

**Commonwealth of Pennsylvania
Department of Human Services
Office of Long-Term Living
Act 150 Program Guidelines**

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ACT 150 PROGRAM GUIDELINES

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A. HISTORY AND PURPOSE OF ACT 150

Pennsylvania's Attendant Care Program began as a state-funded program in 1987 as a result of The Attendant Care Services Act (Act-1986-150, 62 P.S. § 3051 et seq.), also known as Act 150. Act 150 required the Department of Human Services (formerly the Department of Public Welfare) to establish attendant care services for "those mentally alert, but severely physically disabled who are in the greatest risk of being in an institutional setting."

The Act 150 Program Guidelines provide the necessary requirements for the management of the Act 150 Program. They include policy and program areas that are specific to the Act 150 Program. They also reference Office of Long-Term Living (OLTL) policy bulletins, regulations and Act 150 to provide a complete tool for managing the Act 150 Program. These Act 150 Program Guidelines do not supersede or replace regulations or OLTL bulletins, except those policy documents being rescinded with its issuance. If there are any areas in these guidelines that appear to be in conflict with existing regulations or OLTL bulletins, the regulations and bulletins supersede this document and must be followed. All bulletins referenced in the Act 150 Program Guidelines can be found at [OLTL Bulletins](#).

Pennsylvania's Act 150 Program enables adults 18 through 59 years of age who are mentally alert and have physical disabilities to perform activities of daily living (such as eating, personal hygiene, and transporting themselves). Using state funding, in addition to the participant's own resources, the Pennsylvania Act 150 Program assists eligible individuals in obtaining assistance from personal assistance services (PAS) workers in completing tasks in order to lead more independent lifestyles.

The Act 150 Program services are designed to support eligible adults in improving their quality of life by achieving one or more of the following goals:

1. Enabling participants to live in the most integrated community setting as independently as possible;
2. Enabling participants to remain in their homes and preventing unnecessary admission to nursing facilities or other similar institutional settings; and
3. Enabling participants to seek and/or maintain employment.

To meet these objectives, services are provided to enable participants to achieve maximum independence in their daily lives.

The Act 150 Program falls under the authority of 55 Pa. Code, Chapter 52.

B. ELIGIBILITY

Criteria for Act 150 Program Services

Eligibility is based on a level of care assessment, a financial eligibility determination and program eligibility.

To be eligible for the Act 150 Program, a person shall meet all of the following criteria:

1. Be between the ages of 18 through 59.

Participants who are receiving services through the Act 150 Program before turning age 60 may choose either to continue to remain in the Act 150 Program or to transfer their services to a program offered by the Area Agency on Aging (AAA) upon reaching the age of 60. Access to the services through an AAA is subject to availability of funds through the AAA and the applicant's priority of need for services. Transfer to another program through the AAA at age 60 is not guaranteed. The individual's service coordinator (SC) is to provide information about Aging services to a participant nearing age 60 so that the participant may make a fully-informed decision. These options are to be discussed as a part of the person-centered planning process.

2. Be mentally alert and capable of:

- I. Selecting, supervising and, if needed, firing a PAS worker;

- II. Managing one's own financial affairs; and

- III. Managing one's own legal affairs.

3. Experience any medically determinable physical impairment that can be expected to last for a continuous period of not less than 12 months.
4. Because of the physical impairment(s), the person requires assistance to complete functions of daily living, self-care and mobility, including, but not limited to those functions included in the definition of "personal assistance services" (See "Services" below.)
5. Be capable of directing his or her own care.
6. Be found in need of basic services on the basis of an assessment.
7. Be a citizen of the United States or an immigrant lawfully admitted for permanent residence.

8. Be a resident of Pennsylvania. A resident is a person who lives and intends to remain in Pennsylvania, and maintains a continuous physical presence in the state except for a temporary absence. For purposes of satisfying the general eligibility criteria, the following persons who are either United States citizens or immigrants lawfully admitted for permanent residence are considered Pennsylvania residents:
 - I. Persons who declare a place of permanent residence located within the Commonwealth;
 - II. Migrant workers who are seasonally employed or are seeking seasonal employment in the Commonwealth; or
 - III. Students who are attending school in Pennsylvania, if they meet all other eligibility criteria.
9. Be a resident of another state and intend to relocate to Pennsylvania and remain permanently or indefinitely at the time of applying for services.
10. Participate in the eligibility process for the Medicaid Attendant Care Waiver for attendant care services and be found ineligible.
11. Be Nursing Facility Clinically Eligible (NFCE), other than participants who were determined to be Nursing Facility Ineligible (NFI) who were enrolled prior to November 5, 2013. At each participant's annual reevaluation, a level of care determination is to be administered. Any participant enrolled in the program prior to November 5, 2013 who is determined to be NFI upon annual reevaluation, may be permitted to remain enrolled in the Act 150 Program. Any participant enrolled after November 5, 2013 who is later determined to be NFI, is to be disenrolled from the Act 150 Program when an NFI determination is made. Service coordinators (SCs) are to provide to any such participants the necessary information on filing an appeal. (See current OLTL Hearings and Appeals Bulletin issued by OLTL at: [OLTL Bulletins.](#))

If an applicant for Act 150 services is both NFCE and financially eligible for the Attendant Care Waiver (ACW) Program, the applicant shall enroll in the Attendant Care Waiver to receive services. Should a participant who is NFCE, under age 60 and being served through the Act 150 Program become financially eligible for the ACW, the participant shall be enrolled in the waiver in order to continue to receive attendant care services. This would include an ACW participant who qualifies for Medical Assistance for Workers with Disabilities (MAWD).

If a participant is NFCE, over age 60 and becomes financially eligible for a waiver, he or she shall be enrolled in the Aging Waiver Program.

Eligibility Determinations

OLTL uses an Independent Enrollment Broker (IEB) to enroll people into its programs. The IEB facilitates program eligibility determinations, excluding level of care determinations, for multiple home and community-based waivers and the Act 150 Program. The IEB is responsible to do the following to facilitate the eligibility determination process:

- Conduct the initial in-home visit and begin to complete the initial needs assessment;
- Educate individuals on their rights and responsibilities in the waiver or Act 150 Program, opportunities for self-direction, appeal rights, the Services and Supports Directory (SSD), and the right to choose from any qualified provider;
- Provide applicants with choice of receiving nursing facility institutional services, waiver services, Act 150 services, or no services and documenting the applicant's choice on the OLTL Freedom of Choice Form;
- Provide applicants with a list of qualified Service Coordination Entities (SCEs) and document the individual's choice of SCE on the OLTL Service Provider Choice Form;
- Assist the applicant to obtain a completed physician certification form from the individual's physician;
- Refer the applicant to the entity responsible for performing the level of care determinations;
- Assist the participant to complete the financial eligibility determination paperwork; and
- Facilitate the transfer of the new enrollee to their selected service coordination entity (SCE), including sending copies of all completed assessments and forms.

(See current Procedures and Timeframes Related to Performance of Level of Care Assessments and Independent Enrollment Broker Responsibilities Bulletin issued by OLTL Bulletin at: [OLTL Bulletins.](#))

It is not the SC's responsibility to determine eligibility for services. Additionally, it is the responsibility of an applicant/participant to cooperate in providing the verifications listed above. The local county assistance office (CAO) is responsible for the determination of waiver eligibility. However, services in the Act 150 Program are to be denied or terminated if the CAO denies eligibility for the waiver program based on the non-cooperation of the applicant/participant.

