Disability Access Point District Transition Plan

District 7

July – December 2025

IOWA Health and Human Services

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Provider Network

Payment of Services

Short-term Services and Supports (STSS) Invoicing Procedure

Current Framework

- Disability Access Points (DAPs) will build on existing Mental Health and Disability Services (MHDS) Region invoicing processes.
- To ensure a smooth transition, DAP – Short Term Supports and Services (STSS) Contractor will communicate with providers around contracting, invoicing process training, and processing timeline details.
- The DAP will compile contact information of billing staff for provider agencies.
- The DAP will e-mail timelines and training opportunities to support a smooth transition around contracting, invoice process training, and processing timeline details.
- First DAP-specific invoices anticipated early August 2025 for July services.

Action Steps for DAP-Paid STSS Services

- Continue use of existing invoice templates with minor updates as needed.
- DAP billing contracts will provide policy to all program billing staff to assist in proper procedure for billing as well as policy for resolving disputed invoices.
- Submit STSS Policies, Guidance, and Instructions for review and approval by June 1.
- Require providers to:
    - Submit invoices to the DAP-designated billing contact.
    - Use secure email or submission method, based on local DAP preference.
- Internally:
    - Assign staff to verify service eligibility, individual approval, and invoice accuracy.
    - Return incomplete or incorrect invoices within 10 business days.
    - Process payment within 14 days of invoice approval.

Transition to HHS-LTSS Paid Services

- DAPs will send a representative to attend HHS sessions on Long Term Supports and Services (LTSS).
    - Assist in the distribution of HHS claiming toolkit and education opportunities to all affected providers.
    - Direct LTSS providers to Iowa HHS resources, office hours and key contacts for claiming technical assistance.
    - Inform Iowa HHS DAP Program Manager of technical issues brought forward by provider network.

Coordination Across DAPs

- Work with other DAPs to:
  - Standardize invoice templates for STSS where possible.
  - DAPs will know and share individual District policies to support providers spanning multiple Districts.
  - If there are topics that are identified relevant to statewide DAP providers and provide a platform for statewide communication around these issues. If initiated this platform will occur at a uniform day and time to allow for provider planning purposes.

STSS Contracting Strategy

District STSS Contracting Transition

- Each agency who is contracted to be a DAP will maintain its own provider contracting process.
- Each DAP will determine appropriate providers for the provision of STSS in their individual DAP. This process will be a priority of the district assessment to determine the type and number of providers needed. The process/policy for ensuring qualified providers is attached.
- Each DAP will honor the contract of other Districts if utilizing service providers located within these Districts. DAPs will inform other DAPs of contracts with STSS providers by uploading contracts in a centralized location. DAPs will develop District STSS non-Medicaid provider policy.
- DAPs will assist non-enrolled Medicaid LTSS providers to become Medicaid-enrolled if claiming for non-Medicaid LTSS Disability Services.

Contracting Process

- The DAP will establish a standard contracting process for STSS Disability Service providers for claims not payable through the Iowa Department of Health and Human Services (HHS) claiming system.
- This will include:
  - A provider application or intent-to-participate form.
  - Collaboration with current MHDS Region staff to identify opportunity, strength, and concerns for individual providers for ongoing service provision.
  - Verification of appropriate licensure or certification.
  - Review of service type, staffing, accessibility, and service area.
  - Inclusion of contract provisions aligned with statewide expectations, as defined collaboratively by DAPs and HHS.
  - Feedback loop with teams and individuals to support future planning and gap analysis to inform the District planning process.

*Please see Attachment F (Claims and Invoicing Policy)

Service Quality and Oversight

- Contracts will include minimum service delivery and quality expectations.
- Quality assurance activities will include:
  - Invoice and utilization review.
  - Regular provider check-ins and follow-up on concerns.
  - Targeted monitoring where service gaps or complaints emerge.

STSS Rates and Funding System Alignment

- Respite providers with existing Medicaid contracts will bill Iowa HHS through the Safety Net Management Information System (SNMIS).
- DAPs will not duplicate payment for services and will explore all resources for individuals and caregivers, as the payors of last resort.
- A procedure will be established for setting rates for STSS services across all districts.
- The DAP will encourage non-Medicaid providers to pursue Medicaid enrollment.

Contractor Training

- The DAP will work with other districts to:
  - Identify essential STSS provider training needs (e.g., grievance rights, documentation, accessibility)
  - Provide or coordinate onboarding guidance for new STSS providers as needed
  - Collaborate with the Iowa ADRC Training and Technical Assistance Call Center to identify training needs, in opportunities identified by and in collaboration with Iowa HHS.

Grievance and Complaint Process

- All DAP contracts will reference a formal grievance and complaint process, which will be detailed later in the plan.
- Providers will be required to inform individuals of their rights and display grievance procedures clearly.
- The DAP will monitor complaints and track resolution steps as part of contract oversight.

Access Monitoring

- Collaborate with HHS to assess need for access standards for STSS services.
  - Monitor access across the district (e.g., by region, population group, or wait time).
  - Identify gaps and support provider recruitment or service development as needed.
  - Collaborate with other DAPs to coordinate efforts in shared border areas or under-resourced communities.

- Identify opportunities for statewide solutions and systemic efficiencies with the support of Iowa HHS.

Objective What is the measurable step(s) you must take to achieve the goal?	Description of Task/Duties What are the activities you must complete to achieve the objective?	Role(s) Responsible Internal and External Stakeholders	Timeframe for Completion Dates or timeframes (within X days)
Objective 1: Finalize DAP STSS invoice submission and review process	Task 1: Finalize invoice template and secure submission method.	Operations and Finance Team	By July 15, 2025
	Task 2: Communicate invoicing process to providers.	Provider Engagement & Communications Team	By July 22, 2025
	Task 3: Implement invoice review and payment process.	Finance and QA Team	Beginning August 1, 2025
	Task 4: Host provider office hours or Q&A sessions.	Provider Engagement and Contract Managers	Start June 2025, Complete by July
Objective 3: Develop and implement STSS contracting process	Task 1: Create a provider application or participation form.	Contracting Team	By June 1, 2025
	Task 2: Draft contract template including QA and grievance expectations.	Contracting and QA Team	By June 30, 2025
	Task 3: Review and determine provider application for STSS services.	Contracting Team	June 30, 2025
	Task 4: Establish contracts for STSS services.	Contracting Team	June 30, 2025
Objective 4: Establish STSS quality monitoring and complaint oversight	Task 1: Outline internal QA process for reviewing service delivery.	QA Team and Program Oversight Leads	August–September 2025
	Task 2: Coordinate across DAPs for consistent expectations.	Contract Managers and QA Team	Q1 FY26

	Task 3: Ensure provider grievance policy is included in contracts.	Contracting and QA Teams	June 2025
Objective 5: Prepare for potential contractor training expectations	Task 1: Seek clarification from HHS on training expectations.	DAP Leadership	July 2025
	Task 2: Coordinate cross-DAP strategy for essential training topics.	Planning and QA Leads	August 2025
	Task 3: Integrate basic training into provider onboarding as needed.	Contracting and Provider Support Team	Ongoing, beginning Q1 FY26
	Task 4: Collaborate with ADRC TACC for training assessments and development in opportunities identified by and with Iowa HHS.	ADRC TACC, DAP Leadership, DAP DSNs, and Iowa HHS	Ongoing, beginning May 2025

*Please see Attachment A (Contracting and Quality Assurance) for a draft policy of ECR specific contracting requirements.

Provider and Stakeholder Inventory

Provider Type/ ***Service Provision***	***Key District Organizations*** *Include Organization Name and List All that Apply*	***Gap Inventory*** *Denote any initially identified gaps in service or network within the District.*
LTSS		
Supported Community Living (SCL)	• *Abbe Center For Community Mental Health* • *Advancement Services of Jones County* • *B&D Services* • *Cedar Valley Community Support Services* • *Delaware County Community Life* • *Discovery Living* • *Exceptional Persons Inc.* • *Full Circle Services* • *Goodwill Industries of NE Iowa* • *Goodwill of the Heartland* • *Hillcrest Family Services* • *Optimae Life Services*	*Lack of providers in the more rural counties of Jackson, Cedar, Louisa, Des Moines, and Muscatine counties that provide lower Habilitation tiers and 15-minute supported community living.*

	• *REM Iowa* • *The Arc of East Central Iowa* • *The Arc of Southeast Iowa* • *Successful Living* • *Systems Unlimited* • *To the Rescue*	
Employment Services	• *Advancement Services of Jones County* • *The Arc of East Central Iowa* • *The Arc of Southeast Iowa* • *Goodwill of the Heartland* • *Goodwill of NE Iowa* • *Systems Unlimited* • *To the Rescue*	*ECR staff will cultivate relationships with Employment Services providers in Black Hawk, Louisa, Des Moines, Scott, Clinton, Jackson, Muscatine, and Cedar counties. NorthStar will be a provider that is prioritized.*
Facility-Based Residential Programs • *Residential Care Facilities (RCF)* • *Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID)* • *Nursing Facilities (NF)* • *Skilled Nursing Facilities (SNF)*	• *Pillar of Cedar Valley* • *Abbe Center (Penn, Chatham Oaks, Kingston Hills)* • *Hillcrest Family Services* • *Hills and Dales* • *REM*	*ECR staff will cultivate relationships with Facility Based Residential Programs in Black Hawk, Louisa, Des Moines, Jackson, Clinton, Cedar and Muscatine counties.*

Medical Services and Supplies	• •	*ECR has historically utilized medical services and supplies providers on an as-needed basis. Moving forward, ECR will need to establish more formal relationships with providers that will be regularly used.*
Personal Emergency Response Services (PERS)	• *Unity Point – St. Luke's lifeline*	*This service may need to be expanded in District 7. The need will be evaluated via staff and community input sessions during the District Assessment process.*
Respite	• *The Arc of East Central Iowa* • *The Arc of Southeast Iowa* • *B&D Services* • *Camp Courageous* • *Hills and Dales* • *Optimae Life Services* • *Systems Unlimited*	*In some areas it is difficult to find providers that provide hourly 1:1 and group respite services. ECR will cultivate enhanced relationships with EPI in Black Hawk county. ECR will also identify natural supports who are willing to become respite providers for specific individuals when appropriate.*
STSS		
Individual Assessment and Evaluation	• *Abbe Center for Community Mental Health* • *Buchanan County Health Center*	*Lack of providers to do psychological assessments for the ID waiver*

	• *Catholic Charities* • *Integrated Telehealth Partners* • *Hillcrest Family Services* • *Pathways Behavioral Services* • *Davis Psychological Services* • *Mercy Medical Center* • *Family Psychology Associates* • *Tanager Place*	
Transportation	• *To the Rescue* • *LIFTS – Linn County* • *Delaware/Dubuque/Jackson RTA* • *JETS - Jones* • *SEATS - Johnson* • *Iowa Northland Regional Transit* • *Neighborhood Transportation Services - NTS*	*ECR staff will cultivate relationships with Transportation providers in the expanded counties such as River Bend Transit, Non-Emergency Transport (NEMT), and Metropolitan Transit Authority (MET).*

