TO BE RESCINDED

5160-46-04 Ohio home care waiver: definitions of the covered services and provider requirements and specifications.

This rule sets forth the definitions of the services covered by the Ohio home care waiver. This rule also sets forth the provider requirements and specifications for the delivery of Ohio home care waiver services. The services are reimbursed in accordance with rule 5160-46-06 of the Administrative Code.

(A) Waiver nursing services.

(1) "Waiver nursing services" are defined as nursing tasks and activities provided to Ohio home care waiver individuals who require the skills of a registered nurse (RN) or licensed practical nurse (LPN) at the direction of an RN.

(a) All nurses providing waiver nursing services to Ohio home care waiver individuals shall:

(i) Possess a current, valid and unrestricted license with the Ohio board of nursing;

(ii) Possess an active medicaid provider agreement or be employed by an entity that has an active medicaid provider agreement; and

(iii) Provide services within the nurse's scope of practice as set forth in Chapter 4723. of the Revised Code and Administrative Code rules adopted thereunder.

(b) Nursing tasks and activities that shall only be performed by an RN include, but are not limited to, the following:

(i) Intravenous (IV) insertion, removal or discontinuation;

(ii) IV medication administration;

(iii) Programming of a pump to deliver medications including, but not limited to, epidural, subcutaneous and IV (except routine doses of insulin through a programmed pump);

(iv) Insertion or initiation of infusion therapies;

(v) Central line dressing changes; and

(vi) Blood product administration.

(2) "Personal care aide services" as defined in paragraph (B) of this rule may be reimbursed as waiver nursing services when provided incidental to waiver nursing services as defined in paragraph (A)(1) of this rule and performed during an authorized waiver nursing visit.

(3) Waiver nursing services do not include:

(a) Services delegated in accordance with Chapter 4723. of the Revised Code and rules adopted thereunder and to be performed by providers who are not licensed nurses in accordance with Chapter 4723. of the Revised Code;

(b) Services that require the skills of a psychiatric nurse;

(c) Visits performed for the purpose of conducting an RN assessment as set forth in rule 5160-12-08 of the Administrative Code, including but not limited to an outcome and assessment information set (OASIS) assessment or any other assessment;

(d) RN consultations as set forth in rule 5160-12-08 of the Administrative Code, including but not limited to, those performed by RNs for the sole purpose of directing LPNs in the performance of waiver nursing services or directing personal care aides or home health aides employed by a medicare-certified home health agency or otherwise accredited agency;

(e) Visits performed for the sole purpose of meeting the supervisory requirements (including any visit) pursuant to paragraph (B)(6)(c) of this rule;

(f) Visits performed for the sole purpose of meeting the home care attendant service RN visit requirements set forth in rules 5160-46-04.1 and 173-39-02.24 of the Administrative Code; or

(g) Services performed in excess of the number of hours approved pursuant to, and as specified on, the individual's all services plan.

(4) Waiver nursing services may be provided on the same day as, but not concurrently with, an RN assessment and/or an RN consultation as set forth in rule 5160-12-08 of the Administrative Code.

(5) In order to be a provider and submit a claim for reimbursement of waiver nursing services, the RN, or LPN at the direction of the RN, delivering the service must meet all of the following requirements:

(a) Comply with all applicable rules set forth in Chapters 5160-45 and 5160-46 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5160-46-06 of the Administrative Code.

(c) Be employed by a medicare-certified, or otherwise-accredited home health agency, or be a non-agency home care nurse provider.

(d) Not be the individual's legally responsible family member, as that term is defined in rule 5160-45-01 of the Administrative Code, unless the legally responsible family member is employed by a medicare-certified, or otherwise-accredited home health agency.

(e) Not be the foster caregiver of the individual.

(f) Be identified as the provider and have specified on the individual's all services plan, that is prior-approved by the Ohio department of medicaid (ODM) or its designee, the number of hours the provider is authorized to furnish waiver nursing services to the individual.

(g) Be identified as the provider on, and be performing nursing services pursuant to, the individual's plan of care, as that term is defined in rule 5160-45-01 of the Administrative Code. The plan of care must be signed and dated by the individual's treating physician.

(h) Be providing the service for one individual, or in a group setting as defined in rule 5160-46-06 of the Administrative Code, during a face-to-face nursing visit.

(6) Non-agency LPNs, at the direction of an RN, must:

(a) Conduct a face-to-face visit with the directing RN at least every sixty days after the initial visit to evaluate the provision of waiver nursing services and LPN performance, and to assure that waiver nursing services are being provided in accordance with the approved plan of care and within the LPN's scope of practice; and

(b) Conduct a face-to-face visit with the individual and the directing RN before initiating services and at least every one hundred twenty days for the purpose of evaluating the provision of waiver nursing services, the individual's satisfaction with care delivery and LPN performance, and to assure that waiver nursing services are being provided in accordance with the approved plan of care and within the LPN's scope of practice.

(7) All waiver nursing service providers must maintain a clinical record for each individual served in a manner that protects the confidentiality of these records. Medicare-certified, or otherwise-accredited home health agencies, must maintain the clinical records at their place of business. Non-agency waiver nursing service providers must maintain the clinical records at their place of business, and maintain a copy in the individual's residence. For the purposes of this rule, the place of business must be a location other than the individual's residence. At a minimum, the clinical record must contain the information listed in paragraphs (A)(7)(a) to (A)(7)(l) of this rule.

(a) Identifying information, including but not limited to: name, address, age, date of birth, sex, race, marital status, significant phone numbers, and health insurance identification numbers of the individual.

(b) The medical history of the individual.

(c) The name of individual's treating physician.

(d) A copy of the initial and all subsequent all services plans.

(e) A copy of the initial and all subsequent plans of care, specifying the type, frequency, scope and duration of the nursing services being performed. When services are performed by an LPN at the direction of an RN, the clinical record shall include documentation that the RN has reviewed the plans of care with the LPN. The plan of care must be recertified by the treating physician every sixty days, or more frequently if there is a significant change in the individual's condition.

(f) In all instances when the treating physician gives verbal orders to the nurse, the nurse must document, in writing, the physician's orders, the date and time the orders were given, and sign the entry in the clinical record. The nurse must subsequently secure documentation of the verbal orders, signed and dated by the treating physician.

