

State of Tennessee
Department of Disability and Aging (DDA)

**Medicaid Alternative Pathways to Independence
(MAPs)**

PROGRAM RESOURCE MANUAL

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IN.1. Welcome

Thank you for your participation as a provider in the Tennessee system of MAPs programs for people with ID/DD. An adequate network of providers with the ability to deliver quality services and support. DDA is appreciative of you and your agency has made the choice to participate in the MAPs program. We look forward to working with you to ensure that the MAPs experience is the highest quality possible.

IN.2. Development, Update and Distribution of the Provider Manual.

IN.2.a. Development. This resource manual was developed by staff of the Department of Disabilities and Aging (DDA). Many stakeholders, including providers of all types, provider organizations, people who use MAPs supports, family members and advocacy organizations, were involved in the development and review of this manual. We extend our sincere thanks for the patience and willingness to devote time and energy to the completion of this resource manual. This is the initial development of the resource manual and supersedes all other developed resources and manuals.

IN.2.b. Distribution. Primary responsibility for distribution of the manual and manual updates will rest with the Department of Disabilities and Aging. This manual will be available via the DDA MAPs website and available for distribution upon request to the DDA.MAPs@TN.GOV email address. DDA will also publish this manual in PDF formats for printable capacities.

IN.2.c. Update. The resource manual will be updated as needed to communicate changes in policy and program requirements. Changes in provider requirements that result in manual updates will require a public meeting and fiscal impact statement of applicable manual sections as required by state law. Providers will be notified of updates through official written correspondence.

IN.3. Purpose of Program Resource Manual.

The MAPs Program Resource Manual serves as the definitive resource for all MAPs participants, providers, stakeholders, and staff involved in delivering services/supports under the MAPs program. This manual has been clearly articulated empowering providers to deliver services/supports with precision and consistency, as well as empowering participants to self-advocate for the quality of MAPs services/supports to which they are entitled. It addresses the full spectrum of



programmatic needs, including enrollment, service definitions, billing processes, participant rights, incident reporting, and quality assurance standards.

Providers are expected to reference this manual as their primary source of guidance for all operational questions related to the MAPs program. By utilizing this manual, providers can ensure they are upholding the core values of the program, including person-centered care, adherence to regulatory requirements, and alignment with the program's broader mission of promoting independence for individuals with intellectual and developmental disabilities (ID/DD). It is not only a compliance tool but also a key resource for enhancing service delivery, problem-solving, and decision-making within the MAPs framework.

This manual also sets clear expectations for MAPs participants, providers, and stakeholders to remain informed about any revisions, updates, or policy changes. MAPs providers are responsible for staying current with the latest content of the manual, as updates will be issued on an annual basis or in response to critical changes within the program or its regulatory/legislative environment. The manual serves as a living document which evolves alongside the MAPs program, ensuring participants, providers, and stakeholders are equipped with the latest knowledge and tools necessary for program success.

Ultimately, the Program Resource Manual is designed to promote accountability, streamline processes, and ensure that all stakeholders operate in alignment with the MAPs vision. Providers are strongly encouraged to familiarize themselves with the contents of the manual thoroughly and to consult it regularly to address any questions or uncertainties which may arise during their involvement with the program. Consistent reference to this manual will support high-quality, compliant delivery of services/supports, thereby advancing the MAPs mission of helping participants achieve long-term independence where they reside, with their communities, and where they work.

IN.4. Organization of the Program Resource Manual

IN.4.a. Organization of Content. A table of contents is followed by an introduction and fifteen (15) chapters, each of which describes expectations and requirements related to a particular component of service delivery.

IN.4.b. Numbering System. A simple numbering system has been employed to ensure readability and ease in referencing sections and pages within chapters. The numbering system employed within the manual will be as follows:

1. "IN" is used to refer to sections within the Introduction.
2. Each chapter following the Introduction is numbered 1, 2, 3, etc.
3. Each chapter has sections numbered 1.1., 1.2., etc.
4. Subsections will be numbered 1.1.a., 1.1.b., etc.
5. Lists within sections and subsections will be numbered 1, 2, 3 or bulleted.
6. Appendices will be shown as Appendix A, Appendix B, etc.
7. Each page within a chapter will be numbered sequentially.
8. Tables and Illustrations will be numbered with the chapter number followed by the section number and subsection number if applicable.

IN.5. State and Federal Laws, Rules, Regulations

IN.5.a. Federal Laws, Regulations and Policy. The requirements of different programs are typically spelled out in state and federal laws, rules regulations and policies. Federal laws apply to DDA programs that utilize federal funding, such as the Medicaid Waivers. At the federal level, laws and statutes are passed by Congress and are incorporated in the United States Code Annotated (U.S.C.A.). A federal agency is designated to develop regulations that implement the laws or statutes. Federal regulations are published in the Code of Federal Regulations (C.F.R.). Rules are state agency directives that implement, interpret, or describe the procedure or practice requirements of an agency. Policies are generally a more detailed interpretation of regulations that are easier and less time consuming to change because policies generally do not have to go through a promulgation process, which involves public hearings and legal reviews. An example of federal policy is the State Medicaid Manual.

IN.5.b. State Laws, Regulations, and Policy. State laws or statutes are passed by the state legislature. When laws are passed or amended, a particular state agency is responsible for developing or changing state rules to implement the law. Tennessee laws or statutes are published in the Tennessee Code Annotated (T.C.A.). State departments or agencies are responsible for developing rules to implement the law and developing any policies that are needed to interpret the state rules. Rules are promulgated or passed by publishing the proposed rule in the Tennessee Administrative Register (TAR) for thirty days prior to a rulemaking hearing. Public



comments are accepted in writing after the proposed rule is published or interested parties may appear in person at the rulemaking hearing to support or voice any concerns about the proposed rule. If the proposed rule is necessary to public welfare, there are provisions that allow rules to be effective upon publication and promulgated within 90 days. In Tennessee, a statute exists that requires any DDA guidelines that are mandatory for providers to be promulgated like the way rules are promulgated. This manual is an example of mandatory DDA guidelines.

IN.5.c. Court Orders. Court orders may contain programmatic and policy requirements with which the state must maintain compliance.

IN.5.d. Conflicts between Laws, Rules, Regulations, and Policies. The State attempts to ensure that there is consistency in all the governing requirements for programs. However, laws and regulations may be changed, resulting in temporary conflicts that must be resolved all the way down to the policy level. When this occurs at the state and federal level, the language in the statute, rule or regulation governs. When the law and rules are consistent and the related policy is in conflict, the rule or regulation governs over the policy. If a federal law, rule or policy conflicts with a state law, rule or policy, the federal standard governs. States are not typically considered to be against federal requirements if they establish standards that are more stringent than the federal minimum requirement.

IN.6. MAPs Vision, Mission, and Values.

IN.6.a. MAPs Vision Statement. To empower individuals with disabilities through innovative support services and resources, fostering their independence, inclusion, and well-being in their areas of Home, Work and Community.

IN.6.b. MAPs Mission Statement. The MAPs program envisions a society where individuals with disabilities have equal opportunities, access, and support to lead fulfilling lives, realizing their full potential, and contributing actively to their communities through Technology and Provider-Less supports.

IN.6.c. MAPs Values. Values are the principles that apply to all levels of the service delivery system. Values guide the day-to-day decisions that are made in service delivery, as well as the decisions that are made related to the system as a whole. The following values are to be recognized and utilized by all partners in service delivery:

1. Honoring the individual rights of persons supported is crucial and must be maintained at all levels of the system. The Department is committed to assuring that the rights of persons using services are protected and

promoted, including rights afforded by the United States Constitution and the United Nation's Declaration of Human Rights.

2. Focus on persons supported must be maintained at all levels of the system. Persons supported are the most important participants in the system.

3. Effective service and support planning and coordination is crucial to the quality of life, health, and safety of persons supported.

4. Individual choices of persons are the foundation of service planning and delivery. It is incumbent on all individuals touching the lives of persons supported to ensure that they have the information needed to make informed decisions.

5. Opportunities to accomplish personal outcomes, live a meaningful life, and be included in the community are identified in the development and implementation of support plans.

6. Safety and security are essential to a person being able to achieve personal outcomes.

7. Risk identification and planning are essential to achieving a balance between allowing personal choice and protection from harm.

8. Respect of persons and the staff involved in direct delivery of their services is crucial at all levels of the system.

9. Professionalism of state and provider employees is essential to ensure the level of collaboration (guiding, coaching, modeling, and supporting rather than supervising, controlling and caretaking) in the provision of services that will result in achievement of personal outcomes. Expectations for achievement are high and it is expected that services are not intrusive or demeaning.

10. Person- and family-friendly information is necessary to promote understanding, choice, and ownership of the service delivery system. Training opportunities for persons supported and their families are needed to ensure understanding and appropriate utilization of services within the system.

11. Reliable and valid data and information must be easily accessible to all stakeholders to promote understanding of the system, identification of problems and issues and planning for effective ways of improving the system.

12. Stakeholder input is essential to developing and maintaining service delivery mechanisms that meet the needs of persons served from an operational standpoint and that ensure smooth implementation of changes in policy and operational procedure.

13. Systems change and quality improvement (QI) opportunities that benefit persons must be identified and implemented on an ongoing basis. Systemic issues, provider compliance issues, and individual problems must be identified, analyzed, and resolved in an organized, timely manner.

14. Innovative approaches that ensure the best use of available public funds must be employed to ensure that the maximum number of people have access to needed services.

15. Compliance with applicable state and federal statutes, rules, regulations and policies is necessary to ensure that adequate funding is available to provide access to services.

16. Quality assurance (QA) monitoring must be focused on achieving desired outcomes and ongoing compliance. Changes in quality monitoring must be accomplished in an organized manner that ensures stability of the system.

17. Effective provider training and technical assistance opportunities are necessary to ensure that providers achieve and maintain desired outcomes and programmatic compliance.

18. Equity must be achieved and maintained in the provision of services and treatment of providers.

19. Provider payment rates must be such that an adequate provider network is maintained, and quality services are possible within available State appropriations.

IN.7. MAPs Introduction.

The Medicaid Alternative Pathways to Independence (“MAPs”) Program Service Manual is a comprehensive guide designed to support providers, participants, and stakeholders in understanding and implementing the services/supports and procedures which guide the MAPs program. Officially implemented by the Department of Disability and Aging (“DDA” or “Department”) in 2025, this manual outlines the standards and expectations for delivering high-quality, person-centered services/supports to people with intellectual and developmental disabilities (I/DD). The MAPs program is committed to fostering independence, employment, and community engagement through innovative service delivery models.

This manual will be regularly updated to reflect evolving program goals, policy changes, and best practices. Revisions will occur on an annual basis or as needed in response to regulatory/legislative updates, stakeholder feedback, or changes in service offerings. Providers are encouraged to stay informed of all revisions to ensure continued compliance and alignment with MAPs program objectives.

This manual is intended to serve as the primary resource for providers and staff involved with the administration of MAPs services/supports. It serves as a foundational tool for understanding program requirements from participant eligibility to service delivery, incident reporting, and auditing procedures.

Overview of the MAPs Program: MAPs is a program which will set people with I/DD on a path to learn skills to help them work, live independently, learn about their neighborhoods, and find hobbies that interest them. MAPs services/supports give people enrolled in the program the tools, technology, and support they need to meet the goals they set for themselves.

This program is primarily targeted to anyone with an I/DD diagnosis who has either graduated high school or will graduate within three years, however MAPs services/supports are not limited to high school students. MAPs participants cannot be enrolled in another long-term services and supports ("LTSS") program including Employment and Community First ("ECF") CHOICES, Choices, the Katie Beckett program, or 1915(c) waivers.

Who is Eligible for MAPs?

MAPs is funded to serve up to 1250 people with I/DD either exiting the school system or who have recently exited and may be waiting for traditional waiver services/supports.

The MAPs program will provide a person with I/DD with:

- Identifying people and places in local communities who share like interests or that align with future goals.
- Learning how to harness the power of accessible and affordable technologies to foster functional independence.
- Navigating and traveling independently in the community and building natural support networks.
- Independent living skills.

IN.8. Key Definitions.

1. **Assistive Technology:** Any item, piece of equipment, software program, or product system specifically designed to increase, maintain, or improve the functional capabilities of people with disabilities and assist people in carrying out activities of daily living.
2. **Collaborative Roundtable Team:** This is the MAPs participant direct support team. This team includes MAPs person supported, stakeholders/family members, provider agency support staff, innovation coordination agency staff and anyone else the MAPs person-supported would like to include.
3. **Conflict Resolution:** A structured process to resolve disputes between MAPs participants, providers, or stakeholders, ensuring fair and equitable outcomes.
4. **DDA MAPs Team:** These are the staff hired through DDA to oversee and support MAPs participants. This can include Regional Transition Guides, Enabling Technology Champions, Housing Specialists, Employment Specialists, Benefits Counselors.
5. **Disenrollment:** The process by which a participant exits the MAPs program, either voluntarily or involuntarily, based on eligibility or program compliance.
6. **Enabling Technology ("ET"):** Assistive devices or software solutions which assist people with disabilities perform tasks, increase independence, and engage in employment or community activities.
7. **Exception Request:** A formal consideration submitted by an Innovation Coordinator to seek approval for deviations from standard MAPs program procedures or guidelines. These requests are made to address unique or extraordinary circumstances which may impact a participant's ability to meet program requirements or benefit from standard support. Exception requests are considered on a case-by-case basis to ensure participants receive the necessary flexibility and support to achieve their goals within the MAPs program.
8. **Family Member:** An immediate a person who, by birth or marriage, is related to the MAPs participant.
9. **Incident Reporting:** The formal process by which providers report any incidents which impact the health, safety, or well-being of MAPs participants.



10. **Innovation Coordinator ("IC"):** The person/entity who oversees the development and implementation of the PSCP process and applicable MAPs services/supports. The IC services are delivered through contract agreements from the Department and community vendors.
11. **MAPs Program (Medicaid Alternative Pathways to Independence):** A program designed to provide short-term, outcome-focused services/supports to people with I/DD to promote long-term independence through employment, technology, and community-based supports.
12. **Milestone** The selected goal for the MAPs participant based on the menu of available milestones. The MAPs curriculum contains 12 distinct milestones from the outcome areas of Home, Work, and Community. Each participant will select a series of milestones each year to be incorporated within the PSCP, and these will be the goals the provider assists the participant in achieving.
13. **Milestone Payment:** A payment model based on achieving specific, measurable outcomes (milestones) in the delivery of services/supports under the MAPs program.
14. **On-Hold Status:** Any period in which a person supported is unable to participate in the MAPs program or service(s). "On-Hold" typically means the participation or involvement of the person supported is temporarily suspended or put on hold. This could be due to various reasons, such as personal emergencies, medical issues, family emergencies, provider capacity, and/or other unforeseen circumstances which prevent the person from actively engaging in the program or service(s).
15. **Participant:** A person receiving services/supports under the MAPs program, typically someone with an I/DD.
16. **Peer Mentor:** A person who has lived experience with disabilities and provides guidance, support, and mentoring to MAPs participants to help them achieve their independence goals.
17. **Person-Supported Collaborative Plan ("PSCP"):** A personalized framework designed to empower a person by actively involving him/her in the planning and decision-making processes regarding his/her care and support. The PSCP emphasizes collaboration between the participant, his/her support network, and service providers, ensuring services/supports are tailored to meet the person's unique goals/milestones and needs.
18. **Safety Devices:** Tools and systems specifically designed to protect people from harm and ensure their well-being, particularly in situations where they may be vulnerable. For people with I/DD, safety devices might include home



security systems, fire extinguishers, safety ladders, helmets and gloves, certain kitchen utensils, first aid kits, etc. This list includes examples of safety devices but is not comprehensive. These devices help to monitor the person's environment and provide immediate assistance or intervention in case of emergencies, enhancing their overall safety and security.

19. **Service Definition:** A detailed description of the service(s) offered under the MAPs program, outlining eligibility, service objectives, and specific activities covered.
20. **Service Provider:** An agency or individual contracted to deliver services/supports under the MAPs program responsible for adhering to program guidelines, billing procedures, and quality standards.
21. **Quality Assurance ("QA"):** A system of processes and procedures to ensure services/supports provided under the MAPs program meet established standards of quality, compliance, and participant satisfaction.
22. **Validation:** Validation in a program delivering services/supports to people with I/DD refers to the process of confirming and verifying a participant has completed a goal or task. This process involves assessing evidence of completion to ensure it meets predefined standards or criteria. Validation ensures the accuracy and legitimacy of reported achievements, reinforcing accountability and progress within the program.
23. **Value-Based Payment ("VBP"):** A payment model that ties provider compensation to specific outcomes or performance metrics, rather than a fee-for-service model.

Chapter 1:

Eligibility, Enrollment and Disenrollment

The MAPs program is committed to equitable access while maintaining rigorous standards to ensure services align with participant needs and program objectives. Eligibility is determined through a collaborative, person-centered assessment process that evaluates factors such as age, disability or aging-related support requirements, and residency. Applicants must meet predefined criteria outlined by the Department of Disability and Aging (DDA) and provide necessary documentation to verify eligibility, ensuring transparency and compliance with federal and state guidelines. Enrollment is initiated once eligibility is confirmed, with participants and providers partnering to develop individualized service plans that outline milestones, supports, and timelines. The process emphasizes clear communication, with providers responsible for explaining program expectations, rights, and responsibilities to participants and their families. Exceptions or expedited enrollment may occur in urgent cases, provided they adhere to DDA's equity and accountability frameworks.

Disenrollment from the MAPs program is governed by procedural integrity to safeguard participant rights and program continuity. Participants may exit voluntarily upon achieving their goals, relocating outside the service area, or transitioning to alternative supports. Involuntary disenrollment occurs only in exceptional circumstances, such as persistent non-compliance with program requirements or safety concerns, and follows a formal review process that includes written notice, opportunities for appeal, and referrals to appropriate services. Providers are tasked with maintaining thorough documentation throughout a participant's tenure, including exit summaries that capture progress and recommendations for future care. By prioritizing fairness and transparency, the MAPs program ensures that enrollment and disenrollment processes uphold dignity, minimize disruptions, and adapt to evolving participant needs.

1.1: Participant Enrollment and Eligibility

The "Participant Enrollment and Eligibility" section of the MAPs program resource guide explains how to join the program and who can participate. The MAPs program helps people with disabilities and others who need support to live more independently. In this section, you will find the important information about what makes someone eligible to join, what documents they need to provide, and the easy

steps to enroll. This will help make sure that anyone who qualifies can access the services and support they need to improve their lives.

1.1.a. Eligibility Criteria:

To participate in the MAPs program, people must meet specific eligibility criteria designed to ensure the program serves those who can benefit most from its services/supports. Participants must be diagnosed with an I/DD. The program is primarily aimed at people who are seeking to build greater independence in their daily lives through employment, community integration, and the use of Enabling Technology ("ET") solutions. MAPs participants must also be motivated to achieve personal milestones that align with the program's core goals of promoting long-term independence and reducing reliance on traditional LTSS.

In addition to these core criteria, participants demonstrate a willingness to engage with the MAPs program structure, which includes completing milestones, attending regular check-in meetings, and collaborating with their Innovation Coordinator ("IC"). Participants are expected to show progress over time and actively work toward achieving goals set out in their Individualized Person-Supported Collaborative Plan ("PSCP"). This helps ensure the program is supporting those who are both eligible and invested in their personal growth.

The following is an inclusive list of all considerations to determine eligibility within the MAPs Program:

- The person has a diagnosis of an I/DD, **AND**
- The person resides within the State of Tennessee (unless housed on the Fort Campbell Army Base), **AND**
- The person is *NOT* receiving other traditional LTSS, i.e. Employment and Community First ("ECF") CHOICES, Choices, the Katie Beckett program, or 1915(c) waivers, **AND**
- The person is within his/her last three (3) years of exiting a high school setting OR has already left a high school setting.

The Department will utilize Tennessee Code Annotated ("TCA") § 52-1-101 for determining criteria for I/DD diagnosis.

Participants enrolled in the Family Support Program OR Vocational Rehabilitation/Pre-Employment Transition Services are eligible to receive MAPs services/supports.

1.1.b.Enrollment Process:

The enrollment process for the MAPs program begins with the submission of an application, available on the DDA MAPs website. This process is managed by the DDA Intake Coordinator who oversees the application, eligibility determination, and initial enrollment steps for all prospective MAPs participants. Once an application is submitted, the applicant or his/her representative will receive automated correspondence that outlines the next steps. This correspondence will request identifying documentation to confirm the applicant's I/DD diagnosis. Acceptable forms of documentation include, but are not limited to, an Individualized Education Plan ("IEP"), a psychological evaluation, a physician's statement, a statement from the Social Security Administration ("SSA"), or any other official document that verifies the I/DD diagnosis.

After receiving the application, the Intake Coordinator has 30 days to begin reviewing the information and request any necessary supporting documentation. During this time, the Intake Coordinator will work closely with the applicant or his/her representative to collect the required documents. If the supporting documentation is not received promptly, then the Intake Coordinator will maintain communication with the applicant, making up to six contact attempts within a 90-day window. If, by the end of this period, the documentation confirming the I/DD diagnosis has not been submitted, the Intake Coordinator will determine the applicant ineligible for the program. A formal declination letter will then be sent informing the applicant of the decision.

If the applicant submits the required documentation within the allotted timeframe, then the Intake Coordinator will proceed with further eligibility checks. These checks include cross-referencing internal databases to ensure the applicant is not currently receiving other LTSS which could impact his/her MAPs eligibility. Additionally, the application will be reviewed to ensure all other specific program criteria are met, including residency and age requirements, as well as a demonstrated commitment to participating in the MAPs program.

Once all eligibility requirements are confirmed, the participant is officially enrolled in the MAPs program. At this point, the Intake Coordinator will refer the participant to the appropriate Innovation Coordination (“IC”) agency for further support and program engagement. This referral marks the beginning of the participant's journey through MAPs, where they will begin working toward milestones and greater independence with the help of MAPs services/supports.

1.2: What’s next for the Participant?

After you finish your application for the MAPs program, you will get a response email with instructions on how to send in the documents that proves your eligibility. This means you will need to provide some important documentation, such as medical records, school records - Individualized Education Program (IEP), therapy notes or assessments completed by a doctor, and any documents from the Social Security Administration. These documents help show that you meet the requirements to join the program.

Once you submit your documents, the MAPs Intake Department will check a few things, like your age, where you live, and make sure you are not already getting traditional long-term services or supports (like ECF, 1915c) . If everything looks good, you will be deemed eligible and enrolled in the program, depending on the available services. After you are enrolled, you will receive a welcome letter that includes links to training materials you should review before starting the program. This will help you get ready for the collaborative roundtable process, where you’ll work on developing your personal plan, matching with providers, and selecting your goals or milestones. Enrollment can be influenced by available funding.

1.3: Disenrollment (voluntary/involuntary)

The Medicaid Alternative Pathways to Independence Program (MAPs) exists to empower individuals with intellectual and/or developmental disabilities and their families through innovative, person-centered services. While the goal is always to foster long-term partnerships between participants, their support networks, and provider agencies, we recognize that circumstances may arise where services with a provider agency are discontinued. This could occur at the request of the participant or their supporter, or due to a provider agency's decision to end services. Regardless of the reason, the collective priority must be to uphold continuity of care



and ensure seamless transitions that protect the well-being of the individual and align with the program's time-sensitive service framework.

Disenrollment from the MAPs program can occur for both voluntary and involuntary reasons. The process ensures participants are transitioned out of the program smoothly and with appropriate communication to all parties involved.

- Continuity of Care as Our Foundation

MAPs services are time-sensitive, and interruptions risk compromising critical progress for participants. Services must continue without lapse during a transition, pending a formal court order or final decision by stakeholders. Provider agencies are expected to maintain delivery until a transition is finalized, even after notice of discontinuation is given. The Department of Disability and Aging (DDA) targets a maximum transition period of 30 days from notification to the activation of a new Person Supported Collaborative Plan (PSCP) amendment. This timeline reflects our shared obligation to act swiftly, responsibly, and in the participant's best interest.

- Timeliness in Action

When an Innovation Coordination Agency (IC) receives notice of intent to discontinue services, delays are not an option. Proactive planning begins immediately to identify new providers, update plans, and secure approvals. Waiting to initiate these steps risks gaps in care and undermines participant trust. All parties—participants, families, providers, and ICs—are urged to treat transitions with the urgency they demand.

- A Shared Commitment to Collaboration and Transparency

Open communication between providers, ICs, DDA, and participants is non-negotiable. Even amid transitions, monthly check-ins, evidence-based validations, and routine services must proceed uninterrupted. Payment for services remains contingent on completion of agreed-upon milestones; partial deliverables will not be reimbursed. By prioritizing transparency, we mitigate confusion and align expectations.

- DDA as a Partner in Problem-Solving

DDA staff stand ready to assist with complex transitions. However, ICs are expected to first exhaust all problem-solving pathways within their own agencies, including engaging the Circle of Support (COS) and leadership,

before escalating to DDA. This ensures efficiency and reinforces local accountability.

- **Documentation: The Backbone of Accountability**

Detailed case files are vital to protecting participants and justifying decisions. Should budget extensions be necessary, thorough documentation—including evidence of provider capacity challenges or external barriers beyond the participant’s control—will be reviewed to confirm all efforts were made to secure services. Clear records also safeguard against future disputes and inform process improvements.

1.3.a. Voluntary Disenrollment: Voluntary disenrollment occurs when a participant or authorized representative/conservator, if applicable, chooses to leave the program. This may happen for a variety of reasons, such as the participant no longer requiring the services/supports provided, moving out of the service area, or transitioning to another support program that better fits his/her needs. In these cases, participants, or their authorized representative/conservator, if applicable, must notify the MAPs Team in writing, allowing adequate time for the coordination of a smooth exit and any necessary referrals.

1.3.b. Involuntary Disenrollment: Involuntary disenrollment may occur under circumstances where continued participation is no longer feasible or appropriate. This can include reasons such as failure to meet eligibility criteria, violation of program rules or expectations, non-compliance with the PSCP, or consistent non-participation in required check-ins or services/supports. Additionally, involuntary disenrollment may occur if the participant's health or safety is at significant risk due to remaining in the program or if the MAPs Team determines another service is more appropriate for the participant’s needs. Participants and stakeholders are notified in advance of involuntary disenrollment decisions, and the MAPs Team works to ensure a transition to other services/supports, when possible.

In both voluntary and involuntary disenrollment cases, a detailed summary of the disenrollment, including the reasons and steps taken, will be documented.

Additionally, the Department has an appeals process in the event the participant or authorized representative/conservator, if applicable, feels as though the rendered decision was made in error.

1.4: Notice Requirements and Timelines

Both the provider agency and the participant or authorized representative/conservator, if applicable, play critical roles in ensuring smooth transitions in and out of the MAPs program, particularly during disenrollment or significant program changes. To maintain clarity and avoid disruptions in services/supports, specific notice requirements and timelines must be adhered to by all parties involved.

1.4.a. Provider Agency Notice Requirements: Provider agencies are responsible for submitting a formal notice to the participant or authorized representative/conservator, if applicable, and the DDA MAPs Regional Transition Guide) at least 30 days before discontinuing services/supports or disenrollment. This notice ensures the participant has ample time to transition to other services/supports without a gap in care. During these 30 days, the provider agency is still required to offer services/supports and assist in coordinating the handoff of services/supports to another provider or securing necessary resources for the participant.

In the case of an involuntary disenrollment initiated by the provider agency due to non-compliance or other issues, it is also the provider agency's responsibility to document and provide a written explanation to the participant or authorized representative/conservator, if applicable, and MAPs Team, outlining the reasons for this action. The provider agency must assist in facilitating a smooth transition to avoid disruption of services/supports for the participant during this notice period. Below is the expected protocol for continuous supports.

Discontinuing services to a MAPs participant is a last-resort action and should only be pursued after exhaustive problem-solving efforts. Provider agencies commit to delivering three-years of services in good faith, utilizing collaborative team meetings, mediation, and DDA resources to resolve challenges and ensure continuity of care.

Step 1: Written Notice to DDA - MAPs Director

The provider agency submits a written notice via email to the DDA MAPs Director, outlining:

- The decision to discontinue services pending identification of a new provider.

- Reasons for discontinuation (e.g., irreconcilable conflicts, safety concerns).
- Confirmation that internal problem-solving efforts were attempted (e.g., meetings, mediation, DDA collaboration).
- Clarification of whether discontinuation is contingent on a court ruling or an immediate termination request by the MAPs stakeholder/participant.

CC: The state director of the Innovation Coordination (IC) Agency must be copied on all correspondence.

Step 2: DDA Verification and Formal Stakeholder Notification

DDA Review:

- Upon receipt of the notice, the DDA MAPs Director confirms:
 - All problem-solving actions (e.g., team meetings, IC involvement, DDA division collaboration) were exhausted.
 - No viable alternatives remain to maintain the provider-participant relationship DDA will serve Formal Notification:

If efforts are confirmed as exhausted, DDA issues a formal discontinuation notice via email/mail to:

- The MAPs participant/stakeholder (person-supported).
- The IC Agency.
- Relevant DDA representatives.

The notice includes:

- The provider's decision and effective date of discontinuation.
- Next steps for transitioning services to include:
 - Provider Agency will continue to deliver services and supports through the transition period pending person-centered decision from MAPs participant/stakeholder OR court order.

Step 3: IC Agency Referral and PSCP Amendment

The IC Agency initiates a referral process to identify a new provider agency.

The IC Agency collaborates with the participant/stakeholder to:

- Evaluate potential providers.
- Facilitate introductions and transition planning.

The IC should send the PSCP to all providers in the region in the same email. CC'ing the RM and TG. With a script like this:

*TITLE: REGION-E/M/W, MEMBERID-Provider Referral-CLOSURE
DATE XX-XX-XXXX*

*Example: Middle Region, JAYCAM1234-Provider Referral-
CLOSURE DATE 7-17-2025.*

"(Person-Supported Name) is an enrolled MAPs participant seeking a new provider. Person-Supported is in Year (add year) of MAPs. (Validated Milestones include: (add validated milestones, PDI, and/or VCRM). Please respond to this email within the next 10 business days (enter end date here) with interest.

Additionally, the IC should provide the following script to the person-supported or COS:

What to Expect (Provider Matching Process)

Please see the attached document for sample questions when interviewing providers.

You may receive multiple phone calls or emails from providers over the next 10 business days. Please allow this time to meet with all providers and determine which provider is best for you.

To see providers available in your region, please see Provider Contact Information on our website: <https://www.tn.gov/disability-and-aging/disability-aging-programs/maps.html>

Please note that although a provider shows in your region, it does not necessarily mean that they are accepting referrals in your county. If you would like to contact providers that are accepting in your area, please follow up with me.

After the referral has closed, your IC will inform you of providers who indicated a match.

You will need to inform your IC of which provider you choose within 2 business days.

Once a provider has been chosen, your IC will contact you for next steps.

A Person-Supported Care Plan (PSCP) amendment is executed to formalize the new provider agency.

Step 4: Resumption of Monitoring by IC Agency

The IC Agency resumes ongoing monitoring of services to:

- Ensure participant satisfaction.
- Confirm the new provider's adherence to MAPs goals.
- Address any post-transition concerns.

1.4.b. Participant/Authorized Representative/Conservator Notice

Requirements: Participants or authorized representatives/conservators, if applicable, who wish to voluntarily disenroll from the program are encouraged to provide their 30-day notice, as well. This allows the provider agency and MAPs Team to coordinate a smooth transition and avoid gaps in service delivery. However, the Department will accept requests to terminate services/supports effective immediately, as MAPs is a freedom of choice program.

