax returns;
- (7) financial reports or statements;
- (8) checks;
- (9) a contract or lease;
- (10) a payment authorization regarding cash benefits; and
- (11) identification and verification of residence.

(Effective October 1, 1993)

**Sec. 17-619-8. Assessment and mediation**

(a) All eligible applicants shall participate in assessment and mediation pursuant to Section 17-620 of the Connecticut General Statutes as may be amended.

(b) Participation in assessment and mediation is a prerequisite to eligibility for rent bank resources.

(c) Each participating mediation agency shall designate trained staff or contract with individuals or organizations with expertise in landlord-tenant mediation to provide the assessment and mediation services described herein.

(d) All completed applications shall be reviewed and the applicant shall be notified of the disposition of the application and the reasons for the action taken within five (5) working days of receipt of the completed application by the mediation agency. A copy of the notice of disposition shall be provided to any state agency responsible for the referral. The applicant shall be referred to other agencies and social services for assistance, if appropriate.

(e) If the applicant is denied service, he or she shall be advised in writing of the right to a desk review with the mediation agency pursuant to Section 17-619-15

and of the right to a fair hearing pursuant to Section 17-619-16. This written notification shall also include a statement of the right of the applicant and his or her representative to review all information used in the decision to deny assistance.

(f) The mediation agency shall conduct a comprehensive assessment of the eligible family in accordance with this section.

(g) The mediation agency shall determine, within the exercise of professional judgment, the feasibility of mediating a settlement between the family and the landlord or creditors with or without financial assistance.

(h) If the mediation agency determines, within the exercise of professional judgment, through the assessment that mediation is appropriate, a mediation shall be scheduled and conducted.

(i) The mediation agency shall conduct follow-up on all successful mediations at 120 and 360 day intervals.

(Effective October 1, 1993)

### **Sec. 17-619-9. Rent bank**

(a) In order to receive rent bank resources, a family shall participate in the assessment and mediation program as described in Section 17-619-8, and document the existence of a severe hardship which, in accordance with the professional judgment of the mediator(s), is not likely to recur, including, but not limited to:

- (1) loss of income or increase in expenses;
- (2) loss of employment;
- (3) medical disability or emergency;
- (4) loss or delay in receipt of other benefits;
- (5) natural or man-made disaster; or
- (6) substantial and permanent change in household composition.

(b) A family may qualify for rent bank assistance only if, in accordance with the professional judgment of the mediator(s), the family's housing is affordable. Housing is considered affordable if:

(1) The monthly rent or mortgage payment for the dwelling does not exceed 60% of the family's gross income, including the cash value of food stamps, or

(2) Where monthly rent or mortgage payments exceeds 60% of gross income, other factors shall be examined to determine affordability. Such factors include, but are not limited to:

(A) The duration of the family's tenancy or occupancy in the current housing prior to becoming delinquent and the duration of the non-payment of rent or mortgage delinquency.

(B) The inclusion of heat or utilities in the family's rent.

(C) Whether the family expects to receive contributions from other family members or friends who may share in the cost of housing.

(D) Whether there is a reasonable expectation that family income will increase in the near future.

(c) When a successful mediation of a case requires a financial payment and the criteria listed in subsections (a) and (b), of Section 17-619-9 are satisfied, the mediation agency may authorize, in accordance with the professional judgment of the mediator(s), the payment of grants, loans, or a combination thereof to the landlord or creditor on behalf of the participating family.

(d) The amount of the grant and/or loan shall be the minimum amount necessary, within the exercise of professional judgment of the mediator(s), to avoid imminent eviction or foreclosure.

(e) All families shall contribute an amount toward their rent or mortgage arrearage with such amount to be determined on a case by case basis through assessment and mediation in accordance with the professional judgment of the mediator(s).

(f) If a family is receiving a rental subsidy or resides in public housing, the maximum amount of the rent bank assistance approved by the mediation agency shall not exceed six (6) times the monthly family rental contribution, not to exceed a maximum grant of \$1,000 or a maximum loan of \$1,200 in accordance with the professional judgment of the mediator(s).

(g) Prior to committing any rent bank resources, the mediation agency shall ensure that both the family and the landlord or creditor desire that the family remain in the dwelling unit for twelve (12) additional months.

(Effective October 1, 1993)

#### **Sec. 17-619-10. Grants**

(a) Participating families whose income levels are at or below 30% of the state median income level shall only qualify for a grant.

(b) No grant shall exceed \$1,000.

(Effective October 1, 1993)

#### **Sec. 17-619-11. Loans**

(a) Families whose income levels are between 30 and 60 per cent of the state median income adjusted for family size may qualify for a loan.