C. SERVICES AND PROVIDER QUALIFICATIONS

Services available through the Act 150 Program include Service Coordination, Personal Assistance Services (PAS), Financial Management Services (FMS) and Personal Emergency Response System (PERS). These are services designed to enable individuals to live more independently in their homes and communities. All of these services will be provided to meet the participant's needs as determined by an assessment performed in accordance with OLTL requirements and as outlined in the participant's service plan. Act 150 Program services are to be used as services of the last resort. All other resources shall be exhausted before Act 150 services are initiated, including those provided under third party benefits.

Service Coordination

Service Coordination identifies, coordinates and assists participants to gain access to needed medical, social, housing, educational and other services and supports. Service Coordination includes the primary functions of providing information to participants and facilitating access, locating, coordinating and monitoring needed services and supports for program participants. See Long-Term Living Home and Community-Based Services Regulations, 55 Pa. Code Chapter 52, § 52.26 and 27.

Personal Assistance Services

PAS are basic and ancillary services that enable an eligible person to remain in their home and community rather than an institution and to carry out functions of daily living, self-care and mobility. PAS primarily provides hands-on assistance to participants who reside in a private home that is necessary, as specified in the service plan, to enable the participant to integrate more fully into the community and ensure the health, welfare and safety of the participant.

PAS are intended to assist the individual to complete tasks of daily living that would be performed independently if the individual had no disability.

Basic PAS Services

Basic PAS services include:

- Assistance with activities of daily living (e.g., eating, bathing, dressing, personal hygiene), cueing to prompt the participant to perform a task and providing supervision to assist a participant who cannot be safely left alone;
- Getting in and out of bed, wheelchair and/or motor vehicle;
- Feeding, including preparation and cleanup;
- Health maintenance activities provided for the participant;

- Routine support services, such as meal planning, keeping of medical appointments and other health regimens needed to support the participant;
- Assistance and implementation of prescribed therapies;
- Overnight PAS to provide intermittent or ongoing awake, overnight assistance to a participant in their home for up to eight hours (Overnight PAS requires staff to be awake); and

Basic services shall be provided through Act 150 in an amount that exceeds any ancillary services provided.

Ancillary PAS Services

If a person is assessed as needing one or more of the basic services as defined in the PAS definition, the following services may be provided if they are ancillary to the basic services and assure the health, welfare and safety of the participant.

Ancillary services include the following and shall not comprise the majority of the service:

- Homemaker-type services, including, but not limited to, shopping, changing linens, laundry and cleaning;
- Companion-type services, including, but not limited to, transportation, letter writing, reading mail and escort;
- Services to accompany the participant into the community for purposes related to personal care, such as shopping in a grocery store; and
- Assistance with cognitive tasks, including, but not limited to, managing finances, planning activities and making decisions.

PAS services may only be funded through the Act 150 Program when the services are not available to the prospective participant by any other payer, including but not limited to private insurance or Medicare. SCs shall assure that coverage of services provided from other sources continues until the plan limitations have been reached or a determination of non-coverage has been established prior to a service's inclusion in the service plan. Documentation in accordance with OLTL requirements shall be maintained in the participant's file by the SC and be updated with each reauthorization, as applicable.

Costs incurred by the PAS workers while accompanying the participant into the community are not reimbursable under the Act 150 Program as PAS. The transportation costs associated with the provision of PAS outside the participant's home are not included in the scope of Personal Assistance Services.

Activities that are ancillary to the delivery of PAS are provided only when neither the participant nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision.

Basic and ancillary services shall be broken out and documented in the service notes in the Home and Community Services Information System (HCSIS).

Services available through the Act 150 Program are subject to the availability of funds. The Department reserves the right to limit the amount of services, both basic and ancillary, commensurate with the availability of funding. This can include the elimination or denial of ancillary services in order to serve additional participants with basic services. (See Act 150 of 1986, Section 2 (5); and Section 3 (3).)

Agency PAS Provider Qualifications

The following requirements pertain to agencies providing PAS in the Act 150 Program:

An agency shall be a Home Care Agency that:

- Is licensed by the Pennsylvania (PA) Department of Health, per 28 Pa. Code Part IV, Subpart H, Chapter 611 (Home Care Agencies and Home Care Registries), under Act 69;
- Complies with 55 Pa. Code Chapter 1101 and have a signed Medicaid waiver/Act 150 provider agreement;
- Complies with Department standards, regulations, and policies and procedures relating to provider qualifications, including 55 Pa. Code Chapter 52;
- Has a service location in PA or a state contiguous to PA;
- Has Workers' Compensation insurance in accordance with state statute and in accordance with Department policies;
- Has Commercial General Liability Insurance;
- Has Professional Liability Errors and Omissions Insurance; and
- Ensures that employees have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs; and provide staff training pursuant to 55 Pa. Code Chapter 52, § 52.21.

Individuals working for agencies shall meet the following standards:

- Be 18 years of age or older;
- Possess basic math, reading and writing skills;
- Complete training or demonstrate competency by passing a competency test as outlined in § 611.55 under Title 28, Part IV Subpart H of the Health Care Facilities Act;
- Have the required skills to perform services as specified in the participant's service plan;
- Complete any necessary pre/in-service training related to the participant's service plan;
- Agree to carry-out outcomes included in the participant's service plan;
- Possess a valid Social Security number;
- Pass criminal background check as required in 55 Pa. Code Chapter 52 § 52.19;
- Have a child abuse clearance (as per 23 Pa. C.S. Chapter 63) as follows:
 1. Clearances are required for all direct care workers and service providers, including service coordinators and contractors, providing services in homes where children reside. A child is defined as an individual under 18 years of age.
 2. The following three certifications must be obtained prior to providing services in homes where children reside:
 - I. Report of criminal history from the Pennsylvania State Police (PSP);
 - II. Fingerprint based federal criminal history submitted through the Pennsylvania State Police or its authorized agent (FBI); and
 - III. Child Abuse History Certification from the Department of Human Services (Child Abuse).
 3. Requests for criminal history reports can be processed through the Pennsylvania State Police web-based computer application called "Pennsylvania Access To Criminal History" (PATCH), at <https://epatch.state.pa.us>, or by submitting the "Request For Criminal Record Check" form SP4-164 (updated 7/2015) to the following address:

Pennsylvania State Police, Central Repository – 164, 1800 Elmerton Avenue, Harrisburg, PA 17110-9758, (717) 425-5546.