(g) In all instances when a non-agency LPN is providing waiver nursing services, the LPN must provide clinical notes, signed and dated by the LPN, documenting all consultations between the LPN and the directing RN, the face-to-face visits between the LPN and the directing RN, and the face-to-face visits between the LPN, the individual, and the directing RN. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.

(h) A copy of any advance directives including, but not limited to, "do not resuscitate" (DNR) order or medical power of attorney, if they exist.

(i) Documentation of all drug and food interactions, allergies and dietary restrictions.

(j) Clinical notes and other documentation of tasks performed or not performed, arrival and departure times, and the dated signatures of the provider, and the individual or the individual's authorized representative, verifying the service delivery upon completion of service delivery. Nothing shall prohibit the collection and maintenance of documentation through technology-based systems. The consumer's or authorized representative's signature of choice shall be documented on the individual's all services plan, and shall include, but not be limited to, any of the following: a handwritten signature, initials, a stamp or mark, or an electronic signature.

(k) Clinical notes signed and dated by the nurse, documenting all communications with the treating physician and other members of the multidisciplinary team. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.

(l) A discharge summary, signed and dated by the departing nurse, at the point the nurse is no longer going to provide services to the individual, or when the individual no longer needs nursing services. The summary should include documentation regarding progress made toward goal achievement and indicate any recommended follow-ups or referrals.

(B) Personal care aide services.

(1) "Personal care aide services" are defined as services provided pursuant to the Ohio home care waiver's all services plan that assist the individual with activities of daily living (ADL) and instrumental activities of daily living (IADL) needs. If the individual's all services plan states that the service provided is to be personal care aide services, the service shall never be billed as a nursing service. Personal care aide services consist of the services listed in paragraphs (B)(1)(a) to (B)(1)(e) of this rule. If the provider cannot perform IADLs, the provider must notify, ODM or its designee, in writing, of the service limitations before inclusion on the individual's all services plan.

(a) Bathing, dressing, grooming, nail care, hair care, oral hygiene, shaving, deodorant application, skin care, foot care, feeding, toileting, assisting

with ambulation, positioning in bed, transferring, range of motion exercises, and monitoring intake and output;

(b) General homemaking activities, including but not limited to: meal preparation and cleanup, laundry, bed-making, dusting, vacuuming, and waste disposal;

(c) Household chores, including but not limited to washing floors, windows and walls, tacking down loose rugs and tiles; and moving heavy items to provide safe access and exit;

(d) Paying bills and assisting with personal correspondence as directed by the individual; and

(e) Accompanying or transporting the individual to Ohio home care waiver services, medical appointments, other community services, or running errands on behalf of that individual.

(2) Personal care aide services do not include services performed in excess of the number of hours approved pursuant to the all services plan.

(3) Personal care aides shall not administer prescribed or over-the-counter medications to the individual, but may, unless otherwise prohibited by the provider's certification or accreditation status, pursuant to paragraph (C) of rule 4723-13-02 of the Administrative Code, help the individual self-administer medications by:

(a) Reminding the individual when to take the medication, and observing to ensure the individual follows the directions on the container;

(b) Assisting the individual by taking the medication in its container from where it is stored and handing the container to the individual;

(c) Opening the container for an individual who is physically unable to open the container;

(d) Assisting an individual who is physically-impaired, but mentally alert, in removing oral or topical medication from the container and in taking or applying the medication; and

(e) Assisting an individual who is physically unable to place a dose of medication in his or her mouth without spilling or dropping it by placing the dose in another container and placing that container to the mouth of the individual.

(4) Personal care aide services shall be delivered by one of the following:

(a) An employee of a medicare-certified, or otherwise-accredited home health agency; or

(b) A non-agency personal care aide.

(5) In order to be a provider and submit a claim for reimbursement, all personal care aide service providers must meet the following:

(a) Comply with all applicable rules set forth in Chapters 5160-45 and 5160-46 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5160-46-06 of the Administrative Code.

(c) Be at least eighteen years of age.

(d) Be identified as the provider, and have specified, on the individual's all services plan that is prior-approved by ODM or its designee, the number of hours for which the provider is authorized to furnish personal care aide services to the individual.

(e) Have a valid social security number, and one of the following forms of identification:

(i) Alien identification,

(ii) State of Ohio identification,

(iii) A valid driver's license, or

(iv) Other government-issued photo identification.

(f) Not be the individual's legally responsible family member as that term is defined in rule 5160-45-01 of the Administrative Code.

(g) Not be the foster caregiver of the individual.

(h) Be providing personal care aide services for one individual, or for up to three individuals in a group setting during a face-to-face visit.

(i) Comply with the additional applicable provider-specific requirements as specified in paragraph (B)(6) or (B)(7) of this rule.

(6) Medicare-certified and otherwise-accredited agencies must assure that personal care aides meet the following requirements:

(a) Before commencing service delivery, the personal care aide must:

(i) Obtain a certificate of completion of either a competency evaluation program or training and competency evaluation program approved or conducted by the Ohio department of health under section 3721.31 of the Revised Code, or the medicare competency evaluation program for home health aides as specified in 42 C.F.R. 484.36 (as in effect on October 1, 2014), and

(ii) Obtain and maintain first aid certification from a class that is not solely internet-based and that includes hands-on training by a certified first aid instructor and a successful return demonstration of what was learned in the course.

(b) Maintain evidence of the completion of twelve hours of in-service continuing education within a twelve-month period, excluding agency and program-specific orientation. Continuing education must be initiated immediately, and must be completed annually thereafter.

(c) Receive supervision from an Ohio-licensed RN, or an Ohio-licensed LPN, at the direction of an RN in accordance with section 4723.01 of the Revised Code. The supervising RN, or LPN at the direction of an RN, must:

(i) Conduct a face-to-face individual home visit explaining the expected activities of the personal care aide, and identifying the individual's personal care aide services to be provided.

(ii) Conduct a face-to-face individual home visit at least every sixty days while the personal care aide is present and providing care to evaluate the provision of personal care aide services, and the individual's satisfaction with care delivery and personal care aide performance. The visit must be documented in the individual's record.

(iii) Discuss the evaluation of personal care aide services with the case manager.

(d) Be able to read, write and understand English at a level that enables the provider to comply with all requirements set forth in the administrative rules governing the Ohio home care waiver.

(e) Be able to effectively communicate with the individual.