Peer and Parent Support	• *R Place Peer Recovery Center – NAMI Johnson County* • *Cedar Valley Community Support Services* • *Abbe Center for Community Mental Health – Individual and wellness centers* • *Pathways Behavioral Health Services* • *NAMI Dubuque*	*ECR will continue to support Peer and Parent/Caregiver Services in all areas of District 7 as they are available And develop relationships with NAMI Black Hawk County and NAMI Greater Mississippi Valley.*
Time-Limited Rental Assistance	• *County General Assistance* • *Waypoint* • *Section 8* • *Subsidized Apartments (Kar Tay Management, Geneva Towers, Hawthorne Hills)* • *Cedar Valley Friends of the Family* • *HACAP* • *Shelter House Transitional Living*	*The gaps here will depend on what rental assistance the DAP is allowed to provide. Right now, ECR has a robust rent program with provider agencies and private landlords. Gaps for this service are often related to availability of affordable rental units.*
Home and Vehicle Modifications	• *Wheelchair Ramp Accessibility Program (CR)*	*ECR has historically utilized Home and Vehicle Modification providers on an as-needed basis. Moving forward, ECR will need to establish more formal*

		relationships with providers that will be regularly used.
Adaptive Equipment	• *Grace Episcopal Church Lending closet (CR)* • *JBA Mobility* • *Easter Seals*	*ECR has historically utilized Adaptive Equipment providers on an as-needed basis. Moving forward, ECR will need to establish more formal relationships with providers that will be regularly used.*
Other Basic Needs	• *County General Assistance* • *Community Action Programs/LIHEAP* • *Metro Catholic Outreach*	*Through partnerships with the AAAs ECR will strengthen relationships with food programs.*
Community Stakeholders		
Schools	• *Grant Wood AEA* • *Keystone AEA* • *Central Rivers AEA* • *Several school districts*	*ECR will strengthen relationships with Mississippi Bend AEA and key school districts, to ensure smooth transitions of students to adult services and supports.*
Health care	• *All Federally Qualified Health Centers* • *Planned Parenthood* • *Mercy One* • *St. Luke's Hospital* • *Regional Medical Center*	*ECR will strengthen relationships with hospital systems in Black Hawk and Scott Counties.*

	• *UIHC* • *Southeast Iowa Regional Medical Center*	
Public Health	• *All county Public Health departments in the current 9 counties* • *Scott County Public Health*	*ECR will develop strong relationships with other Public Health Departments in District 7.*
Businesses	• *Local churches* • *Lions Club for eyeglasses and hearing aids* • *Metro Catholic Outreach* • *St. Vincent DePaul* • *Salvation Army* • *Matthew 25*	*Moving forward, ECR will continue to make new business connections through community outreach and provider meetings.*
Transportation	• *Volunteer Center (Jones co)* • *LIFTS (Linn Co)* • *Regional Transit Authority* • *Neighborhood Transit Authority*	*ECR will develop relationships with. the expanded counties such as River Bend Transit, Non-Emergency Transport (NEMT), and Metropolitan Transit Authority (MET).*
Housing	• *East Central Iowa housing trust fund ECICOG* • *HUD*	*ECR will develop relationships with housing providers such as East Central Intergovernmental Association, the Eastern Iowa Regional Housing Authority, Operation Thresholds, the*

	• *Waypoint Housing Services* • *Community Solutions of Eastern Iowa* • *Friends of the Family* • *Willis Dady* • *Shelter House* • *HACAP*	*Waterloo Housing Authority, Community Action of Southeast Iowa, and Community Action of Eastern Iowa and Bi-State regional commission other counties in District 7.*
Community Health Centers	• *Eastern Iowa Health Center (EIHC)* • *Crescent Community Health Center*	*ECR will develop a relationship with Community Health Center in Scott County, Community Health Center of Southeastern Iowa in Des Moines County, and People's Community in Black Hawk County.*
Access Centers	• *GuideLink* • *Linn County Access Center* • *North Iowa Regional Services*	*There are no identified gaps with Access Centers. ECR has a solid relationship with the Access Centers in District 7 already.*
Community-based and Faith-based Organizations	• *Catholic Charities* • *Fresh Start Ministries* • *Inside Out* • *HACAP*	*ECR will research similar agencies in Scott and Black Hawk counties for future. relationships such as Grow Cedar Valley, New Life Christian Ministries, Community Action of Southeast Iowa, and Community Action of Eastern Iowa.*

Certified Community Behavioral Health Centers (CCBHCs)	• *Abbe Center for Community Mental Health* • *Pathways Behavioral Health* • *Robert Young Center*	*No identified gaps with CCBHCs. However, there is no CCBHC that covers Dubuque County.*
Transition Age Youth	• *IVRS* • *United Action for Youth* • *Foundation 2* • *Mayor's Youth Empowerment Project* • *Tanager Place*	*As needed, ECR will develop relationships with transition age youth providers in Black Hawk, Des Moines, Louisa, Scott, Clinton, Jackson, Cedar, and Muscatine counties.*
Area Agency on Aging (AAA)	• *Heritage Agency on Aging* • *Northeast Iowa Area Agency on Aging*	*ECR will need to develop a relationship with Milestones AAA in Scott, Muscatine, Des Moines, Louisa, and Clinton Counties.*
Iowa Workforce Development (IWD)	• *IowaWORKS* • *Iowa Vocational Rehabilitation Services (IVRS)*	*ECR will collaborate with the Northeast Iowa LWDA, East Central Iowa LWDA, and Mississippi Valley LWDA.*
Thrive Iowa	•	*Johnson County Empowerment Thrive Iowa pilot program.*

ECR will continue to develop relationships and resources in all 14 counties through community and provider meetings, outreach, and participation in local committees and activities. County resource guides and Iowa Compass will be utilized to complement other strategies.

Continuity of Services

Services for Individuals

Assurance of current service amnesty and updating of plans

Case Inventory and Assignment Review

- DAPs will pull open and active case data from MHDS Region systems.
- Cases will be sorted by service type and provider to support assignment planning.
- Case lists will be confirmed against the HHS-approved service rollover list to ensure all individuals are accounted for by July 1, 2025.
- DAPs and MHDS Regions will coordinate to finalize appropriate case assignments by the transition date.

Transition Meetings and Information Sharing

- Draft Releases of Information will be developed and submitted for Iowa HHS approval.
- Signed Releases of Information will be obtained from individuals.
- DAPs will schedule and conduct transition meetings with MHDS Regions.
- Meetings will ensure warm handoffs occur and complete case records are transferred securely.

Service Documentation and Assessment Planning

- DAPs will collect existing service plans, assessments, and related documentation from MHDS Regions.
- Tracking systems will be developed to monitor due dates for upcoming document updates and reassessments.
- DAPs will coordinate with HHS to understand any future changes to assessment and planning requirements and prepare for statewide alignment.

Objective ***What is the measurable step(s) you must take to achieve the goal?***	**Description of Task/Duties** ***What are the activities you must complete to achieve the objective?***	**Task Format** ***Form, Process, Policy, Meeting, etc.***	**Task Timeframe for Completion** ***Dates or timeframes (within X days)***
Objective 1: Inventory of open/active cases	Task 1: Pull open case lists from MHDS Region systems.	Process	May 2025, June 15 and 30, 2025
	Task 2: Sort cases by service type and provider.	Process	May–June 2025
	Task 3: Confirm alignment with HHS-approved rollover list.	Process	By July 1, 2025
	Task 4: The DAP will work with the MHDS Region to review its case list and decide where each individual will transition on July 1, 2025.	Process	By July 1, 2025
Objective 2: Case transition meetings	Task 1: Draft Release of Information (Iowa HHS Approval Needed).	Form	June 1, 2025
	Task 2: Obtain Release of Information from clients.	Form	Ongoing by June 30, 2025
	Task 3: The DAP will work with MHDS Region service Coordinators to schedule transition meetings for warm hand offs.	Process	Ongoing by June 30, 2025
	Task 4: DAPs will participate in HHS Townhalls and local outreach opportunities to inform the community of transition processes.	Meetings	Ongoing by June 30, 2025
	Task 5: Case transition meetings take place with individual and care team.	Meeting	Ongoing by June 30, 2025
	Task 6: The MHDS regions staff and DAP work together to review appropriate assignments of cases and complete warm-handoff process.	Meeting	Ongoing by June 30, 2025
Objective 3: Inventory of Individual Current Services	Task 1: Collect individual documents from MHDS Regions.	Process	May–June 2025
	Task 2: Develop tracking system for due dates for all required documents and updates.	Process	By July 15, 2025
	Task 3: Coordinate with HHS on future assessment and planning requirements.	Policy	July–August 2025

Identifying Cases for Future Community Integration Opportunities

Flagging and Review Procedures

- Develop a standard set of criteria for identifying individuals who may benefit from reassessment related to community integration opportunities with a priority for individuals in residential settings such as RCFs, ICF-IDs, and nursing homes.
- Create a flagging system within internal tracking tools to tag cases meeting these criteria.
- Coordinate across DAPs to ensure consistent use of flagging criteria and reduce variability statewide.

Reassessment and Action Planning

- Assign flagged cases to appropriate staff for second review and reassessment.
- Conduct team-based case review meetings to evaluate individual needs and opportunities for enhanced integration.
- Document review outcomes using a standardized format and outline any necessary follow-up or service coordination steps.

Objective *What is the measurable step(s) you must take to achieve the goal?*	**Description of Task/Duties** *What are the activities you must complete to achieve the objective?*	**Task Format** *Form, Process, Policy, Meeting, etc.*	**Task Timeframe for Completion** *Dates or timeframes (within X days)*
Objective 1: Establish process to flag cases for second review	Task 1: Develop criteria for flagging individuals for review.	Policy/Process	August 2025
	Task 2: Build internal flagging system in case tracking tools.	Process	August–September 2025
	Task 3: Coordinate with other DAPs on shared flagging criteria.	Process	September 2025
Objective 2: Review flagged cases for integration opportunities	Task 1: Assign flagged cases for reassessment.	Process	October 2025
	Task 2: Conduct team-based case review meetings.	Meeting	Beginning October 2025
	Task 3: Document review outcomes and action steps.	Form/Process	Ongoing after October 2025

Prioritization of STSS Services

Development of Prioritization Criteria

- Define how STSS services will be prioritized in the event of limited funding.
- Coordinate with other DAPs to establish consistent criteria across districts. The initial budget projections were based upon historical data and anticipated need of individuals in additional diagnostic and age groups. District-specific prioritization and budget revision will be completed once a district-wide assessment has been completed and as more data is gathered.
- Develop internal protocols to guide decision-making on service access.

***Please see Attachment G (Eligibility Policy) for further details.**

Equity and Service Mapping

- Map the current landscape of STSS providers and identify underserved populations or geographic areas.
- Conduct outreach and initiate contracts with providers to address identified gaps. Monitor service utilization trends by location and population group to inform ongoing planning.

Addressing Service Duplication and Clarifying Funding Roles

- Review existing STSS services supported by DAPs, Medicaid, and other funding streams.
- Collaborate with HHS and fellow DAPs to determine appropriate funding responsibilities.
- Revise internal funding strategies and contracting approaches based on areas of duplication or overlap.

Coordinating the STSS Service Array

- Compile a centralized inventory of STSS services, categorized by provider and location.
- Develop reference tools (e.g., referral guides or service directories) to support Navigator decision-making.
- Establish a routine communication process with contracted providers to share updates, address service issues, and coordinate care delivery across the district.