4. The Department of Human Services is utilizing Cogent Systems to process fingerprint-based FBI record checks. The fingerprint based background check is a multiple step process. The Cogent Systems Web site https://www.pa.cogentid.com/index_dpwNew.htm allows individuals to apply online, as well as provide detailed information regarding the application process.
5. Child Abuse History Certifications are obtained online at <http://www.compass.state.pa.us/CWIS>, or through the DHS ChildLine and Abuse Registry, P.O. Box 8170, Harrisburg, Pennsylvania 17105-8170, (717) 783-6211 or toll free at (877) 371-5422.
6. For those workers required to have clearances (see above), written results are required prior to the employee/provider initiating services in the participant's home. Workers who are employed by waiver participants who have children residing in their homes must have child abuse clearances completed prior to hire so that participants can make an informed decision on whether to employ a worker who has been named as a perpetrator of founded or indicated child abuse.
7. Beginning July 1, 2015, certifications must be obtained every 60 months regardless of service model. Any employee with current certification issued prior to July 1, 2015, must renew their certifications within 60 months from the date of their oldest certification or if their current certification is older than 60 months.
8. If an employee is arrested for or convicted of an offense that would constitute grounds for denying employment or participation in a program, activity or service, or is named as a perpetrator in a founded or indicated report, the employee must provide the administrator or their designee with written notice not later than 72 hours after the arrest, conviction or notification that the person has been listed as a perpetrator in the statewide database. An employee who willfully fails to disclose information as required above commits a misdemeanor of the third degree and shall be subject to discipline up to and including termination or denial of employment.
9. The employer, administrator, supervisor or other person responsible for employment decisions or acceptance of the individual to serve in any capacity requiring certifications, shall maintain copies of the required information.

10. The F/EA is responsible for securing clearances for prospective support service workers. The cost of conducting clearances is included in the monthly per member per month rate paid to the F/EA. In addition, the F/EA must have a system in place to document that the clearances were conducted.

11. OLTL reviews provider personnel records as part of the biennial monitoring to ensure that the clearances are conducted and documented as referenced in the Quality Improvement section. In addition to regularly scheduled monitoring, OLTL may review records as necessary during incident report investigations or other circumstances as warranted; and

- Have a valid driver's license from PA or a contiguous state if the operation of a vehicle is necessary to provide the service.

Consumer-Directed PAS (CD-PAS) Worker Qualifications

CD-PAS workers are workers hired by the participant.

CD-PAS workers shall:

- Comply with 55 Pa. Code Chapter 1101 and have a signed Medicaid Waiver/Act 150 provider agreement;
- Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 Pa. Code Chapter 52;
- Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
- Have a valid driver's license from PA or a contiguous state if the vehicle is necessary to provide the service;
- Have Workers' Compensation insurance in accordance with State statute and in accordance with Department policies;
- Be a resident of PA or a state contiguous to PA;
- Be 18 years of age or older;
- Possess basic math, reading, and writing skills;
- Possess a valid Social Security number;
- Submit to a criminal background check;

- Have a child abuse clearance (as per 23 Pa. C.S. Chapter 63) as follows:
 1. Clearances are required for all direct care workers and service providers, including service coordinators and contractors, providing services in homes where children reside. A child is defined as an individual under 18 years of age.
 2. The following three certifications must be obtained prior to providing services in homes where children reside:
 - I. Report of criminal history from the Pennsylvania State Police (PSP);
 - II. Fingerprint based federal criminal history submitted through the Pennsylvania State Police or its authorized agent (FBI); and
 - III. Child Abuse History Certification from the Department of Human Services (Child Abuse).
 3. Requests for criminal history reports can be processed through the Pennsylvania State Police web-based computer application called “Pennsylvania Access To Criminal History” (PATCH), at <https://epatch.state.pa.us>, or by submitting the “Request For Criminal Record Check” form SP4-164 (updated 7/2015) to the following address: Pennsylvania State Police, Central Repository – 164, 1800 Elmerton Avenue, Harrisburg, PA 17110-9758, (717) 425-5546.
 4. The Department of Human Services is utilizing Cogent Systems to process fingerprint-based FBI record checks. The fingerprint based background check is a multiple step process. The Cogent Systems Web site https://www.pa.cogentid.com/index_dpwNew.htm allows individuals to apply online, as well as provide detailed information regarding the application process.
 5. Child Abuse History Certifications are obtained online at <http://www.compass.state.pa.us/CWIS>, or through the DHS ChildLine and Abuse Registry, P.O. Box 8170, Harrisburg, Pennsylvania 17105-8170, (717) 783-6211 or toll free at (877) 371-5422.
 6. For those workers required to have clearances (see above), written results are required prior to the employee/provider initiating services in the participant’s home. Workers who are employed by waiver participants who have children residing in their homes must have child abuse clearances completed prior to hire so that participants can make an informed decision on whether to employ a worker who has been named as a perpetrator of founded or indicated child abuse.

7. Beginning July 1, 2015, certifications must be obtained every 60 months regardless of service model. Any employee with current certification issued prior to July 1, 2015, must renew their certifications within 60 months from the date of their oldest certification or if their current certification is older than 60 months.
 8. If an employee is arrested for or convicted of an offense that would constitute grounds for denying employment or participation in a program, activity or service, or is named as a perpetrator in a founded or indicated report, the employee must provide the administrator or their designee with written notice not later than 72 hours after the arrest, conviction or notification that the person has been listed as a perpetrator in the statewide database. An employee who willfully fails to disclose information as required above commits a misdemeanor of the third degree and shall be subject to discipline up to and including termination or denial of employment.
 9. The employer, administrator, supervisor or other person responsible for employment decisions or acceptance of the individual to serve in any capacity requiring certifications, shall maintain copies of the required information.
 10. The F/EA is responsible for securing clearances for prospective support service workers. The cost of conducting clearances is included in the monthly per member per month rate paid to the F/EA. In addition, the F/EA must have a system in place to document that the clearances were conducted.
 11. OLTL reviews provider personnel records as part of the biennial monitoring to ensure that the clearances are conducted and documented as referenced in the Quality Improvement section. In addition to regularly scheduled monitoring, OLTL may review records as necessary during incident report investigations or other circumstances as warranted; and
- Have the required skills to perform PAS as specified in the participant's service plan;
 - Complete any necessary pre/in-service training related to the participant's service plan;
 - Agree to carry-out outcomes included in the participant's service plan; and
 - Be able to demonstrate the capability to perform health maintenance activities specified in the participant's service plan or receive necessary training.

Financial Management Services (FMS) for CD-PAS

FMS consists of acting as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law, in accordance with OLT's procured Fiscal Employer Agent (F/EA) contract requirements.

- The F/EA contractor is an Internal Revenue Service (IRS)-Approved Fiscal/Employer Agent; and
- The F/EA provides specific employer agent functions that support the participant with the employer-related functions.

Responsibilities of the F/EA

- Enroll participants in FMS and apply for and receive approval from the IRS to act as an agent on behalf of the participant;
- Provide orientation and skills training to participants on required documentation for all directly hired PAS workers, including the completion of federal and state forms; the completion of timesheets; good hiring and firing practices; establishing work schedules; developing job descriptions; training and supervision of PAS workers; effective management of workplace injuries; and workers' compensation;
- Establish, maintain and process records for all participants and PAS workers with confidentiality, accuracy and appropriate safeguards;
- Conduct criminal background checks and, when applicable, child abuse clearances, on potential employees;
- Assist participants in verifying PAS workers citizenship or alien status;
- Distribute, collect and process PAS worker timesheets as verified and approved by the participant;
- Prepare and issue PAS workers' payroll checks, as approved in the participant's individual service plan (ISP);
- Withhold, file and deposit federal, state and local income taxes in accordance with federal IRS and state Department of Revenue rules and regulations;
- Secure workers' compensation for all PAS workers through the appropriate agency;
- Process all judgments, garnishments, tax levies, or any related holds on PAS workers' pay as may be required by federal, state or local laws;

- Prepare and disburse IRS forms, W-2's and/or 1099's, wage and tax statements and related documentation annually;
- Assist in implementing the state's quality management strategy related to FMS; and
- Establish an accessible customer service system for the participant and the SC.