(7) Non-agency personal care aides must meet the following requirements:

(a) Before commencing service delivery personal care aides must have:

(i) Obtained a certificate of completion within the last twenty-four months for either a competency evaluation program or training and competency evaluation program approved or conducted by the Ohio department of health in accordance with section 3721.31 of the Revised Code; or the medicare competency evaluation program for home health aides as specified in 42 C.F.R. 484.36 (as in effect on October 1, 2014); or other equivalent training program. The program must include training in the following areas:

(a) Personal care aide services as defined in paragraph (B)(1) of this rule;

(b) Basic home safety; and

(c) Universal precautions for the prevention of disease transmission, including hand-washing and proper disposal of bodily waste and medical instruments that are sharp or may produce sharp pieces if broken.

(ii) Obtained and maintain first aid certification from a class that is not solely internet-based and that includes hands-on training by a certified first aid instructor and a successful return demonstration of what was learned in the course.

(b) Complete twelve hours of in-service continuing education annually that must occur on or before the anniversary date of their enrollment as a medicaid personal care aide provider. Continuing education topics include, but are not limited to, health and welfare of the individual, cardiopulmonary resuscitation (CPR), patient rights, emergency preparedness, communication skills, aging sensitivity, developmental stages, nutrition, transfer techniques, disease-specific trainings, and mental health issues.

(c) Comply with the individual's or the individual's authorized representative's specific personal care aide service instructions, and perform a return demonstration upon request of the individual or the case manager.

(d) Comply with ODM monitoring requirements in accordance with rule 5160-45-06 of the Administrative Code.

(e) Be able to read, write and understand English at a level that enables the provider to comply with all requirements set forth in the administrative rules governing the Ohio home care waiver.

(f) Be able to effectively communicate with the individual.

(8) All personal care aide providers must maintain a clinical record for each individual served in a manner that protects the confidentiality of these records. Medicare-certified, or otherwise-accredited agencies, must maintain the clinical records at their place of business. Non-agency personal care aides must maintain the clinical records at their place of business, and maintain a copy in the individual's residence. For the purposes of this rule, the place of business must be a location other than the individual's residence. At a minimum, the clinical record must contain the information listed in paragraphs (B)(8)(a) to (B)(8)(i) of this rule.

(a) Identifying information, including but not limited to: name, address, age, date of birth, sex, race, marital status, significant phone numbers and health insurance identification numbers of the individual.

(b) The medical history of the individual.

(c) The name of individual's treating physician.

(d) A copy of the initial and all subsequent all services plans.

(e) Documentation of all drug and food interactions, allergies and dietary restrictions.

(f) A copy of any advance directives including, but not limited to, DNR order or medical power of attorney, if they exist.

(g) Documentation of tasks performed or not performed, arrival and departure times, and the dated signatures of the provider and individual or the individual's authorized representative, verifying the service delivery upon completion of service delivery. Nothing shall prohibit the collection and maintenance of documentation through technology-based systems. The individual or the individual's authorized representative's signature of choice shall be documented on the individual's all services plan, and shall include, but not be limited to, any of the following: a handwritten signature, initials, a stamp or mark, or an electronic signature.

(h) Progress notes signed and dated by the personal care aide, documenting all communications with the case manager, treating physician, other members of the multidisciplinary team, and documenting any unusual events occurring during the visit, and the general condition of the individual.

(i) A discharge summary, signed and dated by the departing non-agency personal care aide or the RN supervisor of an agency personal care aide, at the point the personal care aide is no longer going to provide services to the individual, or when the individual no longer needs personal care aide services. The summary should include documentation regarding progress made toward achievement of goals as specified on the individual's all services plan and indicate any recommended follow-ups or referrals.

(C) Adult day health center services.

(1) "Adult day health center services (ADHCS)" are regularly scheduled services delivered at an adult day health center to individuals who are age eighteen or older. A qualifying adult day health center must be a freestanding building or a space within another building that shall not be used for other purposes during the provision of ADHCS.

(a) The services the adult day health center must provide are the following:

(i) Waiver nursing services as set forth in paragraph (A) of this rule, or personal care aide services as set forth in paragraph (B)(1) of this rule;

(ii) Recreational and educational activities; and

(iii) At least one meal, but no more than two meals, per day that meet the individual's dietary requirements.

(b) The services the adult day health center may also make available include the following:

(i) Skilled therapy services as set forth in rule 5160-12-01 of the Administrative Code;

(ii) Transportation of the individual to and from ADHCS.

(c) ADHCS are reimbursable at a full-day rate when five or more hours are provided to an individual in a day. ADHCS are reimbursable at a half-day rate when less than five hours are provided in a day.

(d) All of the services set forth in paragraphs (C)(1)(a) and (C)(1)(b) of this rule and delivered by an adult day health center shall not be reimbursed as separate services.

(2) ADHCS do not include services performed in excess of what is approved pursuant to, and specified on, the individual's all services plan.

(3) In order to be a provider and submit a claim for reimbursement, providers of ADHCS must:

(a) Comply with all applicable rules set forth in Chapters 5160-45 and 5160-46 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5160-46-06 of the Administrative Code.

(c) Be identified as the provider on the individual's all services plan, that is prior-approved by ODM or its designee, the number of hours for which the provider is authorized to furnish adult day health center services to the individual.

(d) Operate the adult day health center in compliance with all applicable federal, state and local laws, rules and regulations.

(4) All providers of ADHCS must:

(a) Comply with federal nondiscrimination regulations as set forth in 45 C.F.R. part 80 (as in effect on October 1, 2014).

(b) Provide for replacement coverage of a loss due to theft, property damage, and/or personal injury; and maintain a written procedure identifying the steps an individual takes to file a liability claim. Upon request, provide documentation to ODM or its designee verifying the coverage.

(c) Maintain evidence of non-licensed direct care staff's completion of twelve hours of in-service training within a twelve-month period, excluding agency and program-specific orientation, and must be completed annually thereafter.

(d) Assure that any waiver nursing services provided are within the nurse's scope of practice as set forth in paragraph (A)(1) of this rule.

(e) Provide task-based instruction to direct care staff providing personal care aide services as set forth in paragraph (B)(1) of this rule.

(f) Maintain, at all times, a 1:6 ratio of paid direct care staff to individuals.

(5) Providers of ADHCS must maintain a clinical record for each individual served in a manner that protects the confidentiality of these records. At a minimum, the clinical record must contain the information listed in paragraphs (C)(5)(a) to (C)(5)(i) of this rule.