(b) Participating mediation agencies may authorize a loan under this program in an amount not less than \$200 and not greater than \$1,200 for a term not to exceed twelve (12) months. Loans may be approved for any increment and timeframe within the provisions listed in subsection (b) of Section 17-619-11 in accordance with the professional judgment of the mediator(s).

(c) Families who qualify for a loan under Section 17-619-11 may not have monthly installment debt in excess of 50% of their net monthly income. The amount of installment debt shall include the following:

- (1) current rent or mortgage payment;
- (2) periodic payments due on any back rent or back-mortgage payment;
- (3) periodic payments due on a loan under this program;
- (4) any motor vehicle loan payment(s);
- (5) credit card loan payments; and
- (6) court ordered alimony and/or child support payments.

(d) Repayment of loans shall be based on a monthly repayment schedule over the life of the loan.

(e) Monthly service fees and any origination fees shall be paid from rent bank funds by the mediation agency on behalf of the borrower. In no event shall the service fee or origination fee be charged to the borrower.

(f) Rent bank loans shall bear interest at an annual rate not to exceed six (6) per cent.

(g) If a family defaults on a loan, the mediation agency shall contact the family to review the obligation, the reason for the default, and, if necessary, negotiate a new financial assistance agreement. For the purposes of these regulations, any loan that is in arrears in excess of forty (40) days shall be considered in default.

(h) After complying with subsection (g) of Section 17-619-11, any uncured or new default shall be reported to the bank servicing the loans for disclosure to any credit reporting agency and reported to the state funding agency for collection as a state debt.

(Effective October 1, 1993)

**Sec. 17-619-12. Loan/grant**

(a) In accordance with the eligibility criteria listed in Sections 17-619-9, 17-619-10, and 17-619-11, an applicant may be eligible for financial assistance in the form of a combination of a loan and a grant.

(b) A mediation agency may authorize a combination of a grant and a loan, in accordance with the professional judgment of the mediator(s), based on the following criteria:

(1) the amount of the loan is not less than \$200 and the total amount of financial assistance in the form of a loan and/or grant does not exceed \$1,200; and

(2) the mediation agency is satisfied that the client has the ability to repay the loan.

(c) The repayment of loans provided under this section shall be in the same manner as described in Section 17-619-11.

(Effective October 1, 1993)

**Sec. 17-619-13. Payments**

Payments of rent bank financial assistance for grants, loans or a combination thereof, shall be made payable to the creditor or landlord or his or her designated agent. For tax purposes, payments for mortgages may be made co-payable to the family and the lending institution holding the mortgage.

(Effective October 1, 1993)

**Sec. 17-619-14. Reporting requirements**

All mediation agencies shall comply with reporting and audit procedures established by the state funding agency for purposes of monitoring and evaluating the Eviction Prevention Program.

(Effective October 1, 1993)

**Sec. 17-619-15. Appeal process**

Any applicant who is denied assistance may request a desk review in accordance with the following procedures:

(a) The applicant shall file a written request for a desk review within fifteen (15) days from the date of the receipt of the written disposition notice addressed to the executive director of the mediation agency and signed by the applicant.

(b) The written request shall state the reason(s) the applicant believes he or she should receive services and include any additional documentation in support of his or her case.

(c) The executive director of the mediation agency may designate a staff employee to conduct the desk review provided that individual has not participated in the decision which is being appealed.

(d) The executive director, or any individual he or she designates, who has not participated in the original decision regarding the applicant, shall make a finding based on the desk review.

(e) The applicant or service recipient may withdraw the request for a desk review if a satisfactory resolution of the matter has been reached.

(f) Within fifteen (15) days from the date of the receipt of the request, the mediation agency shall make a decision based on an evaluation of the evidence as submitted and shall notify the applicant in writing, of the decision. This written decision shall state the reason(s) for the decision.

(Effective October 1, 1993)

**Sec. 17-619-16. Fair hearings**

Any applicant aggrieved by any action or inaction of the Department may request a fair hearing in accordance with Connecticut General Statutes Sections 17-603 and 17-604 as may be amended. The Department of Human Resources' fair hearing procedures are governed by applicable provisions of the Uniform Administrative Procedure Act and Sections 17-603-1 through 17-603-13, inclusive, of the Regulations of Connecticut State Agencies. Decisions made in accordance with the professional judgment of the mediator(s) shall be affirmed unless characterized by abuse of discretion or clearly unwarranted exercise of discretion.

(Effective October 1, 1993)