However, any devices or other equipment purchased through the ET solutions budget which were exclusively for the participant will remain with them, allowing them to continue using those tools independently of the program. Upon providing notice of disenrollment, the participant or authorized representative or conservator, if applicable, is encouraged to work closely with the provider agency and the IC to ensure all outstanding obligations, including returning any necessary equipment, are fulfilled within the appropriate timeline (i.e. 5 business days). **1.5: Provider/Participant Responsibilities during Disenrollment**

In the event of a disenrollment from the MAPs program, both providers and participants have specific responsibilities to ensure a smooth and organized transition. Disenrollment can occur voluntarily or involuntarily, and in either case, all parties must adhere to the established protocols to safeguard the participant's well-being and uphold the integrity of the program.

For participants, voluntary disenrollment may happen when they determine the MAPs program no longer aligns with their current goals or needs. The participant or authorized representative/conservator, if applicable, is strongly encouraged to notify the IC and the provider agency of the reasons for disenrolling and any expectations for continued services/supports until the disenrollment process is complete so the Department may address any systemic issues which may have influenced the decision to voluntarily disenroll, as well as update records associated with the participant and make any referrals to other services/supports outside of MAPs, if needed/desired. Additionally, participants or authorized

representative/conservator, if applicable, must ensure the return of certain programmatic devices originally provided by the MAPs program, as the Department will no longer provide funding for the data associated with the mobile device, loaned ET solutions, or tools required for service delivery. However, all equipment or solutions purchased using the participant's ET solutions budget exclusively will remain the property of the participant and do not need to be returned. Participants or authorized representative/conservator, if applicable, are encouraged to plan for any referrals to other services/supports outside of MAPs, if needed, through the IC.

Provider agencies are responsible for ensuring the participant is fully informed about the disenrollment process and its potential impacts on services/supports. In cases of involuntary disenrollment, such as when a participant no longer meets eligibility criteria or fails to comply with program requirements, provider agencies must promptly communicate the reasons for disenrollment to both the participant and the IC. Provider agencies are also responsible for supporting the participant's transition out of the program, including assisting in returning programmatic devices and connecting the participant to alternative community resources, if necessary. Provider agencies must update all relevant documentation, including progress notes and service delivery logs, and submit a final report to the IC for the participant's case file.

Finally, the IC oversees the initial coordination steps of the disenrollment process, ensuring both the provider agency and participant fulfill their responsibilities (i.e. communication expectations, transfer of records, etc.). The IC verifies any necessary documentation has been completed and program equipment has been returned, if applicable. Additionally, the IC ensures any remaining enabling technologies or devices purchased with the ET solutions budget remain with the participant. The IC's role ensures the participant's exit from the MAPs program is handled smoothly while promoting continuity of care through other community services/supports and updating all relevant documentation systems for thoroughness.

1.6: Transitioning Care After Disenrollment

When a participant is disenrolled from the MAPs program or transitions from one provider agency to another, it is essential to ensure a smooth and coordinated transition of care. This process helps maintain the participant's continuity of services/supports, minimizing disruptions and ensuring his/her needs continue to be met during and after the transition. The following requirements outline the roles



and responsibilities of both the current provider and the participant or authorized representative or conservator, if applicable, along with the MAPs Team, to facilitate a seamless transition to a new provider.

1.6.a. Provider Agency Responsibilities: When a change in provider agency is imminent, the current provider agency must work closely with the MAPs Team to ensure all relevant documentation, service records, and plans are up-to-date and accessible to the new provider agency. This includes ensuring the participant's PSCP, interaction summaries, progress notes, and any other key records are transferred to the new provider agency in a timely manner (within 14 business days of new provider acceptance). Provider agencies are expected to cooperate fully with the transition process, including participating in transition meetings, if necessary, to ensure the new provider agency has all the information needed to continue delivering quality services/supports.

The current provider agency must also maintain services/supports continuity until the official transition date, ensuring there is no gap in care. The current provider agency shall also communicate with the new provider agency regarding any specific challenges, ongoing supports, or adjustments to service delivery which may be beneficial during the transition. This open exchange of information helps the new provider agency prepare adequately for the participant's needs and preferences.

A change in provider agencies will initiate a PSCP amendment in which a new provider agency will begin delivering services/supports. When an amended PSCP has been developed for the participant, the previous provider agency will not be able to submit milestone validation requests.

1.6.b. Participant or Authorized Representative/Conservator, if Applicable, Responsibilities: Participants or their authorized representatives/conservators, if applicable, are strongly encouraged to actively participate in the transition process by communicating any relevant personal experiences, support preferences, and goals with the new provider agency, ensuring a person-centered approach continues without disruption. Participants or authorized representative/conservators, if applicable, are also strongly encouraged to engage in any planning meetings or discussions with the MAPs Team to facilitate a successful transition.

1.6.c. IC Responsibilities: One of the IC's first tasks during the transition is to conduct a comprehensive review of the participant's PSCP. This includes validating all previously completed and requested milestones to ensure the participant's progress is accurately documented. The IC must confirm each milestone has been appropriately met and documented according to MAPs program requirements. This validation ensures the participant's new provider agency has a clear understanding of where the participant is in their service journey, which milestones have been achieved, and what remains to be accomplished.

In addition to milestone validation, the IC is responsible for coordinating with both the current and incoming provider agencies to ensure the transfer of all necessary information. This includes sharing any critical details related to the participant's goals, achievements, support preferences, and any challenges encountered during their time with the current provider. The IC must also confirm the participant's budget tracker is up to date, reflecting the remaining funds and any future services/supports that are planned based on milestone completion.

Throughout the transition process, the IC acts as the primary liaison between the participant, the current provider agency, the new provider agency, and the MAPs Team. They oversee transition meetings, facilitate discussions regarding the participant's progress and service/support needs, and ensure all parties are aligned on the participant's goals moving forward. By maintaining open communication and ensuring accurate, validated records, the IC helps prevent any disruption in the participant's services/supports and ensures a person-centered approach remains at the forefront of the transition.

1.6.d. DDA MAPs Team Responsibilities: The MAPs Team plays a key role in overseeing the entire transition process by ensuring both the current and new provider agencies are adhering to all procedural requirements and maintaining the participant's best interests. The MAPs Team also ensures all necessary documents are transferred and coordinates any necessary transition meetings. Additionally, the MAPs Team works closely with the participant to address any concerns or questions during the transition, ensuring the participant feels supported throughout the process.

By establishing a clear process for transitioning care, the MAPs Team ensures participants continue to receive individualized, high-quality services/supports during periods of provider agency change or disenrollment.

1.7: Re-Enrollment and Continuity of Care

Re-Enrollment and Continuity of Care: Participants who leave the MAPs program, either voluntarily or involuntarily, have the option to reapply for re-enrollment. When a person seeks re-entry into the program, his/her application will be processed in the order in which it is received, ensuring fairness and transparency with the intake process. However, if a participant is re-enrolled, then he/she will resume his/her participation from where he/she left off with the remaining time allocated based on the program's three-year duration. This ensures people do not lose the progress they have made and can continue working towards the milestones that were set during their initial enrollment period.

The MAPs program emphasizes continuity of care, meaning that participants who return to the MAPs program after a leave will not be expected to start over, but will instead pick up where they left off maintaining their established goals and supports (or new milestones may be selected through the collaborative roundtable process selecting from milestones which have not been validated). This approach helps safeguard the participant's journey toward greater independence and ensures any previous investments in skill-building, technology utilization, or employment progress are preserved. MAPs providers will also continue to track progress based on the participant's existing milestone achievements, allowing for a smoother re-integration into the program.

In cases where a participant leaves the MAPs program a second time, either voluntarily or involuntarily, any future re-enrollment requests will be subject to additional operational approval from a designated DDA representative, such as the Commissioner or designee. This additional layer of approval ensures participants are carefully considered for re-entry, especially in cases where previous exits from the program may indicate challenges with commitment or program engagement. This process ensures the integrity of the program while maintaining a person centered approach to supporting individuals. Ultimately, the goal of the MAPs program is to provide a structured, yet flexible path to independence, and re-enrollment processes reflect this commitment. By allowing participants to return and continue their progress, while also establishing necessary protocols for future



admissions, the MAPs program ensures each person receives the services/supports needed to succeed, balanced with thoughtful oversight to protect program integrity.

1.8: Participant Communication and Collaboration with MAPs Team

In the MAPs program, the participant is the central figure and primary decision-maker steering his/her journey toward greater independence and personal goals. Unless a court-appointed conservator has been identified and authorized to make decisions on the participant's behalf, all decision-making and programming should flow through the participant. This person-centered approach is essential to ensuring the services/supports provided align with the person's preferences, needs, and goals. The MAPs program empowers participants to be actively involved in shaping their experience, making them responsible for communicating their needs and decisions with all relevant stakeholders.

Participants, along with their conservators or authorized representatives, if applicable, are expected to maintain regular communication with the provider team, MAPs professionals, and other involved stakeholders. This communication is critical to ensuring services/supports are delivered as planned, adjustments are made when necessary, and any challenges are addressed promptly. Whether through in-person meetings, phone calls, or virtual communications, participants must stay engaged and actively participate in the ongoing dialogue about their services/supports.

Participants are expected to commit to receiving specific services/supports, either in-person or virtually, based on their established MAPs journey. Consistent and clear communication regarding service preferences, availability, and progress is vital to ensuring the program's success. Participants shall notify their provider team if there are changes in their needs or circumstances, and in turn, the provider team will work collaboratively to adjust services/supports, as necessary. This ongoing communication is key to promoting transparency, trust, and mutual responsibility in achieving the participant's goals.

Through regular, proactive communication, the MAPs program creates a collaborative environment where the participant's voice is central to every decision. This expectation of open and continuous dialogue allows for the delivery of tailored services/supports which meet the participant's unique needs, ultimately guiding them toward a more independent and fulfilling life.

1.9: Ethical Standards and Code of Conduct

The MAPs program is committed to fostering an environment of respect, integrity, and accountability. Participants, along with their conservator(s) or authorized representative(s), if applicable, are expected to adhere to these ethical standards and codes of conduct as they engage with the program. These principles are designed to ensure all people involved in the MAPs journey contribute positively to the participant's progress and well-being while maintaining respectful, transparent, and ethical interactions with all team members.

1. Respect for Autonomy:

Every MAPs participant has the right to make decisions about his/her own life and services/supports, with the understanding that their choices guide the program. Conservator(s) or authorized representative(s), if applicable, must respect this autonomy by supporting the participant's ability to make informed decisions, unless they are legally appointed to act on the participant's behalf. The participant's voice should always be prioritized, ensuring decisions are made in his/her best interest.

2. Honesty and Transparency:

All communications between participants, stakeholders, and the MAPs provider team must be honest and clear. Whether related to service preferences, milestones, or challenges encountered, full disclosure is necessary to foster trust and promote positive outcomes. Misrepresentation or withholding of information undermines the integrity of the participant's progress and is not acceptable.

3. Accountability and Responsibility:

Participants are responsible for ensuring they actively engage in their MAPs journey. This includes attending scheduled services/supports, responding to communications from the provider team, and completing required documentation or assessments. Authorized representative(s)/conservators, if applicable, are expected to help facilitate this process by ensuring participants meet their responsibilities and by offering support where needed.

4. Respectful Communication and Conduct:

Mutually respectful interactions are essential to the success of the MAPs program. MAPs provider team members, and participants, along with their conservator(s) or authorized representative(s), if applicable, shall communicate in a manner which is always courteous and professional. Disrespectful or harmful language or actions toward any member of the MAPs provider team or other participants by a participant or their conservator(s) or authorized



representative(s), if applicable, will not be tolerated and may result in reevaluation of program participation. Disrespectful or harmful language or actions by a provider team member toward a MAP's participant or his/her conservator(s) or authorized representative(s), if applicable, will not be tolerated and may result in reevaluation of the provider contract.

5. Confidentiality:

Protecting the privacy of participants and their personal information is of utmost importance. Participants, along with their conservator(s) or authorized representative(s), if applicable, are expected to respect the confidentiality of all interactions and information shared within the program. This includes safeguarding the participant's own information, as well as that of others within the program.

By adhering to these ethical standards and codes of conduct, participants, along with their conservator(s) or authorized representative(s), if applicable, help to ensure a productive and supportive environment, enabling the MAPs program to function effectively and deliver meaningful, participant-driven services/supports.

Chapter 2:

Rights Applicable to All People with ID/DD

The "Rights Applicable to All People with ID/DD" section of the MAPs program resource guide is designed to highlight the fundamental rights that individuals with intellectual and developmental disabilities (ID/DD) possess. This section will delve into key areas such as licensure rights, which ensure that services provided to individuals are delivered by qualified professionals, and the importance of freedom of choice, empowering individuals to make decisions about their own lives and care. Additionally, it will emphasize the critical role of service providers in promoting and respecting the individual rights of those they serve.

Moreover, this section will outline the processes for complaint resolution and grievances, ensuring that participants have clear avenues for voicing concerns and seeking redress. It will also address how individuals and their families can initiate appeals if they disagree with decisions made regarding their care or services. Finally, the section will provide a concise overview of important concepts related to decision-making, including conservatorship, supported decision-making, and the roles of power of attorney and healthcare surrogates. By understanding these rights and processes, individuals with ID/DD and their families can better advocate for themselves and ensure their voices are heard in their care and support.

2.1: Licensure Rules Pertaining to Rights of Persons Supported

In the MAPs program, licensure rules play a vital role in ensuring that the rights of persons supported are upheld and that they receive quality services. These rules establish the standards that service providers must meet to operate legally and effectively. This includes adherence to regulations set forth by the Centers for Medicare & Medicaid Services (CMS), which dictate the frequency, intensity, and availability of supports provided to individuals. All participants in the MAPs program are entitled to receive services that align with these regulations, ensuring that their needs are met in a consistent and reliable manner.

While every individual has the inherent right to make choices about their care and support, it is important to recognize that these choices are influenced by the availability of services and resources within the community. For instance, simply wanting a particular service does not guarantee its availability, nor can new services and rate structures be developed solely based on personal preferences or rights.

Providers must operate within the framework of existing licensure requirements and available funding, which can sometimes limit the options accessible to individuals. Therefore, while the MAPs program prioritizes the right to choose, it also emphasizes the importance of balancing these choices with the practical realities of service availability. Ultimately, this approach ensures that all participants receive the appropriate supports while respecting their rights and preferences.

2.2: The Rights of Individuals Receiving MAPs services

Individuals receiving services through the Medicaid Alternative Pathways to Independence (MAPs) program are entitled to a comprehensive set of rights that are protected by federal statutes and reinforced by licensure and regulatory standards. These rights are fundamental to ensuring dignity, respect, and the ability to make choices about one's life and support services. It is essential to recognize that, unless a court has explicitly removed specific decision-making capacity from an individual, all rights must be honored, upheld, and actively promoted. This commitment reflects the core values of the MAPs program, which aims to empower individuals to take control of their own lives while receiving the necessary support.

Central to the rights of individuals within the MAPs program is the concept of "dignity of risk." Life inherently involves risks, and while some may take a cautious approach to these uncertainties, it is crucial not to overly restrict opportunities for growth and learning. The MAPs program acknowledges that risk can be a valuable teacher, offering participants the chance to develop skills, build confidence, and foster independence. Rather than adopting a risk-averse stance that limits experiences, the program embraces a "duty of risk," encouraging individuals to engage in activities that may involve some level of risk but ultimately contribute to personal development.

Within the framework of the Person Supported Collaborative Plan, the MAPs program promotes the idea that taking calculated risks can lead to meaningful learning opportunities. Individuals are supported in making informed choices about their lives, which include understanding the potential risks and benefits of their decisions. This approach not only respects the autonomy of individuals but also fosters an environment where they can learn to navigate challenges and make decisions that enhance their quality of life.

Ultimately, the rights of individuals receiving MAPs services are grounded in a commitment to dignity, choice, and autonomy. By integrating the principles of

dignity of risk and duty of risk into the support framework, the MAPs program empowers participants to embrace their rights fully, engage in their communities, and pursue their personal goals with the backing of a supportive network. This holistic approach ensures that individuals are not only protected in their rights but also encouraged to grow, learn, and thrive in their journey toward independence.

2.3: Provider/IC Responsibilities Related to Individual Rights

Provider Support Agencies and the Innovation Coordination Agency staff play a critical role in upholding the rights of individuals receiving MAPs services. These agencies are not only responsible for delivering high-quality support but also for ensuring that the rights of individuals are understood, respected, and actively promoted within all aspects of care. This commitment is rooted in the principles of person-centered planning and the recognition that individuals with intellectual and developmental disabilities (ID/DD) are entitled to the same rights as all citizens.

To fulfill their responsibilities, staff members from these agencies must be well-trained and informed about the legal and ethical standards governing individual rights. They must work collaboratively with participants to create an environment that fosters independence and self-determination while ensuring that individuals are aware of their rights and the resources available to them. This includes facilitating open communication, advocating for participant preferences, and providing necessary supports that enhance the individuals' quality of life.

The responsibilities of Provider Support Agencies and Innovation Coordination Agency staff in relation to individual rights can be summarized in the following key areas (not an inclusive list):

- Education and Training: Staff should provide education to individuals about their rights, ensuring they understand what they are entitled to and how to advocate for themselves.
- Person-Centered Planning: Engage individuals in the development of their Person Supported Collaborative Plans, incorporating their preferences, goals, and choices while respecting their autonomy.
- Advocacy: Act as advocates for individuals, helping them navigate the services available to them and ensuring their voices are heard in decision-making processes.

- Respect for Dignity and Choice: Promote and respect the dignity of individuals by recognizing their right to make choices about their lives, including everyday decisions that affect their well-being.
- Support in Risk Management: Provide guidance and support in understanding and managing risks, empowering individuals to engage in activities that may involve risk while promoting learning and growth.
- Access to Resources: Ensure that individuals have access to necessary resources, including legal assistance, support networks, and relevant information about their rights.
- Complaint and Grievance Processes: Inform individuals about the procedures for filing complaints or grievances if their rights are violated and support them in these processes when needed.
- Monitoring and Compliance: Regularly monitor the services provided to ensure compliance with licensure rules and federal regulations that protect individual rights.
- Cultural Competency: Ensure that support is culturally sensitive and that individual rights are upheld regardless of cultural background, beliefs, or preferences.
- Collaboration with Families and Guardians: Work with families and guardians to ensure that they understand the rights of the individuals they support and that their input is integrated into decision-making processes.

By embodying these responsibilities, Provider Support Agencies and Innovation Coordination Agency staff play a vital role in safeguarding the rights of individuals receiving MAPs services. Their commitment to these principles not only enhances the quality of care but also empowers individuals to lead fulfilling lives, make informed choices, and actively participate in their communities.

2.4: Complaint Resolution/Grievances

In the MAPs program, each participant's freedom of choice is prioritized, allowing for autonomy in selecting and receiving services/supports from preferred provider agencies. When conflicts or grievances arise, the MAPs Team offers structured support to address concerns and resolve issues collaboratively. The goal is to foster clear communication and maintain quality service delivery without compromising the participant's choice and agency.

2.4.a. Conflict Resolution Process

When a conflict arises, the MAPs Innovation Coordinator will work with the participant, their chosen provider agency, and any relevant stakeholders to address and resolve the issue. Through this process:

Collaborative Dialogue: The Innovation Coordinator facilitates discussions between the participant, provider agency, and stakeholders, aiming to clarify concerns, identify possible solutions, and reach mutual agreement.

Resolution Attempts: All parties are encouraged to explore alternatives and address misunderstandings to support continuity of care and minimize disruption.

If these resolution efforts are unsuccessful, the participant retains the right to initiate the freedom of choice process to select a different provider agency. This ensures that participants can access services/supports in a way that aligns with their preferences and comfort.

2.4.b. Grievances Process

Any participant, stakeholder, or provider agency may submit a formal grievance if they feel that concerns were not adequately resolved or if they experience issues related to service quality or access. Grievances can be communicated directly to the MAPs Innovation Coordinator, who will document the concern and inform the DDA as appropriate. The DDA will review the grievance, facilitate any further conflict resolution needed, and, if necessary, provide guidance for corrective actions to ensure compliance with MAPs program standards.

2.5: Appeals

In the MAPs program, the appeals process is a critical component that ensures fairness and accountability when it comes to enrollment decisions. If a participant or stakeholder receives notification that their application for enrollment in the MAPs program has been denied, they are entitled to appeal this decision. The notification of ineligibility will include detailed information about their rights to appeal and the specific steps they must follow to initiate the process. It is essential for participants

and stakeholders to thoroughly review this correspondence, as it outlines their options for contesting the decision and provides guidance on how to proceed.

The appeals process is designed to protect the rights of individuals and ensure that all applications are evaluated fairly and consistently. Participants and stakeholders should carefully adhere to the instructions provided in the denial notification, which may include submitting a written appeal, providing additional documentation, or contacting a designated representative for further clarification. By following these procedures, individuals can formally present their case for reconsideration, allowing the MAPs program to reevaluate the decision based on the evidence and information they provide.

It is important to note that the appeals process is specific to enrollment decisions. Once an individual is enrolled in the MAPs program, they are afforded the same access to the curriculum of milestones, budget allocation, and duration of the program as all other participants. This uniformity ensures that every individual experiences equitable treatment within the program framework. As such, ongoing appeal processes related to the fundamental structure of the program do not apply.

If a participant or stakeholder is dissatisfied with any aspect of their experience in the MAPs program, including service delivery or support received, they are encouraged to utilize the complaint and grievance process instead of pursuing an appeal. This process is designed to address concerns related to the quality of services, provider interactions, or any perceived violations of rights. By engaging in the complaint/grievance process, individuals can ensure their voices are heard and their concerns are addressed in a timely manner.

Overall, the appeals process serves as an essential safeguard for individuals seeking enrollment in the MAPs program. It underscores the program's commitment to transparency, fairness, and the protection of individual rights. By providing clear mechanisms for contesting enrollment decisions and fostering a supportive environment for addressing grievances, the MAPs program empowers participants and stakeholders to advocate for their needs and ensure they receive the services and support they deserve.

2.6: Options for Individuals Determined Unable to Make Decisions

For individuals who have been determined to be unable to make decisions regarding their own care, support, or financial matters, there are several options available to ensure that their rights and best interests are protected. It is crucial to



understand that formal, notarized, or court-appointed documentation is necessary to establish these decision-making arrangements. Each option serves a different purpose and provides varying levels of authority and responsibility for the appointed individuals.

1. Power of Attorney (POA): A Power of Attorney is a legal document that allows one person (the principal) to designate another person (the agent) to make decisions on their behalf. This can include financial, legal, or healthcare decisions. The POA can be broad or limited, depending on the principal's wishes. It is important to note that the principal must be able to understand and agree to the terms when the POA is established.

2. Limited Conservatorship: In cases where individuals are unable to make decisions but retain some capacity to do so, a limited conservatorship may be established. This legal arrangement allows a court to appoint a conservator who will have specific authority to make decisions in designated areas of the individual's life, such as medical care or financial management. The conservatorship is tailored to the individual's needs, ensuring that they retain as much autonomy as possible.

3. Supported Decision Making: Supported Decision Making is an alternative to guardianship and conservatorship that allows individuals with disabilities to make their own decisions while receiving support from trusted friends, family members, or professionals. This approach emphasizes the individual's right to make choices about their life, with assistance provided as needed to help them understand options and consequences.

4. Healthcare Surrogate: A healthcare surrogate is a person designated to make medical decisions on behalf of an individual who is unable to do so. This designation is often made through a healthcare advance directive, or a living will. The healthcare surrogate's authority is limited to healthcare decisions and is activated when the individual is incapacitated.

5. Authorized Representative: An authorized representative is someone appointed to act on behalf of an individual, particularly in matters related to accessing services or benefits. This designation can be informal or formal, but it often requires documentation that specifies the scope of authority granted to the representative.

6. Guardianship: In more extreme cases where individuals are unable to make decisions and have no capacity to understand or express their wishes, a full guardianship may be established. This legal arrangement grants a guardian

comprehensive authority over the individual's personal, financial, and medical decisions. Guardianship is typically considered a last resort due to the significant loss of autonomy it entails.

It is essential for individuals and their families to carefully consider the implications of each of these decision-making arrangements. Establishing a POA, conservatorship, or any other formal arrangement requires careful planning and, in many cases, legal guidance to ensure that the individual's rights and preferences are respected. Ultimately, the goal of these options is to provide the necessary support while promoting the dignity and autonomy of individuals who may need assistance in making decisions about their lives.

Chapter 3:

MAPs Program Outcomes, Milestones and Supports

The MAPs Program is dedicated to fostering independence and enhancing the quality of life for individuals with intellectual and developmental disabilities (ID/DD) through a structured approach that emphasizes clear outcomes, achievable milestones, and tailored supports. This section of the resource guide outlines the key outcomes participants can expect to achieve, focusing on personal growth, skill development, and community integration. Milestones serve as significant markers on each participant's journey, providing a framework to measure progress and celebrate achievements while considering each person's unique goals, strengths, and challenges.

Effective supports are crucial in helping participants reach their desired outcomes. The MAPs Program offers a variety of resources and services tailored to meet the specific needs of everyone, empowering them to take charge of their lives and make informed decisions. By fostering a supportive environment that respects individual rights and promotes self-sufficiency, the MAPs Program aims to create opportunities for participants to thrive and achieve greater fulfillment in their daily lives.

3.1: MAPs Outcomes and Milestones

The following outcomes and milestones are the center of the MAPs program. People supported will select which milestones they wish to work on during a program year, and these milestones will be transcribed to the PSCP.

Outcomes, Milestones, VCRM

- Outcome: Home
 - a. Milestone: Home Safety
 - b. Milestone: Personal Hygiene
 - c. Milestone: Health Management
 - d. Milestone: Financial Management
- Outcome: Work
 - a. Milestone: Pre-Employment
 - b. Milestone: Employment Innovation

- c. Milestone: Career Development
- d. Milestone: Independence Achieved
- Outcome: Community
 - a. Milestone: Independent Travel
 - b. Milestone: Community Relationship
 - c. Milestone: Community Activities
- VCRM

The fidelity in the MAPs program lies with a participant completing each of the prescribed milestones. By offering these milestones across the outcomes areas of Home, Work, and Community, the MAPs participant can fully gain methods of independence in each of these areas targeting specific milestones (goals). Each year of the program, the Collaborative Planning Team will develop the PSCP which identifies the specific milestones chosen for that specific year. The provider agency will provide innovative services/supports to the participant to achieve greater levels of independence toward those milestones. Once a milestone has been achieved, the participant is offered the remaining milestones throughout the program in hopes of completing ALL identified milestones. In the event a participant experiences a substantial life-changing event and may benefit from repeating an already completed milestone or require exception consideration for specific milestone requirements, the IC may request an exception to the PSCP and allow a milestone to be repeated or modified. Pending review and submitted justification (i.e. if a person relocates and needs assistance learning a new mode of community transit), the IC may request an exception from the DDA Director of MAPs or designee via the MAPs Exception Request Link ([MAPs Exception Request Form](#)). The DDA Director of MAPs or designee will review the submitted information and notify the IC agency directly of the consideration review. This exception process may evolve through implementation.

3.2: Value-Based Payment Methodology

People supported who enroll in the MAPs program will have access to an array of services/supports which are intended to increase opportunities for independence. These services/supports include areas of support provided within home settings, employment settings, and community settings. Within each of these settings, specific milestones have been developed to allow the person to select services/supports that directly correspond to the selected milestones based on their desired person-centered goals. The MAPs provider will work with the person to implement a PSCP

intended to assist the person achieve greater levels of independence following the person's desired goals. Upon the conclusion and confirmation that the services/supports provided have achieved greater independence for the person supported, payment will be made to provider entities using an Independence Milestone Incentive model (*Value-Based Payment*¹).

MAPs services/supports and milestones have been developed using a curriculum-style approach. It is anticipated, once a person supported has achieved the desired level of independence using the MAPs services/supports, the person supported will have gained the necessary skills to continue to live as independently as possible in the areas of their home, their work, and their community. The MAPs curriculum includes (12) Milestones and (1) Virtual Community Resource Map ("VCRM") goal. Each of the (12) Milestones and (1) VCRM provides a value-based payment approach upon completion. Provider agencies will be able to receive payment for services/supports once a person has achieved the necessary skill independence for each of the identified milestones and VCRM. Providers will not be reimbursed on a fee-for-service² approach.

It shall be the intention of the Department to ensure all validations for a requested milestone are completed using a person-centered approach where the outcome of the implemented service is the desired result and the focus for reviewing validation. Upon submission of the Milestone Validation Request, the primary focus will be individual achievement, rather than provider-implemented processes to secure desired results. In traditional fee-for-service programs, provider agencies must document all services/supports to justify payment processes; in a value-

¹ **Value Based Programs**

Value-based programs reward providers for the quality of services/supports and care they give their members. Value-based programs are designed to provide incentives for achieved person-centered outcomes that serve as proof of a high-quality service delivery model. These value-based programs are essential to the State's intentions of ensuring all Members have access to enabling technology, integrated employment opportunities and person-centered service delivery that will produce Member-driven outcomes.

² **Fee-for-Service VS. Value Based Payments**

In a fee-for-service model, a provider is reimbursed a fixed fee for each service they provide from an approved list. In a value-based payment (VBP) model, providers are responsible for both the cost and quality of support they provide to achieve a desired outcome. VBP's reward a provider financially for delivering efficient, cost-effective supports but can penalize a provider for failing to do so.

based/outcomes-driven payment structure used in the MAPs program, DDA makes payment available upon recognition of milestone achievement and not provider-delivered services/supports. While it is important to ensure providers deliver formal services/supports to achieve milestone completion, the primary focus will center around a status review of the goals of the person supported. Provider agencies are responsible for indicating on the Milestone Validation Request the “initial status of the person-supported” vs. the “ending status of the person-supported.” In the Milestone Validation Request, the provider shall demonstrate how the person supported gained greater independence by assessing “pre-service” status VS “post-service” status. In this comparison, the focus remains on the person supported and attainment of independence skills. The provider will not be required to submit verification of delivered supports contributing to achieving desired results. Instead, the provider will provide evidence of how the person supported increased his/her independence in the identified area. The provider will be issued payment upon verification through the milestone validation process.

3.3: Person-Supported Annual Budget

Each MAPs participant has access to an annual budget of \$20,000.00 for each program year. The program year will be effective on the participant’s date of enrollment and expire after 365 days. It shall be noted this annual budget is intended to provide payment for the value-based payment structure which has been developed within the MAPs program. After each program year, any leftover budgetary amounts will **NOT** roll over to the following program year.

Based on the person's supported available budget, each program year allows for the selection of a certain number of milestones. The budget breakdown allows for the following selection:

YEAR 1: Available Billable Services

- Provider Referral Incentive (Incentive)
- 1 VCRM Development
- 3 Milestones

YEAR 2: Available Billable Services

- 5 Milestones

YEAR 3: Available Billable Services

- 4 Milestones
- Person Supported Establishment (Incentive)



(NOTE: It is possible during the first year of planning that the person may wish to work on the VCRM as the first goal and let the development of the VCRM guide the selection of the Year 1 Milestones).

These milestones will be represented in the PSCP which will be the leading document which guides the provider agency on which services/supports they are to provide to assist the person in achieving milestone independence. Any revisions to the PSCP will be made exclusively by the IC in conjunction with the Collaborative Planning Team through the planning amendment process.

Enabling Technology (“ET”) Funding is available each year of the MAPs program. A person supported may access up to **\$2,500.00** each year for ET solutions towards milestone achievements. See below for more details and refer to Enabling Technology Service Definition for request protocol.