(a) Identifying information, including but not limited to: name, address, age, date of birth, sex, race, marital status, significant phone numbers, and health insurance identification numbers of the individual.

(b) The medical history of the individual.

(c) The name of the individual's treating physician.

(d) A copy of the initial and all subsequent all services plans.

(e) A copy of any advance directive including, but not limited to, DNR order or medical power of attorney, if they exist.

(f) Documentation of all drug and food interactions, allergies and dietary restrictions.

(g) Documentation that clearly shows the date of ADHCS delivery, including tasks performed or not performed, and the individual's arrival and departure times. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.

(h) A discharge summary, signed and dated by the departing ADHCS provider, at the point the ADHCS provider is no longer going to provide services to the individual, or when the individual no longer needs ADHCS. The summary should include documentation regarding progress made toward goal achievement and indicate any recommended follow-ups or referrals.

(i) Documentation of the information set forth in paragraphs (A)(6)(e), (A)(6)(f), (A)(6)(i), (A)(6)(j) and (A)(6)(k) of this rule when the individual is provided waiver nursing and/or skilled therapy services.

(D) Home delivered meal services.

(1) "Home delivered meal service" is defined as the provision of meals to an individual who has a need for a home delivered meal based on a deficit in an ADL or a deficit in an IADL identified during the assessment process. The

service includes the preparation, packaging and delivery of a safe and nutritious meal(s) to an individual at his or her home. An individual may be authorized to receive up to two home delivered meals per day.

(2) Home delivered meals:

(a) Shall be furnished in accordance with menus that are approved in writing by a licensed dietitian who is currently registered with the commission on dietetic registration.

(b) Shall take into consideration the individual's medical restrictions, religious, cultural and ethnic background and dietary preferences.

(c) Shall be prepared by a provider who is in compliance with Chapters 918., 3715. and 3717. of the Revised Code, and all applicable Administrative Code rules adopted thereunder. For the purposes of this rule, reheating a prepared home delivered meal is not the same as preparing a meal.

(d) Shall be individually packaged if it is a heated meal.

(e) May be individually packaged if it is an unheated, shelf-stable meal, or may have components separately packaged, so long as the components are clearly marked as components of a single meal.

(f) May include a therapeutic diet that requires a daily amount or distribution of one or more specific nutrients in order to treat a disease or clinical condition, or eliminate, decrease or increase certain substances in the individual's diet. A therapeutic diet must be ordered by a licensed physician. A new order must be documented in the individual's clinical record every ninety days.

(3) Home delivered meals shall not:

(a) Include services or activities performed in excess of what is approved on the individual's all services plan.

(b) Supplement or replace meal preparation activities that occur during the provision of waiver nursing, personal care aide, adult day health center, home care attendant or any other similar services.

(c) Supplement or replace the purchase of food or groceries.

(d) Include bulk ingredients, liquids and other food used to prepare meals independently or with assistance. Bulk ingredients and liquids include,

but are not limited to: food that must be portioned out and prepared, or any food that must be cooked or prepared.

(e) Be provided while the individual is hospitalized or is residing in an institutional setting.

(4) In order to be a provider and to submit a claim for reimbursement, all home delivered meal providers must meet all of the following requirements:

(a) Comply with all applicable rules set forth in Chapters 5160-45 and 5160-46 of the Administrative Code.

(b) Request reimbursement for the provision of home delivered meal services in accordance with rule 5160-46-06 of the Administrative Code.

(c) Be identified as the home delivered meal provider, and be specified, on the individual's all services plan that is prior-approved by the department or its designee.

(d) Possess any applicable current, valid license or certificate from the local health department, and retain records of all reports related to the licensure or certification.

(e) Assure that all meals are provided as identified on the individual's all services plan.

(f) Submit claims that do not exceed two meals per day per individual.

(g) Maintain documentation as set forth in paragraph (D)(8) of this rule.

(5) Home delivered meal service providers shall assure all meals, with the exception of a therapeutic diet prescribed and prepared in accordance with paragraph (D)(2)(f) of this rule, meet the following requirements with regard to nutritional adequacy:

(a) Meet one-third of the current dietary reference intakes (DRI) established by the food and nutrition board of the institute of medicine of the national academy of sciences.

(b) Follow the current dietary guidelines for Americans as published by the U.S. department of agriculture.

(6) Home delivered meal service providers shall assure the safe delivery of meals as authorized by the department or its designee on the individual's all services plan.

(a) Ready-to-eat, temperature-controlled meals must be labeled with a preparation date. The date shall include the month, day and year the meals were prepared, and shall list, immediately adjacent to this date, the phrase "packing" or "pack date." All other meals shall be labeled with the month, day and year by which the meal shall be consumed or discarded, and shall list the date immediately following the phrase "sell by" or "use before."

(b) The provider must document evidence of a time and temperature monitoring system for food preparation, handling and delivery.

(c) The provider shall ensure all transportation vehicles and containers are safe and sanitary.

(d) When using a thermostatically-controlled meal delivery vehicle, the provider must maintain verification of testing meal temperatures no less than monthly. When using other meal delivery vehicles, the provider must maintain verification of testing meal temperatures no less than weekly.

(e) The provider must establish with the individual, and document in the individual's record, a routine date and time for meal delivery. The provider must notify the individual if delivery of the meal(s) will be delayed more than one hour past established delivery time.

(f) The provider must furnish written delivery instructions to the driver.

(g) The provider must furnish the individual or the authorized representative with clear instructions on how to safely heat or reheat each meal.

(7) Home delivered meal service providers shall assure the following with regard to training and continuing education:

(a) All personnel who participate in food preparation, food handling and/or delivery, including volunteers, must:

(i) Receive training and orientation on the following as relevant for the provider's job duties:

(a) Sensitivity to the needs of older adults and people with physical disabilities or cognitive impairments;

(b) Handling emergencies;

(c) Food storage, preparation and handling;

(d) Food safety and sanitation;

(e) Meal delivery; and

(f) Handling hazardous materials.

(ii) Successfully complete four hours of continuing education each year on the topics relevant to the provider's job duties.

(b) The provider must develop a training plan and conduct and document annual training and continuing education activities.

(8) At a minimum, home delivered meal service providers must maintain and make available, upon request, the following:

(a) A record for each individual served that contains a copy of the initial and all subsequent all services plans, all dietary orders and instructions prepared by the physician, menus approved by the dietitian, and any additional information supporting meal delivery as specified on the all services plan.