Objective ***What is the measurable step(s) you must take to achieve the goal?***	**Description of Task/Duties** ***What are the activities you must complete to achieve the objective?***	**Role(s) Responsible** ***Internal and External Stakeholders***	**Timeframe for Completion** ***Dates or timeframes (within X days)***
Objective 1: Develop district-wide STSS prioritization strategy	Task 1: Define prioritization criteria for STSS service access.	Policy/Process	July–August 2025
	Task 2: Align prioritization criteria across DAPs.	Policy	August–September 2025
	Task 3: Create internal DAP guidance for applying prioritization consistently across all districts.	Process	September 2025
Objective 2: Ensure equitable access to STSS services across the district	Task 1: Map current STSS service providers and identify gaps.	Process	August 2025
	Task 2: Coordinate outreach and contracting to fill geographic or specialty gaps.	Process	September–October 2025
	Task 3: Monitor utilization by geography and priority group.	Policy/Process	Starting October 2025
Objective 3: Identify and address STSS service duplication	Task 1: Review existing STSS services funded across systems (DAP, Medicaid, others).	Process	Within first 90 days
	Task 2: Work with other DAPs and HHS to clarify funding responsibilities for unique services.	Policy	Within first 120 days
	Task 3: Adjust contracting strategy based on findings.	Process	By end of Q1 FY26
	Task 1: Create a centralized inventory of	Process	September 2025

Objective 4: Coordinate the STSS service array across the district	STSS services by provider and location.		
	Task 2: Develop internal reference tools to guide referrals and coordination.	Form/Process	October 2025
	Task 3: Establish communication structure among contracted providers.	Meeting	Quarterly, beginning Q2 FY26

Service Provision Prioritization Work Plan

Transition Preparation and Client Outreach

- Compile a list of active individuals receiving services using a combination of MHDS Region data and local system reports.
- Begin outreach to inform individuals of Disability Access Point (DAP) contact information and available services.
- Monitor for early service access issues and escalate any transition-related concerns, including staffing gaps, to HHS.

Staffing for Service Launch

- Complete hiring and deployment of staff based on anticipated service volumes by the service start date.
- Reassess staffing needs after the District Level Assessment and adjust as needed.
- Ensure readiness to provide Information and Assistance (I&A), Options Counseling, STSS, and Service Coordination for LTSS, with initial limitations in I&A and Options Counseling expected until Iowa ADRC training is completed.

Billing Transition Support

- Identify providers impacted by the transition to SNMIS billing and provide education based on forthcoming HHS guidance.
- Offer technical assistance on SNMIS enrollment and use of fee schedules once they are issued.
- Track and escalate unresolved billing or transition issues to HHS.

Client-Facing Communications

- Draft plain-language Frequently Asked Questions (FAQs) and service explanations for individuals and families.
- Submit materials for HHS review and approval prior to dissemination.
- Launch an informational campaign emphasizing service continuity and Disability Services Navigator introductions.

Service Monitoring and System Assessment

- Design tracking tools to monitor STSS availability and core service staffing patterns.
- Integrate findings into the District Level Assessment to inform future decision-making.
- Modify service delivery strategies in response to assessment outcomes.

Interim STSS Prioritization Planning

- Prepare a temporary plan to prioritize access to STSS services in the event of funding limitations before HHS guidance is issued.
- Apply formal prioritization and waitlist procedures upon receipt of official HHS criteria.
- Communicate clearly with stakeholders and HHS if prioritization or wait listing becomes necessary.

Access Infrastructure and Oversight

- Collaborate with the Iowa ADRC to establish standard access points such as phone, email, in-person hours, and virtual options.
- Publicly post service access information once approved by HHS.
- Begin tracking access data quarterly to identify and address systemic access barriers.

Objective	Description of Task/Duties	Role(s) Responsible	Timeframe for Completion
	Task 1: Finalize list of existing clients based on	Disability Access Point Leadership, HHS	May - June 2025

Objective 1: Maintain continuity of services during transition	available MHDS data and District system pulls.		
	Task 2: Begin outreach to individuals to introduce DAP contacts and services.	Disability Access Point Staff	May - June 2025
	Task 3: Monitor for immediate service gaps during transition period and escalate staffing concerns impacting Information and Assistance, Options Counseling, and Service Coordination to HHS.	Disability Access Point Staff	Ongoing July - December 2025
Objective 2: Ramp up service availability aligned with Disability Services System expectations	Task 1: Complete staff hiring and deployment based on anticipated caseloads to meet July 1, 2025, launch requirements.	Disability Access Point Leadership	May - June 2025
	Task 2: Adjust staffing after October 2025 District Level Assessment if needed.	Disability Access Point Leadership	October - December 2025
	Task 3: Ensure services cover Information and Assistance, Options Counseling, STSS, and Service Coordination of LTSS. Note: Full delivery of Information and Assistance and Options Counseling	Disability Access Point Leadership	July - October 2025

	services may be limited until Iowa ADRC training is completed.		
Objective 3: Prepare providers for SNMIS billing transition	Task 1: Identify providers affected by the billing transition and SNMIS enrollment requirements.	Disability Access Point Staff	June - July 2025
	Task 2: Provide provider education and technical assistance based on HHS SNMIS guidance and published fee schedules.	Disability Access Point Staff	Within 30 days of receiving HHS fee schedules
	Task 3: Track and escalate unresolved billing transition issues to HHS.	Disability Access Point Leadership	Ongoing starting August 2025
Objective 4: Develop and seek approval for client-facing communication materials	Task 1: Draft FAQs, service explanations, and outreach materials for individuals and families.	Disability Access Point Staff	June - July 2025
	Task 2: Submit draft communications to HHS for review and approval.	Disability Access Point Leadership	By July 15, 2025
	Task 3: Launch communication campaign once approved, emphasizing continuity and Navigator introductions.	Disability Access Point Staff	August 2025

Objective 5: Build infrastructure for tracking emerging needs and service gaps	Task 1: Design service tracking methods focused on STSS availability and staffing patterns for core services.	Disability Access Point Planning Staff	June 2025
	Task 2: Integrate findings into formal District Level Assessment.	Disability Access Point Planning Staff	October 15, 2025
	Task 3: Adjust service expansion and staffing plans based on assessment outcomes.	Disability Access Point Leadership	October - December 2025
Objective 6: Prepare for potential STSS waitlist scenarios	Task 1: Develop interim prioritization plan specifically for STSS services if funding gaps occur before HHS issues official waitlist and prioritization criteria.	Disability Access Point Leadership	June 2025
	Task 2: Monitor expenditures monthly for STSS services. Adjust budget amounts within STSS line items as needed. If STSS funding approvals exceed 80% of budget, discuss need for prioritization criteria and/or waiting list. Implement	Disability Access Point Leadership	After July 1, 2025 or upon receipt

	HHS-provided STSS waitlist and prioritization criteria upon receipt.		
	Task 3: Communicate STSS waitlist processes clearly to stakeholders if activated.	Disability Access Point Staff	As needed
Objective 7: Ensure consistent access to Disability Access Point services	Task 1: Collaborate with Iowa ADRC to establish standard methods of access (phone, email, in-person office hours, virtual options).	DAP Leadership	July 2025
	Task 2: Publish information on anticipated public office hours and access channels after HHS approves communication materials.	DAP Communications Staff	June 2025
	Task 3: Track service access patterns quarterly to identify and address barriers.	DAP Planning Staff	Starting October 2025

Notes:

- Historical client data transfer between DAPs will be conducted under HIPAA-compliant procedures, in coordination with HHS.
- Staffing must be fully deployed by July 1, 2025, to meet service continuity expectations.

- Full delivery of Information and Assistance and Options Counseling will depend on completion of Iowa Aging and Disability Resource Center (ADRC)-provided training.
- SNMIS billing procedures and fee schedules are pending HHS publication; internal workflows will be finalized within 30 days of receipt.
- Communication materials must be approved by HHS prior to public dissemination.
- Interim prioritization planning applies only to STSS services, not to I&A, Options Counseling, or Service Coordination; any access issues for core services will be escalated to HHS for direction.

Partnerships for Transition Service Planning and Warm Hand Offs

Warm Handoff Protocol Development

- Outline step-by-step procedures and establish a timeline for initiating warm handoffs.
- Create handoff checklists to ensure critical information is shared and transitions are coordinated effectively.
- Collaborate with state-established external case management providers to develop shared language and expectations for transitions.

Person-Centered Transition Planning

- Involve individuals, families, and caregivers in planning to ensure transitions reflect their preferences and needs.
- Provide each individual with a written summary of the transition at the point of handoff.
- Offer post-transition check-ins, when appropriate, to support continuity of care and promote service engagement.
- DAP leadership team will collaborate with HHS and MHDS Regions to acquire the names and relevant information for all clients transitioning to District 7.
- DAP leadership team and Disability Service Navigators will actively work with the MHDS Regions that currently encompass District 7 to host in-person meetings for targeted warm hand offs of individuals with more complex needs

DAP leadership team will ensure that ECR specific information is forwarded to the Districts 3 and 6 DAP. **Ongoing Coordination and Feedback**

- Establish designated points of contact with each external case management provider.
- Schedule regular coordination meetings to maintain communication and troubleshoot barriers.
- Develop a feedback mechanism to monitor the success of handoffs and identify opportunities for system improvement.

Objective *What is the measurable step(s) you must take to achieve the goal?*	**Description of Task/Duties** *What are the activities you must complete to achieve the objective?*	**Role(s) Responsible** *Internal and External Stakeholders*	**Timeframe for Completion** *Dates or timeframes (within X days)*
Objective 1: Establish a warm handoff protocol for transitions to external case management	Task 1: Define steps and timeline for initiating a warm handoff.	Policy/Process	August 2025
	Task 2: Create checklist for handoff planning.	Form/Process	August 2025
	Task 3: Develop shared language and expectations with state established external case management providers.	Meeting/Policy	August–September 2025
Objective 2: Ensure person-centered and informed transitions	Task 1: Involve individuals, families, and caregivers in the handoff planning process.	Policy/Meeting	September 2025
	Task 2: Provide individuals with written transition summary.	Form	At time of transition

	Task 3: Offer post-transition check-in when appropriate.	Process	Ongoing beginning October 2025
Objective 3: Coordinate with external case management entities	Task 1: Establish contacts within each state established external case management provider.	Process	August–September 2025
	Task 2: Schedule regular coordination meetings.	Meeting	Quarterly beginning Q2 FY26
	Task 3: Create feedback loop for handoff success and issues.	Process	Starting Q4 FY26

Engagement and Outreach

Communication Plan for Stakeholder Engagement

Provider Communication Strategy

- Establish a regular meeting schedule with providers, staff teams, and key system partners across the district.
- Facilitate ongoing discussions with former MHDS Regions and major network partners to support continuity and collaboration.
- Coordinate with Iowa ADRC to inform providers about required training and distribute information about system changes.

Stakeholder Engagement and System Awareness

- Create feedback loops with individuals with lived experience, caregivers, and community stakeholders to ensure continuous communication and improvement.
- Develop outreach strategies to raise awareness of the new system among potentially eligible individuals, community groups, law enforcement, legislators, and others.
- Launch a plain-language public education campaign introducing DAPs and the services available.

Tracking and Cross-District Coordination

- Build a centralized system to log outreach activities and stakeholder interactions.

- Develop templates to summarize stakeholder feedback and identify emerging themes or concerns.
- Establish a cross-DAP data-sharing process to align engagement strategies and track system-wide trends.

Inclusive and Targeted Outreach

- Partner with culturally specific and disability-led organizations to strengthen outreach and ensure diverse community representation.
- Translate outreach materials and disseminate them through relevant networks.
- Leverage peer-led groups and trusted community-based organizations to act as messengers for the new system.