The IC agency (in conjunction with the provider agencies) must work on all validation requests (milestones and incentives) that are submitted, reviewed, and approved by the annual budget cycle. The approval dates of the submitted validations must fall within the annual budget cycle to be credited to the appropriate budget year. All other validation requests will be credited to the corresponding year per the approval date. MAPs providers and IC agencies are encouraged to monitor the annual budget cycle for each participant and ensure adequate time for review is given with each submission. In the event circumstances warrant a submission within the budget cycle that does not allow the required 30 days of review, provider agencies shall ensure all opportunities for clean submissions are completed as a function of the review to ensure the timely processing of all validation requests.

EXAMPLE: All milestone validations/incentives will be credited to the budget cycle based on the actual validation approval/post-claim approval date.

3.4: MAPs Partnerships

The MAPs Program is strengthened by a robust network of partnerships that enhance the delivery of services and support for individuals with intellectual and developmental disabilities (ID/DD). At the core of this network is the MAPs provider network, which consists of private provider agencies contracted to deliver the program and its associated services across the state. These agencies are dedicated to meeting the unique needs of participants, ensuring that they receive high-quality, individualized support tailored to their goals. By collaborating with various providers

statewide, the MAPs Program can offer a comprehensive range of services that promote independence and community integration.

In addition to the provider network, the MAPs Program partners with Innovation Coordination Agencies. These third-party entities play a crucial role in the program by providing essential functions such as plan development, milestone validation, and monitoring the delivery of services. Acting as care coordination or service coordination agencies, they serve as primary supports for MAPs participants and stakeholders, ensuring that all services are aligned with individual needs and preferences. Another key partnership is with AbleLink Tech, a technology partner that provides access to mobile applications specifically associated with the MAPs program. AbleLink Tech also manages the deployment of mobile devices through a mobile device manager and oversees the implementation of the Travel Training curriculum, enhancing participants' mobility and independence.

Furthermore, the Mapping Assets Post School Success (MAPS) initiative collaborates with the program to provide access to the Virtual Community Resource Map (VCRM). This partnership includes training for provider agencies and innovation coordination agencies to ensure fidelity in the VCRM mapping process, enabling participants to identify and access valuable community resources. Additionally, peer mentoring agencies serve as vendors that deliver comprehensive peer-mentoring services to MAPs participants. These services are person-centered and designed to increase independence, fostering a supportive environment where individuals can learn from the experiences of their peers.

Lastly, T-Mobile collaborates with the MAPs Program as the mobile service provider, ensuring that all MAPs participants have access to reliable communication through their mobile devices. This partnership is vital for maintaining connectivity and facilitating access to the various resources and supports available through the program. Together, these partnerships create a cohesive framework that enhances the effectiveness of the MAPs Program, empowering individuals with ID/DD to lead fulfilling lives and achieve greater independence in their communities.

Chapter 4:

Person-Supported Collaborative Plan

The Person Supported Collaborative Plan (PSCP) is a cornerstone of the MAPs Program, designed to empower individuals with intellectual and developmental disabilities (ID/DD) by fostering a person-centered approach to planning and support. This chapter will provide a comprehensive overview of the PSCP, detailing its purpose, the collaborative planning process that leads to its creation, and the key components that make it an effective tool for enhancing the lives of participants. By focusing on individual strengths, preferences, and goals, the PSCP serves as a roadmap for both the person supported and the provider agency, facilitating tailored services that promote independence and community integration.

In the subsequent sections, we will outline the collaborative planning team involved in the PSCP process, including the roles and responsibilities of each member. Essential timelines for the effective date and completion of the PSCP will be delineated to ensure timely execution of services. Additionally, we will address how amendments to the PSCP are made as circumstances change, reflecting the dynamic nature of individual needs. Finally, the general responsibilities of both the person supported and the provider agency will be discussed, emphasizing the importance of active participation and collaboration in achieving the desired outcomes. Through this process, the PSCP not only enhances service delivery but also empowers individuals to take an active role in their own lives and futures.

4.1: The Person Supported Collaborative Plan (PSCP)

The Person-Supported Collaborative Plan (PSCP) is a foundational document within the MAPs (Mentoring, Advocacy, and Peer Support) program. It serves as the driving force behind the services and supports provided to MAPs participants, ensuring that their individual needs, aspirations, and interests are at the forefront of the planning process. The PSCP is designed to be a dynamic roadmap that evolves alongside the participant, reflecting their growth and changes in circumstances over time.

The PSCP is crucial for several reasons:

- Person-Centered Planning: At the heart of the PSCP is the principle of person-centered planning. This approach emphasizes the importance of tailoring services to the unique vision and interests of each participant. By prioritizing the individual's goals, the PSCP fosters a sense of ownership and empowerment, encouraging participants to actively engage in their own development.



- Collaborative Development: The PSCP is crafted with input from all participants in the collaborative Roundtable, including the participant, family members, service providers, and other stakeholders. This collaborative effort ensures that diverse perspectives are considered, resulting in a comprehensive plan that addresses the holistic needs of the participant.
- Annual Review and Renewal: The PSCP is valid for one year, after which a new plan must be developed. This annual renewal process allows for the integration of new milestones and adjustments based on the participant's progress and changing circumstances. It ensures that the plan remains relevant and effective in guiding the participant's journey.
- Assessment-Driven Goals: The development of the PSCP is informed by a variety of assessments that evaluate the participant's current skill levels and areas for growth. These assessments provide a baseline from which specific milestone goals can be established, ensuring that the participant's progress is measurable and targeted.
- Clear Milestone Goal Statements: The PSCP includes milestone goal statements that articulate the participant's present level of skill and outline specific objectives for growth. These goals not only serve as benchmarks for success but also guide the services and supports delivered by provider agencies and peer mentoring entities.
- Coordination of Services: The PSCP plays a pivotal role in ensuring that all stakeholders, including the Innovation Coordinator (IC) and service providers, maintain accurate demographic information and coordinate services effectively. This level of organization is essential for delivering integrated and cohesive support to the participant.
- Flexibility and Responsiveness: The PSCP can be amended as needed, ensuring that any updated plan supersedes previous versions. This flexibility allows for timely adjustments in response to the participant's evolving needs or circumstances, further enhancing the effectiveness of the support provided.
- Accessibility of Information: Prior to the implementation of the plan, draft copies are made available to all stakeholders. This transparency ensures that everyone involved is informed and on the same page regarding the participant's goals and the strategies to achieve them. Each stakeholder bears the responsibility of obtaining and maintaining a copy of the most updated plan, promoting accountability and collaboration.
- Role of the Innovation Coordinator: The final written PSCP is the responsibility of the Innovation Coordinator (IC). The IC synthesizes input from all stakeholders,



ensuring that the participant's voice is central to the document while also adhering to programmatic standards and guidelines.

The Person-Supported Collaborative Plan (PSCP) is more than just a document; it is a vital tool that embodies the MAPs program's commitment to empowering participants through person-centered planning. By leveraging collaborative input, assessment-driven goals, and a commitment to flexibility, the PSCP ensures that participants receive the tailored support they need to achieve their aspirations. This comprehensive approach not only enhances the participant's experience but also fosters a community of engagement and support among all stakeholders involved in the MAPs program.

Planning Types:

- Pre-Plan: The IC will develop a “pre-plan” PSCP which is used as a draft for all collaborative team members to review **PRIOR** to the implementation of the Annual Plan.
- Annual Plan: The annual plan is effective the date it is completed (year 1) and will remain the driving document for the service delivery methodology through the remainder of Year 1 (which ends the date before the enrollment date). This annual plan drives the selected milestones and prescribes the person-specific information. An annual plan is required for each year of the MAPs program.
- Amendment: In the event the annual plan requires revision (updated milestone, significant life-changing event, exception request), the IC will conduct a redacted version of an “amendment” where the identified area of adjustment is updated and will serve as the revised plan.

4.2: PSCP Planning

The development of the Person-Supported Collaborative Plan (PSCP) is a structured yet flexible process designed to ensure that the individual needs and aspirations of the MAPs participant are central to the planning. The process begins with the Innovation Coordinator (IC) who takes the lead in crafting a draft plan. This draft is prepared prior to the collaborative Roundtable meeting, providing a foundational document that outlines initial thoughts, potential milestones, and demographic information relevant to the participant.

Once the draft plan is created, it is distributed to all members of the collaborative Roundtable. This distribution allows each stakeholder—comprised of the participant, family members, service providers, and other key individuals—to review the document in advance of the meeting. The opportunity for early engagement is crucial, as it enables stakeholders to reflect on the information presented, consider their perspectives, and formulate recommendations for improvement.

The collaborative Roundtable meeting is then convened, serving as a platform for open discussion and collective decision-making. During this meeting, participants review the draft plan, provide feedback, and engage in a collaborative dialogue about the selected milestones and goals that will guide the participant's development over the coming year. The inclusion of all demographic information is also discussed to ensure that it reflects the most current and accurate details about the participant.

As the meeting progresses, stakeholders can voice their opinions and suggest modifications. This collaborative environment fosters a sense of shared ownership and accountability, as all members contribute to shaping the final version of the plan. The IC plays a pivotal role in facilitating this discussion, ensuring that all voices are heard and that the conversation remains focused on the participant's individual goals.

At the conclusion of the collaborative Roundtable meeting, the IC takes on the responsibility of consolidating all recommendations and feedback. This involves carefully reviewing the input provided by each stakeholder and integrating it into the final PSCP. The IC ensures that the final plan accurately represents the collective vision and agreements reached during the meeting.

Once the final plan is developed, it is assigned an effective date, marking the commencement of its implementation. All team members are then charged with executing the plan throughout the remainder of the year, working collaboratively to support the participant in achieving the established milestones. However, the plan is designed to be adaptable; should errors be identified, or if significant changes in the participant's circumstances arise, stakeholders can request an amendment. This ensures that the PSCP remains a living document, responsive to the participant's evolving needs and reflective of their ongoing journey.

In summary, the PSCP planning process is a collaborative and iterative journey that emphasizes communication, inclusivity, and responsiveness. Through the initial



draft, stakeholder reviews, and the collaborative Roundtable meeting, the final plan emerges as a comprehensive roadmap that supports the participant's growth and development over the year.

4.3: The Collaborative Planning Team

The Collaborative Planning Team is an important part of the MAPs program. This team brings together different people who are dedicated to supporting the growth and development of the participant. The team operates with the understanding that the participant's voice and preferences are essential to the planning process and should be driving the plan development and MAPs services.

At the center of the team is the Innovation Coordinator (IC), who acts as the facilitator and coordinator. The IC is responsible for creating the initial draft of the Person-Supported Collaborative Plan (PSCP) and leading the collaborative Roundtable meetings. By ensuring that everyone's perspectives are heard and considered, the IC helps keep the focus on the participant's goals. Once feedback is gathered from team members during the meetings, the IC compiles this input to develop the final plan for implementation.

Provider agency staff are also key members of the Collaborative Planning Team. These professionals bring valuable expertise in service delivery and support, offering insights about the resources available to the participant. Their knowledge of best practices helps identify appropriate milestones and goals that align with the participant's individual needs.

The participant plays a crucial role in this collaborative effort. Their involvement is vital, as they provide insights into their own aspirations, preferences, and challenges. By actively participating in the planning process, the participant ensures that the PSCP accurately reflects their vision for the future. Their input drives the discussions and decisions made during the planning meetings.

Family members are another important part of the Collaborative Planning Team. They often have a deep understanding of the participant's history, strengths, and areas for growth. Their perspectives are invaluable in helping to identify goals that resonate with the participant's interests and needs.

The Collaborative Planning Team comes together at least once a year to create the annual plan. While meetings for amendments are not mandatory, this yearly



gathering ensures that the team is aligned and committed to supporting the participant's journey towards independence.

4.4: Person-Centered Planning Principles

Person-centered planning is a key part of creating and developing the Person-Supported Collaborative Plan (PSCP). This approach focuses on the participant as an individual, recognizing that everyone has unique dreams, needs, and strengths. The main idea behind person-centered planning is to put the participant at the center of the planning process, ensuring that their voice is heard and that their preferences guide the decisions made about their support and services.

When developing the PSCP, it is important to listen carefully to the participant. Their thoughts and feelings about what they want to achieve in their life are essential. This means discussing their goals, interests, and any challenges they may face. By understanding what the participant truly wants, the team can create a plan that reflects their personal vision for the future.

In person-centered planning, collaboration is crucial. The participant works together with their family members, the Innovation Coordinator, and provider agency staff to make sure everyone is on the same page. Each member of the Collaborative Planning Team brings different insights and experiences, which helps create a more complete picture of what support the participant needs. This teamwork ensures that the plan is not just a list of goals but a meaningful document that truly represents the participant's journey.

Another important principle of person-centered planning is flexibility. As the participant grows and changes, their needs and goals may also change. The PSCP is not a one-time document; it can be updated and adjusted as needed. This means that if a participant discovers new interests or faces different challenges, the plan can be revised to reflect those changes. This adaptability ensures that the support provided remains relevant and effective.

Ultimately, the goal of person-centered planning is to empower the participant. By focusing on their strengths and aspirations, the PSCP aims to help them gain independence and achieve their dreams. This approach fosters a sense of ownership, as the participant actively shapes their own future with the help of their Collaborative Planning Team. When the planning process revolves around the participant's voice and choices, it creates a powerful foundation for growth and success.

4.5: Timelines for Completion and Review of the PSCP

The development and review of the Person-Supported Collaborative Plan (PSCP) follow a specific timeline to ensure that participants receive timely and effective support. A PSCP should be created within 90 days of enrollment in the MAPs program. This timeline allows the Collaborative Planning Team to gather necessary information and insights to craft a plan that truly reflects the participant's goals and needs.

If any delays are encountered during this initial planning phase, the Collaborative Planning Team should consider submitting exception requests. These requests would allow for modifications to the budget cycle for the participant, accommodating any unforeseen challenges that may arise.

Once developed, the initial PSCP will remain effective until either an amendment is created, or it expires at the end of the year 1 planning budget cycle. The expiration signifies that the plan will no longer be in effect, and a new plan must be developed for the subsequent year.

The year 2 planning cycle is set to begin 365 days after the participant's enrollment date, unless an exception has been approved. To prepare for this upcoming cycle, a pre-plan or draft of the new PSCP will be made available to the Collaborative Roundtable Team 30 days prior to the effective date of the year 2 and year 3 budget cycles. This advance notice provides team members with the opportunity to review, discuss, and provide input on the draft, ensuring a collaborative approach to refining and finalizing the plan for the following year.

4.6: Effective Date of the PSCP

The Person-Supported Collaborative Plan (PSCP) is effective for one year from the date it is finalized. This means that all the goals and strategies outlined in the plan are implemented starting from the effective date. It is important to note that while the PSCP remains in effect for a full year, any amendments made during that time will supersede the specific information addressed in the amendment. This ensures that the plan stays current and accurately reflects the participant's needs and goals as they evolve.

4.7: PSCP Amendments

The PSCP Amendment is an important part of the planning process that allows for updates, modifications, and adjustments to the annual plan. Life is full of changes, and sometimes a participant may need to update their plan to better reflect their current goals and circumstances. The amendment process ensures that the participant has the most accurate and relevant plan possible.

During the initial collaborative Roundtable meeting, the participant will choose specific milestones to work on for that planning cycle. However, as time goes on, they may want to revise those milestones or set new goals. The amendment process makes it easy for participants to change their goals throughout the planning cycle. This flexibility is important because it helps the participant stay on track and focused on what really matters to them.

The amendment document itself is different from the annual planning template. It is specifically designed to include only the information that is being updated. This means that when an amendment is created, it will focus solely on the changes needed, rather than repeating all the details from the original plan. This helps keep the document clear and concise.

There are several reasons why an amendment might be needed. For example, if there is new demographic information that needs to be updated, or if the participant requires exceptions for programming—like repeating a milestone or having a family member deliver certain services—an amendment can address these changes. Additionally, if there is a change in provider agencies or if adjustments are needed for validating a milestone, the amendment process provides a way to make those updates.

Overall, the PSCP Amendment is designed to ensure that the participant's plan remains relevant and effective. It allows for ongoing communication and collaboration among the team, so everyone is aware of any changes and can continue to support the participant in achieving their goals. By using the amendment process, participants can take charge of their planning journey and adapt their plans as their needs and aspirations evolve.

4.8: Person-Supported Responsibilities for Implementing the PSCP

When it comes to implementing the Person-Supported Collaborative Plan (PSCP), the participant has some important responsibilities. The main goal of the participant

is to achieve the milestones set out in the plan. These milestones are specific goals that the participant and the Collaborative Planning Team have identified as important steps toward reaching their overall dreams and aspirations.

To be successful, the participant needs to actively work on these milestones. This means putting in the effort to complete the tasks and activities that will help them make progress. The provider agency is there to assist the participant along the way, offering support and guidance as they work to achieve these goals.

If at any point the participant feels that they want to change a milestone, it's important to communicate that desire to the Innovation Coordinator (IC) and the provider agency. Making changes to milestones is a normal part of the planning process, and the amendment process allows for these updates to happen smoothly. By sharing their thoughts with the IC and provider agency, the participant can initiate a PSCP amendment, which will help ensure that the plan continues to reflect their current goals and needs.

Overall, the participant plays a crucial role in the success of the PSCP. By focusing on the milestones and communicating openly with the team, they can take charge of their journey and work toward achieving a fulfilling and independent life.

4.9: Provider Agency Responsibilities for Implementing the PSCP

The provider agency plays a vital role in the successful implementation of the Person-Supported Collaborative Plan (PSCP). Their responsibilities include ensuring the accuracy of the plan, training staff on its details, and actively participating in its creation.

One of the key tasks for the provider agency is to make sure that the PSCP is accurate and reflects the participant's goals/milestones and needs. This involves collaborating with the participant and the Collaborative Planning Team during the development of the plan. By contributing their expertise and insights, agency staff help create a comprehensive plan that provides the right support for the participant.

Training is another important responsibility. The provider agency must ensure that all staff members are well-informed about the PSCP and understand their roles in supporting the participant. This training helps staff provide consistent and effective assistance as the participant works toward their milestones.

If there are any changes needed in the plan, the provider agency is responsible for initiating amendments. If the participant wishes to change a milestone or there are updates that need to be made, the agency will collaborate with the Innovation Coordinator to ensure that the necessary amendments are documented and implemented.

Additionally, the provider agency is tasked with the storage and management of all documentation related to comprehensive records. This includes keeping track of the PSCP, any amendments made, and all relevant information about the participant's progress. Proper storage and organization of these records are essential for maintaining a clear history of the participant's journey and ensuring that everyone involved has access to the information they need.

In summary, the provider agency is a crucial partner in the implementation of the PSCP. By ensuring accuracy, providing training, participating in the planning process, initiating amendments when necessary, and managing documentation, the agency helps create a supportive environment for the participant to achieve their goals and work towards greater independence.

Chapter 5:

Innovation Coordination Services

The Innovation Coordinator (“IC”) will coordinate MAPs services, including but not limited to, the development of the Person Supported Collaborative Plan (“PSCP”) for each participant and monitor the completion of the MAPs milestones and outcomes for each participant. The IC will provide technical assistance services to MAPs participants and MAPs partners, as needed.

In this section, we will explore the role of Innovation Coordination Services as the designated third-party case manager that facilitates collaborative planning for individuals supported by the MAPs Program. We will outline the frequency of supports provided, the qualifications required for an Innovation Coordinator, and how caseload assignments are determined. Additionally, we will discuss the documentation standards and validation processes that ensure quality and accountability in service delivery. This comprehensive overview will highlight the critical functions and responsibilities of Innovation Coordination Services in supporting individual goals and fostering meaningful collaboration.

5.1: Innovation Coordination Supports (Frequency)

The IC provides consistent and structured support to MAPs participants through a systematic approach which includes monthly check-ins and quarterly in-person visits. Each month, the IC will conduct a check-in via phone or email to discuss the participant's progress, review the utilization of the VCRM, and evaluate overall satisfaction with the services/supports received. These monthly interactions serve as an essential touchpoint, allowing the IC to identify any challenges the participant may be facing and to celebrate successes in achieving their milestones.

In addition to the monthly check-ins, the IC will conduct quarterly in-person visits to provide more in-depth support and foster a stronger rapport with the participant. During these visits, the IC can engage in more comprehensive discussions about the participant's experience, gather feedback on the effectiveness of the resources provided, and assess the overall implementation of the PSCP. Furthermore, the IC will initiate an annual total satisfaction survey to evaluate the effectiveness of services/supports and gather insights that can inform future improvements.

The IC's responsibilities extend beyond participant support to also include providing technical assistance to provider agencies. This involves reviewing all milestone validation requests, assisting in the facilitation of ET solutions meetings, and contributing to the progression of services/supports offered. Throughout this process, the IC must meticulously document interactions and updates, ensuring the

Case File section of SharePoint is regularly updated. This documentation should include written accounts of service progressions, communications regarding issues or challenges, and relevant notes which highlight significant developments within the MAPs program. By maintaining thorough records, the IC helps ensure all stakeholders are adequately informed and that the participant receives cohesive and coordinated support throughout their journey in the MAPs program.

While the MAPs program typically designates support for participants through monthly check-ins and quarterly in-person visits, there may be situations where more frequent support is required to address specific needs or challenges faced by the participant. In these instances, the IC is committed to ensuring the participant's needs are met promptly and effectively. The IC will work closely with the Team to assess the situation and coordinate additional services/supports, as necessary, thereby fostering a responsive and individualized approach to support.

The IC's flexibility in addressing requested supports is crucial for maintaining the participant's engagement and progress within the program. For example, if a participant is experiencing challenges related to their milestones or has identified barriers to utilizing available resources, then the IC can facilitate more frequent communications and interventions. This may involve arranging additional meetings with the participant, coordinating with provider agencies, or sourcing external resources which can provide the necessary assistance. By being proactive in these situations, the IC can help mitigate potential setbacks and ensure participants continue to move forward in their journey.

Moreover, the IC will ensure participants are aware of their right to request additional services/supports whenever they feel it is needed. This open line of communication encourages participants to self-advocate, express their concerns, or seek help reinforcing the collaborative nature of the MAPs program. By fostering a culture of responsiveness and adaptability, the IC plays a vital role in empowering participants to access the resources and support they need to achieve their goals, ultimately contributing to their success within the MAPs framework.

5.2: Qualifications of Individuals Employed as ICs

The selection of Innovation Coordinators (ICs) is a critical component in ensuring the effectiveness of the MAPs Program and its collaborative planning efforts. While agencies will have the autonomy to establish their specific hiring procedures, it is imperative that these procedures are consistently adhered to during each appointment. Organizations should prioritize the recruitment of individuals who possess strong interpersonal and communication skills, as well as a deep understanding of the unique needs and aspirations of the individuals they will



support. Moreover, a background in social work, psychology, or a related field is highly desirable, as it equips ICs with the foundational knowledge and skills necessary to navigate the complexities of person-centered planning.

In addition to educational qualifications, prospective ICs must demonstrate experience in key areas that are vital for their role. This includes proficiency in conducting comprehensive assessments that identify the strengths, preferences, and needs of individuals supported by the MAPs Program. The ability to develop tailored plans that address these aspects is essential, as is the capacity to manage budgets effectively. ICs should also be adept at validating milestones, ensuring that progress is tracked and communicated transparently to all stakeholders involved in the planning process.

Beyond these technical competencies, ICs are expected to provide ongoing technical assistance and coordinate a range of services to facilitate the successful implementation of individualized plans. This requires a proactive approach to problem-solving and a commitment to collaboration with a diverse array of service providers, community resources, and family members. ICs must be equipped to foster relationships that empower individuals, ensuring that their voices are central to the planning and decision-making processes.

Ultimately, the qualifications of ICs play a pivotal role in the overall success of the MAPs Program. By adhering to established hiring procedures and focusing on candidates who not only meet educational and experiential criteria but also embody the values of collaboration and person-centeredness, agencies will be better positioned to create a supportive environment that leads to meaningful outcomes for individuals. This commitment to excellence in hiring will help uphold the integrity of the Innovation Coordination Services and enhance the collaborative planning experience for all involved.

5.3: Caseload Assignments to IC's

Effective caseload assignment for Innovation Coordinators (ICs) is vital to ensuring that each participant receives the quality of support they deserve within the MAPs Program. It is projected that each IC can effectively manage a caseload of up to 30 participants, allowing for sufficient time and attention to be dedicated to everyone's unique needs and goals. This manageable caseload facilitates personalized engagement, enabling ICs to conduct thorough assessments, develop tailored plans, and coordinate essential services in a meaningful and impactful manner.

Organizations are strongly encouraged to regularly evaluate their caseload assignments to ensure that ICs can provide quality supports. Factors such as the complexity of individual needs, the availability of resources, and the level of support required should all be considered during this assessment process. Maintaining a balanced caseload is crucial, as it directly impacts the effectiveness of the services provided and the overall experience of participants. By actively monitoring caseloads, agencies can identify any potential challenges early and implement strategies to address them, thereby safeguarding the integrity of the support system.

In instances where caseloads exceed the recommended limit of 30 participants, such situations should be viewed as temporary and require immediate action. Organizations must develop a clear plan to reduce caseload sizes back to the optimal level as swiftly as possible. This may involve hiring additional ICs, reallocating responsibilities within the team, or implementing interim measures to manage excess cases without compromising service quality. Communication with stakeholders, including participants and their families, is essential during these times to ensure transparency and maintain trust in the support process.

Ultimately, prioritizing appropriate caseload assignments is essential for fostering a supportive environment where ICs can engage deeply with participants. By adhering to the recommended caseload guidelines and proactively addressing situations where caseloads exceed the ideal number, organizations can enhance the effectiveness of Innovation Coordination Services, thereby promoting better outcomes for individuals supported by the MAPs Program.

5.4: Providing Coordinated Services

Initial Assessment-Life Skills Assessment

Within the MAPs program, initial assessments play a vital role in establishing a solid foundation for each participant's journey toward achieving their personal goals. The IC is responsible for conducting these assessments, which include evaluations such as Virtual Services Readiness, Life Skills Assessment, ET solutions, and Milestone Selection. These assessments are critical not only for initiating the participant's engagement with the program, but also for ongoing milestone validation. The information gathered during these assessments helps determine the participant's current status, identifies areas for growth, and informs the development of tailored support strategies. As a result, the assessments serve as essential tools for

measuring actual progress and growth throughout the participant's experience in the MAPs program.

The creation of the Person-Centered Profile referral document is an integral part of this process. The IC oversees the development and completion of this profile, ensuring it accurately reflects the participant's unique preferences, strengths, and goals. This profile serves as a comprehensive overview which guides the design and implementation of personalized services/supports, including provider matching. Assessments will be conducted bi-annually, with additional evaluations performed as needed to validate specific milestones requested by the participant or stakeholders. This ongoing assessment process ensures the services/supports provided remain relevant and effective, adapting to the evolving needs of each person.

To facilitate a smooth assessment experience, the IC is committed to supporting participants and stakeholders throughout the process. If assistance is needed to complete any introductory assessments, including the Person-Centered Profile, then the IC will be readily available to help. This support may extend to conducting home visits to ensure the accuracy and completeness of the documentation. By prioritizing accessibility and collaboration, the IC helps create a person-centered approach which fosters trust and engagement, ultimately contributing to the success of the MAPs program.

PSCP Processes

The IC plays a pivotal role in the development and ongoing management of the PSCP for MAPs participants. This process begins with pre-planning, where a draft plan is created and sent out to the MAPs Collaborative Team 30 days prior to the annual planning meeting. This preliminary plan outlines the participant's chosen milestones and the services/supports to be delivered by the provider agency. During the annual planning meeting, the draft is discussed, refined, and confirmed, resulting in an official annual plan which remains in effect for one year. This comprehensive plan not only sets clear expectations, but also serves as a roadmap for the participant's journey in the MAPs program.

Throughout the planning year, the IC also manages the amendment process, which allows for adjustments to be made to the PSCP as circumstances change. Amendments may be necessary to incorporate new milestones, respond to formal exception requests, or address significant changes in the participant's needs or goals. The IC ensures all changes are carefully considered and documented, fostering a flexible approach which adapts to the participant's evolving circumstances while maintaining alignment with their overall objectives.

As the driving force behind the PSCP process, the IC is responsible for ensuring all members of the MAPs Collaborative Team can provide input and contribute to the plan's development and implementation. The IC monitors the execution of the plan, acting as a gatekeeper to ensure services/supports are delivered as intended, and the participant is supported in achieving their milestones. Additionally, the IC facilitates collaborative roundtable meetings, which can be initiated by any Team member, to discuss progress, address challenges, and make necessary adjustments. By coordinating these meetings, the IC fosters a culture of open communication and collaboration, ensuring the participant's voice remains at the center of the planning process. This inclusive approach enhances the effectiveness of the PSCP and ultimately contributes to the participant's success in the MAPs program.

Milestone Validation and Budget Management

The Innovation Coordination (IC) entity plays a critical role in maintaining the integrity and continuity of the MAPs program by overseeing the milestone validation process. This structured procedure ensures accountability, transparency, and alignment with the program's goals of fostering participant independence and achievement. When a participant selects a milestone, the provider agency begins delivering tailored innovative services designed to support progress toward that objective. Throughout service delivery, the provider agency collects evidence—such as observational data, participant accomplishments, or skill demonstrations—to document the participant's advancement. Once the provider determines sufficient evidence has been gathered to substantiate milestone completion, they submit a formal validation request to the IC for review.

The IC organization conducts a rigorous, standardized evaluation of all submitted evidence to verify that every criterion within the selected milestone has been fully addressed. This involves cross-referencing documentation against predefined benchmarks and assessing whether outcomes reflect meaningful progress toward the participant's goals. The IC may approve the request, deny it due to insufficient evidence, or identify specific gaps requiring further clarification. If elements are missing or incomplete, the IC initiates a technical assistance support strategy to collaborate with the provider agency. Through targeted guidance, the IC helps the provider refine documentation, address discrepancies, or strengthen evidence to ensure compliance with program standards. This collaborative approach minimizes delays and reinforces a shared commitment to participant success.

Following validation, the IC updates participant budget trackers to reflect the milestone's completion and adjust remaining allocations accordingly. This step

ensures accurate fiscal oversight, safeguards against overspending, and maintains alignment with individualized funding plans. The IC also communicates outcomes to relevant stakeholders, including the provider agency and participant, to confirm next steps or revisions. In cases where validation is denied, the IC provides detailed feedback to the provider, outlining actionable steps to resolve deficiencies and resubmit the request.

By integrating milestone validation with robust technical assistance and fiscal accountability, the IC fosters a cohesive system that prioritizes both quality service delivery and responsible resource management. This process not only upholds program fidelity but also empowers participants to achieve measurable outcomes while preserving the flexibility and innovation central to the MAPs mission. Continuous communication between the IC and provider agencies ensures alignment, enabling adaptive support that meets evolving participant needs and sustains long-term program success.

Conflict Resolution

The Innovation Coordination (IC) entity serves as a neutral, solutions-oriented facilitator in resolving conflicts or concerns that arise among stakeholders within the MAPs program, including participants, provider agencies, and external partners. By fostering open communication and collaboration, the IC works to address disagreements related to service delivery, milestone validation, budget allocations, or program expectations. Common conflicts might involve differing interpretations of milestone criteria, resource constraints, or participant-specific challenges. To resolve these, the IC employs strategies such as structured mediation sessions, clarification of program guidelines, or collaborative problem-solving workshops to align perspectives and identify mutually acceptable outcomes.

When concerns are raised, the IC prioritizes timely, transparent engagement to understand root causes and de-escalate tensions. This may include reviewing documentation, coordinating meetings with involved parties, or leveraging data to inform objective decision-making. If necessary, the IC may recommend adjustments to service plans, reallocation of resources, or targeted training for providers to prevent recurring issues. By maintaining a focus on participant-centered goals and program integrity, the IC ensures conflicts are resolved in ways that uphold equity, accountability, and the MAPs program's mission. Proactive communication and a

commitment to continuous improvement further solidify the IC's role in preserving trust and cohesion across all stakeholders.