(b) Documentation that each meal complies with paragraphs (D)(5)(a) and (D)(5)(b) of this rule.

(c) Documentation of each individual's therapeutic diet as set forth in paragraph (D)(2)(f) of this rule.

(d) Documentation from the provider that the individual or the authorized representative has been furnished clear instructions about how to safely heat or reheat each meal.

(e) Documentation that verifies delivery of home delivered meals as authorized on the individual's all services plan. Documentation shall include, but not be limited to, the individual's name, the dated signature of the home delivered meal service provider, the established delivery date and time, the actual time of delivery of all meals and the number of meals delivered, signature or initials of the person delivering the meal(s) and the signature or initials of the individual or the authorized representative receiving the meal(s). Nothing shall prohibit the collection or maintenance of documentation through technology-based systems. individual's or authorized representative's signature of choice shall be

documented on the individual's all services plan, and shall include, but not be limited to, any of the following: a handwritten signature, initials, a stamp or mark, or an electronic signature.

(f) Documentation that the home delivered meal delivery staff possesses a current and valid driver's license.

(g) Documentation of vehicle owner's liability insurance.

(h) Documentation that the provider has established a routine delivery time with the individual.

(i) All local health department inspection reports and documented findings, any resulting plans of correction, and any follow-up reports.

(j) All Ohio department of agriculture inspection reports and documented findings, any resulting plans of correction, and any follow-up reports.

(k) All U.S. department of agriculture inspection reports and documented findings, any resulting plans of correction, and any follow-up reports.

(l) All licensure/certification documents required as a result of paragraph (D) (4) of this rule.

(9) Home delivered meal provider inspections and follow-up.

(a) Home delivered meal service providers cited for critical violations, as that term "critical violations" is used in paragraph (B) of rule 3717-1-02.4 of the Administrative Code, during their local health department inspections, shall notify ODM or its designee no more than forty-eight hours after issuance of the citation. The provider shall, within forty-eight hours, send to ODM or its designee a copy of the inspection report, any plans of correction and any follow-up reports.

(b) Home delivered meal service providers inspected by the Ohio department of agriculture division of food safety and placed on priority status or notice status shall notify ODM or its designee no more than two business days after the issuance of the report of priority status, or after the issuance of the report of notice status in accordance with section 913.42 of the Revised Code. The provider shall, within five business days, send to ODM or its designee, a copy of the report(s) with documented findings, any notices issued by the Ohio department of agriculture, and any resulting plans of correction and follow-up reports.

(c) Home delivered meal service providers inspected by the Ohio department of agriculture division of meat inspection or the U.S. department of agriculture food safety inspection service shall notify ODM or its designee no more than two business days after it takes a withholding action against, or it suspends the provider in accordance with 9 C.F.R. 500.3 (as in effect on October 1, 2014) and/or 9 C.F.R. 500.4 (as in effect on October 1, 2014). The provider shall, within five business days, send to ODM or its designee, a copy of the action issued by the Ohio department of agriculture or the U.S. department of agriculture food safety inspection service, any resulting plans of correction and any follow-up reports.

(d) ODM may immediately suspend and terminate a provider's authorization to furnish home delivered meal services pursuant to section 5164.38 of the Revised Code and rule 5160-1-17.6 of the Administrative Code if ODM or its designee receives credible information that the provider poses a significant threat to the health and welfare of one or more individuals due to noncompliance with one or more of the requirements set forth in this rule.

(E) Home modification services.

(1) "Home modification services" are environmental accessibility adaptations to structural elements of the interior or exterior of an individual's home that enable the individual to function with greater independence in the home and remain in the community. Home modification services are not otherwise available through any other funding source and must be suitable to enable the individual to function with greater independence, avoid institutionalization and reduce the need for human assistance. They shall not exceed a total of ten thousand dollars within a twelve-month calendar year per individual. ODM or its designee shall only approve the lowest cost alternative that meets the individual's needs as determined during the assessment process.

(a) The property owner must give written consent for the home modification that indicates an understanding that the Ohio home care waiver will not pay to have the property returned to its prior condition.

(b) The need for home modification services must be identified by an occupational therapist or physical therapist as licensed pursuant to sections 4755.08 and 4755.44 of the Revised Code, during an in-person evaluation of the site to be modified, and with the individual present.

(c) Home modifications include repairs of previous home modifications excluding those described in paragraph (E)(2)(e) of this rule.

(2) Home modification services do not include:

(a) Changes to a home that are of general utility and are not directly related to the environmental accessibility needs of the individual (i.e., carpeting, roof repair, central air conditioning, etc.).

(b) Adaptations that add to the total square footage of the home.

(c) Services performed in excess of what is approved pursuant to, and specified on, the individual's all services plan.

(d) The same type of home modification for the same individual during the same twelve-month calendar year, unless there is a documented need for the home modification or a documented change in the individual's medical and/or physical condition that requires the replacement.

(e) New home modifications or repair of previously approved home modifications that have been damaged as a result of confirmed misuse, abuse or negligence.

(3) Home modification service providers shall be reimbursed for the actual cost of material and/or labor for the home modification as identified in the bid specification. The reimbursement may only be adjusted if the job specifications are modified in writing by ODM or its designee and the adjustment is warranted. Family members and volunteers shall meet all of the provider requirements set forth in paragraph (E) of this rule, however they shall only be reimbursed for the cost of materials.

(4) In order to be a provider and submit a claim for reimbursement, providers of home modification services must:

(a) Comply with all applicable rules set forth in Chapters 5160-45 and 5160-46 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5160-46-06 of the Administrative Code.

(c) Be identified as the provider, and have specified, on the individual's all services plan, that is prior-approved by ODM or its designee, the home modification services that the provider is authorized to furnish to the individual.

(d) Provide documentation that the home modification was completed in accordance with the agreed upon specifications using all of the materials and equipment cited in the bid.

(e) Provide documentation that the home modification was tested and in proper working order.

(f) Provide documentation that the home modification meets all applicable state and local building codes.

(g) Provide documentation that the home modification meets the individual's needs and complies with the Americans with Disabilities Act (ADA) (as in effect on January 1, 2015), the Uniform Federal Accessibility Standards (UFAS) (as in effect on January 1, 2015) or the Fair Housing Act (FHA), (as in effect on January 1, 2015) as applicable. If a home modification must be customized in order to meet the individual's needs, and that customization will not be compliant with the ADA, UFAS or FHA, it must be prior-approved by ODM or its designee, in consultation with the individual and/or the authorized representative and the individual's interdisciplinary team.

