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**Funding Program for Privately Operated Community Residences
for Mentally Retarded Persons**

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Funding Program for Privately Operated Community Residences for Mentally Retarded Persons

Sec. 17a-230-1. Definitions

(a) **“Admission”** means a private residential facility’s acceptance of an individual into residence.

(b) **“Authorization”** means the department of mental retardation’s acceptance of responsibility for programmatic payment for an individual.

(c) **“Case review”** means examination of referral materials, records of decision making process of regional eligibility teams or private providers, and additional information as needed for the purposes of determining whether or not a person subjected to the authorization process or selection process for residential placement in a private residential facility had been unreasonably denied fair consideration.

(d) **“Commissioner”** means the commissioner of the department of mental retardation.

(e) **“Department”** means the department of mental retardation.

(f) **“Emergency placement”** means the admission of an individual into a private residential facility for reasons considered emergency by the provider (ex: an individual rendered homeless or where his or her principal caretaking person becomes unavailable).

(g) **“Existing facilities”** means private residential facilities except community training homes, residential schools or habilitative nursing facilities, licensed under 19a-467 on or before September 30, 1983.

(h) **“Fair hearing”** means the right of the mentally retarded person or private provider to request a hearing or review for the purposes of providing additional information and requesting a decision or justification of determinations made under the provisions of this statute and regulations.

(i) **“Grandfathered individual”** means a person residing in a private residential facility licensed by the department and receiving state payment for the cost of such services prior to October 1, 1983 or any person who is admitted to a private residential facility for the mentally retarded after October 1, 1983, and not later than December 31, 1983, which private residential facility is licensed by the department after October 1, 1983 and who is receiving state payment for the cost of such services, if (1) not later than July 15, 1983, the applicant for licensure owns or has an interest in the private residential facility or land upon which the private residential facility shall be located, or concludes a closing transaction on any mortgage loan secured by mortgage on such private residential facility or land, (2) such private residential facility is licensed not later than December 31, 1983, and (3) the applicant for licensure presents evidence to the commissioner that commitments had been made by such applicant not later than July 15, 1983, for the placement of individuals in such private residential facility.

(j) **“Impartial individual”** means a person who has had at least two years experience related to residential services to mentally retarded persons and has not participated in any decision on the clients’ eligibility or level of care.

(k) **“Level of care”** means that degree of supervision, programming and intervention necessary to meet the needs of a given population or individual.

(l) **“Mentally retarded person”** means an individual with significant sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

“Mental retardation” means the condition of a mentally retarded person as defined, includes borderline intelligence, and shall be determined by a psychologist licensed in the State of Connecticut.

(m) “**Pre-authorization process**” means the method of determination by a regional eligibility team of the clients’ eligibility for authorization or payment according to his appropriate level of care for the purposes of providing information to private providers essential to the development of private residential facilities and client selection.

(n) “**Overall plan of care**” means an individual written plan of programs and services developed, implemented, reviewed and modified according to the resident’s needs and in accordance with the department’s licensing regulations.

(o) “**Private residential facility**” means any residence licensed by the department or proposed to be licensed by the department pursuant to Section 19a-467 CGS excluding community training homes, residential schools and habilitative nursing facilities.

(p) “**Private sector client**” an individual who resides in his own home, family home, or home of friends, or is residing in a privately operated residential program.

(q) “**Provider**” means an individual, partnership or corporation which owns or operates a private residential program.

(r) “**Public sector client**” means an individual who lives in residential accommodations which are owned or operated by the department or who are mentally retarded, duly considered to be clients of the department through existing department practices, and reside in long term care facilities licensed by the department of health services.

(s) “**Ratios**” means the prevailing relationship between public sector clients, urgent waiting list clients, and private sector clients for the purposes of selection of clients for placement in private residential facilities funded by the department under the provisions of this statute and regulations.

(t) “**Reauthorization process**” means the determination by the department that a person, previously authorized for funding is either no longer eligible for funding or continues to be eligible for funding and, if still eligible for funding whether at the same level of care.

(u) “**Referral**” means the written presentation of essential information regarding a public sector, urgent waiting list or private sector client to a regional eligibility team upon which determination shall be made of that client’s eligibility for authorization in accordance with these regulations.