The F/EA shall provide accurate and timely reports monthly to common law employers (the participant or an individual that he or she has authorized to be the common law employer in his or her stead), service coordinators, and OLTL. These reports include service utilization, written notification of over and underutilization, and notification of any common law employer who does not submit timesheets for two or more consecutive payroll periods. See Participant Direction below.

Personal Emergency Response System (PERS)

PERS is an electronic device which enables Act 150 Program participants to secure help in an emergency. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The individual may also wear a portable "help" button to allow for mobility. The response center is staffed by trained professionals. The PERS vendor shall provide 24 hour staffing, by trained operators of the emergency response center, every day of the year.

PERS services are limited to those individuals who:

- Live alone;
- Are alone for significant parts of the day as determined in consideration of their health status, disability, risk factors, support needs and other circumstances;
- Live with an individual that may be limited in their ability to access a telephone quickly when a participant has an emergency; or
- Would otherwise require extensive in-person routine monitoring and assistance.

Installation, repairs, monitoring and maintenance are included in this service.

PERS Provider Qualifications

- Comply with 55 Pa. Code Chapter 1101 and have a signed Medicaid Waiver/Act 150 provider agreement;

- Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 Pa. Code Chapter 52;
- Have a waiver/Act 150 service location in PA or a state contiguous to PA;
- Have Workers' Compensation insurance in accordance with State statute and in accordance with Department policies;
- Have Commercial General Liability insurance;
- All PERS installed are to be certified as meeting standards for safety and use, as may be promulgated by any governing body, including any electrical, communications, consumer or other standards, rules or regulations that may apply, including any applicable business license; and
- Organization shall have capacity to provide 24-hour coverage by trained professionals, every day of the year.

Individuals working for PERS vendors shall meet the following standards:

- Be at least 18 years of age;
- Comply with all Department standards, regulations, policies and procedures related to provider qualifications, including 55 Pa. Code Chapter 52;
- Have criminal background clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15;
- Have a child abuse clearance (as per 23 Pa. C.S. Chapter 63) as follows:
 1. Clearances are required for all direct care workers and service providers, including service coordinators and contractors, providing services in homes where children reside. A child is defined as an individual under 18 years of age.
 2. The following three certifications must be obtained prior to providing services in homes where children reside:
 - I. Report of criminal history from the Pennsylvania State Police (PSP);
 - II. Fingerprint based federal criminal history submitted through the Pennsylvania State Police or its authorized agent (FBI); and

III. Child Abuse History Certification from the Department of Human Services (Child Abuse).

3. Requests for criminal history reports can be processed through the Pennsylvania State Police web-based computer application called "Pennsylvania Access To Criminal History" (PATCH), at <https://epatch.state.pa.us>, or by submitting the "Request For Criminal Record Check" form SP4-164 (updated 7/2015) to the following address: Pennsylvania State Police, Central Repository – 164, 1800 Elmerton Avenue, Harrisburg, PA 17110-9758, (717) 425-5546.
4. The Department of Human Services is utilizing Cogent Systems to process fingerprint-based FBI record checks. The fingerprint based background check is a multiple step process. The Cogent Systems Web site https://www.pa.cogentid.com/index_dpwNew.htm allows individuals to apply online, as well as provide detailed information regarding the application process.
5. Child Abuse History Certifications are obtained online at <http://www.compass.state.pa.us/CWIS>, or through the DHS ChildLine and Abuse Registry, P.O. Box 8170, Harrisburg, Pennsylvania 17105-8170, (717) 783-6211 or toll free at (877) 371-5422.
6. For those workers required to have clearances (see above), written results are required prior to the employee/provider initiating services in the participant's home. Workers who are employed by waiver participants who have children residing in their homes must have child abuse clearances completed prior to hire so that participants can make an informed decision on whether to employ a worker who has been named as a perpetrator of founded or indicated child abuse.
7. Beginning July 1, 2015, certifications must be obtained every 60 months regardless of service model. Any employee with current certification issued prior to July 1, 2015, must renew their certifications within 60 months from the date of their oldest certification or if their current certification is older than 60 months.
8. If an employee is arrested for or convicted of an offense that would constitute grounds for denying employment or participation in a program, activity or service, or is named as a perpetrator in a founded or indicated report, the employee must provide the administrator or their designee with written notice not later than 72 hours after the arrest, conviction or notification that the person has been listed as a perpetrator in the statewide database. An employee who willfully fails to disclose information as required above commits a misdemeanor of

the third degree and shall be subject to discipline up to and including termination or denial of employment.

9. The employer, administrator, supervisor or other person responsible for employment decisions or acceptance of the individual to serve in any capacity requiring certifications, shall maintain copies of the required information.
10. The F/EA is responsible for securing clearances for prospective support service workers. The cost of conducting clearances is included in the monthly per member per month rate paid to the F/EA. In addition, the F/EA must have a system in place to document that the clearances were conducted.
11. OLTL reviews provider personnel records as part of the biennial monitoring to ensure that the clearances are conducted and documented as referenced in the Quality Improvement section. In addition to regularly scheduled monitoring, OLTL may review records as necessary during incident report investigations or other circumstances as warranted; and
 - Have a valid driver's license from PA or a contiguous state if the operation of a vehicle is necessary to provide the service.

Limitations on the Provision of Act 150 Services

1. Act 150 Program services are to be provided only to persons determined eligible by the appropriate enrollment entity. Prospective participants shall exhaust other sources of service, including those provided under third party benefits, prior to receiving Act 150 services.
2. If a participant in a Medicaid waiver loses eligibility for the waiver due to an increase in income or resources, the participant may apply for enrollment in the Act 150 Program and is subject to the provisions of the Act 150 Program and the OLTL waiting list policy if a waiting list exists. However, a participant may not be enrolled in Act 150 if there is still an active timely appeal regarding waiver services underway.
3. The opportunity to apply for the Act 150 Program upon loss of Medicaid waiver financial eligibility does not apply to persons 60 years of age and over. Such participants would need to access services through the local Link Network (PA's Aging and Disability Resource Center, or ADRC), AAA, or Center for Independent Living (CIL).
4. The Act 150 Program does not pay for services provided by spouses of participants.

5. The Act 150 Program does not pay for services provided by a legal guardian.

6. The Act 150 Program does not pay for services furnished by an active Power of Attorney (POA) of a participant.

Family members who provide PAS shall meet the same provider qualification standards as individuals working for agencies to provide PAS to non-relatives. SCs are to monitor the provision of services in accordance with OLTL established protocols.

Aside from the limitations noted above (#4, #5 and #6), there are no restrictions on the types of family members who may provide PAS.