(h) Maintain licensure, insurance and bonding for general contracting services of applicable jurisdictions and provide proof to ODM or its designee upon request. Family members and volunteers are exempt from this requirement when they deliver home modification services to the individual.

(i) Obtain a final written approval from the individual and ODM or its designee after completion of the home modification service.

(5) Selection of home modification service providers.

(a) In consultation with the individual, authorized representative and/or caregiver(s), ODM or its designee shall develop job specifications based on the in-person evaluation required in paragraph (E)(1)(b) of this rule to meet the individual's environmental accessibility needs using the lowest cost alternative.

(b) At a minimum, ODM or its designee shall send the home modification specifications to every known home modification service provider in the individual's county of residence and all contiguous counties, and shall invite the submission of competitive bids. Home modification providers shall submit bids that include all of the following:

(i) A drawing or diagram of the home modification;

(ii) An itemized list of all materials needed for the home modification;

(iii) An itemized list of the cost of the materials needed for the home modification;

(iv) An itemized list of the labor costs;

(v) A written statement of all warranties provided, including at a minimum, a minimum one-year warranty for all materials and workmanship associated with the home modification; and

(vi) A written attestation that the provider, all employees and/or all subcontractors to be used to perform the job specifications have the necessary experience and skills, and meet all of the provider requirements set forth in Chapters 5160-45 and 5160-46 of the Administrative Code.

(c) ODM or its designee shall review all submitted bids and the home modification service will be awarded to the lowest responsive and most responsible bidder, with price and other relevant factors being considered in the selection process.

(F) Supplemental adaptive and assistive device services.

(1) "Supplemental adaptive and assistive device services" are medical equipment, supplies and devices, and vehicle modifications to a vehicle owned by the individual, or a family member, or someone who resides in the same household as the individual, that are not otherwise available through any other funding source and that are suitable to enable the individual to function with greater independence, avoid institutionalization, and reduce the need for human assistance. All supplemental adaptive and assistive device services shall be prior-approved by ODM or its designee. ODM or its designee shall only approve the lowest cost alternative that meets the individual's needs as determined during the assessment process.

(a) Reimbursement for medical equipment, supplies and vehicle modifications shall not exceed a combined total of ten thousand dollars within a calendar year per individual.

(b) ODM or its designee shall not approve the same type of medical equipment, supplies and devices for the same individual during the same calendar year, unless there is a documented need for ongoing medical equipment,

supplies or devices as documented by a licensed health care professional, or a documented change in the individual's medical and/or physical condition requiring the replacement.

(c) ODM or its designee shall not approve the same type of vehicle modification for the same individual within the same three-year period, unless there is a documented change in the individual's medical and/or physical condition requiring the replacement.

(d) Supplemental adaptive and assistive device services do not include:

(i) Items considered by the federal food and drug administration as experimental or investigational;

(ii) Funding of downpayments toward the purchase or lease of any supplemental adaptive and assistive device services;

(iii) Equipment, supplies or services furnished in excess of what is approved pursuant to, and as specified on the individual's all services plan;

(iv) New equipment or supplies or repair of previously approved equipment or supplies that have been damaged as a result of confirmed misuse, abuse or negligence; and

(v) Activities described in paragraph (F)(2)(c) of this rule.

(2) Vehicle modifications.

(a) Reimbursable vehicle modifications include operating aids, raised and lowered floors, raised doors, raised roofs, wheelchair tie-downs, scooter/ wheelchair handling devices, transfer seats, remote devices, lifts, equipment repairs and/or replacements, and transfers of equipment from one vehicle to another for use by the same individual. Vehicle modifications may also include the itemized cost, and separate invoicing of vehicle adaptations associated with the purchase of a vehicle that has not been pre-owned or pre-leased.

(b) Before the authorization of a vehicle modification, the individual and, if applicable, any other person(s) who will operate the vehicle must provide ODM or its designee with documentation of:

(i) A valid driver's license, with appropriate restrictions, and if requested, evidence of the successful completion of driver training from a

qualified driver rehabilitation specialist, or a written statement from a qualified driver rehabilitation specialist attesting to the driving ability and competency of the individual and/or other person(s) operating the vehicle;

(ii) Proof of ownership of the vehicle to be modified;

(iii) Vehicle owner's collision and liability insurance for the vehicle being modified; and

(iv) A written statement from a certified mechanic stating the vehicle is in good operating condition.

(c) Vehicle modifications do not include:

(i) Payment toward the purchase or lease of a vehicle, except as set forth in paragraph (F)(2)(a) of this rule;

(ii) Routine care and maintenance of vehicle modifications and devices;

(iii) Permanent modification of leased vehicles;

(iv) Vehicle inspection costs;

(v) Vehicle insurance costs;

(vi) New vehicle modifications or repair of previously approved modifications that have been damaged as a result of confirmed misuse, abuse or negligence; and

(vii) Services performed in excess of what is approved pursuant to, and specified on, the individual's all services plan.

(3) In order to be a provider and submit a claim for supplemental adaptive and assistive device services, the provider must:

(a) Comply with all applicable rules set forth in Chapters 5160-45 and 5160-46 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5160-46-06 of the Administrative Code.

(c) Be identified as the provider, and have specified, on the individual's all services plan that is prior-approved by ODM or its designee, the

supplemental adaptive and assistive device services the provider is authorized to furnish to the individual.

(d) Assure that all manufacturer's rebates have been deducted before requesting reimbursement for supplemental adaptive and assistive device services.

(e) Assure that the supplemental adaptive and assistive device was tested and is in proper working order, and is subject to warranty in accordance with industry standards.

(4) Providers of supplemental adaptive and assistive device services must maintain a clinical record for each individual they serve in a manner that protects the confidentiality of these records. At a minimum, the clinical record must contain the information listed in paragraphs (F)(4)(a) to (F)(4)(d) of this rule.

(a) Identifying information, including but not limited to name, address, age, date of birth, sex, race, marital status, significant phone numbers, and health insurance identification numbers of the individual.

(b) The name of the individual's treating physician.

(c) A copy of the initial and all subsequent all services plans.

(d) Documentation that clearly shows the date the supplemental adaptive and assistive device service was provided. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.

(G) Out-of-home respite services.