(v) “**Residential services**” means the provision of intervention, support or training appropriate to a level of care available in a private residential facility to meet the needs of mentally retarded persons and include direct care, administrative and support staff as well as other resources specified in these regulations which are necessary to ensure the provisions of such services.

(w) “**Respite**” means the temporary emergency or relief placement of a mentally retarded person into a private residential facility for the purposes of providing food, shelter and supervision to that person for a period not to exceed thirty days.

(x) “**Supplemental case review**” means a formal examination by an impartial third party of case review materials for which additional information and testimony may be given for the purposes of determining whether or not the individual has been unreasonably denied fair consideration during the authorization or selection process.

(y) “**Transfer**” means the process by which the department shall coordinate efforts to secure an appropriate alternative residential placement for an individual who is not reauthorized for funding or not reauthorized at his present level of care.

(z) “**Urgent waiting list client**” means an individual who is considered to be a client of the department through existing department practices who has met the existing department criteria of urgent need for residential placement as determined clinically through interdisciplinary team review, and whose name is maintained by the department on waiting lists for residential placement.

(Effective June 28, 1994)

Sec. 17a-230-2. Application process

(a) Any provider requesting funding under these regulations shall make application to the department prior to the authorization of the clients or the establishment of a rate by the department of income maintenance during times designated by the Commissioner for receipt of applications.

(b) The application shall be on forms provided by the department and shall at least include the following information:

(1) name and address of corporation, person or persons who will operate the private residential facility,

(2) list of other programs and their addresses currently being run by the corporation or person,

(3) full disclosure of partners or board members, and officers,

(4) if a corporation, a copy of a financial audit conducted within the past two years by an independent certified public accountant, or licensed public accountant,

(5) if a person or partnership, three professional references and present employment information,

(6) concerning the private residential facility for which funds are requested:

(A) type of private residential facility,

(B) proposed opening date,

(C) proposed number of clients,

(D) specific location,

(E) age, sex and disability range of proposed clients,

(F) type of day programs to which clients will have access,

(G) staffing pattern by shift,

(H) professional/clinical services to be provided,

(I) proposed operating budget,

(J) advance payment requirements, and

(K) method of financing the development of the private residential facility and any long term financing requirements.

(c) The commissioner shall review each provider’s application and shall notify the applicant within sixty days of the closing date for the receipt of application as to his decision. In his review, the commissioner shall consider the relationship of the proposal to the department’s residential plan, the financial feasibility of the proposal and its impact on the applicant’s rate and financial condition, the proposal’s contribution to quality, accessibility and cost-effect, residential service and any other factors which the commissioner deems relevant including:

(1) whether the existing or proposed administrative structure is sufficient to properly develop, operate and maintain the proposed private residential facility on a continuous long term basis. Evidence shall include at least the following:

(A) operating policies and procedures, (B) provision for supervision of staff, (C) provision for implementation of clients’ plans of care, (D) availability of program support services, and (E) provision for administrative oversight.

(2) Whether the provider has or can obtain the necessary financial resources to establish and maintain the proposed private residential facility, evidence of which shall include at least the following: (A) availability of capital financing for property development (B) provision for start up and working capital requirements, and (C) financial management abilities.

(d) Project Review Committee

There shall be a statewide project review committee (see P.A. 83-39, Sec. 15) which shall review all proposals to be funded. The committee shall report to the commissioner its findings and recommendations on each application on whether it is appropriate for housing retarded persons and whether it meets the department's statewide residential plan.

(e) The commissioner's approval for funding may include a commitment to: advance payments as provided in Sec. 3 of these regulations, the number of residential beds, levels of care and a specific opening date for the private residential facility. Such commitment shall remain in effect for no more than sixty days past any specified opening date of the private residential facility, approved by the commissioner. An extension of such commitment may be granted by the commissioner if an extension request is received in writing no later than ten days before the specified opening date.

(Effective June 28, 1994)

Sec. 17a-230-3. Advance payments

(a) The commissioner may make payments to a provider in advance of provider's rendering services for any of the following expenditures:

(1) Rent or mortgage, utilities and other costs incurred to open and maintain the private residential facility.

(2) Salaries, fringe benefits and other expenses for direct care, and professional staff incurred in order to (A) develop the residential services, (B) select, evaluate and place clients, or (C) both (A) and (B).

(3) Administrative and organizational expenses incurred in order to develop the private residential facility.