D. SERVICE PLANNING

Service Planning Process

For the purposes of the Act 150 Program, the Service Coordination process identifies, coordinates and assists participants to gain access to needed program services, as well as medical, social, housing, educational and other services and supports. Service Coordination includes the primary functions of providing information to participants and facilitating access to, locating, coordinating and monitoring needed services and supports for program participants. This service is to be provided to meet the participant's needs as determined by an assessment performed in accordance with OLTL requirements, and as outlined in the participant's service plan. See Long-Term Living Home and Community-Based Services Regulations, 55 Pa. Code Chapter 52, § 52.25, 26 and 27 and the current OLTL Bulletin on Individual Service Plan Development, Review and Implementation.

In the performance of providing information to participants, the SC is to:

- Inform participants about Act 150 Program services;
- Inform participants about the Act 150 Program sliding fee scale and participant responsibilities related to paying the appropriate fees for services provided; and
- Inform participants on fair hearing and appeal rights and assist with fair hearing and appeal requests.

In the performance of facilitating access to needed services and supports, the SC is to:

- Make referrals to the AAA to ensure a participant reevaluation of the level of care is conducted annually or more frequently as needed in accordance with OLTL requirements; and
- Coordinate efforts and prompt the participant to ensure the completion of activities necessary to maintain Act 150 eligibility.

In the performance of the coordinating function, the SC is to:

- Coordinate efforts in accordance with OLTL requirements and prompt the participant to engage in the completion of a needs assessment as required by the State to identify appropriate levels of need and to serve as the foundation for the development of and updates to the service plan; and
- Use a person-centered planning approach and a team process to develop the participant's service plan to meet the participant's needs in the least restrictive manner possible. At a minimum, the approach shall:
 - Ensure that services and supports are integrated into the community, including opportunities for employment and work in competitive integrated settings, that participants are engaged in community life, that participants control personal resources and that participants receive services in the community to the same degree of access as individuals not receiving Act 150 services or MA waiver services;
- Ensure for individual rights of privacy, dignity and respect, and freedom from coercion and restraint; and
- Include strategies for solving conflict or disagreement within the process.
- Provide information, referral, and at a participant's request, assist in locating services such as transportation, housing, equipment, medical care and other essential services; and
- *Actively coordinate with other* individuals and/or entities essential in the physical and/or behavioral care delivery for the participant to ensure seamless coordination between physical, behavioral and support services.

In the performance of the monitoring function, the SC is to:

- Respond to and assess emergency situations and incidents and assure that appropriate actions are taken to protect the health, welfare and safety of the participant in accordance with Department policy on Critical Incident Management.
- Review provider documentation of service provision and monitor participant progress on outcomes and initiate service plan team discussions or meetings when services are not achieving desired outcomes.
- Through the service plan monitoring process, solicit input from participant and/or family, as appropriate, related to satisfaction with services.

- Ensure continuity of services, system flexibility and integration, proper utilization of facilities and resources, accessibility and participant rights.
- Participate in any Department identified activities related to quality oversight.
- Ensure that services are delivered in a manner that supports the participant's communication needs, including, but not limited to, age appropriate communication, translation services for participants that are of limited-English proficiency or who have other communication needs requiring translation, assistance with the provider's understanding and use of communication devices used by the participant.

Backup Plans – Individual and Emergency Preparedness

For guidance on Individual Backup Plans and Emergency Preparedness Plans see 55 Pa. Code Chapter 52 Section 52.25 Service Plan and the current OLTL Bulletin on Individual Service Plan Development, Review and Implementation.

Evaluations

A level of care determination is completed by the AAA assessor for each initial evaluation and reevaluation for the Act 150 Program.

Initial Evaluation

The local AAA assessors conduct the initial functional eligibility determination using the Level of Care Determination (LCD). In addition, a physician completes a physician certification which indicates the physician's diagnosis and level of care recommendation. The IEB completes certain sections of the Care Management Instrument (CMI) which is a needs assessment tool, at the time of enrollment. See [Needs Assessment](#).

Information on the IEB

The SC is responsible to complete the unfinished sections of the CMI at the initial service plan development meeting. The initial level of care and needs assessments are to be conducted during in-home visits.

Reevaluations

AAA assessors administer a level of care determination as part of the annual reevaluation for participants that are already enrolled in the Act 150 Program at the request of the SC. In addition, SCs may request level of care determinations to be conducted more frequently, if needed, when there are significant changes in a participant's functioning and/or needs. A physician's certification is to be completed with each reevaluation. In addition, a CMI is completed by the SC at

the time of the reevaluation. SCs are to inform participants of reevaluation results.

The reevaluation process is to be conducted at least once each year within 365 days of the first level of care determination and each subsequent year.

Both the level of care determination and the needs assessment for reevaluations are to be conducted during in-home visits. As part of the reevaluation process for the Act 150 Program, SCs are to consider the updated information recorded in the level of care determination and needs assessment to modify the participant's ISP. This includes information about the participant's strengths, capacities, needs, preferences, health status, risk factors, desired goals, medical changes, recent hospitalizations and changes in functional status (Activities of Daily Living and Instrumental Activities of Daily Living). The information collected on the level of care determination and needs assessment is compared to the information collected in the individual's previous evaluation or reevaluation. The updated information, together with any previous assessment information, assists the assessor in identifying changes and making the level of care reevaluation eligibility determination. This updated information also assists the SC in making appropriate adjustments to the service plan to address any changes in functioning or need. The participant and the SC shall review the service plan for accuracy and sign the participant's service plan if no changes are noted. If changes are warranted, based on the results of updated assessment documentation, a new service plan shall be completed and signed. See the current OLTL Bulletin related to Individual Service Plan Development, Review and Implementation at OLTL Bulletins.

Also at the time of the annual reevaluation, a financial eligibility determination for a Medical Assistance (MA) waiver program shall be completed for every participant who is NFCE. The SC is to assist the participant in collecting the necessary financial information and by making a referral to the appropriate CAO for a financial determination for MA eligibility. If the participant is determined to be financially eligible for an MA waiver program, the SC is to initiate the necessary program transfer to the appropriate waiver program. If the person is found to be NFCE but not financially eligible for a waiver, they may remain in the Act 150 Program.

After the reevaluation is completed, the SC enters information summarizing the results of the evaluation or reevaluation in a service note in HCSIS. The initial evaluation or reevaluation information is also maintained in the participant's file. SCEs need to maintain this information as it is subject to review during OLTL biennial provider monitoring visits and the retrospective service plan review process.

Change in the Level of Service by a Service Coordinator

An SC may modify the provision of service to a participant under the following conditions:

If, as a result of the needs assessment, the participant no longer requires the same service(s) or level of service(s), the SC may proceed to reduce or terminate service(s). The SC shall document the facts supporting his or her determination and shall provide the participant with 30 days advance written notice of the change. The notice shall include an explanation of the proposed change in the scope or level of service(s), the facts supporting the change, the participant's right to appeal the change, and the participant's right to continue to receive service pending the outcome of his/her administrative appeal if his/her appeal is filed within 10 days of the postmark date of the SC's notice.

See the current OLTL Hearings and Appeals Bulletin and OLTL Individual Service Plan Development, Review and Implementation at: [OLTL Bulletins](#).