Objective *What is the measurable step(s) you must take to achieve the goal?*	**Description of Task/Duties** *What are the activities you must complete to achieve the objective?*	**Role(s) Responsible** *Internal and External Stakeholders*	**Timeframe for Completion** *Dates or timeframes (within X days)*
Objective 1: Provider Engagement Communication	Task 1: Establish and advertise regular district meetings and office hours cadence with providers, DAP teams and partners.	Community Development Manager(s), Contracting & Planning Team	Starting July 2025
	Task 2: District meetings w/ Regions and key network partners and leaders for introduction and transition.	DAP Leadership	June 2025
	Task 3: Identify Training Needs for STSS Service Providers, develop training and advertise STSS training opportunities, including but not limited to STSS billing to DAP.	DAP Leadership	June – July, 2025
	Task 4: Collaborate with UCEDD to inform providers of Provider Training and complete outreach for upcoming system trainings (ADRC TA & Call Center).	Provider Engagement and UCEDD Liaison	August–October 2025

	Task 5: Collect District level STSS provider network feedback for future District planning and assessment efforts.	Assessment SME	Ongoing
Objective 2: Stakeholder Engagement Communication	Task 1: Establish regular district feedback and communication feedback loop with individuals with lived experience, caregivers, and stakeholders.	Community Development and Engagement Team	Launch by October 2025
	Task 2: Communication strategies to market system change to potentially eligible individuals, caregivers, community members, legislators, law enforcement, etc.	Communications & Outreach Team, Iowa HHS	September–December 2025
	Task 3: Launch plain-language campaign on Disability Access Points.	Outreach Team with UCEDD Support, Iowa HHS	October 2025
Objective 3: Build infrastructure for tracking outreach and engagement	Task 1: Create centralized tracking log for stakeholder engagement.	Administrative or QA Team	By September 2025
	Task 2: Develop summary template to track trends in feedback.	QA and Planning Team	October 2025
	Task 3: Create data-sharing structure across districts for feedback themes.	DAP Leadership and UCEDD	Starting Q1 FY26
Objective 4: Expand outreach to historically underrepresented groups	Task 1: Identify and partner with culturally specific and disability-led organizations.	Community Development Manager(s)	Beginning August 2025
	Task 2: Translate key outreach materials and distribute via diverse networks.	Communications Team, HHS Iowa	September–October 2025
	Task 3: Engage peer-led and community-based groups as trusted messengers.	Peer Leaders, Faith-Based and Cultural Orgs	October–December 2025

Individuals Served

The DAPs will operationalize engagement with individuals served in two ways:
(1) Upfront engagement during initial contact to welcome participation and promote person-centered services, and
(2) follow-up engagement to understand whether services accessed are beneficial in helping individuals achieve their self-defined goals and live autonomously.

Channels of Communication

Disability Access Points (DAPs) will utilize the following communication channels to engage individuals served:

- Direct conversations during intake (in-person, phone, or video call).
- Follow-up phone calls and secure emails.
- Printed materials such as flyers and intake handouts (pending HHS approval).
- Social media posts and website updates (pending HHS approval).
- Outreach through partners and referral networks.

These strategies will ensure that individuals have clear, repeated opportunities to provide feedback on their experiences and to participate in shaping services in a person-centered and hope-centered way.

Phase 1 efforts will prioritize getting these activities operational by July 1, 2025, with acknowledgment that processes will evolve once HHS systems, Iowa ADRC training, and additional guidance are available.

Key approaches include:

- Upfront communication at intake about the opportunity for individuals to provide feedback later.
- In-the-moment satisfaction checks for Information & Assistance (I&A) encounters.
- Structured voluntary follow-up surveys for Options Counseling, STSS, LTSS Service Coordination, and HCBS Navigation services.
- Use of interim tools initially, transitioning to HHS-provided systems when available.
- Selection of evidence-based tools to measure outcomes in a way that reflects the Science of Hope and person-centered practices.
- Tracking client participation rates, declines, and feedback outcomes to inform system improvements.

Notes:

- Participation in feedback activities will be fully voluntary and offered in a manner that is functional and accessible for the individual.
- Feedback procedures will be updated as needed following Iowa ADRC training and HHS system rollout.
- DAPs will develop and submit outreach and engagement materials for HHS approval before dissemination (targeting July 15, 2025).

Objective	Description of Task/Duties	Role(s) Responsible	Timeframe for Completion
Objective 1: Establish upfront engagement at initial contact (Phase 1)	Task 1: Develop interim standard language for staff to introduce feedback opportunities at intake for July 1 launch.	Disability Access Point Leadership/Iowa ADRC	June 2025
	Task 2: Integrate basic consent tracking into case management system for Phase 1. Plan update after HHS tools are available.	Disability Access Point IT/Planning Staff/Iowa ADRC	July 2025
Objective 2: Implement in-the-moment feedback collection for I&A services (Phase 1)	Task 1: Develop and test a short satisfaction check-in tool for immediate use at intake (Phase 1).	Disability Access Point Planning Staff/Iowa ADRC	June 2025
	Task 2: Train I&A staff on using the immediate check-in tool.	Disability Access Point Training Staff/Iowa ADRC	June - July 2025

	Task 3: Launch basic in-the-moment feedback collection for I&A encounters by July 1.	Disability Access Point Staff/Iowa ADRC	July 2025
Objective 3: Establish structured follow-up methods for Options Counseling, STSS, LTSS, and HCBS Navigation (Phase 1)	Task 1: Develop Phase 1 follow-up timelines and templates for each service type, pending final HHS guidance.	Disability Access Point Planning Staff/Iowa ADRC	June 2025
	Task 2: Create clear procedures for voluntary feedback and opt-out tracking.	Disability Access Point Planning Staff/Iowa ADRC	June 2025
	Task 3: Pilot Phase 1 follow-up procedures and adjust based on early results.	Disability Access Point Staff/Iowa ADRC	July - August 2025
Objective 4: Research and recommend evidence-based feedback tools	Task 1: Identify and review suggested tools such as SWLS, POMs, and WHOQOL-BREF for Options Counseling and Service Coordination.	Disability Access Point Leadership and Planning Staff/Iowa ADRC	May - June 2025
	Task 2: Facilitate DAP-wide discussion and decision on selected tools.	Disability Access Point Leadership/Iowa ADRC	June 2025
	Task 3: Develop implementation procedures	Disability Access Point Planning Staff/Iowa ADRC	July 2025

	for selected feedback tools after approval.		
Objective 5: Develop data tracking and reporting procedures (Phase 1)	Task 1: Develop internal tracking sheets for engagement and follow-up until HHS system is available.	Disability Access Point Planning Staff/Iowa ADRC	June 2025
	Task 2: Transition to HHS-provided tracking and reporting system once available (HHS expected to provide standards and tools by April 15, 2025).	Disability Access Point Planning and IT Staff/Iowa ADRC	Upon receipt from HHS
	Task 3: Analyze feedback trends quarterly to guide service improvements.	Disability Access Point Planning and Leadership Staff/Iowa ADRC	Starting October 2025
Objective 6: Communicate feedback opportunities to individuals (Phase 1)	Task 1: Create interim feedback invitation scripts and materials for July 1 go-live (Phase 1).	Disability Access Point Communications Staff/Iowa ADRC	June 2025
	Task 2: Submit final, polished feedback materials to HHS for review and approval (HHS review required before public dissemination).	Disability Access Point Leadership/Iowa ADRC	July 15, 2025
	Task 3: Launch final approved outreach about	Disability Access Point Staff/Iowa ADRC	August 2025

	feedback opportunities in client communications.		

Advisory Council Work Plan

Recruitment for District Advisory Council

DAPs will design and launch an inclusive recruitment process to establish Advisory Councils representing individuals with disabilities, caregivers, and community members.

- Design the council application form and promotional outreach materials.
- Publish the application and promote widely across the district.
- Create a transparent process and criteria for selecting council members.
- Develop a council charter for HHS review and approval.
- Finalize council membership roster with HHS approval and publicize by August 1, 2025.

Meeting Scheduling

DAPs will set a clear meeting structure to support consistent council functioning.

- Identify preferred meeting days/times based on new members' availability.
- Establish a full-year meeting calendar.
- Create standard templates for agendas and meeting materials to streamline preparation.

Establish Council Function and Process

DAPs will formalize the council’s advisory role and integrate it into DAP operations and planning.

- Define the Advisory Council’s responsibilities and feedback channels.
- Develop onboarding and communication materials for council members.
- Conduct onboarding sessions and offer mentoring support through partnerships with ADRC and DD Council resources.
- Integrate regular council review of district planning and activities.

Sustain Engagement and Ensure Diverse Input
DAPs will build structures to promote long-term engagement and diversity of perspectives within the council.

- Offer stipends or other incentives to reduce barriers to participation
- Ensure all meetings are fully accessible and provide accommodations as needed
- Establish rotating roles and leadership opportunities within the council to encourage ongoing involvement and ownership

Objective *What is the measurable step(s) you must take to achieve the goal?*	**Description of Task/Duties** *What are the activities you must complete to achieve the objective?*	**Role(s) Responsible** *Internal and External Stakeholders*	**Timeframe for Completion** *Dates or timeframes (within X days of Z)*
Objective 1: Recruitment for District Advisory Council	Task 1: Design application form.	Planning Team	June 2025
	Task 2: Develop outreach materials for promotion of application.	Communications and Community Development Team	June 2025
	Task 3: Publish application	Communications & Admin	June–July 2025
	Task 4: Create process/criteria for determining council members.	Leadership Team	July 2025
	Task 5: Develop council charter (Iowa HHS Approval).	Planning Team	July 2025
	Task 6: Finalize council membership (Iowa HHS Approval).	Leadership Team	July 2025
	Task 7: Notification/publicizing council membership.	Communications	August 1, 2025
Objective 2: Meeting Scheduling	Task 1: Identify preferred days/times based on member availability.	Admin or Planning Support	August 2025
	Task 2: Set calendar of meetings for the first year.	Admin Support	August 2025
	Task 3: Create standard meeting agenda and materials templates.	Planning Team	August–September 2025

Objective 3: Establish council function and process	Task 1: Define advisory responsibilities and feedback channels.	Planning & Policy Team	September 2025
	Task 2: Develop Advisory Council onboarding and communication materials.	Planning and Policy Team	September 2025
	Task 3: Provide onboarding session and access to mentoring for new members.	Community Engagement Team, ADRC partners, DD Council	September 2025
	Task 4: Integrate council review of district plan into DAP planning cycles.	Planning and QA Leads	Q4 FY25 onward
Objective 4: Sustain engagement and ensure diverse input	Task 1: Offer stipends or incentives for participation.	Admin & Fiscal Lead	October 2025
	Task 2: Provide accessibility and accommodations for all meetings.	Admin Support & UCEDD	Ongoing
	Task 3: Build in rotating roles and opportunities for leadership.	Council Facilitator & Chair	Ongoing

Operations

Disability Access Point(s)

District	7
Site Location Name	Mental Health/Disability Services of the East Central Region
Address	913 South Dubuque Street, Iowa City, Iowa 52240
Point of Contact Name(s)	Deb Seymour-Guard, CFO and Julie Davison, COO
Hours	8:00 am – 4:30 pm
Phone number	(319) 892-5671 (Intake)

Phone system and operator	Linn County Community Services

*Please see Attachment B (Map of proposed office locations and service coverage areas)

Service Coordinator Caseload Evaluation Process

- During the transition process, DAPs will allow LTSS service coordination caseloads to be up to 60 cases. As DAPs develop LTSS criteria and assess individuals, DAPs will transfer individuals to the appropriate state established case management providers.