(b) Payments may only be made if expenses are incurred during the forty-five days just prior to the initial admission of the first client to the private residential facility.

(c) Prior approval shall be obtained by submitting in writing, on forms supplied by the department, an itemized budget of allowable costs to be incurred. The department may make advance payment prior to the expenditure of funds by the provider. Payments may be made no more than sixty days in advance of the admission of the first client to the private residential facility. Records of expenditures must be maintained by the provider and submitted to the department no later than forty-five days after the admission of the first resident.

(d) Expenditures submitted shall be considered proper if (1) they do not exceed charges made for comparable services to the general public, (2) are for those expenditures described in Sec. 3, (3) have prior approval, and (4) are incurred no earlier than forty-five days prior to the first admission to the private residential facility.

(e) If an expenditure is found to be improper by the department, and payment to the provider has already been made, the provider shall return such payment to the department within thirty days of receipt of written notice.

(f) Advance payments under this section shall be no greater than forty-five days of the per diem rate established for the private residential facility by the department of income maintenance multiplied by the number of approved beds.

(Effective June 28, 1994)

Sec. 17a-230-4. Per diem services reimbursement

(a) Per diem services reimbursement under this section shall be based on the rate established for services under Section 17-313b.

(b) Reimbursement shall be made each month for services rendered the previous month and shall be based upon attendance records submitted by the provider for the previous month. Reimbursement shall be made directly to the private residential facility for clients authorized by the department.

(c) A cash advance shall be paid by the department no later than the fifteenth day of the first month of operation. The advance shall equal thirty days of funding at the rate for services established under Section 17-313b of the General Statutes. It shall be paid for the total number of beds authorized for the private residential facility under Section (e) of Section 17a-230-2 of the Regulations of Connecticut State Agencies into which authorized clients will be placed. The cash advance payment shall be applied to the amount owing for services for the last month of the private residential facility's operation. If the private residential facility is subsequently certified as a medicaid provider, the cash advance will be collected within one year of such certification. If the private residential facility is subsequently converted, with prior approval of the department, to a residential program which does not require licensure, the cash advance shall be retained by the provider and applied to the amount owed for services for the last month of such residential program's operation.

(d) An authorized client may be absent from the private residential facility up to twenty-eight days a year without affecting reimbursement to the private residential facility. To obtain reimbursement for absences in excess of twenty-eight days, the private residential facility shall obtain prior approval of the department. Requests shall be submitted in writing to the department.

(e) Reimbursement shall be authorized for the day of admission and not for the day of discharge of a client, except that: in the case of death, and in the case of an admission and discharge on the same date, reimbursement is authorized for one day of care. A day for other purposes shall be the census of the private residential facility taken at midnight.

(f) The department shall reimburse providers pursuant to an annual contract for services. Such contracts may address advance payments, a commitment for a maximum day of service and cash advance for services at the rate established by the department of income maintenance.

(g) The department shall have a contract with each provider which shall include at a minimum: (1) the number of private residential facilities to be operated by the provider, (2) the number of clients to be served per private residential facility, (3) the level of care that shall be provided for each client, (4) that each client shall have an overall plan of care that shall include the amount, duration and scope of services to be provided, and (5) the maximum total amount to be paid by the department.

(h) The department may revoke or modify any contract with a provider, if it finds that the provider has not met the provisions of this contract as defined in subsection (g) of this section. It may revoke any contract where the provider has misrepresented information required in section 2(b) of these regulations.

(Effective November 17, 1994)

Sec. 17a-230-5. Regional eligibility teams

(a) There shall be a regional eligibility team in each region of the department.

(b) This team shall be composed of five members. One shall be the region's superintendent or his designee who shall function as chairperson, two shall be

department staff. Two shall represent private sector residential, parent or advocacy groups. At least three disciplines shall be represented.

(c) The teams shall (1) meet as often as necessary to provide lists of clients as provided in Section (e) of the department's urgent waiting list, public and private sector eligible individuals in accordance with these regulations to facilitate client selection for private residential facilities in the region, (2) have a quorum present which consists of fewer than three members, alternates and the chairperson included, at least one of which is private sector representative, (3) allow the testimony of the client where appropriate or of other persons who know the needs of those individuals who are being considered for authorization, (4) adopt by-laws in accordance with standards developed by the department with regard to team process and procedures and maintain minutes of all team meetings, (5) be responsible for maintaining lists of eligible urgent waiting list, public and private sector clients in accordance with these regulations, and (6) be responsible for ensuring that timely notifications are provided to appropriate designated parties of the results of the team's determinations.