Detailed instructions for all required data entry and systems locations are to be included in the HCSIS Data Entry Guidebook and Social Assistance Management System (SAMS) User Manual.

Participant Admission to a Hospital or Other Institution

SCs are to conduct an assessment of need and adjust the service plan accordingly prior to release from the hospital or other institution and work with discharge planners on changes to the service plan to ensure that all other resources available to the participant are accessed.

For a 180 day calendar period, an Act 150 Program participant may remain enrolled in the Act 150 Program when the participant is subsequently placed in a nursing facility or intermediate care facility for other related conditions (ICF/ORC). This also applies to short term admission into a hospital.

SCs cannot provide or authorize any services, including ancillary services, during a nursing facility, ICF/ORC or hospital stay.

Service Coordination Entity and Personnel Standards

Service Coordination Entities shall:

- Comply with 55 Pa. Code Chapter 1101 and have a waiver/Act 150 provider agreement;

- Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 Pa. Code Chapter 52;
- Meet the conflict free requirements pursuant to 55 Pa. Code, Chapter 52, §§ 52.27 and 52.28;
- Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
- Have a service location in PA or a state contiguous to PA;
- Have Workers' Compensation insurance in accordance with State statute and in accordance with Department policies;
- Have Commercial General Liability insurance;
- Ensure that employees have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs;
- Comply with and meet all standards as applied through each phase of the standard, annual Department performed monitoring process;
- Ensure 24-hour access to Service Coordination personnel (via direct employees or a contract) for response to emergency situations that are related to the Service Coordination service or Act 150 services;
- Sufficient professional staff to perform the needed assessment/reevaluation, service coordination and service activities; and
- Registered Nurse (RN) consulting services available, either by a staffing arrangement or through a contracted consulting arrangement.

(See 55 Pa. Code, Chapter 52, § 52.27 for Service Coordinator Qualifications and Training.)

E. PARTICIPANT DIRECTION

All participants have the right to make decisions about their Act 150 services and self-direct their services. Participants in the Act 150 Program may choose to hire and manage staff using employer authority. Participants are encouraged to self-direct their services to the highest degree possible. During the actual provision of services, the

participant is responsible for directing the activities of their PAS worker. Under Employer Authority, the participant serves as the common-law employer and is responsible for hiring, firing, training, supervising, and scheduling their PAS workers. (Budget Authority, known in Pennsylvania as Services My Way is not available in the Act 150 Program.)

Participants may choose to self-direct their services during the development of the initial ISP, at reassessment/reevaluation, or at any time. The participant's SC is responsible for presenting all available service options and ensuring that each participant understands the full range of opportunities within the Act 150 Program. OLTL has developed a standardized participant information packet which includes information about self-direction for all Act 150 participants.

As stated previously, the participant may utilize a combination of model(s) to personalize their ISP. The ISP is developed in conjunction with the SC, to ensure that the participant's service needs are met and that it reflects the participant's choice of model of service. SCs shall offer provider-managed services to all participants who have chosen to self-direct their services until the individual's PAS workers are hired. Participants may elect to change their service model at any time by notifying their SC. SCs shall work with participants to ensure they do not experience a disruption in services when participants choose to change service models.

Participants are to receive a full-range of supports to ensure they are successful with the participant-directed experience. Individuals choosing the employer authority model are to receive support from the certified Fiscal/Employer Agent (F/EA) and SCs to assist them in their role as the common-law employer of their PAS workers.

In addition, individuals choosing to self-direct their services are to receive assistance from their SC in developing their ISP. Once the ISP is developed, approved, and authorized, the participant is responsible for arranging and directing the services outlined in their plan with support from the SC. During the implementation and management of the ISP, the SC is to:

- Assist the participant to gain information and access to necessary services, regardless of the funding source of the services;
- Advise, train, and support the participant as needed and necessary;
- Assist the participant to develop an individualized back-up plan;
- Assist the participant to identify risks or potential risks and develop a plan to manage those risks;
- Monitor the provision of services to ensure the participant's health and welfare;

- Assist the participant in understanding and fulfilling their responsibilities outlined in the Common Law Employer Agreement form when the participant chooses to self-direct all or some of their services;
- Assist the participant to secure training of PAS workers who deliver services that would require a degree of technical skill, and would require the guidance and instruction from a health care professional such as an RN.

F. RIGHTS AND RESPONSIBILITIES

SCs and providers are responsible for ensuring that participant rights and responsibilities are maintained.

See current OLTL Standardized Home and Community-Based Services Waiver Participant Informational Materials Bulletin and subsequent additions at: [OLTL Bulletins](#).

G. CRITICAL INCIDENT MANAGEMENT

Incident Reporting

OLTL has initiated a comprehensive incident reporting and management process. Critical events are referred to as critical incidents and defined as an event that jeopardizes the participant's health and welfare. Two OLTL bureaus are involved in the oversight of the Incident Management process – the Bureau of Quality and Provider Management (BQPM) and the Bureau of Participant Operations (BPO).

Individuals/entities that are required to report critical incidents should See 55 Pa. Code, § 52.17 and the current Critical Incident Management Bulletin issued by OLTL at: [OLTL Bulletins](#).

Protective Services

SCs and providers for the Act 150 Program are also mandatory reporters for protective services and should familiarize themselves with the reporting requirements for the Adult Protective Services (APS) Program. See Act 70-2010 and the Older Adult Protective Services Act (OAPSA). Suspected abuse, neglect, and exploitation should be reported by calling 1-800-490-8505.

H. FEES/PAYMENT FOR SERVICES

Financial Eligibility Criteria

- Act 150 services are provided only if an applicant/participant is not eligible for

Medicaid waiver services.

- Applicants whose family monthly gross income exceeds 300 percent of the Federal Benefit Rate, as published annually in the Federal Register, shall pay a fee according to the sliding fee scale promulgated by the Department.
- All applicants shall exhaust all other available third-party benefits prior to receiving Act 150 services.

NOTE: Because the Act 150 is the payer of last resort, SCs shall review availability of third-party resources on a case-by-case basis. If duplicate services are available at no cost to the participant through another agency, the participant shall use those services. Act 150 Program services can be provided for any portion of eligible services that are not available through the other agency as long as there is no duplication of services.

Fee Determination and Redetermination

1. SCs will use the Act 150 Fee Determination/Redetermination form (Attachment I) to calculate weekly fees on the basis of family members in the household, income, and medical and disability expense. Additional documentation should also be included in the service notes in HCSIS to provide further documentation related to the calculation of the weekly fee. For example, details related to installment payments, such as the begin and the end dates of payments, total amount etc.

SCs may conduct the Act 150 Program fee determination and the needs assessment on the same visit as the initial evaluation or annual reevaluation.

Calculation of weekly fees is to be determined as follows:

- I. Calculate the family monthly income;
- II. Adjust the family monthly income by subtracting the amount of family monthly medical and disability expenses. See Countable Income and Excluded Income below; and
- III. Apply the Sliding Fee Scale using the adjusted family monthly income* and the number of family members identified to establish the weekly fee amount.

See current Sliding Fee Scale Bulletin issued by OLTL at: [OLTL Bulletins](#).

*For the purposes of the Act 150 Program weekly fee calculation, adjusted family income refers specifically to adjustments made based on the Act 150 fee scale procedure and is not referring to federal or state tax terminology.