To avoid coordination duplication, will utilize funding navigation to oversee funding requests for individuals receiving LTSS or unique services who are connected with a State established case management providers (ex: Individuals with Medicaid MCOs).

The DAP leadership team will review and revise the existing case weighting criteria for service coordination staff. This revised case weighting will encompass the duties of Information and Assistance, Options Counseling and Access to LTSS, so that the DAP can continuously monitor the need for additional Disability Service Navigators or the need to increase caseloads. A time study will be completed quarterly to determine percentage of time each Disability Service Navigator (DSN) sends providing Information and Assistance, Options Counseling, and Access to LTSS. The case-load maximum will then be determined based on the percentage of time a DSN typically has available for Access to LTSS. If an exception to the 45-case maximum per Service Coordinator is necessary, the DAP will implement a structured process to evaluate and document the rationale. The evaluation process will include both quantitative and qualitative measures to ensure that service quality, responsiveness, and individual outcomes are not compromised.

Evaluation Components:

- **Caseload Review Template:** Supervisors will use a standardized tool to review each Service Coordinator's active caseload, documenting:
  - Number of open cases.
  - Intensity level of each case (e.g., frequency of contact, number of services coordinated).
  - Status of each individual's plan (e.g., new intake, active coordination, maintenance).
- **Workload Balance Factors:**

  - Geographic span and travel demands.
  - Complexity of individual needs.
  - Coordination with external providers or systems (e.g., MCOs, CCBHCs, housing providers).
  - Staff tenure and training level.

Review Process:

- **Monthly Supervisor Review:** Supervisors will monitor caseload counts monthly and flag potential overages.
- **Quarterly Formal Caseload Audits:** A deeper review will occur quarterly to assess workload balance and outcomes.
- **Exception Request Protocol:** If a Service Coordinator's caseload exceeds 45 due to temporary or justified reasons, a formal exception request will be submitted to Iowa HHS with supporting documentation.
- **Action Plan for Adjustment:** If caseload overages are determined to be unsustainable, an action plan will be developed which may include:
  - Reassignment of cases.
  - Hiring additional staff.
  - Temporary reduction in new intakes.

Outcome Monitoring:

- Regular check-ins will assess the impact of caseload size on service quality, timeliness, and individual engagement.
- Feedback from individuals served may be used as part of the quality monitoring process.

Shared DAP Decision Points for Caseload Evaluation

- Agree on a standard caseload review template used across DAPs.
- Establish shared definitions of case complexity to support consistent evaluations.
- Coordinate expectations around what constitutes justification for exceeding the 45-case limit.
- Align on documentation and submission standards for HHS exception requests.
- Collaborate on the format and frequency of reporting caseload data to HHS.

Grievance Policy and Process

Grievance Policy

The East Central Region (ECR) believes all individuals with disabilities should be treated with dignity and respect. DAP offers a grievance procedure for individuals who have a complaint about DAP services or employee interactions for any reason. A grievance must be filed within 30 days of the action or event that triggered the grievance.

Grievance Intake Process

To file a grievance:

Call: (319) 892-5671
Email: admin@ecriowa.org
Fax: N/A
Mail:1240 26th Avenue Court SW, Cedar Rapids, Iowa 52404

If you would like someone to file the grievance for you, please contact xxx to provide written permission and obtain assistance with the next steps. Please fill out the DAP Release of Information form when you submit your grievance.

The grievance must include the following information:

- Date of occurrence.
- Name of individual or concern the grievance is regarding.
- Name of representative filing the grievance (if not the individual).
- Contact information including phone number and address.
- A clear description of the reason for the grievance.

Grievance Review – The Disability Access Point executive staff shall review grievances. The grievant will be contacted by an executive staff member within five (5) working days of the receipt of the grievance. The staff, upon consent, shall collect additional information from the grievant and other sources, if necessary. A meeting with the grievant may be scheduled to discuss the facts, consider additional information the grievant submits relevant to the grievance, and work toward a resolution. Following a review of additional information and all relevant facts, a written decision shall be issued no later than five (5) working days following contact with the grievant. A copy of the decision shall be sent to the grievant and/or representative by regular mail. The grievance will be documented and reported to HHS Iowa as required in quarterly reports.

Work collaboratively with HHS to establish a process for recording and Report Data to HHS Quarterly. The DAP will create a system for recording data and reporting it to HHS on a quarterly basis.

Grievance Policy Posted Location and Visibility

The Grievance Policy will be posted at all DAP office locations and on the DAP website.

Client Intake and Eligibility

Summary:

- No-wrong-door access through walk-ins, phone, email, or referral.
- Crisis response protocols activated immediately when needed.
- Person-centered intake interview conducted within 1–2 business days.
- Comprehensive assessment includes demographics, needs, risks, and supports.
- Financial eligibility determined using Iowa HHS form, with flexibility if documentation is delayed.
- Engagement level determined: Information & Assistance, Options Counseling, Home and Community-Based Services (HCBS) System Navigation, or LTSS Service Coordination.
- Follow-up scheduled based on chosen engagement level.
- All relevant actions and outcomes documented in the case management system.
- Quality assurance includes supervision, feedback loops, and individual rights protections.

Please see Attachments D (Client Intake and Eligibility) and E (DAP Flow Chart) for further details.

DAP Collaboration

Narrative and Operational Outline

The DAP Directors are committed to working collaboratively with each other, Iowa HHS, the ADRC Call Center, ADRC member organizations, the BH-ASO, and system stakeholders to ensure alignment, consistency, and accessibility across the statewide Disability Services System. This collaboration is foundational to the system's design and will continue throughout the launch, transition, and maintenance phases to uphold the integrity of the Disability Services System.

I. Launch Phase: Building Infrastructure and Statewide Alignment
- Maintain daily communication among DAP Directors following award announcements.
- Utilize a centralized Microsoft Teams platform to share documents, coordinate discussions, and co-develop tools.
- Joint development of key implementation tools, including:
- Disability Services Navigator job description.
- Standardized Release of Information form.
- District Transition Plans.
- Conduct weekly Director meetings to:
- Align on shared priorities, timelines, and rollout activities.
- Exchange updates on implementation progress and problem-solving efforts.
- Coordinate development of outreach, training, and internal messaging materials.
- Integrate technical assistance from the ADRC team to guide systems development.
- Collaborate with Iowa HHS to support policy consistency and resolve system design questions.
- Incorporate stakeholder feedback to ensure accessible and inclusive implementation across all districts.

II. Transition Phase: Ensuring Readiness Across Districts
- Evaluate core system components, including the Disability Services Navigator role and service coordination workflows.
- Collect and analyze feedback from individuals served, front-line staff, and partners.
- Modify tools and processes based on district-level experiences and lessons learned.
- Identify and mitigate access disparities across geographic or demographic lines.
- Coordinate inter-district alignment of policies and procedures.
- Share best practices, process refinements, and templates via the shared Teams site.
- Establish shared baseline metrics to support statewide consistency and track progress.

III. Maintenance Phase: Sustaining Collaboration and System Integrity
- Continue monthly DAP Director meetings to:
- Review data related to access, referrals, and service outcomes.
- Coordinate updates to shared procedures and internal tools.
- Plan ongoing training, stakeholder engagement, and public communications.
- Maintain the Microsoft Teams site as a living hub for collaboration.
- Develop a shared calendar of systemwide events, training dates, and critical deadlines.
- Explore shared dashboards or metric-tracking systems to monitor alignment and equity.
- Initiate collaborative quality improvement efforts (e.g., annual joint trainings or inter-district evaluation projects).

Objective *What is the measurable step(s) you must take to achieve the goal?*	Description of Task/Duties *What are the activities you must complete to achieve the objective?*	Role(s) Responsible *Internal and External Stakeholders*	Timeframe for Completion *Dates or timeframes (within X days of Z)*
Objective 1: Establish statewide communication and shared infrastructure for DAP collaboration	Task 1: Create and maintain shared Microsoft Teams platform.	DAP Directors	May 2025
	Task 2: Conduct weekly DAP Director meetings to align implementation.	DAP Directors	Weekly beginning May 2025
	Task 3: Collaboratively develop shared tools (Navigator job description, ROI form, transition plans).	DAP Directors, Iowa HHS	By July 1, 2025
Objective 2: Align system procedures and resolve transition-related issues	Task 1: Integrate ADRC TA guidance into system development.	DAP Directors, ADRC TA Team	Ongoing through Q3 2025
	Task 2: Identify and resolve cross-District disparities or policy gaps.	DAP Directors, Iowa HHS	August–September 2025
	Task 3: Standardize shared baseline metrics for consistency.	DAP Directors, Data Leads	September 2025
Objective 3: Sustain long-term collaboration and continuous improvement	Task 1: Maintain monthly DAP Director meetings to review outcomes and align on system needs.	DAP Directors	Ongoing beginning Q4 2025
	Task 2: Coordinate joint systemwide trainings and public engagement strategies.	DAP Directors, Communications Team	Quarterly beginning Q1 2026
	Task 3: Maintain shared calendar and explore dashboard reporting tools.	DAP Administrative Team, Data Leads	Q1 2026

Attachment List:

Attachment A: Contracting and Quality Assurance Policy

Attachment B: Map of proposed office locations and service coverage areas

Attachment C: Job descriptions of proposed DAP staff

Attachment D: Client Intake and Eligibility

Attachment E: DAP Flow Chart

Attachment F: Claims and Invoicing Policy

Attachment G: Eligibility Policy

Attachment A: Contracting and Quality Assurance Policy

The ECR maintains a network of licensed and accredited, contracted service providers to meet the continuum of service needs of individuals. The DAP retains the right to select service providers, and all must be approved ECR network providers to be eligible for DAP funding. The ECR is encouraging all providers to participate in quality assurance within the disability services system. This will ensure person/family centered, trauma informed, and multi-occurring capabilities are incorporated. The DAP will provide opportunities for training, mentoring and support so that every provider who desires to increase their capabilities will succeed. The DAP values the excellent services that take place daily in the counties throughout the District and knows that all providers take every opportunity to enhance the skills of their workforce. Consequently, it is believed that the provider network that exists today will continue to exist in the future.

To be included in the District 7 provider network, a provider must meet at least one of the following criteria:

- Currently licensed, accredited or certified by the State of Iowa, or
- Currently enrolled as a Medicaid provider, or currently accredited by a recognized state or national accrediting body (Joint Commission on Accreditation of Health Care Organization-JCAHO, Council on Rehabilitation Facilities-CARF, etc.).
- Currently has a contract with any Iowa DAP.
- Ability to meet unmet needs for the proposed services.
- Provider experience in providing the services.

All providers included in the ECR provider network subject to licensure or accreditation shall meet all applicable standards and criteria and must maintain their license or accreditation to remain network providers. If the situation warrants an immediate change in providers, the DAP shall assist in the transfer of individuals to another network provider.

ECR will recognize the following provider tiers:

1. Traditional (licensed or accredited)
2. Certified with additional training
3. Non-traditional - not expected to have licensure or training

The ECR will make efforts to approve non-traditional providers as part of the service provider network. The following is the criteria and process for selecting and approving providers not currently subject to license, certification, or other state approval standards:

- All applicants will provide documentation that service outcomes achieved by the non-traditional provider, as identified by the individual, must be comparable to services provided by traditional licensed providers
- All applicants will provide evidence that they have no current record in any of the following registries:

  - Criminal
  - Sex offender
  - Child abuse/dependent adult abuse
- All applicants shall provide evidence of applicable insurance (including liability insurance) and the mental/physical abilities or other qualifications needed to perform the service (i.e. driver's license, ability to lift, ability to read labels, etc.)
- When applicable, staff at non-traditional provider agencies will be expected to have the following training:
  - Dependent Adult Abuse
  - HIPAA training
  - Iowa Peer Workforce Collaborative (for Peer Run organizations and activities)

New providers may be added to the provider network if it is determined either a particular individual will benefit from the service (as determined by the individual's inter-disciplinary team), or that the provider will provide STSS that will enhance the service system.