(d) Private sector residential, parent and advocacy groups shall nominate from their staff or membership from the region those whom they recommend for the superintendent's appointment to fill the two non-department positions of the team. The superintendent shall appoint from the nominees unless none or only one is received from the private sector. Appointees shall serve one year terms commencing with the first meeting of the regional eligibility teams. An alternate shall also be appointed to serve in the absence of the regular members of both department and private sector representative. Members and alternates may be reappointed to no more than four consecutive terms.

(e) The purpose of the regional eligibility team shall be to: (1) review client referral material submitted by the department and private providers to determine client eligibility for authorization according to Section 7 of these regulations; (2) assign each referred client to a level of care in accordance with these regulations; (3) develop lists of eligible clients according to assigned levels of care; (4) develop lists of department urgent waiting list authorizable clients according to assigned levels of care; (5) provide data on numbers of clients of each level of care to private providers developing residential services; (6) provide lists and referral information to private providers; (7) protect the confidentiality of individuals; (8) inform the individual, his or her parent or legal representative and referring provider of decisions in a timely manner and in writing; and (9) conduct case reviews, in accordance with Section 14 of these regulations.

(Effective June 28, 1994)

Sec. 17a-230-6. Referral process

(a) Referrals, as defined in these regulations, shall be made on forms provided by the department, by private providers or department agencies for persons who are known to these providers or agencies and who are currently requesting or receiving services from these providers. Referrals shall be made with permission of the individual, parent, guardian or other legal representative or by the responsible state agency.

(b) Referral information provided to the regional eligibility team shall be sufficient to substantiate the referring party's position: (1) that the individual is mentally retarded as defined in these regulations and therefore potentially eligible for department funding; (2) that there is justification of the individual's need for residential services at a level of care provided for in Section 7 (b) of these regulations according

to some or all of the following factors; (A) the need to deinstitutionalize that person, (B) the need to prevent that person's institutionalization, (C) the need for age-appropriate or other specific types of residential services, (D) the urgent need of that person for placement to prevent functional deterioration; and (E) that the person's financial statement confirms his receipt of aid to the disabled, aid to the blind or aid to the elderly or that his ability to pay for residential services as defined in Section 7 (c) of these regulations, does not exceed the potential cost of such level of care.

(c) In the event of an emergency placement, as defined in these regulations, of a client by a private provider into one of its private residential facilities, the same information called for in sub-section (b) of this section shall be provided to the regional eligibility team within seven days after the emergency placement in order to determine that client's eligibility for authorization. Sufficient documentation to verify the nature of the emergency and the need for residential placement shall be provided to the department within seven days of the placement.

(Effective June 28, 1994)

Sec. 17a-230-7. Eligibility determination

(a) Determination of client eligibility for authorization shall be based on the regional eligibility team's review of the information provided in written referral materials in accordance with Section 6 of these regulations. This review shall include, but shall not be limited to, verification of the client's diagnosis of mental retardation as defined in these regulations, determination of the level of care required by the client and determination of need for residential services. The commissioner or his designee may waive the level of care assigned to a specific client by the regional eligibility team, and assign a different level, if the commissioner or his designee deems such action reasonable to facilitate or promote an otherwise appropriate placement.

(b) There shall be five levels of care: (1) Level I shall be the supervised level of care which shall provide minimal protection and supervision, limited professional, consultative and support services concentrating on the use of generic community services, refinement of independent living skills and counseling for placement into employment. Residents shall have self-preservation skills and shall be capable of self-administering any medications they may require. (2) Level II shall be the semi-structured level of care which shall provide the supervision of basic living skills, training in the use of leisure time and development of social skills. Residents shall have self-preservation skills, shall be capable of administering any medications they may require and shall receive training to assure maintenance of these skills. (3) Level III shall be the structured level of care which shall provide training in basic living skills, training in the use of leisure time and development of social skills and professional consultative and support services as needed. Residents may not have acquired self-preservation skills or may not be capable of self-administering medications and shall receive training in both. (4) Level IV shall be the intensive level of care which shall provide training in basic self-care skills, behavioral intervention and modification of problem behaviors, and direct professional support services. Residents shall receive intensive training designed to develop self-preservation skills and shall have medications administered by appropriately training personnel. (5) Level V shall be the highly intensive level of care which shall provide total support for self-care, intensive behavioral intervention and modification, and direct professional support services. Residents shall require twenty-four hour supervision due to total

lack of self preservation skills and may require up to twenty-four hour medical monitoring.