Specialist Referrals

The Innovation Coordination (IC) entity streamlines access to specialized supports by managing the referral process for participants requiring expertise beyond the scope of their primary provider agency. This includes connecting individuals with Enabling Technology Champions, Housing Specialists, Benefits Counselors, or other targeted professionals to address complex needs that align with their milestone goals. When a participant's plan indicates a need for specialized services—identified through assessments, provider recommendations, or participant input—the IC collaborates with the provider agency to submit a formal referral. The IC ensures referrals adhere to program guidelines, include necessary documentation (e.g., justification, goal alignment), and are routed to vetted specialists within the MAPs network.

To optimize outcomes, the IC coordinates communication between providers, specialists, and participants, clarifying roles, timelines, and expectations. They also monitor referral progress, track service delivery, and address logistical or procedural barriers, such as eligibility conflicts or resource availability. If gaps arise, the IC provides technical assistance to refine referral criteria or identify alternative solutions. By centralizing this process, the IC reduces fragmentation, accelerates access to critical supports, and ensures specialists contribute meaningfully to participant independence and milestone achievement.

On-Going Case Management

The Innovation Coordination (IC) entity ensures continuous, proactive oversight of participant progress through systematic case management practices. This includes conducting routine audits of individual case files to verify compliance with program standards, accuracy of documentation, and alignment with Person-Centered Service Plan (PSCP) objectives. Audits help identify discrepancies, outdated information, or missed updates, enabling the IC to collaborate with provider agencies on corrective actions. Case notes and PSCP processes are dynamically revised to reflect evolving participant needs, milestone adjustments, or changes in service delivery, ensuring records remain current and actionable.

Monthly check-ins with provider agencies and participants serve as a cornerstone of ongoing support, allowing the IC to review progress, address emerging challenges, and celebrate achievements. These touchpoints also provide opportunities to validate data, assess resource utilization, and recalibrate strategies as needed. To preempt gaps in milestone progression, the IC conducts targeted outreach to stakeholders and participants, gathering feedback and identifying barriers—such as service delays or unmet needs—that may require intervention. By integrating audit findings, check-in insights, and stakeholder input, the IC fosters a responsive, data-driven approach to case management that prioritizes participant success while maintaining accountability across the MAPs program.

5.5: Documentation of IC Services

In the MAPs program, effective case management and documentation are pivotal to ensuring individuals receive the appropriate services/supports they need. The Department and the IC agency are committed to maintaining a collaborative approach to documentation systems. This narrative outlines the frequency and structure of documentation related to IC/case management services, ensuring all relevant information is systematically recorded and accessible.

Collaborative Documentation Systems

The Department and the IC agency may collaborate on documentation systems to streamline the management of individual case files. The IC is responsible for overseeing and managing these case files, which are essential for tracking the progress and needs of participants. All communications with stakeholders, including family members, must be documented in the Case Notes section of a designated collaborative space, such as SharePoint. This shared documentation system allows for transparency and accessibility of information among all authorized parties involved with the participant's care.

Requirements for Documentation

When documenting communications, it is essential to adhere to specific guidelines to maintain clarity and professionalism. All correspondence should include the following elements:

1. **Date and Time:** Every entry must indicate when the communication occurred, providing a chronological record of interactions.

2. Brief Summary of Discussion: A concise overview of the topics discussed should be included, capturing the essence of the communication without extraneous details.

3. Factual Content: All documentation must be entirely factual and objective. Personal anecdotes, opinions, or subjective interpretations are not permitted, as they can lead to misunderstandings and detract from the professionalism of the case file.

Monthly and Quarterly Communication Protocols

To establish and maintain effective communication with participants and stakeholders, the IC is required to engage in regular outreach. The following protocols should be observed:

- a. Monthly Communication: The IC should make a concerted effort to communicate with participants and stakeholders at least once a month. This communication can take various forms, including phone calls, emails, or virtual meetings. Each instance of communication must be documented accordingly in the Case Notes section on SharePoint, following the documentation requirements.
- b. Quarterly In-Person Visits: In addition to monthly communications, the IC is expected to conduct in-person visits with the participant at least once every quarter. These visits provide an opportunity for more in-depth discussions about the participant's needs, progress, and any changes in their situation. Each in-person visit should also be documented in the case file, reflecting the date, time, and a summary of the interactions.
- c. Monthly Check-In Form: As part of the monthly check-in process, when establishing contact with participants and stakeholders, the IC must document this occurrence directly on the monthly check-in form itself. This form serves as a consolidated record of all monthly interactions, ensuring no communications go unrecorded.

Documentation of Electronic Correspondence

In between in-person sessions, any email or electronic correspondence with participants, family members, or other stakeholders must be documented in the case file. This includes tracking important communications which may occur due to changes in the participant's circumstances or the need for additional support. Each electronic communication should follow the same documentation guidelines, ensuring all relevant information is captured and accessible.

The frequency and thoroughness of documentation within the MAPs program are critical for effective case management and the provision of services/supports to individuals with developmental disabilities. By following the established protocols for communication and documentation, the IC can ensure all interactions are recorded accurately and comprehensively. This not only enhances the quality of care provided, but also fosters collaboration among all involved stakeholders, ultimately leading to better outcomes for participants. Adhering to these guidelines will promote a culture of accountability and transparency, reinforcing the commitment of both the Department and the IC agency to support participants in their journey toward achieving their goals.

5.6: Changing IC's

The need for a change in Innovation Coordinators (ICs) can arise from various circumstances, each requiring careful consideration and a structured approach to ensure a seamless transition for participants supported by the MAPs Program. Common scenarios that may lead to a change in an IC include participant choice, turnover at the IC agency, agency-driven matching processes to better align ICs with participant needs, and the necessity for stand-by or initial roll-out support during times of high demand. Regardless of the reason, it is essential that agencies have clear procedural guidelines in place to manage these transitions effectively.

When an IC change is initiated, it is vital to update all relevant case files promptly. This includes documenting the reasons for the change, the date of transition, and any important notes regarding the participant's support plan that may assist the incoming IC in providing continuity of care. Ensuring that all documentation is accurate and comprehensive not only supports the new IC in their role but also protects the integrity of the participant's support process. Agencies should have established procedures for completing these updates, including timelines and responsible parties, to promote accountability and thoroughness.

In addition to updating case files, notifying stakeholders and participants about the change is a critical step in the transition process. Clear communication helps to alleviate any concerns participants may have regarding their support and fosters trust in the agency's commitment to their well-being. Notifications should include detailed information about the new IC, their qualifications, and how they can be contacted. Agencies should also provide reassurance that the transition will not disrupt the continuity of care, and that the incoming IC is well-informed about the participant's needs and preferences.

The responsibility for developing and implementing step-by-step processes for IC changes lies with the IC agency. Agencies should create and maintain a comprehensive protocol that outlines the specific actions to take when an IC change is necessary. This protocol should include guidelines for assessing the need for a change, steps for transitioning responsibilities, timelines for completing necessary documentation, and communication strategies for informing all relevant stakeholders. Regular training and reviews of these procedures will help to ensure that all staff members are familiar with the processes and can execute them effectively, minimizing disruption and maintaining the quality of supports provided.

By addressing these considerations and establishing clear processes for IC changes, agencies can ensure that transitions are handled smoothly and that participants continue to receive the high-quality support they deserve, regardless of any changes in their Innovation Coordinator.

5.7: Milestone Validation

The Innovation Coordinator (IC) plays a pivotal role in the milestone validation process within the MAPs Program, ensuring that each participant's progress is accurately tracked and validated against established goals. As the primary entity responsible for this function, the IC will oversee the collection, organization, and review of all requests related to milestone achievement. This process begins with the IC receiving documentation from participants or their support teams, which includes evidence and metrics that demonstrate progress toward specific milestone goals. It is crucial for the IC to meticulously organize this information to ensure a thorough and efficient validation process.

Once the IC has gathered all relevant requests and supporting documentation, their next responsibility is to confirm that the milestone goal statement has been achieved in alignment with the corresponding milestone achievement statement.

This step requires a careful review of the submitted evidence to ascertain that all necessary metrics have been met. The IC must evaluate the quality and relevance of the documentation, ensuring that it directly correlates with the milestone goal being assessed. By maintaining a detailed and structured approach to this review, the IC can provide objective validation that reflects the participant's accomplishments accurately.

Upon completing the review of the submitted evidence, the IC will validate the milestone, formally acknowledging that the participant has met the criteria outlined in their support plan. This validation not only serves as a record of progress but also communicates to participants, stakeholders, and funding agencies that the goals set forth are being achieved. The IC's role in this process is vital, as it reinforces the accountability and integrity of the MAPs Program, ensuring that all milestones are assessed fairly and transparently.

In addition to validating milestones, the IC is also responsible for submitting exception requests when necessary. These requests may include scenarios such as a milestone repeat, where participants may need additional time or support to meet a specific goal, or a budget extension, which would allow for additional resources to be allocated as needed. The IC must clearly articulate the reasons for these exceptions, providing supporting evidence and rationale to justify the requests. By proactively managing these exceptions, the IC ensures that participants receive the flexibility required to progress effectively while maintaining the program's standards and goals.

Ultimately, the IC's comprehensive involvement in milestone validation and exception requests not only supports the individual journey of each participant but also reinforces the MAPs Program's commitment to fostering meaningful outcomes through structured oversight and personalized support. Through careful organization, diligent review, and responsive action, the IC serves as a crucial link between participants and the broader goals of the program, facilitating an environment where achievement is recognized and celebrated.

5.8: Management of Participant Budget

The IC plays a vital role in managing the participant's budget within the MAPs program, ensuring funds are allocated efficiently and effectively to support the achievement of milestones. Each participant is allocated an annual budget of \$20,000 to cover various services/supports necessary for their development. In addition,

participants have access to a dedicated ET solutions budget of \$2,500 per year, specifically earmarked for technology-related enhancements which promote independence and facilitate the overall program experience. The IC's responsibility extends beyond simple oversight; they must actively engage in budgeting processes to ensure participants can access the resources they need while maintaining fiscal accountability.

The management of the participant's budget begins with careful monitoring during the milestone validation process. As milestones are achieved and validation requests are approved, the IC assesses the associated costs to ensure they align with the overall budget constraints. Each approved milestone incurs specific expenses, which the IC must track closely to avoid exceeding the allocated funding. This process includes a thorough review of service delivery costs, ensuring participants receive the necessary supports without compromising their budgetary limits. The IC's role is crucial in facilitating discussions with provider agencies to confirm service costs are reasonable and aligned with the participant's goals.

Once a milestone is validated, the IC is responsible for updating the participant budget tracker in SharePoint within 24 to 48 business hours. This prompt action is essential for maintaining an accurate reflection of available funds and ensuring all stakeholders have access to real-time budget information. The budget tracker serves as a comprehensive tool which not only outlines current spending, but also provides forecasts for future expenditures, thereby enabling participants and their Support Teams to make informed decisions about resource allocation. Regular updates to this tracker enhance transparency and accountability, allowing participants to see how their funding is being utilized throughout their journeys in the MAPs program.

In addition to monitoring milestone-related expenditures, the IC must also manage the ET solutions budget. This includes facilitating the allocation of funds for necessary technology supports which enhance the participant's experience and promote independence. By managing both budgets effectively, the IC helps participants maximize their resources while ensuring they receive the appropriate support to achieve their milestones.

The IC must engage in ongoing communication with participants and their Support Teams regarding budget management. This involves discussing the available funding, reviewing expenditures, and strategizing future allocations based on upcoming milestones and needs. By fostering an open dialogue about budgeting, the IC empowers participants to take ownership of their funding and encourages proactive planning for their ongoing support.

In summary, the IC's responsibilities in managing the participant's budget encompass the entire spectrum of budgeting processes, from monitoring expenses during



milestone validation to updating the budget tracker promptly. Their commitment to maintaining accurate financial records and facilitating open communication ensures participants can access the necessary resources to achieve their goals while staying within their budgetary constraints. Through diligent budget management, the IC plays a crucial role in enhancing the overall success of the MAPs program and supporting participants on their journeys toward independence.

Chapter 6:

General Provider Requirements

Providers participating in the MAPs program must adhere to foundational requirements designed to uphold program quality, accountability, and participant safety. First and foremost, all provider agencies must maintain appropriate licensing, certifications, and credentials as mandated by state and federal regulations, as well as MAPs-specific standards. This includes ensuring staff delivering services meet competency criteria and complete ongoing training relevant to their roles (e.g., Enabling/Assistive technology use, or behavior support strategies, MAPs Orientation Training, etc.). Providers are also responsible for notifying the Innovation Coordination (IC) entity of any changes to their service capacity, or scope of practice to ensure uninterrupted participant support.

MAPs contracted provider agencies are responsible for delivering the identified MAPs services. Provider agencies will utilize innovative approaches to the delivery of the services and are encouraged to utilize least-to-most intervention strategies to avoid learned dependency on provided supports. Using ET solutions, providers will assist people in achieving milestone independence in the above-mentioned areas. After gaining independence, the provider agency will follow the IC milestone validation processes which will initiate the value-based payment and invoicing processes. It shall be noted that the PSCP shall be the driving document which outlines and describes the selected milestones for the MAPs participant.

To adapt to evolving participant needs, providers are expected to develop and expand their service offerings in alignment with MAPs' innovative, person-centered framework. This requires establishing internal policies and procedures that address critical areas such as participant rights, confidentiality, risk management, grievance resolution, and cultural responsiveness. Providers must also implement a formal Quality Assurance (QA) plan that outlines processes for monitoring service delivery, evaluating outcomes, and addressing deficiencies. The QA plan should include routine self-audits, stakeholder feedback mechanisms, and corrective action protocols. Additionally, meticulous service documentation is mandatory: providers must maintain accurate, timely records of all interventions, progress notes, participant communications, and milestone-related evidence. Documentation must align with Person-Supported Collaborative Plan (PSCP) objectives and be submitted to the IC in accordance with program timelines.

Providers are strongly encouraged to proactively develop internal operating guidelines that operationalize these requirements. This includes creating staff training programs,

standardizing documentation practices, and designating roles for compliance oversight. By embedding these standards into daily operations, providers not only ensure regulatory adherence but also enhance their capacity to deliver consistent, high-quality services that drive participant success. Regular collaboration with the IC—through trainings, audits, and feedback loops—further strengthens alignment with MAPs’ mission and fosters a culture of continuous improvement.

6.1: Licensure Requirements

All MAPs provider agencies must obtain proper licensing through the Department to deliver MAPs services effectively. This requirement ensures all providers meet the established standards for quality, safety, and accountability in supporting people with I/DD. Licensing is a crucial step in maintaining a consistent level of care across the MAPs program, helping to ensure participants receive the highest quality of services and supports tailored to their unique needs.

Licensing in the MAPs program is NOT limited by geographical region. Provider agencies that hold a single license in one area are permitted to deliver services statewide, expanding their capacity to assist participants across various locations. This flexibility allows for a more comprehensive network of support, enabling providers to reach people who may benefit from MAPs services regardless of where they live within the state. As a result, participants have access to a broader range of resources and services and supports, enhancing their opportunities for growth and independence.

6.2: Personnel Requirements

Provider agencies retain flexibility in designing staffing structures that align with their organizational capacity and service delivery models, provided they ensure all personnel directly involved in delivering MAPs program supports meet mandatory training and competency standards. While agencies may allocate staff across multiple programs or roles, any individual assigned to MAPs-related services must complete training on program-specific requirements, including but not limited to: person-centered planning practices, MAPs documentation standards, milestone validation processes, confidentiality protocols, and participant rights. Training must be completed prior to service delivery and refreshed periodically to align with program updates.

Agencies are responsible for establishing administrative systems that mitigate challenges associated with staff who split time across programs. For example,

providers may implement role-specific training trackers, designate MAPs program coordinators, or develop internal cross-training resources to ensure compliance without compromising service quality. Staffing structures could include dedicated MAPs teams, shared roles with clear accountability, or hybrid models supplemented by administrative supports (e.g., documentation specialists or quality assurance officers). While the MAPs program does not prescribe specific staffing ratios or hierarchies, agencies must demonstrate that their chosen structure enables consistent, uninterrupted service delivery and adherence to all program policies.

Providers are encouraged to proactively identify and address potential gaps in staff capacity, such as scheduling conflicts or knowledge retention, through strategies like mentorship programs, streamlined communication channels, or technology-aided workflows. Regular internal audits of training records and staff performance evaluations should be conducted to ensure ongoing compliance. By balancing autonomy with accountability, the MAPs program empowers providers to tailor staffing solutions to their unique operational needs while prioritizing participant outcomes and program fidelity.

6.3: Required Provider Policies

Provider agencies participating in the MAPs program must establish and maintain a comprehensive set of policies that align with program standards, regulatory requirements, and best practices in service delivery. While agencies may leverage existing policies developed for other programs, they must ensure these are explicitly adapted or expanded to address MAPs-specific priorities. At a minimum, providers are required to implement the following policies:

1. **MAPs-Specific Training Policy:** A policy outlining mandatory training for all staff involved in MAPs services, including initial and ongoing education on person-centered planning, milestone validation processes, documentation standards, and participant rights. Training completion must be tracked and verified.

2. **Enabling Technology Utilization Policy:** A framework for assessing, implementing, and promoting enabling technology tools that enhance participant independence and milestone achievement. This includes staff training on relevant technologies and protocols for integrating these tools into service plans.

3. **Value-Based Payment (VBP) Recognition Policy:** A policy demonstrating alignment with MAPs' value-based payment structure, which ties reimbursement to



participant outcomes and milestone completion. This should define how the agency tracks, reports, and optimizes services to meet performance metrics.

4. Participant Rights and Confidentiality Policy: Clear guidelines ensuring adherence to confidentiality laws (e.g., HIPAA), informed consent practices, and protections for participant autonomy, dignity, and privacy.

5. Service Documentation and Compliance Policy: Protocols for maintaining accurate, timely records of services delivered, progress notes, and evidence submitted for milestone validation. Documentation must meet audit-ready standards and align with Individualized Service Plans (ISPs).

6. Quality Assurance (QA) and Continuous Improvement Policy: A structured QA plan that includes regular internal audits, stakeholder feedback mechanisms, corrective action processes, and annual reviews to refine service delivery.

Providers are encouraged to develop internal operating guidelines that operationalize these policies, ensuring staff understand expectations and workflows. For example, agencies might create manuals, checklists, or digital tools to standardize compliance. Additionally, providers should prepare for oversight by external entities (e.g., the Innovation Coordination entity, state regulators, or third-party auditors) by maintaining organized, accessible records and designating compliance officers.

By integrating these foundational policies into their operations—whether adapted from existing frameworks or developed anew—providers uphold program integrity, mitigate risks, and foster a culture of accountability. Regular policy reviews and updates, informed by stakeholder input and evolving MAPs guidelines, ensure continued alignment with the program’s mission to drive innovation and participant success.

6.4: Provider Quality Assurance Plans

Provider agencies must implement a Quality Assurance (QA) Plan that ensures adherence to MAPs program standards, promotes continuous improvement, and safeguards participant outcomes. While agencies may adapt QA plans developed for other programs, the plan must explicitly address MAPs-specific operational considerations, including milestone validation, participant-centered service delivery, and innovation-driven practices. At minimum, the QA Plan must incorporate the following elements:

1. **Milestone Validation Audits:** Processes to routinely review documentation and evidence submitted for milestone validation, ensuring alignment with program criteria and participant goals. This includes verifying that provider staff follow standardized procedures for evidence collection, submission, and corrective action if gaps are identified.

2. **Participant-Centered Service Reviews:** Mechanisms to evaluate whether services align with Individualized Service Plans (ISPs) or Person-Centered Service Plans (PSCPs). This may involve case file audits, participant interviews, or observations to ensure services remain tailored to individual needs and preferences.

3. **Enabling Technology Integration Checks:** Assessments to confirm staff competency in utilizing enabling technologies and that these tools are consistently integrated into service delivery to maximize participant independence.

4. **Documentation Compliance Monitoring:** Regular audits of service records, progress notes, and milestone-related documentation to ensure accuracy, timeliness, and compliance with MAPs and regulatory requirements.

5. **Stakeholder Feedback Systems:** Structured channels (e.g., surveys, focus groups, or grievance logs) to collect input from participants, families, and the Innovation Coordination (IC) entity. Feedback must inform QA improvements and address systemic barriers.

6. **Corrective Action Protocols:** Clear steps to resolve deficiencies identified through audits or feedback, including root-cause analysis, staff retraining, and timelines for remediation.

7. **Continuous Improvement Strategies:** Annual reviews of QA processes to incorporate MAPs updates, emerging best practices, and lessons learned from milestone outcomes or stakeholder input.

Providers are encouraged to align their QA Plans with existing organizational frameworks (e.g., accreditation standards or state compliance programs) but must ensure MAPs-specific priorities are distinctly addressed. Collaboration with the IC entity is critical; providers must share audit findings, improvement plans, and progress updates as requested. By embedding these components into their QA infrastructure, providers not only meet compliance requirements but also foster a culture of accountability, innovation, and participant-driven excellence. Regular staff

training on QA protocols and transparency with external monitors further solidify the plan's effectiveness in advancing the MAPs mission.

6.5: Provider Subcontracts

The MAPs program operates under the terms and conditions outlined in the Grant Contract Agreement, which serves as the governing authority for all relationships with contracted provider agencies. Sub-contracting arrangements are generally not accepted within the MAPs framework, as the program emphasizes direct service delivery by contracted entities to ensure accountability, continuity, and alignment with participant-centered goals. Exceptions to this standard are strictly limited and must comply with all stipulations set forth in the Grant Contract Agreement.

In the rare instance where sub-contracting may be considered, the primary provider agency retains full responsibility for fulfilling all programmatic, financial, and compliance obligations under the Grant Contract Agreement. Sub-contractors, if utilized, must meet all MAPs program requirements, including licensing, training, and quality standards equivalent to those mandated for primary providers. Any proposed sub-contracting arrangement must be justified through formal documentation that demonstrates its necessity, alignment with participant goals, and adherence to the Grant Contract Agreement. Providers are strongly encouraged to address capacity or expertise gaps through internal staff development, resource reallocation, or program-supported partnerships rather than sub-contracting. By prioritizing direct service delivery, the MAPs program upholds its commitment to consistency, innovation, and participant trust.

6.6: Provider Direct Services/Supports (In-Person vs. Virtual)

As a core responsibility within the MAPs program, provider agencies are tasked with delivering high-quality, person-centered direct support to participants. These supports are crucial in helping people with I/DD achieve greater independence, engage in meaningful community activities, and progress toward identified milestones. Provider agencies must ensure their services are aligned with the goals outlined in each participant's PSCP and tailored to meet the unique needs and preferences of the participant. Direct supports play a critical role in promoting personal growth and building the skills necessary for long-term independence.

Direct services and supports within the MAPs program are delivered through both in-person and virtual methods, depending on the specific service area and participant needs. In-person services and supports may include job coaching, life skills training,

social engagement activities, and/or other hands-on assistance required to meet the participant's objectives. These face-to-face interactions often offer valuable opportunities for real-time feedback, socialization, and personalized guidance. Provider agencies must ensure in-person services and supports are delivered safely and effectively, considering the health, safety, and accessibility needs of each participant.

In contrast to in-person services and supports, virtual services and supports have become an increasingly important service delivery option within the MAPs program. Virtual services and supports can encompass services such as tele-support consultations, virtual mentoring, remote skill-building activities, or employment readiness coaching delivered through digital platforms. Virtual services and supports delivery offer participants greater flexibility, allowing them to access support from their home, workplace, or community settings. This flexibility can be particularly beneficial for participants who face barriers related to transportation, mobility, or scheduling. Provider agencies are encouraged to adopt innovative approaches and ET solutions to enhance the virtual services and supports experience while maintaining the same high standards of care expected with in-person interactions.

Regardless of the method of delivery, provider agencies are responsible for ensuring all direct services and supports—whether in-person or virtual—are designed to meet the specific needs of each participant. Provider agencies must continuously monitor participant progress, adjusting services and supports as necessary to address changing needs or goals. They must also ensure all direct services and supports are documented thoroughly, capturing the services delivered and any progress toward milestone completion. Whether in-person or virtual, the goal remains the same: empowering MAPs participants to grow, thrive, and achieve greater independence in their daily lives.

6.7: Provider Agency Roles and Expectations

Provider Agency Roles and Expectations: The provider agency plays a pivotal role in the success of the MAPs program by ensuring participants receive tailored, high-quality, and innovative services that align with the MAPs program's goals of promoting independence, community integration, and the effective use of ET solutions. This responsibility requires a commitment to creativity, collaboration, and adherence to best practices which drive meaningful outcomes for participants with I/DD.

Key Responsibilities:

- Innovation in Service Delivery:

Provider agencies are expected to leverage cutting-edge approaches, technologies, and strategies to meet the diverse needs of participants. This includes implementing ET solutions which support participants in achieving greater independence, fostering social connections, and navigating community environments. Provider agencies must continuously evaluate and adapt their methods to stay ahead of emerging trends and ensure services remain dynamic and person-centered.

- **Person-Centered Practices:**
Agencies must prioritize person-centered planning and service delivery. This includes collaborating with participants, their families, and stakeholders to create and implement the PSCP. The PSCP must reflect each participant's unique preferences, goals, and aspirations, while providing a clear roadmap for service implementation.
- **Flexibility and Responsiveness:**
Providers must demonstrate flexibility in addressing participants' evolving needs. This includes adapting service delivery models, offering additional or adjusted services and supports when warranted, and collaborating with the MAPs program support personnel. to ensure timely interventions that maintain continuity of care.
- **Data-Driven Decision Making:**
Agencies are expected to track progress toward milestones using data to validate achievements and inform services and supports adjustments. This involves maintaining detailed records of interactions, conducting specific milestone assessments as a pre- and post-measure of a participant's goals and achievements, providing monthly check-ins, and submitting comprehensive reports to the Innovation Coordination agency. Transparency and accuracy in data collection are essential for ensuring accountability and refining service delivery.
- **Collaboration with MAPs Innovation Coordinators:**
Provider agencies must work closely with ICs to align services and supports with program expectations. This includes participating in joint assessments, milestone validations, and budget management processes. Provider agencies should actively contribute insights and recommendations which enhance participant outcomes while fostering a cohesive and collaborative service network.
- **Commitment to Training and Professional Development:**

Provider agencies are responsible for equipping staff with knowledge and skills necessary to deliver innovative services and supports. This includes participating in MAPs program trainings, staying informed about industry advancements, and fostering a culture of continuous learning within the organization.

- **Advocacy and Empowerment:**
Provider agencies must advocate for participants' rights and opportunities, empowering them to make informed choices and take ownership of their lives. This involves identifying and addressing barriers to independence, promoting community inclusion, and encouraging participants to pursue meaningful goals.
- **Adherence to Ethical Standards and Compliance:**
Provider agencies must uphold the highest ethical standards in services and supports delivery and comply with all MAPs program policies, state regulations, and contractual obligations. This includes safeguarding participant privacy, ensuring informed consent, and delivering services with integrity and respect.

6.8: Service Documentation

The Department contracts with community provider agencies that have demonstrated leadership characteristics in employment supports, person-centered practices, and utilization of ET solutions. The DDA is proud to partner with these provider agencies to deliver MAPs services and supports. Value-based payment processing differs from fee-for-service in that the provider agency is not expected to deliver the services and supports in accordance with a direct frequency. MAPs provider agencies are encouraged to implement innovative and collaborative approaches to the delivery of services and supports, which results in documentation requirements differing from what is expected in a fee-for-service program. Value-based payment processes require evidence showing the identified milestone/goal has been achieved. This begins by identifying a "present level" during plan development and is indicated within the Milestone Goal Statement. Once that "present level" has been assessed and established, the provider agency will implement the MAPs services and supports to increase that "present level" showing growth of independence over time towards the milestone definition. Provider agencies are encouraged to implement documentation strategies which allow them to gather necessary data regarding service delivery which leads to confirmation of milestone achievement. The IC agency will request evidence of milestone completion as the primary component to approve milestone validation request processes. Provider agencies participating in the MAPs program are required to maintain

accurate and comprehensive documentation of all interactions and services and supports delivered to MAPs participants. This documentation serves multiple purposes, including ensuring compliance with program standards, supporting the validation of milestones and fostering clear communication between provider agencies, participants, and the MAPs program administration. Provider agencies are encouraged to use innovative tools and strategies to capture and track participant progress while ensuring all required documentation is submitted in a timely and organized manner.

At the core of this documentation requirement is the monthly check-in report, which must be completed by the 20th of each month, covering all services and supports delivered in the previous month. The monthly check-in serves as the primary means of tracking participant progress, summarizing all provider agency interactions, and securing the evidence needed to confirm the completion of milestones. Provider agencies have flexibility in how they document their interactions, whether through digital tracking tools, secure communication platforms, or traditional record-keeping methods. However, the monthly check-in is a non-negotiable element of provider responsibility and must be submitted within the designated timeframe.

In addition to monthly reports, provider agencies must gather and submit supporting documentation for milestone validation. This may include photos, videos, progress notes, pre- and post-assessment data, or other relevant evidence that verifies a participant's achievement of key program outcomes. Provider agencies are encouraged to be creative in how they capture evidence, but all submissions must demonstrate milestones have been met according to the program's guidelines.

Required Documentation for MAPs Participants

- Consents: All signed consent forms for participation in the MAPs program.
- PSCP: Initial PSCP and any subsequent amendments.
- Monthly Check-Ins: Documentation of monthly progress check-ins with the participant.
- Completed Assessments on VCRM: All assessments conducted using the VCRM.
- Community Relationships: Records of participant, engagement, and relationships within the community.
- Community Outings: Documentation of community outings and participation in events.

- Independent Transportation Assessments: Evaluations related to the participant's ability to navigate transportation independently.
- Home/Safety Assessments: Assessments focusing on the safety and suitability of the participant's living environment.
- Medical Management Assessments: Evaluations related to the participant's management of health needs (excluding health-related records).
- Financial Literacy Management Assessments: Assessments focusing on the participant's financial literacy and management skills.
- Milestone Evidence: Documentation evidencing the achievement of specific milestones outlined in the PSCP.
- ET Solutions Assessments and Plans: Records of assessments and plans related to the use of ET solutions to support independence.
- Any additional consultations (Benefits Counseling assessments, Housing Plans, etc.,)

By adhering to these documentation expectations, MAPs provider agencies will ensure they are supporting participants effectively and consistently, while also fulfilling their responsibilities for compliance and quality assurance.

6.9: Required Documentation and Frequency

- Interaction Summaries
 - Description: A summary of all provider-participant interactions, noting progress, challenges, and services supports delivered.
- Frequency: Ongoing (document as interactions occur).
- Monthly Check-In Report
 - Description: A comprehensive report summarizing all services and supports provided during the previous month. This report is required for ongoing participant tracking and milestone validation.
 - Frequency: Monthly (by the 20th, covering the previous month).
- Milestone Validation Evidence

- Description: Documentation confirming the achievement of specific milestones. This may include photos, videos, progress reports, or any other relevant evidence.
 - All provider agencies should conduct a pre-assessment on the chosen milestone for the participant. This pre-assessment will establish the “present level” of the participants independence towards the chosen milestone.
 - All providers should conduct a post-assessment on the chosen milestone for the participant once the milestone has been completed. This post-assessment will establish the “achieved level” of the participants independence towards the chosen milestone.
- Frequency: As milestones are completed (submit upon completion of each milestone).
- Assessment Notes
 - Description: Detailed notes outlining the participant’s development and any notable changes in services and supports delivery or outcomes.
 - Frequency: Ongoing (submit with monthly check-in and milestone validation processes, as necessary).