2. The following family members are included for the purpose of fee calculation if they reside in the participant's household:
 - I. The participant;
 - II. The participant's spouse;
 - III. Dependent children who are under age 18; and
 - IV. Dependent children of the participant or spouse who are under age 24 and who are full-time students at an accredited institution of higher learning, including a licensed trade or vocational school.

Children placed in the household for foster care or group care, whether or not related to the participant or spouse, are not counted for purposes of fee calculation.

3. SCs shall use the sliding fee scale corresponding to the calendar year for which the fee is being calculated.
4. For the purpose of calculating weekly fees, if the cost of a participant's approved weekly hours of service is less than the calculated fee, the weekly fee is limited to the cost of the approved weekly hours.
5. For the purpose of collecting weekly fees, the full fee or the cost of service, whichever is less, is due for the week if a participant receives any portion of the approved service hours during the week. If a participant receives no hours of service during a week, no fee is due.
6. In the case of a husband and wife who both receive services in the Act 150 Program, separate calculations need to be made for each. This is to result in each participant having a fee established based on the sliding fee scale.

SCs shall complete fee determinations at the following intervals:

- I. Every 12 months, or
- II. When the SC learns of a change in circumstance that could affect the fee calculation.

It is the responsibility of the participant to notify the SC or service coordination entity if their personal circumstances change warranting a reevaluation of the fees to be applied. Failure to make such a notification could result in the recalculation of fees and require payment of the fees calculated back to the point in time when the circumstances changed. Failure to meet this requirement and pay any back fees owed will result in the termination of services.

General Requirements Related to Fee Determination and Redetermination

1. The SC shall inform applicants orally and in writing of the fee policy during the initial assessment visit. The SC shall include in the notification that Act 150 Program services may be terminated if payment is not received according to the payment schedule. A copy of the participant's responsibilities related to Act 150 fee payments is to be given to the participant at the initial visit. This information is included in the OLTL Bulletin on participant information materials. The written notification of termination of services shall include a Notice of Service Determination and the Right to Appeal (MA 561) form.
2. SCs shall provide participants with an annual reminder of the agency's payment schedule and the fee policy. A copy of the reminder must be placed in the participant's file.
3. Participants are to be given the Notice of Service Determination and the Right to Appeal form (MA 561) at the time of the initial fee determination and any subsequent fee determinations that result in an increase in fees. The MA 561 can be found at: [MA 561 Form](#)
4. Participants may appeal the calculation of the fee.
5. Participants cannot appeal the application of the fee for attendant care services provided through the Act 150 Program.

Collection of Act 150 Participant Fees

SCEs are responsible for collecting participant weekly fees from Act 150 Program participants and submitting them to the Commonwealth consistent with the most recent OLTL Bulletin regarding the Act 150 Program Sliding Fee Scale. See current Act 150 Program Sliding Fee Scale Bulletin issued by OLTL at: [OLTL Bulletins](#).

Blank copies of the monthly Act 150 Participant Fee Report "Under Age 60" and Participant Fee Report "Age 60 and Over" are included in that Bulletin.

Delinquent Fees

SCEs shall use the following procedure when a participant is delinquent in the payment of assessed fees:

1. SCE staff shall contact a participant in writing who is 2 weeks late in the remittance of fees to remind the participant of the obligation to remit the fees according to the prearranged schedule and to determine if a situation has developed that would temporarily prevent the participant from paying the fee.

2. When a participant is 3 weeks late in the remittance of fees and has not remitted fees after being contacted, SCE staff shall notify the participant in writing that failure to make prompt payment within 1 week from the date of the letter can result in termination of the participant's Act 150 Program services. SCE staff shall offer the participant the opportunity to negotiate a payback schedule for past-due fees.
3. SCE staff shall terminate the enrollment of a participant who is 4 weeks late in the remittance of fees, and has not made arrangements for the remittance of late fees following issuance of the letter referenced above. SCE's shall provide the participant with the necessary information related to Hearings and Appeals. See OLTL Bulletin regarding Hearings and Appeals at: [OLTL Bulletins](#)
4. SCE staff shall place in the participant's file, copies of correspondence and forms generated in the collection of late fees. SCE staff shall document in HCSIS in the service notes all communications regarding delinquent fees and agreements for remittance of late fees. This includes telephone calls related to late fees and an agreed-upon payback schedule. If the participant leaves the Act 150 Program with outstanding fees owed, the SCE staff shall make a note of the balance due in the final Plan Comments in HCSIS.
5. Individuals reapplying for Act 150 services who have outstanding prior fees are not to be reenrolled in the Program until the outstanding fees are paid.

Countable Income

Includes the following sources of actual family income received:

1. Money, wages or salary earned by family members 14 years of age or older before deductions for taxes, Social Security, bonds, pensions, union dues, health insurance, and similar purposes for work performed as an employee including commissions, tips, piece rate payments, and cash bonuses.
2. Armed Forces pay which includes base pay plus cash housing and subsistence allowances but does not include the value of rent-free quarters.
3. Voluntary or court-ordered support received by a present or former spouse.
4. Voluntary or court-ordered child support.
5. Gross income from self-employment, farm or non-farm. (Gross income is determined by deducting the verified costs of producing or continuing the income from the gross receipts.)
6. Gross income from the rental of real property. (Gross income is determined by deducting the verified costs of producing or continuing the income from the gross receipts.)

7. Social Security retirement benefits, survivors' benefits, children's Social Security benefits, permanent disability insurance payments, and special benefit payments made by the Social Security Administration before deductions of health insurance premiums.
8. Supplemental Security Income (SSI) payments received by a minor or adult child identified as a dependent under the Fee Determination and Re-determination section above.
9. Railroad retirement, disability, and survivors' benefits payments made by the United States Government under the Railroad Retirement Act of 1974 (45 U.S.C.A. Sections 231 -231v) before deductions of health insurance premiums.
10. Private pensions and annuities, including retirement benefits paid to a retired person or that person's survivors by a former employer or by a union, directly or through an insurance company, individual retirement accounts or other similar insurance company, individual retirement accounts or other similar retirement payment products.
11. Government employee pension payments received from retirement pensions paid by federal, state, county, or other governmental agencies to former employees including members of the Armed Forces or their survivors.
12. Unemployment compensation received from governmental unemployment insurance agencies or private companies during periods of unemployment and strike benefits received from union funds.
13. Workers' compensation received from private or public insurance companies for injuries incurred at work. The cost of this insurance must have been paid by the employer and not by the worker.
14. Payments made by the Veterans Administration to veterans or their families.
15. Dividends, including dividends from stock holdings or membership in associations.
16. Interest on savings or checking accounts and bonds.
17. Income from estates, trust funds and settlements.
18. Income from gas or oil leases, royalties, signing bonuses or other related income.