(c) The department shall determine if the client meets the following financial eligibility requirements: (1) the client is eligible for or receiving aid to the disabled, aid to the blind or aid to the elderly, or (2) the client does not have the ability to pay for any portion of the residential services at his assigned level of care at the established rate, as evidenced by a signed financial disclosure statement on forms provided by the department, or (3) the client has the ability to pay for only a portion of the residential services at his assigned level of care at the established rate, as evidenced by a signed financial disclosure statement on forms provided by the department.

(d) If financial eligibility is based on ability to pay for a portion of residential services as in sub-section (c) (3) of this section, the client shall be eligible for authorization for funding of only that portion of the residential services for which he is unable to pay.

(e) The regional eligibility team shall create three separate lists of individuals who are determined to be eligible for authorization in accordance with sub-sections (a) and (b) above as follows: (1) public sector clients, (2) department's urgent waiting lists of clients from the private sector, (3) private sector clients. Each list shall be maintained according to levels of care in order to facilitate residential development and client selection by the private sector according to the established prevailing ratios addressed in Section 8 of these regulations.

(f) The regional eligibility team shall create a separate list of individuals who are determined to be eligible for respite in accordance with (a) and (c) above and without regard to whether the individual is from the public sector or the private sector.

(g) Appeals under Section 7 shall be processed according to Section 14—Hearings and Reviews.

(Effective June 28, 1994)

Sec. 17a-230-8. Ratio

(a) The ratio as defined in these regulations shall be set at: three clients from the public sector, one client from the department's urgent waiting list, and two clients from the private sector.

(b) Such ratio shall be in effect until it is reviewed and revised by the commissioner in consultation with the commission on long term care and private sector representatives. Review shall occur one year after the effective date of these regulations and at least annually thereafter.

(c) Regarding new private residential facilities, such ratios shall be applied to either an individual private residential facility or several private residential facilities sponsored by the same provider provided these private residential facilities are approved for development in accordance with Section 2 of these regulations and shall be available in a timely way agreed upon in advance by the developing provider and the department.

(d) Regarding existing private residential facilities, such ratio shall be applied only to vacated beds.

(e) Nothing in this section shall prevent a private residential facility from selecting more than the specified number of clients from the public sector.

(Effective June 28, 1994)

Sec. 17a-230-9. Client selection

(a) The provider planning to develop or manage a specific private residential facility, upon receiving a commitment from the department to proceed with such

development shall have access to lists of individuals who have been determined by regional eligibility teams to need the level of care to be provided by the private residential facility and are therefore eligible for authorization. Likewise, existing private residential facilities operating under the provisions of these regulations which seek to fill a vacancy shall have similar access to such lists of clients, determined to need the level of care provided by the private residential facility.

(b) The availability of these lists of eligible clients shall not be unreasonably restricted by geographic catchment area, however, it is understood that for some persons there may be an optimal region of placement that shall be considered during the selection process.

(c) From these lists of public and private sector individuals, the designated staff or individuals charged by the provider with the responsibility for client selection (1) shall have access to referral information concerning the eligible individuals being considered for placement which is contained in department files; (2) shall have access to visitation with those individuals and staff of those person's current residential and day program; and (3) may contact those individuals' families. Staff involved in these selection activities shall adhere to statutory requirements regarding client confidentiality.

(d) To qualify for funding under these regulations, the licensee shall select individuals for residence from among clients determined to be eligible by the regional eligibility team and in accordance with the ratio set forth in Section 8.

(Effective June 28, 1994)

Sec. 17a-230-10. Client authorization

The commissioner shall authorize a client for funding at the rate established by the department of income maintenance under Section 17-313b of the General Statutes when he finds that the client has been determined eligible for funding according to Section 7 of these regulations, that the client has been selected by an eligible private residential facility that can provide the level of care he needs and that his selection conforms with the ratio as set forth in Section 8. Such authorization shall remain in effect until the next reauthorization or until the client leaves the private residential facility.