Based on contracting criteria, the ECR will contract with agencies whose base of operation is in the District 7 to meet the service needs of the population. The DAP will also honor contracts that other DAPs have negotiated with local providers. The ECR may also choose to contract with providers outside of District 7. A contract may not be required with providers that provide one-time or as needed services.

When a non-traditional provider arrangement is more appropriate than a fee-for-service (FFS) approach with a contracted provider, the ECR will make efforts to recruit and approve non-traditional providers as part of the service provider network and will utilize the criteria and process for selecting and approving providers not currently subject to license, certification, or other state approval standards designated in the ECR District Plan. A non-traditional provider may be an individual, organization and/or business who delivers services in a person's home and/or other community setting. Non-traditional providers typically are individuals, organizations, or businesses which do not provide disability services as a part of their normal business. These services are supportive and may be rehabilitative in focus and are initiated when there is a reasonable likelihood that such services will benefit the person's functioning, assist them in maintaining community tenure, and act as an alternative way to achieve the person's stated goals or outcomes. One-time or as needed services may be provided without a formal contract.

Quality Assurance (QA)

Purpose

To ensure that all providers of ECR-funded services—whether clinical, non-clinical, residential, transportation-related, or utility-based—deliver high-quality, compliant, and person-centered services. This policy aims to uphold standards of safety, accountability, effectiveness, and system of care principles across all service types.

General Quality Assurance Standards

Licensure, Accreditation, and Regulatory Compliance

- All providers who are required by federal, state, or local law to be licensed, certified, or accredited must maintain current and valid credentials at all times.
- This includes, but is not limited to, licensed clinicians, certified Peer or Parent Support Specialists, landlords operating rental properties (e.g., rental certificates or housing inspections), transportation vendors (e.g., DOT-compliant), and utility providers (e.g., municipally approved vendors).
- Providers must also adhere to any city or county ordinances applicable to their services. For example, ECR will not authorize rental assistance for properties lacking required rental permits or occupancy certifications as mandated by local jurisdictions.

Performance Monitoring

- All providers are subject to routine and as-needed monitoring, including documentation audits, service utilization reviews, and analysis of service delivery outcomes.
- Monitoring may include site visits, interviews with clients, review of compliance with service authorization terms, and verification of adherence to approved rates and billing protocols.

Service Reviews

- ECR may conduct service reviews to ensure each service aligns with district-defined system of care principles, fulfills intended purposes, and contributes positively to individual outcomes.
- Specific attention will be paid to timely service delivery, client feedback, billing accuracy, and overall impact on quality of life.

Incident Reporting

- All providers must report incidents involving client safety, abuse, neglect, exploitation, service interruptions, or other serious events as required by Iowa Code or ECR policy.
- Reports must be submitted within required timeframes, and follow-up information must be made available to ECR upon request.

Corrective Action

- If performance concerns or non-compliance issues are identified through monitoring or complaint investigation, providers may be required to submit and implement a corrective action plan.
- ECR will monitor the implementation and effectiveness of the plan and may restrict referrals, suspend payment, or terminate provider status if compliance is not achieved.

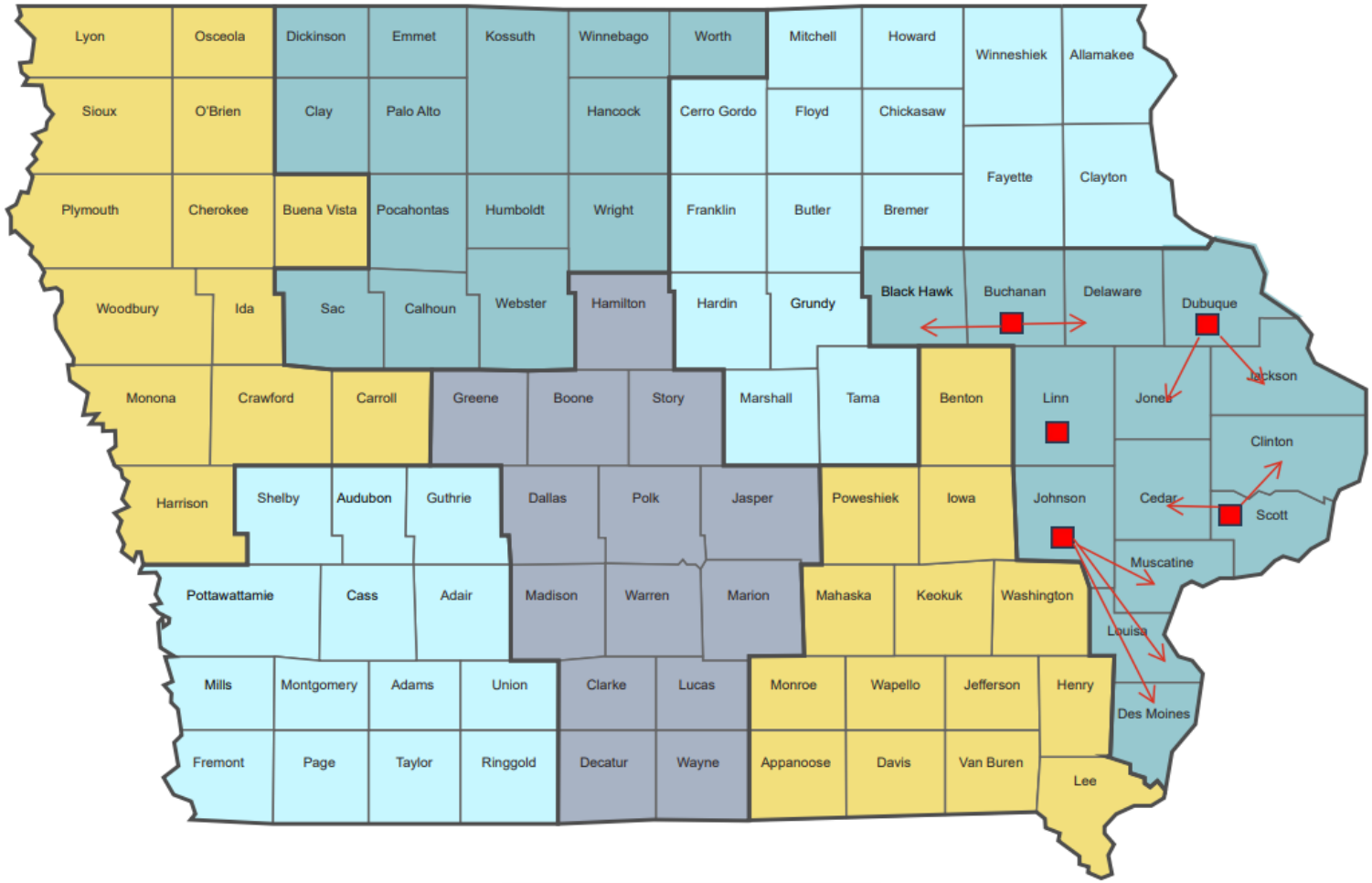
Provider Education and Technical Assistance

- ECR may require participation in training or technical assistance to ensure providers understand and can implement expectations related to service quality, documentation, eligibility, and person-centered practices.

Attachment B: Map of proposed office locations and service coverage area

Anticipated Office Locations and Coverage Areas for System Navigation Beginning July 1,2025

Mental Health/ Disability Services of the East Central Region



Attachment C: Job descriptions of proposed DAP staff

Attachment D: Client Intake and Eligibility

District 7 Disability Access Point (DAP) Intake and Eligibility

Effective Date: May 1, 2025

Date of Last Revision: N/A

Purpose: To establish a standardized, person-centered process for engaging individuals (adults and children), their families and caregivers who seek assistance through the DAP. This policy ensures that all individuals experience a welcoming, “no-wrong-door” process where their needs are assessed and addressed in alignment with person-centered philosophy and the Science of Hope framework.

Scope or Responsibility: DAP staff and partner personnel who provide information and assistance, options counseling, Home and Community-Based Services (HCBS) navigation, or Long Term Services and Supports (LTSS) service coordination to individuals, their families or caregivers, regardless of how they access services – in-person, via telephone, or electronic communication.

Policy Statement: DAP staff are committed to a no-wrong-door, person-centered process. Information and assistance will be provided in a manner convenient to the individual, families or caregivers, but not limited to, in person at the individual's home, community or at the DAP or partner agency as an appointment or walk-in, via telephone, virtually, via email, or through written correspondence.

All individuals, their families and caregivers who contact the DAP will be:

- Treated with respect and receive prompt and courteous engagement.
- Provided with information and assistance.
- Receive an assessment of their needs and personal preferences.
- Get assistance with identifying the most appropriate resources and support to meet their identified needs.
- Connected with services providers.
- Provided information to meet their needs using a person-centered approach. This may include:

- Effective communication by arranging accommodation as needed.
- Use of language interpretation or translation services.
- Involving a support person for individuals with cognitive impairments or communication challenges.
- Providing accessible materials or formats, as appropriate.

The initial intake will be completed through the Information and Assistance process. We have outlined the process in the workflow chart.

Procedure:

Information and Assistance

A service that provides the individual with current information on opportunities and services available within their communities, including information relating to assistive technology: identifies the strength and needs of the individual; links the individual to the opportunities and services that are available; and to the maximum extent practicable, ensures that the individual receives the services needed and is aware of the opportunities available, by establishing adequate follow- up procedures. Primarily provides to individuals who mainly need quick information or referral and can largely self-direct after receiving assistance.

Eligibility

All individuals (adults and children) with disabilities, older individuals age 60+, and their families and caregivers. There are no financial, resources or needs based eligibility criteria.

Crisis Situations

1) Ensuring safety and addressing urgent needs take priority over completing standard steps of process.
2) If an inquiry reveals a crisis, staff will immediately initiate emergency response protocols.
3) Staff will follow up with the individual based off emergency response protocols.

Procedure

1) Receive inquiry: Staff will respond to all contacts, whether in person, by telephone, electronic or walk in in person-centered manner.
2) Answer the phone by stating approved greeting and identifying yourself to the individual.
3) Respond to requests for information and assistance within one business day. If necessary, the initial response may be to acknowledge the request and schedule an appointment with the individual at their preferred time and date.
4) Collect relevant personal, demographic, and financial information using *Iowa HHS-approved forms*
5) Evaluate the call or request by:
    a) Establishing rapport with the individual.
    b) Supporting and encouraging the individual.
    c) Identifying the issue(s) that led to the inquiry.
    d) Determining the nature of the situation.
    e) Evaluating the knowledge, capacity, and personal preference of the individual to determine how to best provide assistance.
    f) Identifying the most appropriate resource(s) to meet the individual's needs
    g) Determining need using the *standardized tool* for next steps for possible connection with:
        - Options Counseling
        - HCBS System Navigation
        - Long Term Supports and Services (LTSS) Service Coordination
        - Managed Care Organization (MCO) or Fee for Services (FFS)- Community Based Case Management (CBCM)
        - Integrated Health Home (IHH)
        - Certified Community Behavioral Health Center (CCBHC)
        - Behavioral Health – Administrative Service Organization (BH- ASO) Primary Care Association (PCA)
6) Provide the individual with information that is:
    a) Accurate, useful, and hope-centered
    b) Relevant to the individual's expressed need and personal preferences
    c) In the language and formats that are easiest for the individual to understand
    d) Objective and does not appear to favor or attempt to persuade the individual to choose any setting, program, services, or provider
7) Obtain consent for any information sharing.
8) Provide referrals or assistance in accessing public and private resources. The information gathered while evaluating the call or request will be used to determine what referrals and assistance will be provided to the individual.
9) Provide the individual with specific information and referrals addressing each need identified. This may include agency names, contact persons, program brochures, or even helping the individual make a phone call to initiate

services while at the DAP. Staff may help fill out applications. Ensure the individual understands the information. This includes checking if they are comfortable contacting the referrals given and answering any questions about how those services work. Printed materials or an email summary are provided as needed for clarity.