6.10: Comprehensive Records Storage Expectations

Maintaining comprehensive and accurate records for MAPs participants is essential to ensure the delivery of high-quality services and supports. Effective documentation not only facilitates continuity of care, but also enhances accountability and transparency within the program. Provider agencies are expected to keep detailed records which reflect each participant's journey, including their assessments, goals, achievements, and any relevant consent forms. This structured documentation process allows for informed decision-making and helps identify areas for improvement, ultimately fostering a more person-centered approach to housing navigation and support.

Provider agencies and IC agencies are advised to retain records for a minimum of 10 years to avoid potential liability and ensure compliance with regulations.

6.11: Provider Communication and Collaboration with MAPs Team

Effective communication and collaboration between provider agencies and the MAPs Program support personnel and Innovation Coordination staff are essential to delivering high-quality, person-centered services/supports. Provider agencies are expected to maintain open, regular communication with all MAPs personnel, ensuring all updates, concerns, and services/supports adjustments are shared promptly. This collaborative effort supports the smooth delivery of services/supports and ensures participant needs are consistently met through the active exchange of relevant information.

Provider agencies must engage in scheduled monthly check-ins with the MAPs Program support personnel, including updates on participants' progress toward goals, any challenges encountered, and potential modifications to the PSCP. In addition to these formal check-ins, provider agencies are encouraged to maintain ongoing communication outside of scheduled meetings, particularly in the event of changes in a participant's status, such as emerging health concerns, changes in living arrangements, or adjustments in service needs.

Collaboration also extends to ensuring all parties work together in planning and implementing services/supports. Provider agencies are expected to collaborate with the IC and other MAPs Team members to support participants in achieving their milestones. This involves not only fulfilling the service requirements, but also offering input on how services/supports can be enhanced or modified to better align with each participant's evolving goals. Provider agencies should also coordinate with the MAPs Team to ensure all documentation, including interaction summaries and evidence for milestone validation, is accurate, complete, and submitted according to established timelines.

Ultimately, the success of MAPs participants relies heavily on the quality of communication and partnership between provider agencies and the MAPs Team. A collaborative approach helps to resolve challenges quickly, ensures continuous alignment with the participant's PSCP, and fosters an environment where the participant's growth, independence, and well-being are prioritized at every stage of service delivery.

6.12: Ethical Standards and Code of Conduct

Provider agencies delivering services/supports within the MAPs program are expected to uphold the highest ethical standards and adhere to a strict code of conduct. These guidelines ensure all actions taken by provider agencies align with the values of dignity, respect, and person-centered care always promoting the well-



being and rights of participants. The following ethical standards and codes of conduct are required for all provider agencies:

- Respect for Participant Autonomy and Dignity

Provider agencies must always respect the rights, preferences, and dignity of participants. This includes ensuring participants have the right to make decisions about their care, participate in the development of their PSCP, and exercise control over their daily lives. Provider agencies should engage participants in meaningful discussions about their services/supports and outcomes, ensuring their choices are honored whenever possible.

- Commitment to Person-Centered Care

Provider agencies are required to deliver services/supports which are person-centered, individualized, and focused on the participant's unique goals and aspirations. Each service/support provided must be based on the individual's PSCP and consider their abilities, strengths, and desired outcomes. Provider agencies should avoid a "one-size-fits-all" approach and instead tailor their services/supports to enhance the participant's independence and quality of life.

- Confidentiality and Privacy

Provider agencies are entrusted with sensitive information about participants and their families and are expected to handle this information with the utmost confidentiality. Personal information must only be shared with authorized individuals and in accordance with legal and regulatory requirements. Provider agencies must comply with Health Insurance Portability and Accountability Act ("HIPAA") and other relevant privacy laws to protect the confidentiality of participant records and communications.

- Integrity and Transparency

All provider agency actions and decisions must be conducted with honesty, transparency, and integrity. This includes accurate reporting of services/supports delivered, the proper use of funds, and the honest communication of any issues or concerns. Provider agencies must avoid any conflicts of interest which could compromise the participant's care or their professional judgment.

- Commitment to Professionalism and Accountability

Provider agencies are expected to maintain the highest levels of professionalism in all interactions with participants, their families, and MAPs Team members. This



includes treating all individuals with respect, being responsive to communication, and meeting agreed-upon timelines for service delivery. Provider agencies must also be accountable for their actions, taking responsibility for ensuring services/supports are delivered as outlined in the PSCP and meeting all compliance and regulatory requirements.

- Non-Discrimination

Provider agencies must deliver services/supports without bias or discrimination. All participants, regardless of their race, ethnicity, religion, gender, disability, or any other protected characteristic, must be treated equally and fairly. Provider agencies should foster an inclusive environment which supports diversity and ensures equal access to services/supports for all participants.

- Advocacy and Participant Rights

Provider agencies are expected to advocate for the rights of participants and support them in accessing the resources, services/supports, and opportunities they need to thrive. Provider agencies should educate participants about their rights, encourage self-advocacy, and take appropriate actions to address any violations of participant rights. This includes reporting incidents of abuse, neglect, or exploitation to the appropriate authorities.

By adhering to these ethical standards and the code of conduct, provider agencies play a critical role in ensuring the safety, well-being, and empowerment of MAPs participants. Provider agencies are expected to review these standards regularly and integrate them into all aspects of their service delivery.

6.13: Provider Termination of Services

If a provider's MAPs services/supports are terminated, whether voluntarily or involuntarily, it is essential to recognize that this situation may arise and to prepare for a seamless transition for participants. The termination process must be conducted with careful consideration of the affected participants' needs to ensure their continuity of care. It is expected that all necessary provisions are put into place to minimize disruption to services/supports, including timely communication with participants and their support networks.

Collaboration during this transition phase is of utmost importance, as it allows for the identification of alternative service providers and the implementation of individualized transition plans. The MAPs program is committed to facilitating this



process, ensuring that participants continue to receive the support and resources they require to achieve their goals, even amidst changes in their service providers. By prioritizing continuity of care, we uphold our commitment to the well-being and stability of all MAPs participants throughout the transition process.

6.13.a: Voluntary Termination of Services

When a provider wishes to voluntarily terminate their agreement with the MAPs program, it is crucial to adhere to established timelines and steps to ensure an orderly transition and continuity of care for participants. The following outline provides a clear framework for this process, while also emphasizing the need to comply with all contractual requirements.

Timeline and Steps:

1. **Notice of Intent to Terminate:**

The provider must submit a written notice of intent to terminate their agreement at least 30 days prior to the desired termination date. This notice should specify the reasons for termination and the intended last day of service.

2. **Review of Contractual Obligations:**

Upon receipt of the termination notice, the MAPs program will review the provider's contractual obligations to ensure compliance with any specific stipulations regarding termination. This includes any required notifications to participants and other stakeholders.

3. **Participant Communication:**

The provider is responsible for informing all affected MAPs participants the upcoming termination in a timely manner. This communication should outline the transition plan and provide information on alternative service options.

4. **Transition Planning:**

The provider and MAPs program will collaborate to develop a transition plan that ensures continuity of care for participants. This plan should identify alternative providers, outline steps for transferring care, and set timelines for completing the transition.

5. **Final Documentation and Handover:**

Prior to the termination date, the provider must complete all necessary documentation related to participant care, ensuring that all relevant

information is readily accessible for the new service providers. This may include care plans, progress notes, and any other pertinent records.

6. Post-Termination Follow-Up:

After the termination process is complete, the MAPs program will conduct follow-up assessments with the transitioned participants to ensure that their needs are being met and that they have successfully connected with new providers.

By adhering to these timelines and steps, the MAPs program and the voluntarily terminating provider can work together to minimize disruption for participants, uphold contractual obligations, and maintain a high standard of care throughout the transition process.

6.13.b: Involuntary Termination of Services

In the event of an involuntary termination of services/supports from the Department to a provider agency, it is imperative to follow a structured process to ensure the orderly transition of care and minimize any potential disruption to MAPs participants. The following steps outline the necessary actions and timelines to be considered during this process, while also emphasizing compliance with contractual requirements.

Timeline and Steps:

1. Notification of Involuntary Termination:

The Department will provide written notification to the provider agency regarding the decision to terminate services/supports. This notification will include the reasons for termination and the effective date of the termination, which shall typically allow for a minimum of 30 days for transition planning.

2. Review of Contractual Obligations:

The Department will review the provider's contractual obligations to confirm compliance with any provisions related to involuntary termination. This includes assessing the need for notifying participants and other stakeholders about the change in services/supports.

3. Participant Communication:

The provider agency must promptly inform all affected MAPs participants about the involuntary termination, providing them with details regarding the transition plan and information about alternative service options available to them.



4. Transition Planning:

The Department will collaborate with the provider agency to develop a transition plan aimed at ensuring continuity of care for participants. This plan should identify alternative service providers, outline the necessary steps for the transfer of care, and establish timelines to facilitate a seamless transition.

5. Final Documentation and Handover:

Before the termination date, the provider agency is required to complete all relevant documentation related to participant care. This includes ensuring that care plans, progress notes, and other critical records are organized and accessible for new service providers to ensure continuity of care.

6. Post-Termination Follow-Up:

Following the completion of the termination process, the Department will conduct follow-up assessments with participants who have transitioned to new providers. This assessment will help verify that participants' needs are being met and that they have successfully integrated into new service arrangements.

By adhering to these timelines and steps, the Department can facilitate a structured and compassionate transition for participants affected by an involuntary termination, while upholding contractual obligations and maintaining the quality of care throughout the process.

6.13.c: Grounds for Termination of Provider Contracts

Termination of a contract with a provider agency can arise from a variety of circumstances, reflecting the need for adherence to contractual obligations and the overall health of the partnership. Below is a thorough narrative outlining several grounds for termination, which should be viewed as examples and not an exhaustive list.

1. Breach of Contract

One of the most common grounds for termination is a breach of contract. This occurs when one party fails to fulfill their obligations as outlined in the agreement. Breaches can be categorized into two types:

- Material Breach: This is a significant violation that undermines the contract's purpose. For example, if a provider agency fails to deliver essential services or goods, or if the services/supports provided do

not meet the quality standards specified in the contract, it constitutes a material breach and may warrant termination.

- Minor Breach: While not as severe, a minor breach may still justify termination if it affects the overall performance of the contract or if the provider has a history of repeated minor breaches.

2. Failure to Meet Performance Standards

Contracts often include specific performance metrics or standards that must be met by the provider agency. If the agency consistently fails to meet these standards—such as deadlines, quality of service, or compliance with regulations—this could serve as grounds for termination. For example, if an agency is contracted to provide timely reports and repeatedly submits them late, this could indicate a failure to perform as agreed.

3. Non-Compliance with Laws and Regulations

A provider agency must operate within the legal and regulatory framework relevant to their services/supports. Non-compliance with applicable laws, industry regulations, or licensing requirements can be grounds for termination. For instance, if a provider is found to be operating without the necessary licenses or permits, or if they violate health and safety regulations, the contract may be terminated to mitigate potential legal risks.

4. Insolvency or Financial Instability

The financial health of a provider agency is crucial to their ability to fulfill contractual obligations. Signs of insolvency, such as filing for bankruptcy or having a history of late payments, may indicate that the agency is unable to sustain its operations. In such cases, termination may be necessary to protect the interests of the contracting party and ensure continuity of services/supports.

5. Unsatisfactory Communication and Collaboration

Effective communication and collaboration are vital for a successful partnership. If a provider agency demonstrates a pattern of poor communication—such as failing to respond to inquiries, not attending scheduled meetings, or being uncooperative—this can hinder project progress and impact outcomes. Continued communication breakdowns may be grounds for termination, especially if they impede the ability to resolve issues or achieve mutually agreed-upon goals.

6. Change in Ownership or Control

A significant change in the ownership or control of a provider agency can also be grounds for termination. If the agency is sold, merges with another entity, or undergoes a substantial restructuring that affects its ability to meet contractual obligations, the contracting party may choose to terminate the agreement. This is especially relevant if the new ownership does not align with the values or standards of the original contract.

7. Misrepresentation or Fraud

If a provider agency is found to have misrepresented its capabilities, qualifications, or any aspect of its services/supports during the contracting process, this can be grounds for termination. Fraudulent behavior, such as falsifying documents or providing misleading information to secure the contract, not only breaches trust but also violates the terms of the agreement.

8. Lack of Availability or Resources

A provider agency must have the necessary resources, including personnel, equipment, and technology, to fulfill its contractual obligations. If the agency becomes unable to provide these resources—due to staffing shortages, equipment failures, or other operational issues—this may jeopardize the contract's execution and serve as grounds for termination.

Terminating a contract with a provider agency is a serious decision that should be made with careful consideration of the circumstances. The grounds for termination outlined above provide a framework for understanding when such action may be warranted. Each situation may require its own assessment, and it is advisable to consult legal counsel or contract management professionals to ensure compliance with legal requirements and to mitigate potential repercussions. Ultimately, maintaining clear communication and addressing issues promptly can often prevent the need for termination and foster a more productive partnership.

6.13.d: Process for Appealing Contract Termination

If a provider agency's contract with the MAPs program is terminated, it is crucial to ensure that there is a fair and transparent process for appealing the decision. Providing an avenue for appeal not only upholds the principles of due process but also fosters accountability and trust between the contracting authority and provider agencies. While the decision to terminate a contract may arise from various



factors—such as performance issues, compliance failures, or funding changes—the opportunity for providers to present their case allows for a thorough review of the circumstances surrounding the termination.

The appeal process is designed to be equitable and straightforward, allowing provider agencies to contest the termination in a structured manner. This process can serve as a mechanism for identifying and addressing any misunderstandings or miscommunications that may have contributed to the termination decision.

Moreover, it provides an opportunity for the contracting authority to reassess the situation and consider any mitigating factors that could lead to a different outcome.

Appeal Process Steps

1. **Notification of Termination:** Upon the decision to terminate a contract, the provider agency will receive a formal notification detailing the reasons for the termination and the effective date.
2. **Request for Appeal:** The provider agency may submit a written request for appeal within a specified timeframe (e.g., 10 business days) after receiving the termination notice. This request should include a clear statement of the reasons for the appeal, any supporting evidence, and the desired outcome.
3. **Review Panel Formation:** Upon receipt of the appeal request, the contracting authority will establish a review panel comprised of impartial members who were not involved in the initial termination decision. This panel will assess the appeal.
4. **Appeal Hearing:** The provider agency will have the opportunity to present their case during a scheduled hearing. This may include submitting additional documentation, providing witnesses, or making a verbal presentation to support their appeal.
5. **Decision:** Following the hearing, the review panel will deliberate and render a decision. The outcome will be communicated to the provider agency in writing, along with an explanation of the rationale behind the decision.
6. **Finality of Decision:** The decision made by the review panel will be considered final and binding.

By allowing for an appeal process, the MAPs program not only ensures fairness in the management of provider contracts but also promotes a culture of continuous improvement and collaboration. It is essential, however, to consult legal counsel to ensure that the appeal process aligns with contractual obligations and regulatory frameworks governing the MAPs program. This consideration is vital for maintaining compliance and mitigating potential legal risks. Ultimately, fostering a transparent and fair appeal process can strengthen relationships and enhance the overall effectiveness of the MAPs program.

6.13.e: Reapplication and Reinstatement Considerations

The MAPs program values the contributions of all provider agencies and recognizes that circumstances can change, creating opportunities for reengagement in the MAPs network. Agencies that have previously participated in the program and wish to reapply are encouraged to do so through a transparent and structured Requests for Applications (RFA) process. This process is designed to ensure that all reapplications are considered fairly and equitably, allowing for the continued enhancement of services/supports offered to participants.

To be eligible for reapplication, provider agencies must demonstrate their competencies and leadership in alignment with the Division of Developmental Disabilities (DDA) pillars of transformation, which include employment supports, ET solutions, and person-centered practices. Agencies are expected to provide clear evidence of their commitment to these principles, showcasing innovative approaches, successful outcomes, and ongoing efforts to enhance the quality of support offered to individuals.

Once the applications are received, they will be reviewed and scored by a panel of impartial reviewers who possess expertise in the relevant areas. This panel will assess each application based on established criteria that reflect the DDA's pillars of transformation, ensuring that only those agencies that meet the necessary standards and demonstrate a commitment to excellence will be considered for funding.

It is important to note that the number of available contracts for the MAPs network is subject to appropriations and funding availability. Therefore, while all applications will be evaluated thoroughly, the final decision on contract awards will be influenced by the resources allocated to the program.



Through this structured reapplication process, the MAPs program aims to foster a dynamic network of providers committed to delivering high-quality, person-centered services/supports which empower individuals to thrive in their communities. We encourage agencies to take this opportunity to showcase their growth, innovation, and dedication to advancing the goals of the MAPs program.

Chapter 7:

Staff Development and Training

The MAPs (Medicaid Alternative Pathways to Independence) program recognizes that the quality of supports provided to individuals is directly tied to the knowledge, skills, and preparedness of its staff. This section outlines the comprehensive approach to staff development and training designed to equip team members with the tools and competencies necessary to deliver innovative, person-centered MAPs supports effectively.

While traditional Direct Support Professional (DSP) onboarding training forms the foundation of core skills, the MAPs program has developed specialized training modules tailored to its unique mission and methodologies. These program-specific courses emphasize cutting-edge strategies and technology-driven components integral to MAPs, such as leveraging the virtual community resource map and implementing individualized travel training programs. By blending foundational DSP principles with MAPs innovations, staff will gain the expertise needed to empower individuals in building independence, community connections, and self-determined futures.

Agencies are advised to consult the DDA-developed MAPs Training Matrix for the most up-to-date requirements, which serves as the definitive guide to mandatory and recommended training pathways. This section should be referenced as a dynamic resource, providing clarity on course expectations, competency benchmarks, and opportunities for ongoing professional growth. Together, these elements ensure staff are not only prepared to meet the evolving needs of those they serve but also aligned with MAPs' commitment to creativity, adaptability, and unwavering person-centered focus.

Through intentional training and continuous development, MAPs staff will embody the program's vision, transforming potential into progress for every individual.

7.1: Competency-Based Training Courses

The MAPs program embraces a blended approach to staff training, recognizing that diverse learning styles and operational demands require flexibility in how knowledge and skills are delivered. To cultivate well-rounded, confident professionals, agencies are encouraged to leverage multiple methodologies, including online learning management systems (LMS), in-person instruction, and on-the-job shadow training. Each method serves a distinct purpose: online LMS modules offer self-paced, accessible learning for foundational concepts, such as navigating MAPs-specific tools like the virtual community resource map. In-person



training fosters collaborative learning through workshops and role-playing scenarios, enabling staff to practice person-centered strategies and troubleshoot real-world challenges in a guided environment. Meanwhile, on-the-job shadowing bridges theory and practice, allowing staff to observe seasoned professionals, refine techniques like travel training, and gain firsthand experience in dynamic, individualized support settings.

Agencies should view these methodologies not as standalone options but as interconnected components of a holistic training strategy. By layering online coursework with interactive sessions and hands-on mentorship, staff deepen their understanding of MAPs principles while adapting to the unique needs of those they serve. Providers are advised to expand upon MAPs' pre-required training by tailoring supplementary activities—such as agency-specific simulations or peer-led tech tool demonstrations—to reinforce competencies. Regularly consulting the DDA's MAPs Training Matrix ensures alignment with evolving standards, while agency-led innovations in delivery methods help maintain engagement and relevance. Together, this multi-faceted approach ensures staff are not only compliant with requirements but also equipped with the practical confidence and creativity to uphold MAPs' mission and represent your organization with professionalism and empathy.

Different Methodologies of Training Opportunities

a. Relias

Relias is an online learning software utilized by the Department of Disability and Aging (Department) for required trainings. All courses on Relias are web-based and can be completed at your own pace. Each agency has its own Relias administrator who is responsible for the assignment of all classes throughout the Relias portal. Each Direct Support Professional (DSP), Employment Staff, and Supervisor should consult with their Relias administrator to ensure assignment of all classes.

b. Live Events

Live events are trainings that occur at a set date and time with a live trainer within the Relias ELS. Provider administrative staff are responsible for the registration of all live event training sessions within Relias.

c. Shadow Training

Provider organizations are responsible for the implementation of shadow

training for all staff. MAPs has no requirements regarding shadow training outside of the requirements determined by the provider agency.

7.2: Staff Categories Training Requirements

The Department has established a training matrix that is accessible via the MAPs website. This training matrix outlines all required training for all MAPs staff. Provider agencies are encouraged to reference this training matrix for updates and to ensure the provider agency is compliant with required training. This training matrix can be located by visiting this site [\(MAPs Training Matrix\)](#).

This Training Matrix allows for provider agencies to access required training for the following supporters:

- DSPs and DSP Supervisors
- Job Coaching Supports
- Job Development Supports
- Innovation Coordination Staff (IC's, Supervisors, and Administrative Staff)
- Optional Training

Provider agencies should ensure the timelines and access to the trainings are addressed for each staff prior to the delivery of MAPs services.

Provider Agency Training Requirements **Provider Orientations**

MAPs Provider Orientations are required introductory trainings for all new provider agency staff who will be implementing MAPs services. All 3 Provider Orientations are available on Relias.

1) Exploring Medicaid Alternative Pathways to Independence: An Introductory Overview- Provider Orientation 1

This session is on Relias with the Course Code MAPs_ProviderOrientation_1.

This session introduces the MAPs program for all provider agencies.

The following topics are discussed in the training session:

- What is MAPs?
- MAPs Development, MAPs Enrollment, What makes MAPs Different

- MAPs Outcomes and Milestones, Payment Breakdowns
- MAPs Partnerships

2) Charting Independence: Exploring MAPs Outcomes, Services and Milestones- Provider Orientation 2

This session can be found on Relias with the Course Code MAPs_ProviderOrientation_2.

This session dives deeper into the MAPs program and important information for providers as they begin to deliver MAPs services.

The following topics are discussed in the training session:

- MAPs Milestones
- MAPs Service Definitions
 - VCRM
 - Independence Coaching
 - Employment Innovation
 - Community Navigator
 - Enabling Technology
 - Innovation Coordination
- MAPs Payment Structure
 - Billing Resource Guide
- VCRM Validation Tool

3) Discovering Independence Routes: Additional MAPs Resources- Provider Orientation 3

This session can be found on Relias with the Course Code MAPs_ProviderOrientation_3.

The following topics are discussed in the training session:

- MAPs Incentive Payments
- MAPs Service Rates and Frequency
- MAPs Access to Smartphone Devices and Data Plans
- MAPs Exploration Series
- Enabling Technology Process
- Exception Request Resource Guide

These resources are available on the [MAPs website](#) under the “More Provider Resources” tab.



- [MAPs Person-Supported Establishment Incentive](#)
- [MAPs Provider Development Incentive](#)
- [MAPs Value Based Payment and Incentive](#)
- [MAPs Access to Smartphone Devices and Data Plans](#)
- [MAPs Service Rates and Frequency](#)
- [MAPs Transition Guide Exploration Series](#)
- [Exception Request Resource Guide](#)

4) Milestones/Outcomes/Service Definitions

Training regarding the MAPs program milestones, outcomes, and service definitions is provided through the Provider Orientation 2 training curriculum.

All MAPs service definitions can be located on the MAPs website in the Provider Resources section.

The following service definitions are available via the MAPs Website.

- Community Navigator
- Employment Innovation
- Enabling Technology
- Independence Coaching
- Virtual Community Resource Mapping (VCRM)
- Peer Mentoring
- Innovation Coordination Services

All the above services are monitored as a part of the Person-Supported Collaborative Plan (PSCP) by the Innovation Coordination agency.

5) AbleLink Applications

AbleLink Smart Living Technologies has developed a suite of downloadable applications accessible via a mobile device. These applications will assist the MAPs participants to achieve greater levels of independence at home, at work, and in the community. To ensure all stakeholders can effectively utilize these applications, the Department has made the following trainings accessible.

MAPs program staff should enroll in training on the AbleLink applications at the following link: [AbleLink Training Form](#).

To sign up for the trainings on Visual Impact and Endeavor, please select Smart Living Application Training on the form. Instructions to log in to the

platform to the AbleLink training courses will be sent to the email of the trainee that completed the form.

Additionally, step-by-step training on the AbleLink applications and downloadable resources are available online on the [AbleLink MAPs Resources page](#). The learning library provides video tutorials for utilizing the Endeavor, Visual Impact, and Wayfinder applications.

An in-depth training on the Wayfinder application is provided through the required Travel Training (see Travel Training Resource Guide).

Please note that all MAPs program staff are required to take both the Travel Training and Smart Living Application Training (Visual Impact and Endeavor).

The following applications are available on each participant's MAPs phone and are to be utilized to assist with the delivery of MAPs services.

- **WayFinder:** With AbleLink WayFinder, specific travel routes can be created, then activated from the GPS location. The GPS-based tracking triggers WayFinder to safely guide the user with step-by-step visual and audio instructions. WayFinder can help ensure the traveler that they are on the correct route by pointing out important landmarks along the way and even telling them "This is not your stop" when they see others departing.
- **Endeavor:** AbleLink Endeavor provides time-based reminders, calendar management, and audio to-do lists in a cognitively accessible format. Events are presented with an alarm, image, and audio instruction and can be linked to detailed tasks in Visual Impact.
- **Visual Impact:** AbleLink Visual Impact is an engine for completely customized creation of step-by-step instructional content. Images, video clips, audio messages, and checklists can all be incorporated for personalized guidance. Time-sensitive Visual Impact tasks can be linked to calendar reminders in Endeavor.

6) Provider Actions- What's Next?

Orientation with Innovation Coordination Services

All provider organizations will conduct a new provider orientation session with the MAPs innovation coordinator agency.

Orientation with IC covers the following topics:

- Mission/Philosophy of IC Agency
- Phase 1: Getting to Know the Person Supported
- How to Prepare for MAPs Referrals

- Phase 2: Receiving and Responding to a Provider Referral Snapshot (as applicable)
- Ready for Payment: Provider Development Incentive
- Phase 3: How to Prepare for the Collaborative Roundtable Meeting
- Phase 4: How to Report Monthly Progress
- How to Contact your IC

Your MAPs transition guide can assist you with coordinating this Innovation Coordination agency orientation. Note: this training is not required for all DSPs. The Department recommends agency leadership responsible for the oversight and delivery of the MAPs program to attend this IC orientation.

7.3: Completing Training within the Required Time Frames

Timely completion of training is critical to maintaining the integrity and effectiveness of the MAPs (Medicaid Alternative Pathways to Independence) program. Adherence to established training timelines ensures that all staff possess the up-to-date knowledge, skills, and certifications necessary to deliver safe, innovative, and person-centered supports to MAPs participants. Provider agencies must prioritize compliance with these requirements to uphold service quality, safeguard participant outcomes, and align with the Department of Developmental Administration (DDA) policies. Failure to meet training deadlines risks gaps in staff competency, which may directly impact the well-being and progress of individuals served.

MAPs training requirements—including foundational onboarding, program-specific modules, and technology-focused instruction—are designed to equip staff with the expertise to implement MAPs methodologies confidently, such as utilizing the virtual community resource map or facilitating travel training. Agencies are responsible for tracking staff progress, addressing delays proactively, and ensuring all training is completed within the DDA-mandated timeframes. Non-compliance with these deadlines will be formally documented during the provider's annual Quality Assurance (QA) Monitoring Commitment review. Persistent or unresolved training deficiencies may trigger enforcement actions in accordance with DDA regulations, underscoring the importance of diligence in meeting these benchmarks.

By adhering to training timelines, agencies not only demonstrate their commitment to operational excellence but also reinforce their accountability to participants, families, and regulatory partners. This section serves as a reminder that timely training completion is non-negotiable—it is foundational to delivering the high-standard, compliant services that MAPs participants deserve. Providers are urged to



reference the MAPs Training Matrix regularly and implement internal tracking systems to ensure staff remain on schedule, fully prepared, and aligned with the program's mission of fostering independence and community inclusion.

7.4: Training Documentation

Accurate documentation and verification of training completion are essential to uphold the standards of the MAPs program and demonstrate compliance with DDA requirements. Provider agencies must maintain thorough, organized records for all staff training activities—including online coursework, in-person sessions, and on-the-job shadowing—to confirm that competencies are achieved within mandated timeframes. These records serve as a critical safeguard, verifying that staff possess the knowledge and skills necessary to deliver safe, effective, and person-centered supports to MAPs participants.

Agencies are responsible for implementing systems to track and archive training completion certificates, competency assessments, and attendance logs. Documentation should be readily accessible for review during DDA audits, annual Quality Assurance (QA) Monitoring Commitment evaluations, or other compliance reviews. Staff supervisors must verify completion of all MAPs-specific and foundational training modules prior to assigning independent responsibilities to ensure readiness. Failure to produce validated records may result in non-compliance findings during monitoring, underscoring the importance of rigorous documentation practices. By prioritizing meticulous record-keeping, agencies not only protect their operational integrity but also reinforce their commitment to transparency, accountability, and the highest standards of care for those they serve.

7.5: Training Resources

The MAPs program provides a suite of training resources to ensure staff are fully equipped to deliver high-quality, compliant supports. Central to this effort is the MAPs Training Matrix, developed by the DDA, which outlines all mandatory and recommended training pathways, timelines, and competency benchmarks. This matrix serves as the primary roadmap for agencies to align staff development with program standards. Additional specialized guides—such as the Travel Training Resource Guide and Virtual Community Resource Map (VCRM) Training Resource Guide—offer step-by-step instructions, best practices, and troubleshooting strategies for implementing MAPs' innovative, technology-driven components.



Agencies should also reference the MAPs Overall Training Resource Guide, a comprehensive document consolidating program philosophies, operational protocols, and links to supplementary materials. These resources are designed to complement one another, creating a cohesive framework for staff preparedness. Provider agencies are urged to consult these guides routinely, alongside other applicable DDA policies, to stay informed of updates, clarify expectations, and address emerging challenges. Training materials are living documents, refined to reflect evolving best practices and regulatory requirements. By proactively leveraging these resources, agencies empower staff to master MAPs methodologies, uphold person-centered principles, and maintain compliance while fostering independence for participants.

Chapter 8:

Protection from Harm/Reportable Events Management

The Medicaid Alternative Pathways to Independence (MAPs) program is committed to safeguarding the health, safety, and rights of all participants. This section aligns with the Developmental Disabilities Administration (DDA)'s policies and protocols for identifying, reporting, investigating, and resolving incidents that pose risk or harm. MAPs adheres to all mandated timelines for reporting critical events, including abuse, neglect, exploitation, significant injuries, or rights violations, ensuring immediate notification to the DDA and other relevant authorities. Staff and providers are trained to recognize and mitigate risks, employ preventive strategies, and follow standardized procedures for documentation, corrective action, and participant advocacy. Collaboration with stakeholders—including caregivers, healthcare providers, and oversight agencies—ensures transparency and accountability while prioritizing the dignity and well-being of individuals served.

MAPs maintains a proactive stance toward risk management by integrating continuous quality improvement into its Protection from Harm framework. All reportable events undergo rigorous root-cause analysis to address systemic gaps and prevent recurrence. By fostering a culture of vigilance, education, and ethical responsibility, MAPs ensures compliance with regulatory requirements while upholding its mission to empower individuals with disabilities in safe, supportive environments. This dual focus on adherence and innovation reinforces the program's dedication to minimizing risks and promoting accountability at every level of service delivery.