(Effective June 28, 1994)

Sec. 17a-230-11. Grandfathered individuals

(a) The commissioner shall pay for the per diem reimbursement costs as established by Section 4 of these regulations after June 30, 1984 when the regional eligibility team determines that a grandfathered individual (1) is eligible for authorization at his current level of care in accordance with Section 7 (b) of these regulations; (2) requires a different level of care which is currently available in his current private residential facility or; (3) is not appropriate at the present level of care but that a transfer is clinically contraindicated at the time; (4) meets the financial eligibility requirements of Section 7 (c) and (d).

(b) The regional eligibility team shall provide notice in writing within thirty days after the review to any grandfathered individual who does not meet the conditions addressed in sub-section (a) of this section, of its determination that the client is not eligible for department funding after June 30, 1984. Copies of such notice shall also be forwarded to the provider operating the private residential facility in which the client currently resides. Clients denied eligibility for authorization may appeal the regional eligibility team decision under the provisions of the statute. The depart-

ment shall, however, provide funding at the level provided by the department of income maintenance prior to July, 1984, until final disposition of the appeal.

(c) The transfer process according to Section 13 of these regulations shall be implemented immediately upon receipt of notice from the regional eligibility team that a grandfathered client has been determined financially ineligible for department funding or determined to be eligible for funding at a different level of care than provided at the private residential facility in which he currently resides.

(Effective June 28, 1994)

Sec. 17a-230-12. Reauthorization

(a) Client reauthorization for funding, as defined in these regulations, shall be conducted for each funded individual by the department on at least an annual basis.

(b) Reauthorization may be conducted more frequently at the request of the individual, his legal representative, the private provider providing residential services, or the department. Justification for any such request may include: (1) change of client's functioning which would warrant a different level of care, or (2) emergency transfer of the client in accordance with Section 13 of these regulations.

(c) Reauthorization shall include a review of the client's record to: (1) verify diagnosis of mental retardation as defined in these regulations; (2) determine the client's appropriateness for the level of care provided by the private residential facility where he resides at the time of reauthorization using criteria for levels of care established in Section 7 (b) of these regulations, and (3) determine the client's financial eligibility for funding according to criteria established in Section 7 (c) and 7 (d) of these regulations.

(d) Reauthorization at the same level of care shall occur when the department determines: (1) that the individual is mentally retarded as defined in these regulations, (2) that the individual is financially eligible for funding, and (3) that the individual is (A) appropriate for his current level of care (B) appropriate for a different level of care which is not currently available in either his current private residential facility or in another private residential facility within the regional center catchment area, or (C) appropriate for a different level of care but a transfer is clinically contraindicated at the time.

(e) Reauthorization at a different level of care shall occur when the department determines (1) that the individual is mentally retarded as defined in these regulations, (2) that the individual is financially eligible for funding, and (3) that the client is inappropriate for current level of care but the appropriate level of care is available in either his current private residential facility or in another private residential facility within the regional center catchment area and transfer is not clinically contraindicated at the time.

(f) The department shall provide notice in writing within thirty days of any review to all individuals subject to the reauthorization process regarding its decision of (1) reauthorization at the same level of care, (2) reauthorization at a different level of care, or (3) denial of reauthorization. Copies of such notice shall be sent to the provider operating the private residential facility in which the client currently resides and the appropriate parties of the department according to procedures established to implement these regulations.

(Effective June 28, 1994)

Sec. 17a-230-13. Transfers

(a) The department shall initiate the transfer of a client when it is determined that a client is (1) reauthorized at a level of care that is not being provided in the

client's present private residential facility, or (2) found to be ineligible for reauthorization.

(b) When the department has found an appropriate placement for transfer, notice of the transfer shall be provided at least fifteen days preceeding the date on which transfer is to occur, to the individual or his representative and all other involved parties.

(c) Funding shall continue until the transfer takes place. No individual shall be transferred while awaiting a determination.

(d) The department shall not fund any individual who (1) has exhausted his right of appeal under Section 14, and (2) has been given proper notice of transfer and refuses the transfer.

(e) When a transfer is initiated by a private residential facility, funding for that client shall continue if prior approval is obtained from the department.