10) Follow up with the individual on referrals and service connections and determine whether their needs were met and whether they need additional information and assistance.
11) Advocate on behalf of the individual who has issues with access to services.
12) Verify whether the individual's immediate needs have been met with the assistance provided.
    a) If yes, no further in-depth involvement is scheduled (beyond the follow-up call).
    b) If not, or if the individual expresses uncertainty, review concerns and apply engagement strategies.
13) Complete *HHS I&A forms* and log into the case management system.
14) If applicable, complete a warm handoff to agreed-upon program/agency.

Options Counseling:

It is an interactive process whereby individuals receive guidance in their deliberation to make informed choices about long-term support. The process is directed by the individual and may include others whom the individual chooses or those who are legally authorized to represent the individual. It is person-centered and typically short-term, concluding when a plan is made and initial steps taken.

Options Counseling may include:

1) Personal interview and assessment to discover strengths, values, and preferences of the individual and screening for entitlement program eligibility.
2) A facilitated decision-making process that explores resources and service options, and supports the individual in weighing pros and cons.
3) Action steps developed toward a goal or a long-term support plan and assistance in applying for and accessing support options.
4) Follow-up to ensure support and decision are assisting the individual.

Eligibility

All individuals (adults and children) with disabilities, older individuals age 60+, and their families and caregivers. There are no financial, resources or needs based eligibility criteria.

Procedure

1) The DAP Disability Services Navigator (DSN) will provide Options Counseling. This may be the same staff who provided Information and Assistance.
2) Individuals will be informed of their rights at the initial meeting. They will receive an Individual Rights and Responsibilities handout. If the meeting is telephoned or electronic will offer handout to be e-mailed to them.
   If an individual wishes to file a grievance at any point, the DSN will support and guide them through the process, following established grievance policies.
   This includes:
   a) The right to confidentiality,
   b) The right to be treated with dignity and respect.
   c) The right to appeal funding or service decisions
3) The DSN will schedule with the individual dedicated session(s) focused on exploring the individual's options and needs.

4) During Options Counseling sessions, the DSN will complete an assessment if needed. A structured framework or checklist will be used to ensure all relevant factors are considered.
5) The DSN will determine needs using the *standardized tool* for next steps for possible connection with:
    - STSS funded services
    - HCBS System Navigation
    - Long Term Supports and Services (LTSS) Service Coordination
    - Managed Care Organization (MCO) or Fee for Services (FFS)- Community Based Case Management (CBCM)
    - Integrated Health Home (IHH)
    - Certified Community Behavioral Health Center (CCBHC)
    - Behavioral Health – Administrative Service Organization (BH- ASO) Primary Care Association (PCA)
6) The DSN will provide comprehensive information on each option. This could include explaining eligibility criteria, application processes, wait times, and likely outcomes for each choice.
7) The DSN will use Person-Centered Planning: The outcome of Options Counseling is a clear plan or decision.
    a) The DSN will use motivational interviewing and coaching techniques to help the individual weigh what matters most to them ensuring the decision aligns with their life goals.
    b) The individual or their authorized representative will have the final choice in deciding which options will meet their needs. The DSN will then help map out the steps to implement that choice. These steps are documented in an Action Plan document.
8) The DSN will also address any fears or barriers the individual has about the options. This is done by providing encouragement, discussing contingency plans, and, if available, offering to connect the individual with peer support (someone who has been through similar decisions) for additional perspective. This supportive approach ties into the Science of Hope by reinforcing the individual's sense of efficacy and hope for the future.
9) Follow-Up:
    a) Once the plan is in motion, the DSN will monitor progress for a short period. They check in biweekly or monthly to see if the needed services have started or decisions have been implemented. If the plan is stalled or needs revision, additional Options Counseling sessions can be held. When the plan is successfully implemented, the case can transition to closure or to a maintenance mode. If during follow-up it becomes clear that ongoing coordination is needed beyond making the decision, the support can be stepped up to LTSS Service Coordination. All follow-ups and final outcomes are documented. Finally, the DSN will ensure the individual has contact information to re-engage the DAP in the future and provide a summary of what was accomplished for their records.
    b) The DSN will contact the individual within a short period (typically 1–2 weeks) to inquire if they successfully connected with the referrals and if any additional help is needed. This follow-up is logged. If the individual did not obtain the service needed, the DSN will either provide additional options or consider bringing the case back for a higher level of support. Once the individual confirms their needs are met or they are actively

engaged with the referrals provided, the DSN will discontinue current level of support. The individual may be re-enrolled anytime if the individual seeks help again.

10) The DSN will complete *HHS Options Counseling forms* and log into the case management system.
11) If applicable, the DSN will complete a warm handoff to the agreed upon program/agency.

LTSS Service Coordination

Is an active, transitional, and ongoing process that involves assisting an eligible individual in gaining access to and coordinating the provisions of services; using person-centered practices in all contacts with individuals and their caregivers; and coordinating the services identified in the service plan.

Eligibility

To be eligible and individual will meet the following:

1) Financial
    a) An adult with disabilities will have an income equal to or less than 200 percent of the federal poverty level.
    b) A family of a child with disabilities will have an income equal to or less than 200 percent the federal poverty level.
    c) A person who is eligible for federally funded services and other support will apply for such services and support.
    d) Income will be verified using the best information available
    e) Financial eligibility will be reviewed on an annual basis and may be reviewed more often in response to an increase or decrease in income.
    f) An individual who is eligible for medical assistance must apply for and exhaust such funding for services and support prior to utilization of disability service system funding.
2) Resources
    a) There are no resource limits for the family of a child seeking children's disability services.
    b) An adult with disabilities must have resources that are equal to or less than $2000.00 in countable value for a single-person household or $3000.00 in a countable value for a multi-person household or follow the most recent federal supplemental security income guidelines.
    c) The countable value of all countable resources, both liquid and non-liquid, shall be included in the eligibility determination except as exempted in this sub-rule.
    d) A transfer of property or other assets within five (5) years of the time of application with the results of, or intent to, qualify for assistance may result in denial or discontinuation of funding.
    e) The following resources are exempt:

- The homestead, including equity in family home or farm that is used as the individual household's principal place of residence. The homestead shall include all land that is contiguous to the home and the buildings located on the land.
- One automobile used for transportation.
- Tools of an actively pursued trade.
- General household furnishings and personal items.
- Burial account or trust limited in value as to that allowed in the medical assistance program.
- Cash surrender value of life insurance with a face value of less than $1,500.00 on any one person.
- Any resource determined excludable by the Social Security Administration because of an approved Social Security Administration work incentive.

f) If an individual does not qualify for federally funded or state funded services or other supports but meets all income, resource and functional eligibility requirements of this chapter, the following types of resources are also exempt from consideration in eligibility determination:
- A retirement account that is in the accumulation stage.
- A medical savings account.
- An assistive technology account.
- A burial account or trust limited in value as to that allowed in the medical assistance program.

3) Needs- Based
   a) An individual must be a resident of Iowa, or if a minor, the custodial parent is a resident of Iowa
   b) An individual must have a diagnosis of intellectual disability, developmental disability, brain injury or serious mental illness as defined by in Iowa Code Section 135.22, or an individual who resides in or are at risk of residing in institutional setting due to their disability.
   c) The results of a standardized functional assessment support the type and frequency of disability services identified in the Individual's case plan. A functional assessment must be completed within sixty (60) days of application for services.

<u>Procedure</u>

1) Assignment
   a) A DSN is assigned to the individual.
   b) The DSN will contact the individual within one business day to introduce themselves and schedule a time to meet.
2) Determining Eligibility
   a) The DSN or assigned staff will process eligibility within ten (10) business days of receipt of a completed application.

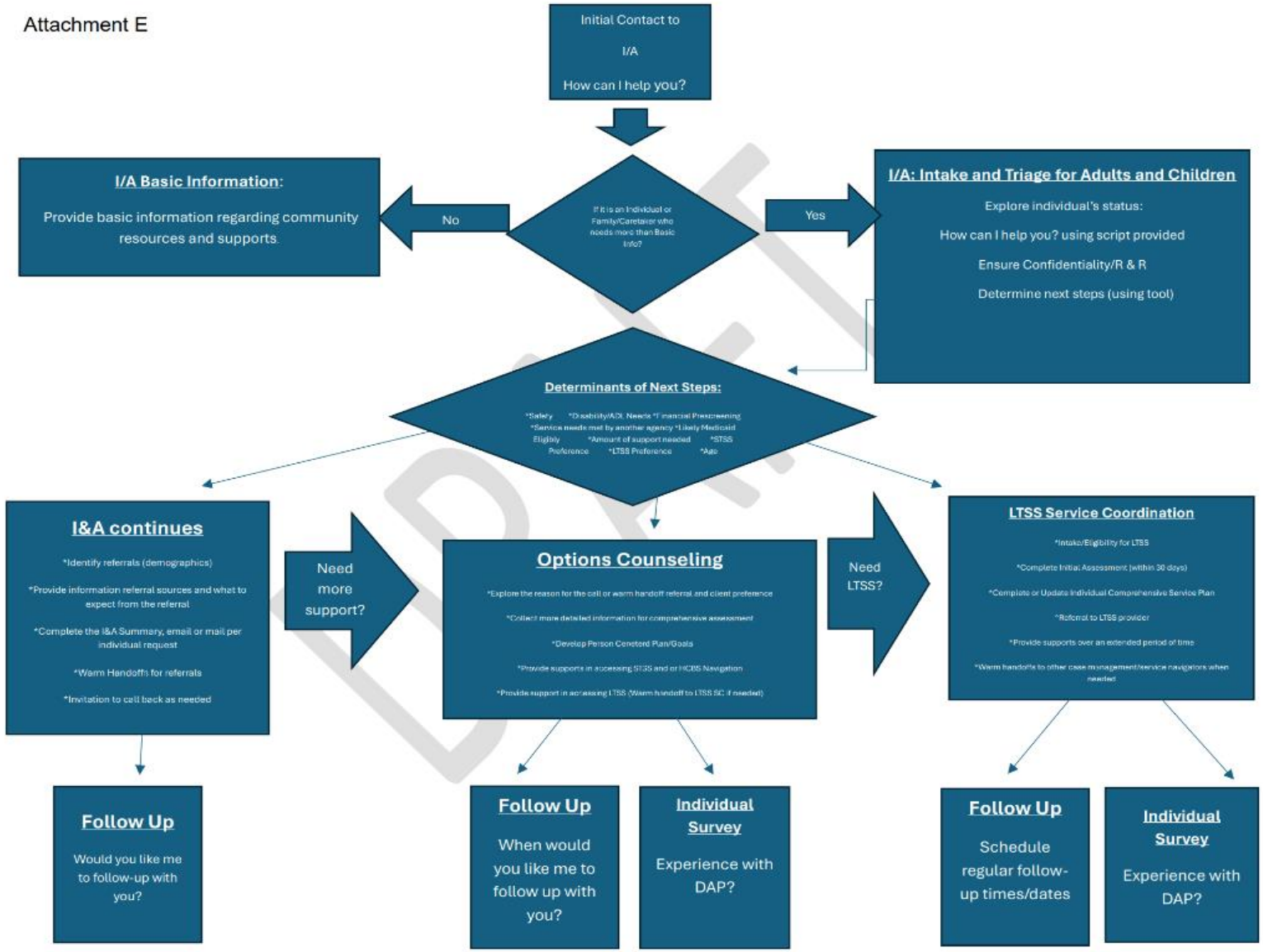
        i) If processing eligibility takes longer than ten (10) business days this data will be included in monthly reporting.
3) Individual Needs Assessment
    a) The DSN will initiate needs assessment requirements upon determination of eligibility.
    b) The DSN will complete an Initial Assessment within thirty (30) days with the individual and their team, when applicable.
        i) If initial assessment takes longer than thirty (30) days this data will be included in monthly reporting
    c) The DSN will complete a functional assessment within sixty (60) days of application for services.
4) The DSN will develop and complete a *service plan* with the individual and team using the HHS provided service plan template to identify supports and services needed and plan to refer and link.
5) The DSN will follow up with the individual on referrals and service connections and determine whether their needs were met and whether they need additional information and assistance.