8.1: Notification

The MAPs program strictly adheres to all DDA's notification timelines and protocols for reportable events, including but not limited to allegations of abuse, neglect, exploitation, significant injuries, or rights violations. As mandated reporters, MAPs staff are required to immediately escalate concerns to DDA and relevant authorities (e.g., Adult Protective Services, law enforcement) in accordance with state and federal regulations, regardless of DDA's concurrent obligations. This dual accountability—aligning with DDA's policies while independently fulfilling mandated reporting duties—ensures transparency, prioritizes participant safety, and upholds legal and ethical standards across all levels of the program. Training on these requirements is reinforced annually to maintain compliance and responsiveness.

8.2: Reportable Events Management Requirements

The MAPs program adheres rigorously to DDA's established protocols, policies, and procedures for managing reportable events, ensuring alignment with state and federal mandates. All incidents falling under DDA's defined categories—including abuse, neglect, exploitation, significant injuries, rights violations, and unexpected deaths—must be promptly identified, documented, and reported in accordance with DDA's timelines, investigation standards, and corrective action frameworks. MAPs staff and providers are required to follow DDA's prescribed processes for incident reporting, risk mitigation, and participant protection without exception, including collaboration with DDA investigators and external agencies as needed. Training on these requirements is standardized across the program to ensure consistency, accountability, and compliance. By mirroring DDA's expectations without deviation, MAPs reinforces its commitment to safeguarding participants, upholding regulatory obligations, and maintaining trust in the integrity of its services.

8.3: Investigation Requirements

The MAPs program fully adopts DDA's investigation requirements, ensuring all reportable events are reviewed with the rigor, objectivity, and transparency mandated by DDA policy. Investigations align with DDA-defined protocols, including timelines for initiation, evidence collection, witness interviews, and final reporting. MAPs staff and providers cooperate fully with DDA/Provider-led investigations and any external agencies (e.g., law enforcement, Adult Protective Services) involved, adhering strictly to confidentiality and procedural standards. Corrective actions, when required, are implemented in accordance with DDA guidelines to address root causes and prevent recurrence. Training on investigative expectations is integrated into staff onboarding and annual refreshers, reinforcing compliance with DDA's framework. MAPs does not deviate from these requirements, ensuring accountability and uniformity in upholding participant safety and program integrity.

Chapter 9

MAPs Services Definitions and Incentives

The MAPs program is designed to empower individuals with disabilities and aging adults through a holistic, person-centered framework that fosters independence, community integration, and personal growth. This chapter outlines the core services integral to the MAPs program, each tailored to address distinct aspects of a participant's journey toward milestone independence. These services include Community Navigation, Independence Coaching, Employment Innovation, Virtual Community Resource Mapping (VCRM), Peer Mentoring, and Enabling Technology. Together, they form a cohesive network of support, enabling participants to build skills, access resources, and engage meaningfully in their communities. While this section provides a high-level overview of each service's purpose and role within the MAPs model, detailed operational guidelines, and implementation protocols can be found in the accompanying "Service Definitions" documents.

Central to the MAPs program is the recognition that sustainable progress requires both individualized support and systemic flexibility. Community Navigators assist participants in connecting to local resources, while Independence Coaches focus on skill-building for daily living and self-advocacy. Employment Innovation partners with employers and participants to create inclusive, adaptive work experiences for participants, and VCRM ensures personalized access to community programs that align with personal interests and goals. Peer Mentoring fosters empowerment through shared lived experiences, and Enabling Technology provides tools to enhance autonomy, safety, and communication.

By aligning these services with the MAPs program's mission, providers play a pivotal role in helping participants achieve their unique aspirations. This chapter underscores the importance of fidelity to service definitions while encouraging creativity in tailoring approaches to individual needs. Providers are urged to leverage the incentives embedded within the MAPs framework—such as value-based funding allocations to amplify their impact and sustain long-term participant success. For comprehensive details on service delivery standards, refer to the "Service Definitions" section of this manual.

9.1: Service Rate Description

The purpose of the Milestone/Incentive Rate Structure resource is to provide Innovation coordinators ("IC's") and provider agencies with detailed information and clear parameters for the payments that are made available through the MAPs program. This payment structure provides access to the services offered through MAPs, the budget management considerations, and a single payment structure for

each Milestone/Incentive payment that is available throughout the duration of the MAPs program. Provider agencies are encouraged to reference this Rate Structure sheet to confirm the accuracy in payment details when submitting invoices.

Description:

The MAPs program makes payment(s) available to vendors and partners on a Value-Based Payment Structure in which MAPs enrollees can access their annual budget to provide payment for the achievement of Milestones and/or Incentive payments. This resource will guide the available rates associated with Milestone and Incentive payments.

MAPs Services: Persons who enroll in the MAPs program will have access to three (3) years of funding for the following services, which will be delivered by contracted MAPs providers.

Independence Coaching	Virtual Community Resource Mapping (VCRM)
Community Navigator	Employment Innovation
Enabling Technology	Peer Mentoring

Budget Management: Persons who enroll in the MAPs program will have access to an annual service budget of \$20,000 per year for three (3) years (totaling \$60,000). The services/incentives described below are funded from the person's annual budget of \$20,000. Payments for services will be tracked by the Innovation Coordination Agency and DDA to ensure each person successfully manages their funding and does not exceed their maximum annual budget.

The enrollee's \$20,000 budget is accessible for the Value-Based payment approach to services delivered by contracted provider agencies. When an enrollee has attained greater levels of independence in the below-mentioned milestones, this budget will be accessed to provide services payment to the contracted provider agency.

ANNUAL BUDGET ALLOTMENTS DO NOT CARRY OVER FROM YEAR TO YEAR.

MAPs Payment Structure:

MAPs Payment Structure	RATE (Per Enrollee)	Frequency
<u>Provider Development Incentive</u>	\$3,000	A single payment is available during the first year of MAPs program. Upon a

	Single Payment	provider agency accepting to support a new MAPs enrollee, this Provider Development Incentive is an available billable payment for the provider agency. <i>NOTE: Not transferrable from provider to provider and is a one-time single payment.</i>
<u>Virtual Community Resource Map (VCRM)</u>	\$5,000 Single Payment	Single payment upon verification of VCRM completion.
<u>Milestone Payments (11)</u> - Home Safety - Personal Hygiene - Health Management - Financial Management - Pre-Employment - Employment Innovation - Career Development - Independence Achieved - Independent Travel - Community Relationships - Community Activities	\$4,000 Per Milestone	Each Milestone Payment is available one time over the course of a person's three-year MAPs program.
<u>Enabling Technology</u>	Per Occurrence	Persons supported will have access to an annual budget of up to \$2,500 that can be used toward the purchase and/or implementation of Enabling Technology solutions. Costs for remote support (when a person is not receiving direct in-person support) will be evaluated on a case-by-case basis.
<u>Person-Supported Establishment Incentive</u>	\$4,000 Single Payment	At the conclusion of a person's third year of receiving MAPs services, if the person has been successful at achieving 6 MAPs Validated and Distinct Milestones of the 11 Milestones through the lifespan of the MAPs program, they will be eligible to receive a one-time Person-Supported Establishment Incentive payment. <i>NOTE: The Establishment Incentive payment must be deposited into an ABLE account for the person supported.</i>

9.2: Pre-Claim Service Validation Requests

Provider agencies will utilize a “Pre-Claim Service Validation” process to initiate milestone/incentive validation. In this process, the provider agency will submit a request to the Innovation Coordination Agency, requesting verification of specific Incentive, Milestone, or VCRM completion. The submission process will be used when a provider has achieved completion of incentive criteria OR validation of specific Milestone in accordance with this Billing Resource Guide.

Upon completion of a MAPs Incentive AND/OR Milestone, the provider agency may submit the Pre-Claim Service Validation Request Form ([MAPs - Pre-Claim Service Validation Request](#)) with associated evidence and information for review. Upon submission, the IC will review all submitted information for validation consideration (see below).

This Pre-Claim Service Validation Request process requires accuracy and thoroughness on behalf of the provider agency to ensure timely processing. Each section of the Pre-Claim Service Validation Form MUST be completed accurately and thoroughly for each submission. Any discovered error in the completion of the Pre-Claim service request will result in a denial of the submission. Provider agencies are encouraged to ensure that all details are submitted accurately and accordingly. This form consists of the following:

MAPs Participant Information

- Last Name
- First Name
- Member ID (1st 3 letters of First name, 1st 3 letters of last name and last 4 of SS# I.E. JayCam1234)
-

Provider Information

- Provider Information/Provider Point of Contact /Address and Email
- Participants Innovation Coordinator

NOTE: Accuracy within the email addresses will ensure that all automated notification processes are completed accordingly.

Service/Milestone Validation

- Selection of Service/Milestone (only one service/milestone can be selected with each request)
 - In the event the provider is requesting payment for the Enabling Technology Post-Claim submission, an additional opportunity will avail where the provider can input the actual

amount used to procure the enabling technology solutions. This amount will correlate with the actual reimbursement noted on the invoice AND proof of purchase (receipt). All 3 components are needed for payment for Enabling Technology.

Service Start Date (the date when the provider agency initiated the implementation of services associated with that Milestone). For the provider development incentive, this is the enrollment date of the participant.

Service Completion Date (the date when the provider agency completes the implementation of services associated with Milestone. This date shows the timeline in which a provider worked with a person supported to achieve milestone independence. This date will be reviewed to confirm that the milestone was completed within the applicable planning year. This date does not reflect the date the provider is submitting the pre-claim request).

PSCP Initial Milestone Goal Statement

- *Enabling Technology Requests should CONFIRM chosen milestone for completion.*
- *Milestone Goal Statements are ONLY mandatory for Milestone Validation Requests. For Incentive Payments and VCRM, providers can indicate "N/A" in this section).*

EXAMPLE:

Initial Milestone Goal Statement: Community Relationships

Brock is active in his community with his family and natural supports. He attends church and participates in Special Olympics sports. He would like to find more activities where he can build more relationships and friendships in his community on his own. Over a month-long observation period, Brock will be observed having recurring and natural relationships or contacts either with unpaid support or with other community members in POIs. This includes but is not limited to showing independent, naturally occurring, and regular contact with their social network and/or POIs and showing proficiency in navigating social engagements and challenges to maintain sustainable relationships and/or memberships.

PSCP Milestone Achievement Statement

- Enabling Technology Requests should CONFIRM Anticipated Milestone Achievement.
- Milestone Achievement Statements are ONLY mandatory for Milestone Validation Requests. Incentive Payments and VCRM, the provider can indicate "N/A").

EXAMPLE:

Milestone Achievement Statement: Brock has made connections and developed relationships in the community beyond his natural support. He is going to the gym where he has met a friend that he works out with. He found a golf group that he has joined at local driving ranges and is independently asking a cousin to be invited to tee times once a month. He is better about initiating conversation with others via text instead of waiting for them to call or text him. Over a month-long observation period, he was observed having recurring and natural relationships or contacts either with unpaid support or with other community members in POIs. This includes, but is not limited to showing independent, naturally occurring, and regular contact with their social network and/or POIs and showing proficiency in navigating social engagements and challenges to maintain sustainable relationships and/or memberships.

- Link to Virtual Community Resource Map
- Additional Correspondence

Note: This section can include where additional evidence can be located for validation requests. This section will allow the provider agency to indicate additional narratives to be considered for Milestone/Incentive validation.

Enabling Technology Pre-Claim Service Requests:

All Enabling Technology Funding requests will also use this pre-claim service request process. Within the Pre-Claim Service Validation Form, there are 2 designated options for Enabling Technology requests.

1. Enabling Technology **(Pre-Claim Approval)**: This request is to confirm that the MAPs person supported has available funding within the annual ET budget. Upon receipt of this approval, the Provider agency, in addition to other ET protocol requirements, can progress towards the procurement of the ET solutions in association with the Enabling Technology plan. Items required for ET Pre-Claim Validation:

- a. Enabling Technology Plan (completed by MAPs Provider Agency).
- b. Quote from ET Vendor identifying targeted ET solutions.

2. Enabling Technology **(Post-Claim Approval)**: This request is for AFTER the ET solutions have been secured and installed. This approval will be necessary for invoice submission and reimbursement to the provider agency. NOTE: Associated milestone completion is NOT required for Post-Claim Approval. Access to reimbursement of ET solutions ensures that the

provider agency can access timely reimbursement for the procurement of the ET solution. Upon readiness to submit for Enabling Technology reimbursement, the provider must submit the following for processing of ET reimbursement:

- a. Email Approval for ET Post-Claim Validation
- b. Invoice confirming the actual amount of purchased solution.
- c. Proof of Purchase (a receipt is an example; other confirmations may be accepted as well)

All 3 correspondences must ensure that the noted amount is identical. Any discrepancy will result in a denial of processing the invoice.

Submission through the online portal is the **PRIMARY** means for submitting Milestone/Incentive Validation requests. In the event the online portal is not functioning, MAPs provider agencies and IC supports will be notified indicating that the PDF version (available on the DDA MAPs website) will be accepted as a secondary means of submission. When available, the online portal will resume as the primary method for the Pre-Claim Service Validation request.

Upon receipt, the IC will have 30 calendar days to review the validation request and at during targeted intervals throughout the validation review process, automated notifications will be sent to the IC and Provider Agency of "STATUS" of the formal request. In the event additional evidence is necessary, the IC will work directly with the provider agency to identify methods to confirm additional evidence (all Technical Assistance measures will be noted in the collaborative SharePoint for review).

Upon approval of Milestone/Incentive Validation, an automated email will be sent to the email address identified by the provider in the submission process confirming approval. This email will be used in conjunction with the MAPs Invoice for payment processes.

PLEASE NOTE: INVOICES WILL NOT BE PROCESSED WITHOUT CONFIRMATION OF APPROVED EMAIL OR SIGNED PDF MILESTONE VALIDATION REQUEST.

9.3: MAPs Invoice

To receive payment for DDA MAPs services/supports, each vendor must be a recognized supplier through Edison. Additional information on how to become a registered supplier through Edison can be located here: [\(Edison Supplier Information\)](#). Upon verification of being a recognized supplier through Edison, provider agencies are encouraged to develop a STANDARD FORMAT for invoice processing. DDA provides access to a standardized template located here: [MAPS Invoice Final.](#)

Provider agencies should complete these invoices accurately and thoroughly to ensure processing of invoice payment processes. In the event an invoice is received and is not complete/clean, the entire invoice will be denied and sent back to the provider with an explanation of the findings. The provider will be responsible for resubmitting the entire claim for processing (invoice, approval notification, AND proof of purchase (if applicable)). DDA will only process CLEAN CLAIMS.

Provider Information: Agency: Address: Phone: Email:	 Medicaid Alternative Pathways Invoice Invoice #: Date: Pay Now
To: DDA Invoicing Department of Disability & Aging UBS Building, 8th Floor 315 Deaderick Street Nashville, TN 37243 Email to: DIDD.MAPS@tn.gov	For: Account Name: Edison Record #: Edison Vendor #: Federal Employer ID #:

The top portion of the invoice should be completed in its entirety by the provider agency.

- **Provider Information**
 - **Agency:** This is the name identified on the Contract Agreement between DDA and the Supplier/Provider Agency.
 - **Address:** This is the physical address located within the Contract Agreement between DDA and the Supplier/Provider Agency.
 - **Phone:** This is the contact phone number located within the Contract Agreement between DDA and the Supplier/Provider Agency.
 - **Email:** This is the Email address located within the Contract Agreement between DDA and the Supplier/Provider Agency.

Invoice #: This is the invoice number assigned by the Supplier/Provider Agency. Provider agencies are encouraged to identify an invoicing coding procedure that allows distinct differentiation between all invoices (*i.e., MAPS_120102023 OR MAPS_01-01-2024_DDA*). *NOTE: these are examples, and any variation of coding can be utilized if there are distinct differences between invoices. This invoice number cannot be duplicated on future invoices.*

Date: This is the date by which the Supplier/Provider Agency is submitting the invoice.

For

- Account Name: This is the name directly from the Contract Agreement
- Edison Record #: This number can be located directly from the Contract Agreement. Often referred to as the Contract #.
- Edison Vendor #: This number can be located directly from the Contract Agreement.
- Federal Employer ID #: This number is directly associated with the Federal ID number assigned to the Supplier/Provider Agency and on record within the Edison supplier portal.

NOTE: The “FOR” section will only change if/when a new contract agreement is executed and can be copied/pasted from one invoice to the next (pending no contract changes OR changes within Edison).

Date Completed	Milestone/Incentive Claim	Person ID	Amount
	Select Item:		
	Select Item:		
	Select Item:		
	Select Item:		
	Select Item:		
	Select Item:		
	Select Item:		
	Select Item:		
	Select Item:		

Date Completed: This is the date the Milestone/Incentive was completed. This date should correspond with the date of the approval on the validation review.

Milestone/Incentive Claim: This section is reserved for the selection of individual milestones/incentives that the Supplier/Provider Agency identified as billing.

Person ID: This is the same as the MEMBER ID (see above).

Amount: This amount will be determined using the MAPs Service Reimbursement Structure MAPs - Services Reimbursement and Frequency

NOTE: A provider may include multiple Milestone/Incentives on a single invoice sheet. A new invoice sheet is NOT needed for every single Milestone Validation payment request.

TOTAL: The total at the bottom of the invoice should include all the individually requested Milestone/Incentive requests included on the invoice.

9.4: Milestone Validation and Approval

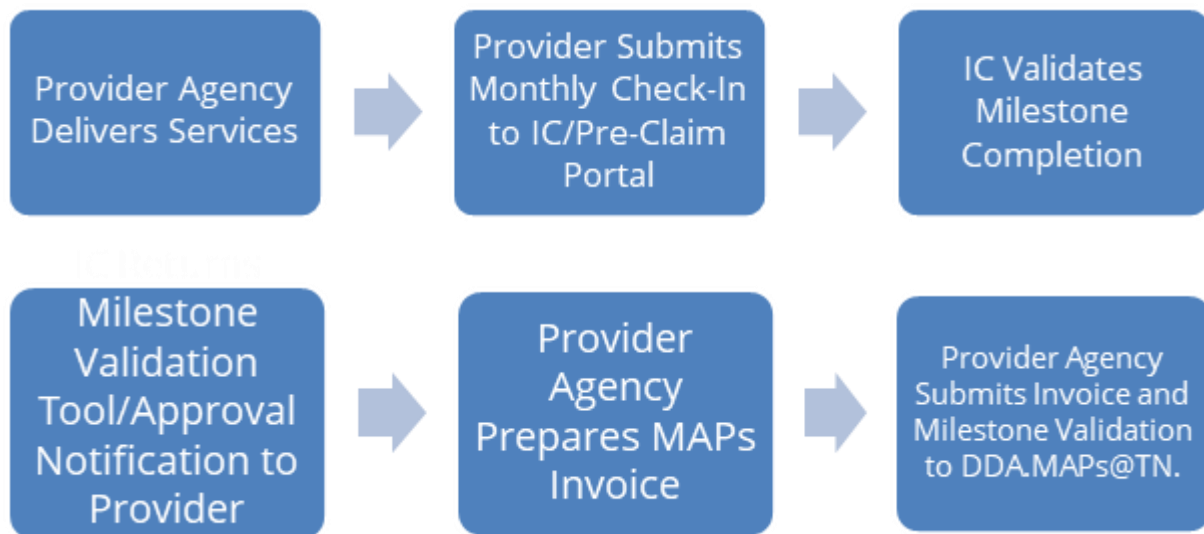
Upon the completion of the VCRM, completion of milestones, and incentive criteria, the MAPs Provider agency shall submit a Service Validation Request and Documentation to the IC for review/approval. If approved, then the provider agency will receive approval notification (automated email from online submission) OR IC will return the approved **Service Validation Form** MAPs Service Approval Form to the MAPs Provider agency.

- Once the approved Service Validation notification/form is received from the IC agency, the MAPs Provider agency will utilize a standardized **invoice form** to generate invoiced services. The MAPs Provider agency must submit the Invoice and approved Service Validation form to the DDA MAPs email address (DDA.MAPs@TN.GOV) within **30 calendar days of service validation** approval to ensure timely processing. Upon receipt and review of the submitted documents, a MAPs Operational Representative will submit the documentation to DDA Purchasing for payment processing.

NOTE: Approval from MAPs Operational Representative is needed for DDA Purchasing to process submitted payment. Invoices submitted directly to DDA purchasing will not be processed.

9.5: Billing Process Summary

- 1) MAPs Provider agency delivers support in accordance with PSCP and selected milestones.
- 2) MAPs Provider agency assists persons supported to reach milestone independence and notifies the IC of completed milestones via the **Provider Monthly Check-In** Process.
- 3) MAPs Provider agency will submit for milestone validation using the Pre-Claim submission portal [Milestone Validation Form - Online Version \(primary\)](#).
- 4) IC will review submitted **evidence** against validation tools for approval or denial of request.
- 5) Provider agency will receive an EMAIL verification of approval OR IC will submit the **Milestone Validation Approval form** back to the MAPs Provider agency.
NOTE: IC will only return the Milestone Validation form IF the PDF (backup) form was used to request milestone validation.
- 6) MAPs Provider agency will prepare specific invoice for the billing process.
- 7) MAPs Provider agency will submit verification of the APPROVED Milestone Completion form **AND** MAPs Invoice to DDA.MAPs@TN.GOV for final request approval.
- 8) DDA MAPs Operational Representative will submit the Invoice AND Validation form to DDA.Purchasing@TN.GOV for payment processing.
- 9) Payment will be released from DDA via Electronic Funds Transfer to the Provider agency.
- 10) MAPs Provider agency is encouraged to monitor receipt of payment and communicate directly with DDA MAPs Operational Representative if payment is not received within 4-6 weeks.



9.6: Milestone Validation and Denial

Upon the completion of VCRM, completion of milestones, and incentive criteria, the MAPs Provider agency shall submit Milestone/Service Validation Documentation via **ONLINE** submission OR [\(Milestone Validation Form\)](#) to the IC for review/approval.

If denied, then IC will forward supporting documents and milestone verification form denoting denial with justification to the MAPs Provider agency with a request for additional supporting documentation.

Once the MAPs Provider agency gathers and submits the additional documentation to the IC agency, the IC agency will review and render a final approval or denial.

If approved, then the workflow for Approval and Billing (Approved) will be followed.

If denied, then the MAPs Provider agency may opt to **appeal the decision** to the DDA Innovation Division following the **MAPs Appeal Process**.

9.7: Milestone Reconsideration/Appeal Process

If billing is denied by the IC agency, then the MAPs Provider agency may opt to have the decision reconsidered by the DDA Division of Program Innovation.

Once the DDA Division of Program Innovation receives the **Reconsideration Request Form** [DDA MAPs Milestone Validation Review Appeal Request](#) and all corresponding documentation from the MAPs Provider agency, an internal panel of three (3) people will review the documentation. Eligible panel members include the following members of the DDA Division of Program Innovation: the Deputy Commissioner of Program Operations, the Director of Program Innovation, the Director of MAPs, the Director of Statewide Enabling Technology, MAPs Transition Guides, and the Director of Employment Services.

If the panel determines to approve the billing previously denied by the IC agency, then the Approval and Billing process will be followed.

If the panel determines to uphold the denial of the IC agency, then the Director of MAPs will notify the MAPs Provider agency of the decision.

The MAPs Provider agency will have ten (10) business days from the date of notification by the MAPs Provider agency to submit supplemental documentation for appeal. If such supplemental documentation is not received within ten (10) business days, then the initial denial of the billing is final.

If such supplemental documentation is timely received, the panel will review the supplemental documentation and render a final decision in writing to the MAPs Provider Agency.

After the appeal process, the provider will be able to complete billing processes for Milestone Validation and applicable completion incentives. These requests (if new) must be completed within 30 days of the appeal decision and will be credited within the applicable budget category for the participant.

9.8: Provider Development Incentive

Provider agencies enrolled and approved in the MAPs program are eligible to receive a one-time per-person “Provider Development Incentive” payment upon accepting a person supported into their program. It shall be noted that eligibility determination is impacted by a person’s supported status within the program; the initial provider development incentive will only be applicable during the **first year** of services and upon immediate enrollment into the MAPs program¹ and when certain criteria are met, as noted below.

This provider development incentive is a payment to the provider as an agreement to complete the person-centered plan, begin completion of VCRM, and work towards milestone achievements. It is a payment made available to the provider agency to assist with operational expenses while the provider agency works towards milestone completion. Specific criteria must be met to maintain receipt of the provider development referral incentive, as outlined below. In the event these criteria are not met, applicable recovery/recoupment practices will be required.

- In the event the person supported disenrolls from the MAPs program within 30 days of the Provider Agency Acceptance of MAPs participant OR (either voluntarily or involuntarily) the provider agency will need to return these funds to DDA.
- In the event the MAPs person supported selects another provider agency within 30 days of Provider Agency Acceptance, the initial provider agency will need to return these funds to DDA.
- In the event it is determined that no provider supports have been delivered within the initial 60 days of Provider Agency Acceptance, that person supported will be referred to another provider agency and the provider agency will need to return these funds to DDA.

Provider agencies are eligible to bill this incentive immediately upon acceptance of a MAPs participant into their program, however, a provider agency must submit for payment within **60 calendar days** of acceptance into their MAPS program.

Please note, if the provider selects to wait for the collaborative roundtable meeting prior to submitting the Provider Develop Incentive Invoice and this time exceeds 60 days, the providers invoice MAY still be approved and payment will be rendered.

9.9: Virtual Community Resource Mapping (“VCRM”)

A large support function of the MAPs program centers around the identification, implementation, and development of the Virtual Community Resource Map (VCRM) for each person supported in the MAPs program. The VCRM is a fully customized, online interactive resource map that is used by a person supported to organize resources, assist with person-centered planning, and complete travel training experiences for the person. This resource map is intended to be the tool/support that provides organization and access to resources for the MAPs participant throughout the duration of the MAPs program and beyond. Through ongoing implementation, it is anticipated the VCRM will be updated to reflect newly identified milestones and individual goals for the MAPs person supported. DDA has partnered with Mapping Assets Post School Success to develop customized training and validation procedures for VCRM implementation. All direct supports who assist a person supported to work towards VCRM independence must follow the required DDA training requirements, which consist of 1) VCRM Basic Certification and 2) VCRM Advanced certification.

The digital map is a resource, but it is also an instructional environment where a person can:

- Increase individuals’ geographical awareness and knowledge of what is available to them within their community.
- Build their daily schedules on the map with customized text descriptions and pictures.
- Learn how to travel in the community.
- Access supports and services.
- Participate in social and recreational activities with peers.

Provider Agencies are encouraged to implement innovative and collaborative approaches to assist the MAPs participants in developing their own personal VCRM. This can include developing an **AGENCY SPECIFIC BASE MAP** that encompasses the identified layers necessary for validation² regarding guidance for active VCRM Implementation. This is the tool designed to provide step-by-step directions for the provider to implement the necessary processes to assist in the development of a functional VCRM for the MAPs person supported. Provider



organizations are encouraged to use the person supported VCRM to include/attach evidence of completed milestones.

Certain components are **REQUIRED** for the validation confirmation of a VCRM, and providers must ensure these components are included within each VCRM for validation. There are also **OPTIONAL** tools that are available within the VCRM Implementation and Validation Checklist packet that a provider can utilize to achieve the expected result. The required components for each VCRM include:

- Provider has submitted IC Monthly Check-Ins confirming the VCRM is ready for validation.
- VCRM Coordinator Progress Monitoring Form submitted to IC.
- Person Supported Progress Monitoring Form submitted to IC. *NOTE: This form can be provided in any format for review and validation. A specific format is not required for validation.*
- Link to VCRM is shared with the IC during the Milestone Validation Request process.
- MAPs Transition Planning Tool (“TPT”) completed and uploaded in the VCRM “All About Me” layer. While any format of the Tool is acceptable, providers are encouraged to implement this Tool with the MAPs participant and ensure that the person can provide input on this Tool. The MAPs person supported/Provider Agency does need to indicate which assets will have Media/Text by selecting this option on the TPT. This notation can be accepted in any way if it is clearly indicated (highlighting is an option, but not mandatory).

OPTIONAL TOOLS FOR SUBMISSION of VCRM VALIDATION:

- VCRM LET’s MAP Document
NOTE: DDA acknowledges that provider agencies may also have alternative methods for identifying community resources and noting the resources for VCRM development. Final VCRM products will be reviewed to ensure that the above-mentioned requirements are included.

ADDITIONAL CONSIDERATIONS FOR VCRM VALIDATION:

STEPS FOR VALIDATION OF A VCRM

Step 1: Ensure there are 8 layers that coincide with the 8-layer requirements per DDA VCRM Validation tool.

NOTE: it is important to note that these layers do NOT need to be titled the same. DDA promotes the progression of a MAPs participant identifying descriptors on a person-centered basis.

NOTE: The MAPs participant CAN include additional layers (9-10) that are person-centered and do not require all additional considerations for validation (they do not require media/text or other considerations).

Step 2: The “All About Me” layer needs to be 1st layer and house the “Transition Planning Tool”.

NOTE: This is a great space to include the applicable PSCP’s or other assessment documents that the person would benefit from.

Step 3: Each Layer MUST have at least 1 asset with Media and Text

NOTE: Media/Text is not required for every asset. The goal is to ensure that the MAPs participant is aware and capable of adding Media/Text for future revisions and the progression of VCRM utilization.

Step 4: There should be at least 1 custom icon in each of the 8 layers.

Step 5: Open the Transition Planning Tool located in the “All About Me” layer of the VCRM. Review the tool to ensure that it has one goal and asset listed in each domain. Check to ensure that assets listed on the Transition Planning Tool are transcribed within a layer on the VCRM.

Note: The Domains listed on the Transition Planning Tool do not directly correlate with VCRM LAYERS and therefore these assets CAN be located within any layer of the VCRM.

Step 6: Review and confirm the Progress Monitoring Form to ensure that the necessary VCRM revisions are evaluated for prompting needs. This step is critical in ensuring that the MAPs participant has access to updating the VCRM throughout the MAPs program and beyond. This tool MUST confirm that if there is assistance needed at any level, there is an identified person/plan to ensure that the person can continue to utilize the VCRM revision process beyond this initial implementation.

9.10: Community Navigator

Community Navigator supports include but are not limited to; travel training, assistance to participate in drivers’ education courses, providing coaching/modeling of soft skills needed for typical social interactions, facilitating development of both geographic familiarity of the community and site-specific awareness of Points of Interest (“POI”), as identified within the VCRM, and the development of “routines” which promote comfort in both scheduled and impromptu community interactions.

Independent Travel: A MAPs Provider agency may submit documentation or additional verification that Milestone Requirements have been achieved.

Examples:

- Verify the VCRM or WayFinder application is set up with people the person supported engages with on a regular basis and places frequently visited. Has the person supported completed the Travel Training curriculum? VCRM review.
- Use of Google Forms/Microsoft Forms for a quick survey the person supported could complete embedded in the VCRM.



- Has the person completed Driver's Education Training to complete the self-initiated travel? The person supported can submit photo evidence of a driver's permit as an example. Video evidence that the person supported can safely and successfully use the WayFinder (or other independent modes of transportation) application for independent travel in the community is also an option. NOTE: This milestone will require observation over a month-long period.
- **Additional innovative evidence can be accepted.**

Community Relationships: A MAPs Provider agency may submit documentation or additional verification that Milestone Requirements have been achieved.

Examples:

- VCRM could include confirmation of relationships developed over the period and that there is evidence using the VCRM that the person is participating in activities in the community socially.
 - NOTE: Initial VCRM Validation is confirmed using the VCRM Implementation and Validation directions. Ongoing VCRM implementation *should* include the continued build-out of new acquaintances developed within the community (as person supported chooses) and the identification of chosen milestones.
- MAPs Provider agencies may submit photo evidence of a person supported and social acquaintances in the community.
- MAPs Provider agencies may submit a video of the person supported engaging the community with social acquaintances.
- **Additional innovative evidence can be accepted.**

Community Activities: A MAPs Provider agency may submit documentation or additional verification that Milestone Requirements have been achieved.