Excluded Income

Sources of income excluded in determining family monthly income are:

1. Earned income of a child as follows:
 - I. Earned income of a child less than 14 years of age.
 - II. Earned income of a child who is under 18 years of age and a full-time student.
2. Proceeds from the sale of property, such as a house or a car, unless the person was engaged in the business of selling such property, in which case the net proceeds would be counted as income from self-employment.
3. Borrowed money.
4. Tax refunds or rent rebates from any source.
5. Gifts.
6. The value of food stamp benefits in an Electronic Benefit Transfer (EBT) card available under the Food Stamp Act of 1977 as amended by (Public Law 108–269, July 2, 2004). This program is also referenced as the Supplemental Nutrition Assistance Program (SNAP). These benefits are included electronically in an ACCESS card for Pennsylvania recipients.
7. The value of donated foods.
8. The value of supplemental food assistance under the Child Nutrition Act of 1966 (as amended by Public Law 111- 296-Dec 13, 2010) known as the “Healthy, Hunger-Free Kids Act of 2010”, (U.S.C.A. Section 171 1-1785) and the special food service programs for children under the National School Lunch Act (as amended through Public Law 112-55- November 18, 2011), known as the Richard B. Russell National School Lunch Act.
9. Loans and grants, such as scholarships, obtained and used under conditions that preclude their use for current living costs.
10. Grants or loans to an undergraduate student for educational purposes.
11. Payment received under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (42 U.S.C.A. Sections 1415, 2473, 3307, 4601, 4602, 4621-4638, and 4651-4655; 49 U.S.C.A. Section 1605).
12. Home produce used for household consumption.

13. The value of rent-free quarters.
14. Foster care payments by a state agency.
15. Employee reimbursements for travel or other expenses to the extent that the reimbursement does not exceed the expense.
16. Income from reverse mortgages.

Support Deduction

When calculating the Act 150 weekly fee, SCs shall subtract from the family monthly income the amount of support paid by individuals included as family members as follows:

1. Voluntary or court-ordered support paid by the participant, spouse or adult child to a present or former spouse not residing in the participant's household; or
2. Voluntary or court-ordered support paid by the participant, spouse or adult child for a child who is not residing in the participant's household.

Participants shall provide verification of the expense in order to receive the deduction.

Medical and Disability Expense Deductions

When calculating the Act 150 weekly fee, SCs shall subtract from the family monthly income the amount of family monthly medical and disability expenses paid by individuals included as family members. The following provisions apply in determining allowable deductions:

- The amount considered is the actual, anticipated, or obligated monthly amount.
- The expense is the responsibility of the family and is not paid or will not be paid by a third party.
- Anticipated monthly medical and disability expenses must be based upon previous or present documented medical obligations or documented cost.
- Expense deductions may be included in the calculation only if the SC places a copy of the bill or paid receipt in the participant file. One month's receipts are required for recurring medical expenses.
- If installment payments are made, the amount considered is the actual amount paid per month. (If installment payments are made, the SC shall document in the Act 150 Fee Determination/Redetermination Form the beginning and ending dates of the payments and the initial amount of obligation. SCs are to attach additional

information to the form as necessary to document installment payments/payment plan, as well as documenting information in the Service Notes in HCSIS.)

- The participant fee for Act 150 services established under this part is **not** considered as an expense deduction.

The following expenses are considered in determining family medical and disability expense deductions:

- Doctor(s), including psychiatrists or psychologists.
- Providers of mental health treatment.
- Hospital care.
- Dental care.
- Eye care.
- Health care premiums.
- Prescription drugs and insulin.
- Prosthetic devices.
- Durable medical equipment (purchase, repair, maintenance or maintenance agreements).
- Vehicle and modification expenses that are unique to a disability.
- Home modifications that are unique to a disability.
- Clothing modifications that are unique to a disability.
- Medical supplies related to the care and treatment of a medical condition.
- Incontinence products related to a disability.
- Other reasonable medical or disability expenses that would not have been incurred in the absence of a disability.
- Certain service animal expenses such as, the cost of purchasing or acquiring a dog, but not other costs such as maintenance of the dog (i.e., food, veterinary costs, chew toys, shampoo, dog collars, dog brush, nail clippers, heart/tick medicine, medical procedures). (See Guidance on Service Animals.)

- Medical transportation expenses that are not subject to reimbursement by a third party.
- Medical transportation expenses, which may include the following:
 - The actual cost of public transportation.
 - 12 cents per mile while driving their own vehicle.

NOTE: If the applicant/participant fails to cooperate in providing verification, services can be denied or terminated with proper notice. If the applicant/participant fails to cooperate in providing verification of medical expenses, eligibility will be determined without a deduction for the medical expense(s) in question.

Items Not Allowable as Expense Deductions

SCs may not consider the following items as family medical or disability expense deductions:

- Cellular telephones, Internet access services, home monitoring or security systems, medical alert systems.
- Food items.
- Vehicle insurance, except the cost of insurance relating to vehicle modification expenses that are unique to a disability.
- Vehicle expense not expressly related to a disability, such as tires or maintenance or an accessible van.
- Expense for services similar to Act 150 Program or companion services procured at a participant's choices, which are over and above the services authorized by the Act 150 Program.
- Supplemental hourly payments or bonuses made to a PAS worker, which are over and above the payments authorized by the Act 150 Program.
- Luxury items, such as swimming pools, home spas or home exercise rooms, even if recommended by a physician.

Guidance on Service Animals

In the United States, the applicable law covering places of public accommodation is the Americans with Disabilities Act of 1990. In 2010, the U.S. Department of Justice, Civil Rights Division, Disability Rights Section issued "ADA 2010 Revised Requirements; Service Animals." It states that:

"Service animals are defined as dogs that are individually trained to do work or perform tasks for people with disabilities. Examples of such work or tasks include guiding people who are blind, alerting people who are deaf, pulling a wheelchair, alerting and protecting a person who is having a seizure, reminding a person with mental illness to take prescribed medications, calming a person with Post Traumatic Stress Disorder (PTSD) during an anxiety attack, or performing other duties. Service animals are working animals, not pets. The work or task a dog has been trained to provide must be directly related to the person's disability. Dogs whose sole function is to provide comfort or emotional support do not qualify as service animals under the ADA."

This revised federal definition excludes all comfort animals, which are pets that owners keep with them solely for emotional reasons that do not ameliorate their symptoms of a recognized "disability"; animals that do ameliorate the conditions of a medical disability, however, such as animals that ameliorate the symptoms of post-traumatic stress disorder, are included in the definition. Unlike a service animal, a comfort animal is one that has not been trained to perform specific tasks directly related to the person's disability. Common tasks for service animals include flipping light switches, picking up dropped objects, alerting the person to an alarm, reducing the anxiety of a person with post-traumatic stress disorder by putting its head on the patient, or similar disability-related tasks. A service dog may still provide help to people with emotions related to psychiatric disabilities, but the dog must be trained to perform specific actions, such as distracting the person when he or she becomes anxious or engages in stimming or other behaviors related to his or her disability.

The U.S. Department of Justice permits businesses to ask two questions:

1. Is this a service dog required because of disability?
2. What is it trained to do to mitigate the disability?

In determining if the animal is a service animal these questions need to be answered to ensure their function is that of a service animal and not a comfort animal or pet. The reasons for service animal status need to be documented in the participant's service plan, on the Act 150 Fee Determination/Redetermination Form and in service notes in HCSIS.

Attachments

1. Act 150 Fee Determination/Redetermination Form
2. Your Sliding Fee Scale Responsibilities as an Act 150 Program Participant