References:

This policy is guided by the District Plan and is designed to ensure compliance with all applicable state and federal laws. The process is based on evidence-based practices and frameworks that promote accessible, coordinated, and hope-centered services.

All staff are required to follow this policy to provide a consistent, person-centered, and positive experience for every individual, their families or caregivers seeking assistance through the DAP.

Attachment E: DAP Flow Chart



Attachment F: Claims and Invoicing Policy

ECR Claims and Invoicing Policy

The East Central Region (ECR) maintains a network of licensed and accredited, contracted service providers to meet the continuum of service needs of individuals. The Disability Access Point (DAP) retains the right to select service providers, and all must be approved ECR network providers to be eligible for DAP funding. Once providers are enrolled in the network and services are authorized for individuals, providers may submit claims for reimbursement of Short-Term Services and Supports (STSS).

Invoicing Requirements

Service providers must submit billing invoices within sixty (60) calendar days of service delivery. Each invoice must include:

- Full name and unique identifier of the individual served.
- Dates of service.
- Invoice number.
- Number of units delivered.
- Unit rate and total cost per individual.
- Copayments or third-party charges shown as deductions.
- Actual amount requested from the DAP.
- Supporting documentation, such as attendance records, if requested.

Claims Review and Authorization

- All invoices will be reviewed for consistency with service funding authorizations.
- Only ECR staff may authorize funding.
- Unauthorized services will be deducted from payment.

Claims Payment

- ECR will pay eligible claims within sixty (60) days of receiving complete and required documentation.
- Claims submitted more than sixty (60) days after the close of the fiscal year (July 1 – June 30) will not be considered unless a legal obligation exists.

Provider Compensation

- Providers must accept ECR reimbursement as full payment, less any applicable copayments or other individual charges.
- Rates must be agreed upon in advance or through contract.

Compliance

- Failure to comply with this policy may result in delayed payment, denial of claims, or corrective actions.

Appeal of Denied Claims

- Providers may appeal a denied claim by submitting an appeal letter to Chief Financial Officer within 60 days of receiving notification that any or all a claim was denied.

- The letter must include full detail of the denial and contain compelling evidence to reverse the decision.
- The Chief Financial Officer will review the appeal and notify the provider of the decision within 30 days.

Attachment G: Eligibility Policy
The ECR is committed to providing services and supports to individual who meet the following criteria:

General Eligibility Criteria

Programmatic Eligibility

- The individual must have a documented disability and require assistance to live in the home and community of their choice in an integrated setting.
- STSS supports the individual and, when needed, their family or caregivers to maintain or enhance independent community living.

Short-Term Services and Supports (STSS) Definition
"Short-Term Services and Supports (STSS)" means time-limited activities focused on supporting people with disabilities to live in the home and community of their choice in an integrated manner and offering support to their families and caregivers as needed toward this purpose. STSS includes:

- Individual Assessment and Evaluation
- Transportation
- Respite
- Peer and Parent Support
- Time-Limited Rental Assistance
- Home and Vehicle Modifications
- Adaptive Equipment
- Other Basic Needs

Financial Eligibility

- Income Limit: Household income must not exceed 200% of the Federal Poverty Level (FPL).
- Resource Limit:
  - $2,000 for an individual.
  - $3,000 for households with more than one person.
- **Verification:** Proof of income and resources must be submitted with each application.

Payer of Last Resort

- ECR funding is available only when no other sources (e.g., Medicaid, private insurance, County General Assistance, or other public or private assistance) are available to cover the service.

Time Limitation for Short-Term Services

- ECR assistance is limited to no more than 90 days per qualifying episode of service.
- Time-limited assistance is designed to promote stabilization, independence, or transition and is not intended for ongoing or permanent support.

Service-Specific Eligibility

ECR will use these criteria to ensure consistency, accountability, and alignment with person-centered, recovery-oriented, and least-restrictive principles across all service categories.

Individual Assessment and Evaluation
"Individual Assessment and Evaluation" means the clinical review by a licensed professional of the individual's current functioning regarding the individual's situation, needs, strengths, abilities, desires, and goals.

1. **General:**
   - Must be conducted by a licensed clinician.
   - Documentation must be clinically sound, individualized, and reflect strengths, needs, and recovery goals.

2. **Eligibility:**
   - Resident of District 7.
   - Meets general eligibility criteria.

3. **Prioritization:**
   - Individuals at risk of institutionalization or hospitalization.
   - Those without recent evaluations (within 12 months).

4. **Approval:**
   - Request submitted through a disability services navigator.

Transportation
"Transportation" means services or aid provided for individuals to conduct business, medical, or essential errands, travel to and from employment or day services, and reduce social isolation. Minors will need to be accompanied by a parent, guardian, or designated adult.

1. **General:**

- Vehicles used must be insured, roadworthy, and meet applicable safety and accessibility standards.
- Drivers must have valid licenses and, where applicable, background checks.

2. **Eligibility:**
   - Resident of District 7.
   - No other funding sources available.
   - Must demonstrate need to access essential services.

3. **Prioritization:**
   - Medical and employment-related travel prioritized.
   - Community or social outings are secondary.

4. **Approval:**
   - Request submitted through a disability services navigator.
   - Must include verification of purpose and need.
   - Minors must be accompanied by an adult.

Peer and Parent Support

"Peer and Parent Support" means services provided by a Peer or Parent Support Specialist that assist the individual or family of an individual to live successfully in the family or community, including, but not limited to, education and information, individual advocacy, family support groups, and respite to assist individuals in achieving stability in the community.

- "Peer and Parent Support Specialist" means an individual who has lived experience as an individual with disability or is a parent, primary caregiver, foster parent, or family member of an individual with a disability, and has successfully completed standardized training to provide peer or family support services through the medical assistance program.

1. **General:**
   - Providers must maintain standardized certification and have documented supervision.
   - Peer notes must reflect supportive, non-clinical engagement in line with recovery principles.

2. **Eligibility:**
   - Individual or family member experiencing disability-related challenges.
   - Must meet general eligibility requirements.

3. **Prioritization:**
   - Individuals recently discharged from a higher level of care.
   - Families lacking sufficient natural support systems.

4. **Approval:**
   - Request submitted through a disability services navigator.
   - Must include a support plan.

Time-Limited Rental Assistance

"Time-Limited Rental Assistance" means non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for their own living expenses. When no other funding source is available this assistance can be provided for up to 3 months or 90 days.

1. **General:**
   - Landlords must provide a current rental certificate or equivalent documentation required by local housing authorities, if applicable.
   - ECR reserves the right to deny payment to landlords not in compliance with municipal rental regulations.
2. **Eligibility:**
   - Resident of District 7.
   - No other funding sources available.

3. **Prioritization:**
   - Clients exiting residential or psychiatric facilities.
   - Homeless or unstably housed individuals.

4. **Approval:**
   - Request submitted through a disability services navigator.
   - Reviewed monthly for continued need.

Home and Vehicle Modifications

"Home and Vehicle Modifications" means physical modifications to the individual's home or vehicle that directly address the individual's medical or remedial need. Modifications shall be necessary to provide for the health, welfare, or safety of the individual and enable the individual to function with greater independence in the home or vehicle. Home and vehicle modifications are not furnished to adapt living arrangements that are owned or leased by providers of services, including any facility-based setting. Home and vehicle repairs, motorized vehicle purchase or lease, and regularly scheduled upkeep and maintenance of a vehicle are not allowable. DAPs shall utilize Iowa Medicaid HCBS waiver services timeframes and rates for provision of home modification services.

1. **General:**
   - Work must be completed by insured and qualified contractors.
   - Projects must meet local building codes and pass any required inspections before payment is issued.

2. **Eligibility:**
   - Resident of District 7.
   - Must support a medical or remedial need and promote independence.

3. **Prioritization:**
   - Individuals at risk of losing housing or requiring higher levels of care.
   - Barriers to essential daily functions.

4. **Approval:**
   - Request submitted through a disability services navigator.
   - Professional evaluation required.
   - Quotes and scope of work must be submitted.
   - Must follow Iowa Medicaid HCBS standards.
   - Excludes provider-owned properties and routine maintenance.

Adaptive Equipment

"Adaptive Equipment" means practical equipment products that assist individuals with activities of daily living and instrumental activities of daily living that allow the individual more independence. Adaptive equipment is not medical in nature. Products shall align with items approved by Medicaid. Adaptive equipment includes, but are not limited to:

- Long reach brushes
- Extra-long shoehorns
- Non-slip grippers to pick up and reach items
- Dressing aids
- Shampoo rinse trays and inflatable shampoo trays
- Double handed cups
- Sipper lids
- Enabling technology.

1. **General:**
   - Items must be purchased from reputable vendors with quality guarantees.
   - Equipment must be safe, durable, and match approved needs as documented by supporting professionals.

2. **Eligibility:**
   - Request submitted through a disability services navigator.
   - Resident of District 7.
   - Must meet medical, functional, or independence-related needs.
   - Items not covered by other sources.

3. **Prioritization:**
   - Requests improving health, safety, or independence.
   - Clients with limited informal support.

4. **Approval:**
   - May require recommendations from a health professional.
   - Must align with Medicaid-approved items.
   - Vendor invoice required.

Other Basic Needs

“Other Basic Needs" means needs and items for personal or household use by the individual which provide for the health and safety of the individual that non-insurance covered items to support the individual to remain in their current living situation and community.

1. **General:**
   - Providers of items such as utility services or durable goods must demonstrate legitimacy (e.g., business licensure, vendor tax ID).
   - Any items purchased must directly support the individual's health, safety, or independence.

2. **Eligibility:**
   - Resident of District 7.
   - Request must support the health and safety of the individual in their home/community.

3. **Prioritization:**
   - Individuals facing immediate risk to safety or housing stability.
   - Lack of informal or alternative supports.

4. **Approval:**
   - Request submitted through a disability services navigator.

- Application with itemized list and justification.
- Reviewed by ECR for compliance with policy.
- Documentation of lack of other funding required.