Examples:

- MAPs Provider agencies may submit monthly calendars that show the person supported engaging in their community on a routine basis. These locations should coincide with locations identified within the VCRM, as well as the people identified within those locations (i.e., natural supports, acquaintances, friends, etc.).
- VCRM can be reviewed for confirmation that the person supported is meeting with people of their choosing at the location by adding descriptions within the VCRM Asset.
- Additional evidence can include confirmation of joining groups, clubs, church associations, etc., on documentation OR video evidence of the person supporting attending these locations to develop relationships.

- MAPs Provider agencies can submit evidence of completing a survey with the person/person's family confirming there have been increased opportunities for engagement in community activities.
- **Additional innovative evidence can be accepted.**

9.11: Employment Innovation

Employment Innovation Services are provided to a person who needs support to obtain, maintain, and/or advance in competitive, integrated employment, including customized or self-employment, for which the person is compensated at or above minimum wage with consideration of a reasonable startup period for self-employment. The expected outcome of these services is competitive, integrated employment ("CIE"), which may be conducted at the workplace or remotely, or self-employment consistent with the individual's personal and career goals. Employment Innovation Services are designed to be person-centered and take a person through all phases of deciding to work, identifying, obtaining, and advancing in their chosen career path.

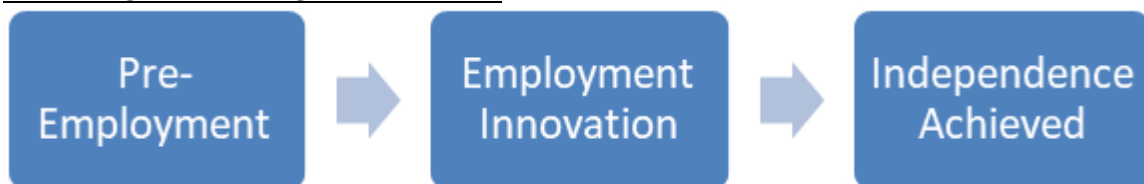
The Department recognizes that a MAPs participant may choose to work on various employment paths toward employment independence. As a result, the Department will recognize the progression of an employment path where a Participant may work towards "Self-Employment" and pursue each of these available Milestones while also being able to work a "Traditional Employment" path and still have access to all the available milestones. This will allow each employment Milestone to be available on 2 separate occasions as long as the milestones are geared towards each path available (i.e., the Pre-Employment Milestone is not available on 2 occasions to work on a Self-Employment Path 2 times, the participant may select the Pre-Employment Milestone once for each path available).

The following visual depicts both available paths of employment.

SELF-EMPLOYMENT PATH



TRADITIONAL EMPLOYMENT PATH



Using the above model, Pre-Employment is an available milestone on 2 occasions as long as the person is working towards both Self Employment AND Traditional Employment (the same applies to Employment Innovation and Independence Achieved).

Please note, if a MAPs Person Supported is not interested in both Traditional Employment and Self-Employment, then the various paths DO NOT apply, and they would stick to their one desired employment path.

Pre-Employment: A MAPs Provider agency may submit documentation or additional verification that Milestone Requirements have been achieved. This service is designed to help a person prepare for and find employment, which includes but is not limited to: (anything Before the participant begins their job is Pre-Employment, i.e. interviewing, searching for a job, etc.).

Examples:

- Providing information, resources, and exposure to different career paths to support making an informed decision about pursuing CIE or Self-Employment; (exploration)
 - Supporting a person to choose a career path based on their strengths, skills, interests, and available resources in the community; (Discovery)

- Assisting with successfully obtaining a job (Job Development)
 - Planning for logistics related to work, including but not limited to identifying potential transportation resources that can reliability be accessed to get to/from work. (Discovery/Job Development)
 - If Self-Employment is desired, help with developing a business plan (Job Development), connecting the person to business development resources and mentors in the community, and identifying supports that are needed to successfully operate the business.
 - Google Form (or other documentation) uploaded in the VCRM demonstrating the person's experience with the desired job path experience.
 - A MAPs Provider agency can submit a report indicating the anticipated steps after reviewing the pre-employment components (Providing information/Resources, developing a career path, assisting with pursuing a job, planning for transportation to employment, etc.).
 - Recording of person supported completing pre-employment service and uploading into the VCRM.
- Benefits Counseling Analysis: Verification that introductory education on work incentives has been completed and a referral made to a Benefits Coordinator. This referral will consist of 2 approaches based on Person-Centered Needs. Referrals to Benefits Counseling can be made [Benefits Counseling - Formstack](#)

Approach 1:

If the person supported is not actively in need of any benefits counseling at this time, the referral will provide the person supported with a general overview of what Benefits Counseling is with the DDA Benefits Counseling One-Pager being provided for future use. [\(Benefits Counseling One-Pager\)](#)

Approach 2:

If the person supported is actively in need of benefits counseling, the Benefits Counselor will complete the intake assessment and develop a person-specific plan for ongoing and active benefits counseling. As a part of Milestone Validation, this assessment will need to be accessible. NOTE, the Benefits Counselor Intake Assessment is NOT required for pre-employment. This assessment will be a function of Independence Achieved.

REQUIREMENTS OF BENEFITS COUNSELING CONFIRMATION:

1. It shall be expected that a "Benefits Counseling" asset will be added to the MAPs person Supported VCRM that identifies contact information for the Benefits Counselor.

- NOTE: The organization of this asset is flexible, it can be located either in the “Employment Layer” OR “Additional Tennessee Resources” Layer.

2. Any completed assessments OR one-pagers will also be uploaded into this asset so that a person supported can access benefits counseling if/when needed and/or refer to the assessment to confirm that active counseling services have begun.

▪ **Additional innovative evidence can be accepted.**

Employment Innovation: A MAPs Provider agency may submit documentation or additional verification that Milestone Requirements have been achieved. Examples:

- Verification that the person has obtained a job AND has worked for 30 days (ex: paystubs showing date of employment, written calendar of days worked the previous month, survey with family/person-supported).
- Verification that the person has identified and has learned how to use reliable transportation to and from place of employment (ex: video evidence of independent travel, written confirmation of completion).
- Submission of Job Coach Fading Plan showing reduction of job coaching support needs.
- VCRM should be updated to include employment location, schedule, contact information, and other relative information to employment experience.
- **Self-Employment:** Execution of Business Plan
- **Additional innovative evidence can be accepted.**

Independence Achieved: A MAPs Provider agency may submit documentation or additional verification that Milestone Requirements have been achieved. Examples:

- Verification that a person supported can complete job functions without needing in-person supports. This can be verified through a submitted video of a person completing duties using technology.
- A person supported can provide a survey confirming the in-person supports are no longer needed.
- A MAPs Provider agency can submit evidence via documentation where on-site assessments have been completed confirming the person supported is able to achieve results without staff support. Monthly Summary.
- **Benefits Counseling Analysis:** This referral will consist of 2 approaches based on Person-Centered Needs. Referrals to Benefits Counseling can be made [Benefits Counseling - Formstack](#)

Approach 1:

If the person supported is not actively in need of any benefits counseling at this time, the referral will provide the person supported with a general overview of what Benefits Counseling is with the DDA Benefits Counseling One-Pager being provided for future use. ([Benefits Counseling One-Pager](#))

Confirmation that this asset is still present in the VCRM.

Approach 2:

If the person supported is actively in need of benefits counseling, the Benefits Counselor will complete the intake assessment and develop a person-specific plan for ongoing and active benefits counseling. As a part of Milestone Validation, this assessment will need to be accessible (if applicable).

NOTE, the Benefits Counselor Intake Assessment is NOT required for independence achieved IF it is determined that this assessment is NOT needed. This determination is made by the DDA Benefits Counselor.

- **Additional innovative evidence can be accepted.**

Career Development: A MAPs Provider agency may submit documentation or additional verification that Milestone Requirements have been achieved.

*NOTE: Career Development **IS** an available milestone during each year of the MAPs services. This means that the provider can assist the person supported by providing this milestone each year of the program.*

Examples:

- Verification that a person has obtained an increase in job responsibilities and/or a promotion. This could include the submission of an updated Job Description confirming the increase in duties/role.
- Verification (including updated VCRM) of acceptance to an apprenticeship, technical/trade program, community college, or four-year university.
- A MAPs Provider agency may submit a survey conducted with a person-supported/family which confirms acceptance into post-secondary education program.
- **Additional innovative evidence can be accepted.**

9.12: Independence Coaching

Independence Coaching focuses on functional life skill development and is intended to teach and prepare a person for independent living. Supports provided by the Independence Coach may include teaching skills related to maintenance and



organization of the home, personal hygiene, and self-care, and providing resources and training on enabling technologies and smart home products designed to accommodate needs and provide for greater efficiency and independence in the home. Additional areas of focus may include instruction on skills related to financial management, home safety, meal preparation, and more. The intended outcome is for each person to have the ability to manage their home environment, practice self-care, and self-direct their personal development in accordance with their expressed goals.

Home Safety: A MAPs Provider agency may submit documentation or additional verification that Milestone Requirements have been achieved. NOTE, the following are necessary for Home Safety Milestone Validation:

1. Person Supported shows discretion when opening doors to visitors (*Required for Validation*).
2. Person supported understands how to cook safely (*Required for Validation*).
3. Person supported confirms understanding of how to respond in emergency situations (including how/when to communicate with appropriate community responders) (*Required for Validation*)

EXAMPLES OF ACCEPTED EVIDENCE:

- VCRM updated to show the person safely opening the door to visitors (video evidence, recorded interview, etc.).
- VCRM updated to show the person safely cooking a meal from start to finish. Enabling Technology solutions can be implemented here using AbleLink's task reminder software (each MAPS participant will receive a suite of program applications through AbleLink that can be used for creating task reminders, visual impact directions, and scheduling prompts).
- VCRM updated to show the person responding to necessary contact information across emergencies.
- Provider can submit evidence of completed fire drills and roleplay scenarios.
- Provider can submit confirmation that the person supported has reviewed a series of instructional videos/YouTube videos of scenarios.
- Monthly reporting documentation showing reliability and consistency in the person successfully demonstrating these skills.
- Confirmed skill acquisition plans to identify task AND prompting level needed over a period to confirm independence.
- Person-supported survey confirming skill acquisition.
- **Additional innovative evidence can be accepted.**

Personal Hygiene and Self-Care (Health and Hygiene): A MAPs Provider agency may submit documentation or additional verification that Milestone Requirements have been achieved. NOTE, the following are necessary for Personal Hygiene and Self-Care Milestone Validation:

1. Person supported demonstrates the ability to plan for and prepare meals in accordance with dietary goals/preferences (*Required for Validation*).
2. Person supported demonstrates the ability to maintain personal hygiene and appearance in a manner that is preferred and appropriate, including how to dress for weather/temperature and desired educational or career path (*Required for Validation*).

EXAMPLES OF ACCEPTED EVIDENCE:

- A MAPs Provider agency may submit a video in the VCRM of the person supported preparing a weekly food menu.
- A MAPs Provider agency may submit a series of planned weekly menus demonstrating the ability and reliability of meal planning.
- A MAPs Provider agency may submit a monthly summary showing where the person has demonstrated milestone independence through observation.
- A MAPs Provider agency may submit a person-supported survey verifying that the person supported may successfully plan for and prepare meals.
- A MAPs Provider agency may submit a monthly checklist/tracker of the personalized scheduler when the person completes bathing routines.
- A MAPs Provider agency may submit confirmation that a person can demonstrate appropriate work attire/educational attire vs. recreational attire.
- **Additional innovative evidence can be accepted.**

Health Management (Medical Management): A MAPs Provider agency may submit documentation or additional verification that Milestone Requirements have been achieved. NOTE, the following are necessary for Health Management Milestone Validation:

1. Person supported demonstrates the ability to manage their health by taking their medications (if applicable).
2. Person supported demonstrates knowledge of when to visit their medical professionals/doctors (*Required for Validation*).
3. Person supported demonstrates the ability to schedule medical appointments and how to ask for medical help (*Required for Validation*).
4. Person supported knows how to apply their medical insurance coverage for the medical appointment (*Required for Validation*).

EXAMPLES OF ACCEPTED EVIDENCE:

- Use of VCRM to show health care providers/offices, use scheduling tool within MAPS phone for alerts of appointments, need to schedule appointments, etc. The MAPs Provider agency could consider implementing a various Q&A discussions/interview with the person supported to ensure the person understands when to make a medical appointment, that the person knows how to use the VCRM to locate contact information for the physicians, etc., and the results of this interview with the person could be provided to the IC for verification.
- Video of person using an Enabling Technology solution which promotes independent management of health-related tasks.
- The IC could validate the discovery by interviewing the person supported.
- **Additional innovative evidence can be accepted.**

Financial Management: A MAPs Provider agency may submit documentation or additional verification that Milestone Requirements have been achieved. NOTE, all the following are necessary for Financial Management Milestone Validation:

1. Person supported demonstrates the ability to maintain personal finances by developing a personal checking/savings account (if applicable).
2. Person supported understands responsibility to maintaining a line of credit (*Required for Validation*).
3. Person supported understands the responsibility to pay bills on time (*Required for Validation*).
4. Person supported has developed a monthly budget (*Required for Validation*).
5. Person supported has been informed on financial exploitation and how to avoid it (*Required for Validation*).
6. Person supported has reviewed the necessary information for understanding "What is an ABLE account?". Ideally, this information and confirmation will be accessible via the VCRM (*Required for Validation*).

EXAMPLES OF ACCEPTED EVIDENCE:

- Person supported has a plan for how any income is going to be secured in a checking account (ideally the person has established their checking account, but this can look different for everyone). Verification of a checking account (specific checking account information can be provided for validation).
- Person supported has developed a personal budget and it is available for access within the VCRM.
 - Many mobile applications can be installed on the MAPs/Personal devices for additional validation

(banking institution applications, budgeting applications, etc.).

- Person supported can provide evidence of competency by completing financial management training (as applicable).
- IC could validate the discovery by conducting an interview with the person supported.
- **Additional innovative evidence can be accepted.**

9.13: Enabling Technology

Enabling Technology (ET) is equipment and/or methodologies that, alone or in combination with associated technologies, provide the means to support the individual's increased independence in their home, communities, and workplaces. The service covers purchases, leasing, shipping costs, ongoing utilization of devices/maintenance, and as necessary, repair of equipment required by the person to increase, maintain, or improve the functional capacity to perform daily tasks that would not be possible otherwise.

Persons enrolled in MAPs will have access to up to **\$2500.00** annually to cover approved Enabling Technology equipment and associated services to support the accomplishment of their independence goals. At the conclusion of the person supported MAPs participation (up to 3 years), the person supported will assume ownership of all Enabling Technology equipment/devices and all recurring Enabling Technology costs (including all recurring subscription costs) will become the responsibility of the person supported.

Enabling Technology is available support for all aspects and places of a person's supported life in MAPs. It is expected that Enabling Technology options will be evaluated within every identified milestone and at the assessment and implementation phase of ET.

EXAMPLE: If a person selects to work towards a milestone of "Home and Safety" using the Independence Coaching service, an assessment of ET options will be included to identify applicable tech options. Each tech proposal will include an itemized breakdown of proposed costs for the implementation of the tech solution and maintenance, this itemized amount will be reduced from the Enabling Technology Budget. The total amount available for Enabling Technology solutions across a given year is \$2500.00 (this amount does not roll over from year to year) and can be divided up amongst all applicable yearly milestones (if selected).

Provider agencies and Innovation Coordination agencies are encouraged to utilize the **Enabling Technology Utilization Protocol for MAPs** outlined in the Enabling Technology Service Definition ([Enabling Technology Service Definition](#)). Upon the

identification and initial approval of an Enabling Technology Support for the MAPs person supported, the Provider Agency will be responsible for initiating the processes to secure the identified item. This means that the provider agency will originally purchase the identified ET solution and then seek reimbursement from DDA from the person's supported annual ET budget. Once the item has been secured and verification of purchase is on hand, the provider agency DOES NOT have to await milestone completion for reimbursement. The provider agency may submit for repayment of the identified solution through the traditional Billing/Invoicing processes. Items to submit for reimbursement:

- Invoice
- Milestone Validation Approval
- Proof of purchase

NOTE: Enabling Technology Referrals are completed by MAPs Providers using the [DDA Enabling Technology Screening Tool & Referral Form](#). In the event the person-centered facilitation is submitted within a period of less than 30 days toward the end of the participants annual budget cycle, the DDA Tech Champion will not be able to guarantee that the facilitation will be completed prior to the end of the budget cycle. In this event, the facilitation will be automatically "rolled over" to the next years planning cycle.

Collaborative Planning Teams are urged to ensure proper planning is instituted when submitting the [DDA Enabling Technology Screening Tool & Referral Form](#). A traditional facilitation incorporates various meetings, exploration of possible tech solutions, development of the individual tech plan, etc. and as a result this process can take upwards of 30+ days. Collaborative planning teams are encouraged to utilize the annual budget timeline accordingly and ensure that we are beginning the ET facilitation process EARLY within the planning cycle.

9.13.a: MAPs Mobile Devices

Persons enrolled in The Medicaid Alternative Pathways to Independence program (MAPs) will have the option of receiving a mobile device (preferred), T-Mobile cellular service, a protective phone case, and technical support for the duration of the program (if a person selects to receive the provided device, all data rates, protective case and technical support will be made available, if a person does not select the provided device, they are also opting out of the data rates, protective case and technical support). Insurance on the device will be the responsibility of the person supported (if desired). This device will be a smartphone which is pre-loaded with applications for successful participation in MAPs. The device can only be used for purposes related to the MAPs program. After a person enrolls in MAPs, their

Innovation Coordinator (IC) will initiate the device procurement process through AbleLink. The device will be mailed directly to the person or the person's applicable representative.

Persons enrolled in MAPs may choose to use a personal device if the device will support the necessary applications for successful MAPs participation. During the onboarding and assessment process initiated by the Innovation Coordinator, a check will be conducted on the operating functionality of the personal device. If minimum specifications are present and will successfully launch the MAPs applications, then the device will be recognized and permitted to be used for the program. In the event those minimum specifications are not verified, the Innovation Coordinator will initiate the device procurement process to have a MAPs device sent to the person supported. During the assessment process conducted by the Innovation Coordination Agency, an evaluation into other person-centered applications which are desired by the MAPs person supported will be conducted and if identified will be included in the device notification/procurement process.

Please note, the following are Minimal Mobile Device Requirements to process the MAPs Applications (If the personal device does not meet these specifications, the device procurement process through MAPs will be initiated and the person-supported will receive a new device from T-Mobile).

- Android 10 or newer
- IOS 13 or newer

Due to the application's heavy reliance on GPS, the mobile device should have at least 8 hours of battery capacity.

In the event the person-supported intends to utilize a personal device, and not the device provided through T-Mobile as a part of the MAPs program, that person-supported would be responsible for all rates, fees, and protections on the personal device. DDA would not complete a transfer of the data rates to the T-Mobile account.

User Damage to MAPs device: A person's first/initial device and cellular service provided for the MAPs program will be funded outside of their annual program budget. However, if the device is lost, stolen, or damaged and is no longer usable, a person supported by MAPs is responsible for having it repaired or replaced and may need to use their annual MAPs Enabling Technology budget to do so (any breakage or replacement costs would be charged to that person's Enabling Technology Budget for that planning year). DDA, MAPs providers, and the Innovation Coordination Agency will not be responsible for devices that are lost, stolen, or damaged beyond repair. DDA does not make insurance available for these devices,

if a person-supported wishes to pursue insurance on the device, they would do so outside of any MAPs funding/budget requests.

DDA has contracted with AbleLink to manage the devices through a Mobile Device Management (MDM) solution. In addition to this MDM, AbleLink will also provide direct technical assistance on the AbleLink applications listed on the next page AFTER initial consultation with DDA Regional Technology Champion.

Note, if the person-supported has already utilized their annual Enabling Technology budgeted allotment and requires additional phone repairs/replacement, that person will need to wait until adequate funds are available in their ET budget for said repairs.

Mobile Device Management (MDM): The devices provided for the MAPs program will be managed by AbleLink via a Mobile Device Management (MDM) solution. System updates to all MAPs-provided devices will be implemented and controlled through the MDM, as needed. If a device has been misplaced, then a person should make a request to AbleLink to utilize the MDM to attempt to locate the device.

When a device is received from AbleLink, it will include pre-programmed applications which may change over the course of the program. AbleLink will monitor the program's applications through MDM and may remove applications if they do not support the implementation of the MAPs program. This list of applications is intended to serve as a guide and is not exhaustive:

- Standard Android Applications
 - Google Suite
 - The Google app for searching, news feeds and organizing “information”.
<https://play.google.com/store/apps/details?id=com.google.android.googlequicksearchbox&hl=en>
 - Google Chrome web browser app
 - Google Maps navigation app
 - Gmail email app
 - Google Drive
 - Google Docs
 - Google Forms
 - Google Sheets
 - Play Store app
 - Camera app
 - Contacts app
 - Phone app
 - Settings app
 - Samsung Messages (default SMS app)

- Samsung My Files (file explorer app)
- Knox Manage
- Online Meeting Applications (TEAMS, Webex, Zoom, Etc.)

Note: If it is determined that AbleLink applications are not beneficial to a person, then they can be removed through the MDM System after a period of 6 months.

Note: Personal devices will NOT be enrolled into the Mobile Device Management System managed by AbleLink. As a result, the person supported would be ultimately responsible for ensuring that all necessary protections and updates are maintained on the personal device.

Requesting Additional Applications: Persons supported by MAPs will receive a pre-programmed device dedicated to the implementation of MAPs services. These applications will be necessary for the completion of the travel training curriculum, Milestone Achievement and the development of the Virtual Community Resource Map (VCRM). If a person-supported uses additional applications which assist with skill building, activities of daily living, communication, or any other function, then a request can be submitted which would allow the installation of additional applications to the device. This process will include verifying the requested application through DDA's Enabling Technology Department and the regional Technology Champion will confirm the functionality and intent of the requested Application. Once reviewed and approved, the request will be sent to AbleLink for installing the application through the Mobile Device Management solution.

DDA has created an *AbleLink Mobile Device Request Form* which can be submitted for consideration. If there are person-centered accessibility applications which are preferred to be installed on the device, then the person supported's IC can request these applications be added through this process. Each device will be enrolled into a Mobile Device Management (MDM) Database where applications, updates, and other needed processes will be "pushed" to the specific device through the MDM.

In the event the person supported wishes to install paid applications on the device, these approval requests will still go through the Enabling Technology review process and after approval, if it is determined that the requested applications increase opportunities for independence, these applications can be paid through the individuals Enabling Technology annual budget of \$2500.00 per year.

Monitoring the annual Enabling Technology budget will be the responsibility of the Innovation Coordination Agency who will trigger the initial request confirming their approval.

Conclusion of MAPs: After a person's three-year MAPs program, the person supported will be able to keep the device as personal property. Any remaining fees, including the ongoing cost of cellular service and/or application fees, will then become the responsibility of the person supported.

Return of Device: In the event a person supported decides to exit the MAPs program before completing 3 years of the services, it shall be the expectation the device provided will be returned to AbleLink. To streamline this process, DDA will make all necessary arrangements to compensate for the return of this item, upon the successful completion of the AbleLink Request portal (Return Shipping Label Request). The IC will submit this request through the portal, to be approved by DDA.

Additionally, if a person supported exits the MAPs program before the completion of the 3rd year of services, all additional device applications that were installed as a part of the MAPs program will be removed from the personal device.

Disclaimer: Please note that any third-party systems, programs, or applications operated through the mobile device provided through T-Mobile or AbleLink may collect data from its users, including GPS navigation data, subject to the user agreements and/or terms of those third-party systems, programs, or applications. Data from the use of any third-party systems, programs, or applications on the mobile device is NOT collected, stored, or used in any capacity by DDA or the State of Tennessee. DDA makes no representations in the expected use OR expected deliverables as a function of using the devices and/or associated systems, programs, or applications. By accepting the device and using the provided systems, programs, and applications, the person supported represents that they understand they have the right to not use any systems, program or application, that the use of any systems, programs or applications is NOT a condition for participation in MAPs, that they may alter any settings on the mobile device, such as the ON/OFF toggle, related to the use of these systems, programs or applications, and that any user agreement with the third-party systems, programs or applications is between the person supported and that third-party and would not involve either DDA or the State of Tennessee as a party.

9.13.b: AbleLink Suite of Applications

As a function of the MAPs program, each participant will have immediate access to AbleLink's Smart Living suite of applications. These applications will be installed on the MAPS device OR made available to the participant to install on their personal devices. These applications are intended to be of benefit to assist people in



achieving their milestones using technology. The following applications are made available through the Smart Living Suite of applications.

AbleLink Applications

- WayFinder:
 - With AbleLink WayFinder, specific travel routes can be created and then activated from the GPS location. The GPS-based tracking triggers WayFinder to safely guide the user with step-by-step visual and audio instructions. WayFinder can help ensure the traveler that they are on the correct route by pointing out important landmarks along the way and even telling them “This is not your stop” when they see others departing.
- Endeavor:

AbleLink Endeavor provides time-based reminders, calendar management, and audio to-do lists in a cognitively accessible format. Events are presented with an alarm, image, and audio instruction and can be linked to detailed tasks in Visual Impact.
- Visual Impact:

AbleLink Visual Impact is an engine for the completely customized creation of step-by-step instructional content. Images, video clips, audio messages, and checklists can all be incorporated for personalized guidance. Time-sensitive Visual Impact tasks can be linked to calendar reminders in Endeavor.

9.14: Peer Mentoring Supports

Persons enrolled in the MAPs Program will have access to Peer Mentoring. Peer Mentoring is an authentic support for those who are seeking peer support and/or assistance with problem-solving as they move toward high school graduation and beyond. It is designed to assist individuals in exercising choices to maintain or increase their independence. Peer mentoring is also a process through which a more experienced individual encourages and assists a less experienced individual to develop their potential within an area of interest. The resulting relationship is a reciprocal one in that both individuals in the partnership have an opportunity for growth and development.

Peer Mentors share the lived experience of MAPs Participants and have received training to assist others in acquiring skills, knowledge, and attitudes to be more successful within the MAPs Program. Peer Mentors are qualified, professional trainers and supports hired through partnerships developed with East Tennessee State University and The Arc of Tennessee. Peer Mentors are available to all MAPs Participants during the course of their MAPs services. Peer Mentors will receive ongoing supervision and support from MAPs Peer Mentoring Agency. Regular check



ins and performance evaluations will ensure the quality and effectiveness of the mentoring relationships.

A Peer Mentor may be requested at any point during a MAPs Participant's services to assist with motivation and self-esteem, social interaction, friendship, conflict resolution, employment interests, job skills, education opportunities, communication and assertiveness skills, and general support and companionship.

Service Objectives:

1. **Empower** participants by enhancing self-confidence and independence by providing relatable mentorship.
2. **Guide** participants with practical advice and strategies to navigate personal and professional challenges.
3. **Support** participants by serving as a sounding board, helping participants articulate and address concerns and aspirations.
4. **Motivate** participants by inspiring them to pursue goals and overcome obstacles by sharing stories and coping strategies.
5. **Encourage** participants to use Enabling Technology to promote independence and self-reliance.
6. **Impact** the participants journey through shared experience and diversified support.

Service Delivery: Peer Mentoring is provided at least monthly in a medium accessible to the mentee. Peer mentors offer experiential and personal advice to the persons supported. Peer Mentors are trained to field interests, concerns and needs to assist the mentee with practical outlets that offer continued skill acquisition and achievement. Mentors are trained to assist mentees find options available and possible consequences for each action. Mentors assist mentees with setting personal goals or discussing milestones and program opportunities. Mentors monitor progress towards goals and provide ongoing feedback and guidance to achieve milestones. Crucial to this role is communicating the lived experience of having a disability and offering practical solutions that has been impactful for the mentor. Mentors, as part of the MAPs Participant's Circle of Support, can assist with creation and revisions to Person-Centered Plans, and to advocate for the mentee when applicable.

Mentors will use initial contacts to build rapport and establish a trusting relationship, as well as establishing relationships within the family and support



network. Mentors will use sessions to review milestones and personal goals or aspirations. Mentors will gather the reflections and experience of the mentee and use tools, resources and personal experience to provide practical solutions and feedback to the mentee to encourage progress. Mentors may refer to or advocate for service opportunities or revisions to better reflect the mentee's needs. Mentors are valuable members of the support team for a MAPs Participant.

Scope of Activities

1. One-on-One Mentoring Sessions conducted in person, via phone, or virtually. Sessions focus on mentee goals, challenges and progress.
2. Assisting Participants with goal setting, supporting, encouraging and celebrating progress.
3. Sharing resources, tools, and contacts that can promote understanding and connection within the MAPs Program.
4. Emotional Support for participants to share their experience and voice concerns with empathetic listening and constructive feedback.

For Mentors and Mentees:

Peer Mentoring is a support driven by the lived experience of MAPs Participants. Accessing or becoming a Peer Mentor is an expected step in a MAPs Participant's journey. During the course of services, a MAPs Participant may choose to request a Peer Mentor. In order to qualify for a Peer Mentor, the MAPs Participant must currently be receiving support with an active PSCP. The MAPs Peer Mentoring Service Referral Link is available on the MAPs website. Interested participants will complete the referral link and be referred to one of DDA MAPs partner organizations managing the Peer Mentoring program. Peer Mentors will be matched with applicants based on interests, goals and experiences. Once matched, Peer Mentors will make contact with the Mentee to begin services. MAPs Participants have access to their Peer Mentor throughout the entirety of the program.

MAPs Participants interested in becoming a Peer Mentor may choose to apply for available Peer Mentoring positions when they become available. Job postings are managed by the respective DDA MAPs Peer Mentoring partners. Applicants to become a Peer Mentor must first qualify before consideration. Peer Mentoring is a part-time position through partner organizations. Upon hire, the Peer Mentor will undergo the Peer Mentoring curriculum developed through DDA and Vanderbilt



University. This curriculum will be delivered by the peer mentoring agency. (Training requirements are reflected on the MAPs Training Matrix.)

Peer Mentoring Eligibility Requirements:

- Having Lived Experience with ID/DD.
- Be 18 years or older.
- Demonstrated success in academic, volunteer, employment, and/or independent living settings.
- Capacity to ensure documentation/confirmation of delivery of peer mentoring supports are available.
- Demonstrated ability to address virtual connectivity and ability to travel for peer mentoring meetings, as desired by the person supported.
- Ability to convey empathy.
- Ability to collaboratively problem-solve.

9.15: Person-Supported Establishment Incentive

ABLE Account: An ABLE account, also known as a 529 ABLE or 529A account, is a state-run savings program for eligible people with disabilities in the United States. Rules governing ABLE accounts are codified in Internal Revenue Code section 529A, which was enacted by the Achieving a Better Life Experience (ABLE) Act in 2014. With limitations, funds in an ABLE account are exempt from the Supplemental Security Income (SSI) and Medicaid asset limit, and earnings are exempt from federal income tax.

Qualified Disability Expense: A qualified disability expense is related to the designated beneficiary's blindness or disability. Each person is unique, and the needs of the individual can vary depending on the disability, circumstances, and specific treatment.