(1) "Out-of-home respite services" are services delivered to an individual in an out-of-home setting in order to allow respite for caregivers normally providing care. The service must include an overnight stay.

(a) The services the out-of-home respite provider must make available are:

(i) Waiver nursing services as set forth in paragraph (A) of this rule;

(ii) Personal care aide services as set forth in paragraph (B)(1) of this rule; and

(iii) Three meals per day that meet the individual's dietary requirements.

(b) All services set forth in paragraph (G)(1)(a) of this rule and delivered during the provision of out-of-home respite services shall not be reimbursed as separate services.

(2) Out-of-home respite services do not include services performed in excess of what is approved pursuant to, and specified on, the individual's all services plan.

(3) In order to be a provider and submit a claim for reimbursement, providers of out-of-home respite services must:

(a) Comply with all applicable rules set forth in Chapters 5160-45 and 5160-46 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5160-46-06 of the Administrative Code.

(c) Be identified as the provider, and have specified, on the individual's all services plan that is prior-approved by ODM or its designee, the number of hours for which the provider is authorized to furnish out-of-home respite services to the individual.

(d) Be either:

(i) An intermediate care facility for individuals with an intellectual disability (ICF-IID) licensed and certified in accordance with rules 5160-3-02 and 5160-3-02.3 of the Administrative Code; or

(ii) A nursing facility (NF) licensed and certified in accordance with rules 5160-3-02 and 5160-3-02.3 of the Administrative Code; or

(iii) Another licensed setting approved by ODM or its designee.

(e) Be providing out-of-home respite services for one individual, or for up to three individuals in a group setting on the same date.

(4) All providers of out-of-home respite services must:

(a) Comply with federal nondiscrimination regulations as set forth in 45 C.F.R. part 80 (as in effect on October 1, 2014).

(b) Provide for coverage of an individual's loss due to theft, property damage, and/or personal injury; and maintain a written procedure identifying the steps an individual takes to file a liability claim. Upon request, provide documentation to ODM or its designee verifying the coverage.

(c) Maintain evidence of non-licensed direct care staff's completion of eight hours of in-service training within a twelve-month period, excluding agency and program-specific orientation. In-service training must be initiated immediately after the non-licensed direct care staff's first anniversary of employment with the provider, and must be completed annually thereafter.

(d) Assure that any waiver nursing services provided are within the nurse's scope of practice as set forth in paragraph (A)(1) of this rule.

(e) Provide task-based instruction to direct care staff providing personal care aide services as defined in paragraph (B)(1) of this rule.

(5) Providers of out-of-home respite services must maintain a clinical record for each individual served in a manner that protects the confidentiality of these records. At a minimum, the clinical record must contain the information listed in paragraphs (G)(5)(a) to (G)(5)(i) of this rule.

(a) Identifying information, including but not limited to name, address, age, date of birth, sex, race, marital status, significant phone numbers and health insurance identification numbers of the individual.

(b) The medical history of the individual.

(c) The name of individual's treating physician.

(d) A copy of the initial and all subsequent all services plans.

(e) A copy of any advance directives including, but not limited to, DNR order or medical power of attorney, if they exist.

(f) Documentation of all drug and food interactions, allergies and dietary restrictions.

(g) Documentation that clearly shows the date of out-of-home respite service delivery, including tasks performed or not performed. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.

(h) A discharge summary, signed and dated by the departing out-of-home respite service provider, at the point the service provider is no longer going to provide services to the individual, or when the individual no longer needs out-of-home respite services. The summary should include

documentation regarding progress made toward goal achievement and indicate any recommended follow-ups or referrals.

(i) Documentation of the information set forth in paragraphs (A)(6)(e), (A)(6)(f), (A)(6)(i), (A)(6)(j) and (A)(6)(k) of this rule when the individual is provided waiver nursing.

(H) Emergency response services.

(1) "Emergency response services (ERS)" are emergency intervention services composed of telecommunications equipment (ERS equipment), an emergency response center and a medium for two-way, hands-free communication between the individual and the emergency response center. Personnel at the emergency response center intervene in an emergency when the center receives an alarm signal from the ERS equipment.

(2) ERS equipment shall include a variety of remote or other specialty activation devices from which the individual can choose in accordance with the individual's specific needs. All ERS equipment shall have an internal battery that provides at least twenty-four hours of power without recharging and sends notification to the emergency response center when the battery's level is low. Equipment includes, but is not limited to:

(a) Wearable waterproof activation devices;

(b) Devices that offer:

(i) Voice-to-voice communication capability,

(ii) Visual indication of an alarm that may be appropriate if the individual is hearing impaired, or

(iii) Audible indication of an alarm that may be appropriate if the individual is visually impaired;

(3) ERS does not include the following:

(a) Equipment such as a boundary alarm, a medication dispenser, a medication reminder, or any other equipment or home medical equipment or supplies, regardless of whether such equipment is connected to the ERS equipment.

(b) In-home communication connection systems used to supplant routine supervision of individuals who are under the age of eighteen.

(c) Remote monitoring services.

(d) Services performed in excess of what is approved pursuant to the individual's all services plan.

(e) New equipment or repair of previously approved equipment that has been damaged as a result of confirmed misuse, abuse or negligence.

(4) In order to be a provider and submit a claim for ERS, the provider must:

(a) Comply with all applicable rules set forth in Chapters 5160-45 and 5160-46 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5160-46-04 of the Administrative Code.

(c) Be identified as the provider, and have specified on the individual's all services plan, the ERS that the provider is authorized to furnish.

(5) ERS provider requirements.

(a) Providers shall assure that all individuals are able to choose the ERS equipment that meets their specific needs as set forth on their all services plan.

(b) Providers shall furnish each individual receiving ERS with an initial face-to-face demonstration and training on how to use their ERS equipment. Additional training shall be provided to designated responders as part of the monthly service in accordance with paragraph (H)(5)(c) of this rule, and to the individual, caregiver and ODM or its designee upon request.

(c) Before, or during the delivery of ERS equipment, the provider shall work with the individual and/or the authorized representative, and the case manager to develop a written response plan regarding how to proceed in the event the ERS signals an alarm. The written response plan shall be updated as often as desired by the individual and/or the authorized representative, but shall be reviewed no less than every six months.