(f) In the event of an emergency placement of a previously unfunded client into a private residential facility authorized for funding according to Section 2 of these regulations, written notice shall be provided to the department agency of the region in which the private residential facility is located within seven days after the emergency placement. It shall be the responsibility of the private provider to refer the client to the appropriate regional eligibility team to determine his eligibility for funding according to Section 7 of these regulations. All provisions of these regulations regarding appeals, reauthorization and transfers shall apply to individuals placed on an emergency basis under this subsection.

(Effective June 28, 1994)

Sec. 17a-230-14. Hearings and reviews

(a) Case Review, as defined in these regulations:

(1) Shall be offered to persons: (A) who have been denied initial eligibility for authorization under Section 7, (B) who dispute the level of care that was initially assigned to them by the regional eligibility team, or (C) who have been denied admission by a private residential facility.

(2) The request for a case review shall be made in writing by the individual, or his legal representative, to the superintendent of the region or to the private residential facility or to both according to subsections (4) and (5) below. The superintendent or the private residential facility shall transmit such request to the regional eligibility team within five days. The request shall be made within fifteen days after the receipt of notice of denial or eligibility, dispute of level of care or denial of admission to a private residential facility.

(3) At the time of request for a case review, any additional information may be submitted by the client or his legal representative.

(4) If a client has been denied eligibility or disputes his level of care, the regional eligibility team shall, within thirty days after receipt of request for case review, review its previous decision and any new information submitted and either confirm or change its original decision.

The chairperson of the regional eligibility team shall notify the individual of the team's decision in writing.

(5) If a client has been denied admission to a private residential facility, the private residential facility's selection body shall review its decision and if the initial decision prevails, a notice shall be sent to the client stating the reasons for denial of admission. A copy of the decision shall be sent to the regional eligibility team.

(b) A supplemental case review, as defined in these regulations, shall apply as follows:

(1) A client or his representative, who is not satisfied with the decision in subsection (a) (4) and (5) may request a supplemental case review.

(2) Request for a supplemental case review shall be made in writing to the superintendent of the region in which the decision was made. Requests shall be made within fifteen days of receipt of notice of the case review decision.

(3) The superintendent of the region, upon receipt of such request, shall appoint an impartial individual to review the decision of the regional eligibility team of the private residential facility.

(4) The impartial individual shall solicit any information from the client or his legal representative and the regional eligibility team or the private residential facilities and may require attendance at a meeting by such parties in order to make a binding determination of the dispute.

(5) If the impartial individual schedules a meeting of the parties, he shall do so within five days of the receipt of the request for supplemental case review and such meeting shall be held within fifteen days of receipt of the request.

(6) The decision of the impartial individual shall be sent in writing to all parties involved within ten days of any meeting or if no meeting is held, within ten days of receipt of the request and will be binding.

(c) Fair hearings, as defined in these regulations, shall apply:

(1) Whenever a regional eligibility team declines to reauthorize a person for continued funding or there is a change in the level of care of a previously authorized individual, the regional eligibility team shall give thirty days notice in writing to the individual and such individual's parent, conservator, guardian, or other legal representative and the private residential facility in which the person lives. Such notice shall also inform such individual the reason for determination and of his right to contest the determination by submitting in writing a request for fair hearing under the provisions of this subsection.

(2) Request for a hearing shall be made to the commissioner in writing within fifteen days of receiving the notice required by this subsection.

(3) The hearing, if requested, shall be held within thirty days of the request with proper notification to all parties.

(4) The hearing shall be conducted in accordance with the provisions of Section 4-177 to 4-184 inclusive of the General Statutes.

(Effective June 28, 1994)

Sec. 17a-230-15. Respite

(a) Any private provider applying for funding from the department may request that one or more of the beds to be developed be designated as a respite bed.

(b) The department may at the time of approval for funding under Section 2 (b) authorize the private provider's request to establish a respite bed.

(c) Clients entering respite beds and requesting funding shall be previously determined eligible for respite by the regional eligibility team under Section 7 (f).

(d) For the purposes of funding, respite authorizations shall not be according to level of care determinations.

(e) Payment made to the provider shall be at a rate established by the department of income maintenance.

(f) For the purposes of rate setting, the utilization of the bed shall only be counted when a client occupies the bed.

(g) Payment for an authorized respite client shall be no more than 30 consecutive days and no more than a total of 90 days per year.

(Effective June 28, 1994)