(i) The written response plan shall include a summary of the individual's health history and functioning level, as well as the name of, and contact information for, at least one individual who will serve as the individual's designated responder. If the individual identifies more than one designated responder, he or she shall also indicate the order in which the responders should be contacted. For the purposes

of this rule, "designated responder" means a person or persons who the individual and/or his or her authorized representative chooses to be contacted by the ERS provider in the event the ERS signals an alarm. If fewer than two individuals are designated as responders, then emergency service personnel shall be designated as responders in the plan.

(ii) The provider shall furnish initial training to all designated responders before activation of the individual's ERS equipment, and on an annual basis. At a minimum, the training shall include:

(a) Instruction regarding how to respond to an emergency, including how to contact emergency service personnel; and

(b) Distribution of written materials regarding how to respond to an ERS signal.

(iii) The provider shall work with the individual and/or the authorized representative, and the case manager to revise the written response plan when there is a change in designated responders.

(a) If the individual has only one designated responder, the provider shall secure a replacement within four days after notification of the change, and document this change in the plan.

(b) If the individual has two or more designated responders, the provider shall secure a replacement responder within seven days after notification of the change, and document this change in the plan.

(c) If the provider is unable to secure a replacement responder within the required time period, then the provider shall notify the case manager, and emergency service personnel shall be designated as the responder in the plan.

(iv) In the event the individual sends a signal but a designated responder cannot be reached, the provider shall contact emergency service personnel and shall remain on the line until emergency service personnel arrive on the scene of the emergency.

(d) Providers shall assure that emergency response centers:

(i) Employ and train staff to receive and respond to signals from individuals twenty-four hours per day, three hundred sixty-five days per year.

(ii) Maintain the capacity to respond to all alarm signals.

(iii) Maintain a secondary capacity to respond to all incoming signals in case the primary system is unable to respond to alarm signals.

(iv) Respond to each alarm signal within sixty seconds of receipt.

(v) Notify ODM or its designee of all emergencies involving an individual within twenty-four hours.

(vi) Conduct monthly testing of ERS equipment to assure proper operation.

(vii) Replace, within twenty-four hours of notification and at no cost to the individual, or ODM or its designee, malfunctioning ERS equipment that has not been damaged as a result of confirmed misuse, abuse or negligence.

(viii) Replace, at no cost to the individual, or ODM or its designee, no more than one ERS pendant per year.

(ix) Operate all ERS communication lines free of charge.

(6) At a minimum, providers of ERS must maintain the documentation set forth in paragraphs (H)(6)(a) to (H)(6)(h) of this rule. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.

(a) A log containing the name and contact information of each individual, and his or her authorized representative.

(b) A copy of the individual's all services plan.

(c) All records necessary and in such form so as to fully disclose the extent of ERS provided and significant business transactions pursuant to rule 5160-1-17.2 of the Administrative Code.

(d) Documentation of all individual, designated responder and ERS provider training that is required pursuant to paragraph (H)(5) of this rule.

(e) A written record of the date of delivery and installation of the ERS equipment, with the individual's or authorized representative's signature verifying delivery and installation. The individual's or authorized representative's signature of choice shall be documented on the all services plan and shall include, but not be limited to, any of the following: a handwritten signature, initials, a stamp or mark, or an electronic signature.

(f) A written record of the monthly testing conducted on each individual's ERS equipment including date, time and results of the test.

(g) A record of each service-related contact with the individual including, but not limited to, the date and time of the contact, a summary of the incident, the service delivered (including the service of responding to a false alarm), and the name of each person having contact with the individual.

(h) A copy of the individual's written response plan as set forth in paragraph (H)(5)(c) of this rule.

(I) Supplemental transportation services.

(1) "Supplemental transportation services" are transportation services that are not available through any other resource that enable an individual to access waiver services and other community resources specified on the individual's all services plan. Supplemental transportation services include, but are not limited to assistance in transferring the individual from the point of pick-up to the vehicle and from the vehicle to the destination point.

(2) Supplemental transportation services do not include services performed in excess of what is approved pursuant to, and specified on, the individual's all services plan.

(3) In order to be a provider and submit a claim for supplemental transportation services, the provider must:

(a) Comply with all applicable rules set forth in Chapters 5160-45 and 5160-46 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5160-46-06 of the Administrative Code.

(c) Be identified as the provider, and have specified on the individual's all services plan that is prior-approved by ODM or its designee, the amount

of supplemental transportation services the provider is authorized to furnish to the individual.

(4) Agency supplemental transportation service providers must:

(a) Maintain a current list of drivers.

(b) Maintain documentation that all drivers providing supplemental transportation services are age eighteen or older.

(c) Maintain a copy of the valid driver's license for each driver.

(d) Maintain collision and liability insurance for each vehicle and driver used to provide supplemental transportation services.

(e) Obtain and exhibit evidence of a valid motor vehicle inspection from the Ohio highway patrol for each vehicle used in the provision of supplemental transportation services.

(f) Obtain and maintain a certificate of completion of a course in first aid for each driver used to provide supplemental transportation services that:

(i) Is not provided solely through the internet;

(ii) Includes hands-on training provided by a certified first aid instructor; and

(iii) Requires the individual to perform a successful return demonstration of what was learned in the course.

(g) Assure that drivers are not the individual's legally responsible family member, as that term is defined in rule 5160-45-01 of the Administrative Code.

(h) Assure that drivers are not the individual's foster caregivers.

(5) Non-agency supplemental transportation service providers must:

(a) Be age eighteen or older.

(b) Possess a valid driver's license.

(c) Maintain collision and liability insurance for each vehicle used to provide supplemental transportation services.

(d) Obtain and exhibit evidence of a valid motor vehicle inspection from the Ohio highway patrol for each vehicle used in the provision of supplemental transportation services.

(e) Obtain and maintain a certificate of completion of a course in first aid that:

(i) Is not provided solely through the internet;

(ii) Includes hands-on training provided by a certified first aid instructor; and

(iii) Requires the individual to perform a successful return demonstration of what was learned in the course.

(f) Not be the individual's legally responsible family member, as that term is defined in rule 5160-45-01 of the Administrative Code.

(g) Not be the individual's foster caregiver.

(6) All supplemental transportation service providers must maintain documentation that, at a minimum, includes a log identifying the individual transported, the date of service, pick-up point, destination point, mileage for each trip, and the signature of the individual receiving supplemental transportation services, or the individual's authorized representative. The individual's or authorized representative's signature of choice shall be documented on the individual's all services plan and shall include, but not be limited to any of the following: a handwritten signature, initials, a stamp or mark, or an electronic signature.

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