Examples Include:

- a. Education
- b. Housing
- c. Transportation
- d. Employment
- e. Training and Support/ Assistive Technology
- f. Personal Support Services
- g. Health, Prevention and Wellness
- h. Financial Management
- i. Administrative Services/Legal Fees
- j. Expenses for Oversight and Monitoring



k. Funeral and Burial Expenses

After their three-year program, people supported by MAPs will have acquired the skills to continue increasing their independence and accomplishing their personal goals. This may include but is not limited to enrolling in college or other post-secondary education programs, as well as exploring opportunities to live more independently, either on their own, with friends/partners, or with family members/natural support. To assist people supported by MAPs with pursuing these opportunities, they will be eligible to receive a one-time Establishment Incentive payable into an ABLE account to assist in those additional goals.

Requirements for Establishment Incentive Payment:

Persons who complete the MAPs program and achieve at least **6 MAPs Validated and Distinct milestones of the 11** available Milestones will be eligible for a one-time payment of \$4,000 to deposit into an ABLE account. Once MAPs program completion and Milestone achievement have been verified by the Innovation Coordination Agency, a person will become eligible for the payment. DDA expects that funds deposited into a person's ABLE account will be spent according to the criteria for a Qualified Disability Expense. However, once the deposit is made, it will be the responsibility of the person and/or their guardian (if applicable) to understand and fulfill the rules for ABLE expenditures, including reporting requirements, allowable expenses, and prohibited expenses. DDA will pass these funds through the appointed MAPs Provider agency so that the provider agency may help establish the ABLE account.

More Information about ABLE Accounts:

ABLE accounts can help people who became disabled before the age of 26, or their families pay for disability-related expenses. These expenses include housing, education, transportation, health, prevention and wellness, employment training and support, assistive technology, and personal support services. For more information on the utilization of ABLE Accounts, refer to the IRS website and State of TN Treasury website:

- [ABLE accounts: A valuable financial solution for people with disabilities | Internal Revenue Service \(IRS\)](#)
- [ABLE TN: Achieving a Better Life Experience](#)

Chapter 10:

Quality Assurance and Auditing

Quality assurance is the cornerstone of the MAPs program, ensuring that every participant receives consistent, effective, and person-centered support aligned with their goals. The Department of Disability and Aging (DDA) and MAPs provider agencies share a collective responsibility to uphold rigorous standards of care, accountability, and continuous improvement. Recognizing that excellence begins at the organizational level, the foundation of this process lies in each agency's internal protocols for monitoring the quality of services. These protocols—tailored to the agency's structure and participant needs—form the first layer of safeguarding program integrity, participant safety, and ethical practice.

DDA complements these efforts through systematic auditing processes designed to validate compliance, identify opportunities for growth, and foster innovation. Together, internal and external quality assurance mechanisms create a robust framework that prioritizes transparency, equity, and measurable outcomes. This section outlines the expectations for agency-led quality monitoring, the DDA's auditing procedures, and the collaborative strategies that drive the MAPs program toward its ultimate objective: empowering participants to achieve milestone independence with dignity and confidence.

10.1: Overview of Auditing Process

The MAPs program's auditing process is a systematic, participant-centered approach designed to ensure services align with the Department of Disability and Aging's (DDA) standards for quality, equity, and impact. Provider agencies are audited by DDA's Quality Monitoring teams using established protocols that evaluate compliance with operational guidelines, milestone achievement, and participant outcomes. Audits occur annually for all providers, with additional unscheduled reviews triggered by incident reports, participant grievances, or regulatory requirements. The process incorporates a mix of reviews of documentation, stakeholder interviews, and on-site observations to assess fidelity to MAPs' mission of fostering independence through person-centered supports.

A core focus of the MAPs quality monitoring experience is the participant's lived experience, and the completion of milestone processes tied to social determinants of health. Auditors prioritize evaluating how well providers address factors such as



housing stability, community engagement, employment access, and health equity within service delivery. Life experience assessments—tools that capture participants’ perspectives on their progress, dignity, and satisfaction—serve as critical indicators of program success. As such, the QA process emphasizes the collection and analysis of qualitative and quantitative data that reflect these outcomes. Providers are expected to demonstrate not only procedural compliance but also measurable improvements in participants’ overall well-being and autonomy.

The audit methodology follows a structured framework:

1. Documentation Review: Verification of milestone tracking, service logs, and evidence of social determinants of health-aligned supports.
2. Stakeholder Feedback: Interviews with participants, families, and staff to gauge satisfaction and identify systemic barriers.
3. Deficiency Tracking: Identified gaps are categorized by severity (e.g., minor, major, critical) and documented in a corrective action plan (CAP).
4. Reporting & Follow-Up: Providers receive a detailed audit report within 14 business days, outlining required improvements and timelines. Non-compliance with QA standards may result in mandated technical assistance, targeted training, or, in persistent cases, contract reevaluation.

To promote proactive quality improvement, organizations are encouraged to implement internal mechanisms that routinely measure participant satisfaction and SDOH outcomes. This includes embedding standardized surveys into service check-ins, hosting participant-led feedback forums, and training staff to recognize and respond to unmet social needs. By prioritizing continuous feedback loops—rather than relying solely on audit cycles—providers can address challenges in real time and align services with the evolving priorities of those they support. DDA offers resources, including SDOH assessment templates and QA toolkits, to assist agencies in cultivating this culture of accountability and innovation.

10.2: Provider Record-Keeping Process

Importance of Documentation

Accurate and comprehensive record keeping is a critical component of the MAPs program, serving as the foundation for tracking participant progress, validating



outcomes, and ensuring accountability. Documentation not only captures the journey toward milestone independence but also substantiates the effectiveness of services, informs care planning, and fulfills billing and audit requirements. Providers are entrusted with the responsibility to maintain meticulous records that reflect each participant's unique goals, challenges, and achievements.

Milestone Tracking & Validation

The heart of the MAPs program lies in its focus on milestone achievement, which is measurable indicators of progress toward greater independence, such as mastering daily living skills, securing employment, or engaging with community resources. Providers must:

- Define Clear Milestones: Collaboratively establish participant-specific milestones during intake and ongoing planning meetings within the development of Milestone Goal and Achievement statements.
- Track Progress Systematically: Use standardized tools (e.g., progress notes, checklists, digital trackers) to document incremental advancements.
- Validate Outcomes: Collect objective evidence (e.g., photos, participant journals, third-party observations) to corroborate milestone attainment.

Evidence Collection & Organization

Mandatory Evidence Collection: Providers must gather and organize evidence demonstrating increases in independence. Examples include:

- Pre- and post-assessments of skill proficiency.
- Signed participant or caregiver attestations.
- Time-stamped logs of community activities or employment hours.

Billing Compliance: Milestone validation is directly tied to reimbursement. Incomplete or unsupported documentation may result in delayed or denied payments.

Audit Preparedness: Organized records must be readily accessible for DDA audits, which verify adherence to program standards and accuracy of reported outcomes.

Documentation Policies



While DDA mandates rigorous milestone documentation, providers retain the authority to develop agency-specific policies for per-visit documentation, provided they align with MAPs' overarching goals. Examples of flexible practices include:

- Customized Templates: Tailor progress note formats to reflect service types (e.g., community navigation vs. independence coaching).
- Digital vs. Paper Systems: Choose platforms that suit operational needs but ensure data security and ease of retrieval.
- Staff Workflow Preferences: Designate timelines for documentation completion (e.g., within 24 hours of service delivery).

Data Storage Requirements

- Secure Storage: All records, including evidence of milestone achievement, must be stored in HIPAA-compliant systems (see Data Storage Standards section).
- Retention Periods: Maintain records for a minimum of 10 years post-service termination or as required by state/federal law.
- Accessibility: Ensure records are searchable and retrievable within 48 hours of a DDA audit request.

Effective record keeping is both a procedural obligation and a testament to the transformative impact of the MAPs program. By balancing flexibility in day-to-day documentation with unwavering attention to milestone validation, providers uphold program integrity, secure funding, and—most importantly—celebrate participant successes. Agencies are encouraged to regularly review and refine their documentation processes in partnership with the DDA to ensure alignment with evolving best practices.

10.3: Audit Preparation and Compliance

The Department of Disability and Aging (DDA) conducts audits to ensure MAPs providers adhere to program standards, regulatory requirements, and participant-centered practices. Audits serve as a mechanism to verify compliance, validate service quality, and identify opportunities for improvement. By fostering accountability and transparency, audits uphold the integrity of the MAPs program and safeguard participant outcomes.

Audit Preparation Steps



Providers are responsible for maintaining ongoing readiness for audits, both scheduled and unscheduled. Key preparation steps include:

1. Internal Record Review

- Conduct routine self-audits to ensure documentation (e.g., service logs, progress notes, milestone evidence) is complete, accurate, and aligned with DDA standards.
- Cross-reference records with billing submissions to confirm consistency.

2. Document Organization

- Ensure all participant files, staff training records, and policy manuals are stored securely and retrievable within 48 hours of request.
- Use standardized naming conventions and indexing systems for digital files.

3. Staff Preparedness

- Train staff annually in audit procedures, including how to respond to auditor inquiries and locate documentation.
- Designate an Audit Liaison to coordinate with DDA auditors and manage on-site logistics.

4. Mock Audits

- Perform annual mock audits using DDA's audit checklist (available on the MAPs Provider Portal) to identify gaps.

Compliance Expectations

Documentation Requirements:

- Service logs with dates, duration, and summaries of participant interactions/monthly check-ins.
- Signed participant consent forms and individualized service plans.
- Evidence of milestone achievement (e.g., assessments, photos, third-party verification, video evidence, validation approvals).
- Policy Adherence:
- Follow HIPAA, data security, and record retention protocols (see Data Storage Standards and Participant Data Protection sections).
- Align staff practice with current MAPs service definitions and operational manuals.

1. Notification

- Scheduled audits: Providers receive notice annually on the scheduled audit.
- Unscheduled audits: May occur in response to complaints, incidents, or regulatory mandates.

2. On-Site or Remote Review

- Auditors examine records, interview staff, and observe service delivery (if applicable).
- Providers must grant access to digital systems, physical files, and relevant personnel.

3. Exit Conference

- Preliminary findings are discussed with provider leadership, with a formal report issued within 14 business days.

Post-Audit Requirements

1. Corrective Action Plan (CAP)

- Address deficiencies identified in the audit report within 30 days of receipt.
- Submit a CAP to DDA outlining steps, responsible personnel, and timelines for resolution.

2. Follow-Up

- DDA may conduct a follow-up audit to verify CAP implementation.
- Persistent non-compliance may trigger penalties (see Consequences below).

Consequences of Non-Compliance

- Minor Violations: Mandatory staff retraining or revised internal policies.
- Major Violations: Financial penalties, suspended billing privileges, or termination of provider contracts.
- Legal Action: Referral to regulatory bodies for HIPAA breaches or fraud.

10.4: Corrective Actions Following Audits

The identification of areas for improvement through audits or routine monitoring is not a failure but an opportunity to strengthen the quality and impact of MAPs



services. Corrective actions are essential to address gaps, refine practices, and ensure alignment with the program's mission to prioritize participant dignity, independence, and holistic well-being. The Department of Disability and Aging (DDA) views corrective action plans (CAPs) as collaborative tools, fostering accountability while empowering providers to innovate and grow.

Proactive Quality Improvement

Quality support is not defined solely by audit outcomes but through ongoing engagement with stakeholders and participants. Waiting for a single audit cycle to gather feedback risks overlooking critical insights and delays meaningful improvements. To ensure consistency and responsiveness:

- Routine Stakeholder Check-Ins:

- Conduct quarterly meetings with participants, families, and community partners to review service effectiveness, challenges, and unmet needs.
- Use structured tools (e.g., surveys, focus groups) to capture feedback on accessibility, cultural competence, and goal progression.

- Continuous Staff Input:

- Involve frontline staff in monthly debriefs to identify operational barriers or training needs.
- Integrate participant success stories and challenges into team discussions to ground decisions in real-world experiences.

Life Experiences & Social Determinants of Health

The MAPs program recognizes that quality supports extend beyond clinical or procedural metrics. True excellence is measured by how well services address the social determinants of health (e.g., housing stability, education, social inclusion) and honor participants lived experiences. Providers must:

- Embed Assessments of Social Determinants:

- Use validated tools to evaluate factors like food security, transportation access, or social connectivity during service planning.
- Adjust supports mitigating barriers (e.g., partnering with housing agencies, facilitating community integration).

- Center Participant Narratives:

- Document life experiences and personal goals as core components of individualized plans.
- Train staff to recognize and respect cultural, linguistic, and socioeconomic diversity in service delivery.

- Implementing Corrective Actions

When audits or monitoring reveal opportunities for improvement, providers must act swiftly and transparently:

1. Root-Cause Analysis:

- Collaborate with DDA to identify systemic or procedural sources of the issue (e.g., staff training gaps, outdated policies).

2. CAP Development:

- Submit a plan within 14 days of audit findings, detailing:
- Specific actions (e.g., revised workflows, staff retraining).
- Timelines and responsible personnel.
- Metrics to evaluate success (e.g., reduced incident reports, improved participant satisfaction scores).

3. DDA Partnership:

- Request technical assistance from DDA's Quality Improvement Team to design and execute CAPs.
- Participate in progress reviews every 30 days until the CAP is fully implemented.
- Monitoring & Sustainability
- Track CAP outcomes for at least 6 months to ensure lasting change.
- Celebrate improvements publicly to reinforce a culture of learning and accountability.

Corrective actions are not punitive measures but steppingstones toward excellence. By embracing routine stakeholder engagement, centering social determinants of health, and acting decisively on feedback, providers transform challenges into catalysts for innovation. DDA remains committed to supporting this journey, ensuring the MAPs program evolves as a model of participant-driven, equitable care.

Chapter 11:

Program Exception Requests

The MAPs program prioritizes a person-centered approach, recognizing that individualized circumstances may occasionally necessitate exceptions to standard operational protocols. These exceptions are designed to ensure equitable access, uphold participant dignity, and address unique needs that cannot be fully accommodated through existing guidelines. The Department of Disability and Aging (DDA) maintains a formal exception review process to

evaluate such requests, ensuring decisions align with the program's mission while safeguarding accountability and fairness.

It is critical to emphasize that exceptions are granted solely to advance the well-being, independence, or safety of participants—not to compensate for provider agency operational shortcomings, staffing challenges, or lapses in procedural compliance. This section outlines general principles and processes for submitting requests; however, it cannot anticipate every potential scenario. Stakeholders are encouraged to proactively submit exception requests, accompanied by thorough documentation and rationale, for DDA review. When in doubt, transparency and collaboration remain the best path forward.

11.1 General Guidelines for Exception Requests

Criteria for Submitting Requests

The MAPs Program Review Team recognizes that unforeseen circumstances may arise, requiring flexibility to ensure the continuity of support and the delivery of truly person-centered services. To maintain the integrity of the program, while also accommodating unique participant needs, specific criteria have been established for submitting Exception Requests.

Exception Requests should be submitted when:

1. **Unanticipated Events:** Circumstances, such as medical emergencies, significant changes in the participant's living situation, or other unexpected life events, which necessitate a deviation from standard program procedures to maintain continuity of care.
2. **Participant-Centered Needs:** The participant's specific needs or goals cannot be adequately addressed within the existing program framework, and an exception is essential to provide personalized and effective support for the participant.
3. **Program Milestones and Progression:** The participant requires additional time or resources to achieve program milestones due to barriers beyond his/her control, such as the need for repeating a milestone to ensure sustainability or temporarily pausing participation to address critical issues and/or a circumstance has changed necessitating the access to repeat a particular milestone.
4. **Family Involvement:** There is a justified need for a family member of the person supported to deliver direct support to the participant, ensuring that the care provided is consistent, familiar, and in the best interest of the participant's overall well-being.

This is not an inclusive list, DDA and MAPs recognize there may be additional circumstances which warrant an exception consideration. ICs are encouraged to collaborate with DDA on those specific instances and submit exception requests even if not all the requested information is entirely applicable to the categories listed above.

Each Exception Request must include comprehensive documentation detailing the specific circumstances, the rationale for the request, and how the exception will benefit the participant if granted. This process ensures every decision is grounded on the principles of person-centered care, promoting the best possible outcomes for each MAPs participant.

Process for Approval and Review

Step 1: Submission of Exception Request

Prepare Documentation: The IC must compile all necessary documentation, including a detailed description of the circumstances, the specific exception being requested, and a clear rationale for why the exception is needed.

Submit Request: The completed Exception Request form and supporting documentation should be submitted to the designated MAPs program review team via the specified submission channel (e.g., online portal).

Step 2: Initial Review

Preliminary Assessment: Upon receipt, the MAPs Program Review Team will conduct a preliminary assessment to ensure the request is complete and that all necessary documentation is provided.

Clarification Requests: If additional information or clarification is needed, then the MAPs Program Review Team will contact the IC to obtain the required details.

Step 3: Detailed Evaluation

Review by Experts: The request will be evaluated by a panel of experts, including program managers, clinical advisors, and other relevant DDA stakeholders. The panel will assess the request based on established criteria, considering the participants' needs and the potential impact on their program experience.

Consistency Check: The MAPs Program Review Team will ensure the request aligns with the principles of the MAPs program and adheres to regulatory and policy guidelines.



Step 4: Decision Making

Approval or Denial: The MAPs Program Review Team will then decide to approve or deny the Exception Request (after the detailed evaluation). The decision will be based on the documented evidence, the rationale provided, and the anticipated benefits for the participant.

Conditions and Limitations: The DDA review panel may impose specific conditions or limitations prior to the approval of a modified exception to ensure the exception is implemented effectively and does not negatively impact the program's integrity or the person supported.

Step 5: Notification

Communicating the Decision: The IC will be notified of the decision in writing, including any conditions, limitations, or modifications associated with the request as it has been approved. If the request is denied, then the notification will include the reasons for denial and, if applicable, any possible alternatives to the requested exception.

Participant Involvement: The participant and his/her support team will also be informed of the decision and any subsequent steps required to implement the exception.

Step 6: Implementation and Monitoring

Action Plan: For approved requests, an action plan will be developed to integrate the exception into the participant's support framework. This plan will outline the specific steps to be taken, parties responsible for implementing the steps, and timelines for the steps.

Ongoing Monitoring: The IC will monitor the implementation of the exception to ensure it meets the participant's needs and maintains program standards. Regular updates will be provided to the MAPs Program Review Team (Regional Transition Guides and Director of MAPs).

Step 7: Review and Evaluation

Periodic Review: Approved exceptions will be subject to periodic review to assess their continued relevance and effectiveness. Adjustments will be made, as necessary, to align with evolving participant needs and program goals.

Feedback and Improvement: Feedback from participants, families, and staff will be gathered to inform future decisions and enhance the overall exception request process.

This structured approval and review process ensures that Exception Requests are handled systematically, transparently, and in a manner which prioritizes the participant's best interests while upholding the integrity of the MAPs program.

11.2 MAPs Services Budget Extension (On-Hold) Request

Background:

The Department of Disability and Aging (“Department”) is administering the Medicaid Alternative Pathways to Independence (“MAPs”) program to people across the state of Tennessee who have intellectual and/or developmental disabilities. The MAPs program provides access to three (3) years’ worth of services for each person enrolled.

The MAPs program is a pilot program, which means the Department is implementing a series of approaches to deliver cost-effective and provider innovation-encouraged support to reduce the dependency on traditional long-term services and supports. The implementation of the MAPs program was developed using a progressive approach whereby services would be rolled out incrementally across the state of Tennessee. Through this implementation, plans have been identified where a limited number of contracted provider agencies would be secured to allow for controlled and sustained growth of the program. As additional people are enrolled in the MAPs program, additional providers may be reviewed and enrolled into the MAPs network to meet that demand. As the MAPs program continues to expand, it is expected that certain delays may be experienced, and the Department wishes to ensure each participant can maximize their service time within the program.

Purpose of Budget Extension (On-Hold) Status:

The “On-Hold” status provides a framework for maintaining support for services in the MAPs program during extenuating circumstances, which include, but are not limited to, behavioral crises, medical emergencies, provider capacity, and other circumstances outside the control of the MAPs person supported. Due to the MAPs program being a time-sensitive, 3-year limited program for services, an “On-Hold” status would create a space to ensure all MAPs participants receive their full 3 years’ worth of services, while also ensuring diligence in monitoring appropriations for service delivery. The need for an “On-Hold” status is a circumstantial decision, which would be approved solely based on a case-by-case basis scenario by the Department. It is important to note that an “On-Hold” status is **temporary**. It should

be noted that, during an “On-Hold status, the Department and MAPs program staff will be working diligently to address the underlying reasons for the “On-Hold” status so MAPs services can be resumed to minimize any negative impacts on people supported.

The specific circumstances under which benefits may be expanded to people with intellectual/developmental disabilities can vary depending on the program and the policies in place. Circumstances where benefits may be expanded are as follows:

1. **Medical emergencies:** If a person experiences a medical emergency which prevents him/her from participating in the program, then he/she may be granted an extension or additional support(s).
2. **Natural disasters:** In the event of a natural disaster, such as a hurricane, earthquake, fire, or flood, people may be unable to access services. In such cases, benefits may be expanded to accommodate the disruption caused by the disaster.
3. **Family emergencies:** If a person has a family emergency, such as a death in the family or a serious illness of a caregiver, then he/she may be granted additional support(s) or a temporary suspension of program requirements.
4. **Personal emergencies:** Certain personal emergencies, such as accidents or sudden health issues, may prevent a person from participating in the program. In such cases, benefits may be expanded or adjusted to accommodate the situation.
5. **Behavioral Crisis:** A behavioral crisis refers to a situation in which a person exhibits intense and disruptive behaviors which may pose a risk to his/her safety or the safety of others. These behaviors often surpass the person’s typical patterns of conduct and may include, but are not limited to, aggression, violence, self-harm, or other actions which create an immediate and challenging situation.
6. **Unforeseen circumstances:** There may be other unforeseen circumstances which prevent a person from program participation, such as legal issues, transportation problems, or sudden financial hardships. These situations may be considered on a case-by-case basis, and benefits may be expanded or adjusted accordingly.
7. **Circumstances out of control of MAPs participants** may be a public health emergency, a transition between service providers, or other unforeseen events which may necessitate a cause for an “On-Hold” status need, and which will be reviewed on a case-by-case basis.
8. **Provider Capacity:** A Provider is an agency or organization that provides MAPs services to people with disabilities. The capacity of a MAPs service provider refers to



that provider's ability to effectively deliver services and support to people eligible for the MAPs program. Provider capacity encompasses various aspects which contribute to the provider's ability to meet the needs of the people they support. Capacity is dynamic and may evolve based on each provider.

NOTE: This *is not an inclusive list, and other circumstances could be approved upon request.*

It is important to note that the specific circumstances and the process for expanding benefits may vary depending on the program and the organization providing the services. It is recommended to consult the program guidelines or contact the relevant authorities for accurate and up-to-date information.

11.3 Eligibility and Implementation of "On-Hold" Service Plan:

People supported and enrolled in the MAPs program will begin MAPs services by completing an initial interest assessment, skill assessment, and technological utilization assessment administered by the Innovation Coordination Agency. At the time of enrollment, the person supported will begin their 3-years' worth of services (*i.e., MAPs Person Supported Budget Year begins on the date of enrollment and will renew at each enrollment date for the next 2 years totaling 3 years of MAPs services*). During this process, the MAPs person supported and/or legal representative, if applicable, will be introduced to the available MAPs providers. The MAPs person supported and/or legal representative, if applicable, will select his/her provider of choice to deliver the MAPs services.

The Department will implement a consideration process whereby a MAPs person supported may have his/her Annual Budget Date placed on a temporary "On-Hold" status in the event a provider agency is unable to accept the referral to initiate services OR if the person experiences a disruption in his/her services outside of their control. By placing the person's status "On-Hold", the Department will be able to ensure the person supported will continue to have access to three (3) years of MAPs services.

Procedures for On-Hold Requests:

The following procedures shall be implemented through the "On-Hold" status consideration:

1. All "On-Hold" status requests will be submitted by the IC to the MAPs Regional Transition Guide.

- A. All "On Hold" requests will be submitted via the IC to a developed Microsoft Requesting Form:

[MAPs Exception Request \(Click Here\)](#)

B. In the event a person-supported is requesting the “On-Hold” consideration, the person-supported will initiate this request by notifying the IC of the interest in the request AND accompanying reasons. Progress to #2.

C. In the event the request is being initiated by the IC due to provider capacity, the following procedures will occur.

a. The IC will submit a person-supported referral to all applicable providers within the MAPs network and document within the Individual Case File reasons for denial for tracking purposes (to include reasons why the provider was unable to accept the referral).

b. Upon exhausting all initial options with the MAPs provider network (including providing Technical Assistance to the already identified providers to accept the MAPs person supported within a reasonable time), the IC will communicate to the Department if a MAPs person supported has exhausted all current options for provider supports AND/OR meets “On-Hold” status request criteria based on any of the above-mentioned circumstances. This notification will be sent to the Regional MAPs Transition Guide AND a Case Note will be completed in the MAPs participant Case File.

c. The MAPs status will read as “PCSP Planning in Process OR Enrolled” based on the active status of the participant.

2. The MAPs Transition Guide will assist in potential problem-solving and planning processes to avoid a MAPs “On-Hold” status implementation with the IC staff. If unsuccessful in identifying a solution, then the following steps will be initiated.

a. The MAPs Program Review Team will review the request of “On-Hold” status and make a notification in the Case File that the request has been reviewed.

Internal Case Note to include:

- Date of Request
- Date of Review

- MAPs Program Review Members of the Department
- Summary of Circumstances
- Resolution by the Department
- Effective Dates of Extension

EXAMPLE: 3/21/2024 DDA received a request for “On-Hold” status and met to review on 3/26/24 with the MAPs Program Review Team—Brea, Jay, and Carly. Participant’s family home was impacted by a natural disaster on 12/10/23 and the family has been displaced, impacting the finalization of completion of the Home Safety Milestone. Initial 30-day request granted until 3/26/2024, additional 30-day extension granted until 4/26/2024.

b. At the conclusion of all efforts, the MAPs Program Review Team will prepare a written statement to the MAPs person supported/stakeholder, provider agency, and IC agency regarding the recommendation of an “On-Hold” status to ensure the MAPs person supported does not lose any possible MAPs support time due to circumstances outside of the control of the MAPs person supported. This publication will include the following:

- Name
- Date
- Summary of Circumstances
- Resolution by the Department
- Expected engagement criteria during “On-Hold” Status

c. Once this notice has been sent to the stakeholders, the MAPs Transition Guide will ensure the notification is included and attached to the Extension Request SharePoint Site (internal use only).

d. The Department and/or IC agency will review each “On-Hold” case frequently to ensure plans for correction are being developed to remove the “On-Hold” status and resume MAPs services.

e. Upon conclusion of the “On-Hold” status, the SharePoint site will be updated to reflect an “Enrolled” status, and dates will

be updated to represent the time in which the person supported was "On-Hold".

f. The MAPs person-supported Budget Tracker will be updated by DDA staff to reflect the new ending date of the planning year to account for the "time" while a person was "On-Hold". This will result in adjustments to Years 2 and 3 budget start and end dates.

NOTES:

"On-Hold" status consideration and this resource are subject to change at any time pending program advancements, funding implications, and/or changes in the delivery approach of MAPs services. The Department reserves the ability to adjust this consideration without notice.

The Department will not implement a review/appeal request process for this consideration. The decision made at the onset of the request shall be the initial and final review for that consideration.

MAPs Budget Extension "On-Hold" Status Frequently Asked Questions (FAQs)

What circumstances might warrant pausing services (placing the status to "On-Hold") under the MAPs?

This resource is intended to recognize situations where a MAPs participant may not be able to receive the intended MAPs services. It is expected that, when these situations occur, a participant will be able to go to "On-Hold" status and not lose service time associated with the time-sensitivity of the MAPs services. Some circumstances which could warrant consideration for someone going "On-Hold" include, but are not limited to, the following:

- Medical Emergencies
- Natural Disasters
- Family Emergencies
- Personal Emergencies (e.g., Behavioral Crises)
- Provider Capacity
- Unforeseen Circumstances

How can a participant request to pause his/her services, OR have his/her status temporarily changed to "On-Hold"?

The assigned IC will be responsible for initiating the request for an "On-Hold" status for the participant. The MAPs participant would need to communicate to the assigned IC his/her need to be considered for an "On-Hold" status, while also including specific reasons why the services cannot be received. The IC will forward these requests to the MAPs Program Review Team for review. These



requests can be sent directly to the MAPs Transition Guide OR Director of MAPs in writing via an identified process within the On-Hold Resource Guide.

What documentation or process is required to initiate a pause in services?

The Department must receive all requests via writing from the assigned IC. If the MAPs participant wishes to request this status change, then he/she may do so directly to the assigned IC, however, the Department will only accept requests in writing directly to the assigned Regional Transition Guide. Once received, the Transition Guide will initiate the associated procedure for review and consideration.

Are there specific criteria or eligibility requirements for pausing services?

This recognition intends to ensure the MAPs participant has access to a full 3 years' worth of MAPs services. In the event access to MAPs services is disrupted/unavailable for a reason outside of the control of the MAPs participant, then consideration will be given to credit the participant with any time lost because of the disruption. The Department will review each request on a case-by-case basis to determine if the circumstance(s) warrant consideration. In the event it is determined that adequate justification exists, the Department will grant the "On-Hold" status providing additional time for the MAPs participant. MAPs participants should reserve requesting for "On-HOLD" consideration as a last resort, as it is not intended to be utilized as a convenience for the MAPs participant or other stakeholders.

How long can services be paused, and is there a maximum duration?

MAPs services will be eligible for pausing for up to 30 days at a time, to be possibly extended at the end of that 30-day time-period. During a planning year for the MAPs participant, the maximum duration that can be considered is 90 days. Any disruption beyond 90 days would require disenrollment from the MAPs program. That participant would be eligible to re-enroll in MAPs services (pending availability, funding, and other considerations) when they can resume services. Participants can request for "On-Hold" consideration a maximum of 3 times per year (pending circumstances).

Will pausing services affect the participant's eligibility or access to other benefits?

No. If the participant continues to communicate with the IC during their "On-Hold" status, the participant will be able to resume the services as expected upon the completion of the "On-Hold" status.

What happens to the participant's support plan and goals during the pause in services?



All services, plans, and milestones are placed on “pause” while the participant is “On-Hold” from the MAPs program. In the event the participant needs to revise the chosen milestones AFTER the “On-Hold” status expires, a collaborative roundtable meeting would be necessary to review all changes within the Person-Centered Support Plan (“PCSP”) and identification of new milestones.

Can services be resumed after they have been paused, and what is the process for doing so?

It is expected that services will resume after the pause. At the conclusion of the “On-Hold” period, the IC will notify the participant of the intent to resume services. This notification will also include notifying the selected provider agency so services can resume.

How does pausing services impact the participant's relationship with their assigned support coordinator or case manager?

The IC agency will continue to maintain an OPEN record for the MAPs participants while they are placed on “On-Hold”. At the conclusion of the “On-Hold” period, the IC will resume monitoring of services. Each MAPs participant should expect that the IC will routinely communicate with the participant during the “On-Hold” status to ensure all necessary planning is to resume MAPs services.

What are the potential consequences of not adhering to the guidelines for pausing services?

In the event it is determined that a participant is not acting in good faith to adhere to the reception of MAPs services, the participant may be disenrolled from the MAPs program.

Who can participants or stakeholders contact for further clarification or assistance regarding pausing services under the program?

MAPs participants are encouraged to communicate directly with the assigned IC for information relating to their MAPs program and services. The Department will also ensure additional information can be accessed via the DDA MAPs Transition Guides and Director of MAPs.

11.4 Milestone Repeat Exception Request

Background

The MAPs program is designed to foster greater independence for participants over a span of three years by guiding them through 11 distinct milestones over 3 main Outcome Areas (Home, Work, and Community). Each milestone represents a specific goal or set of skills that participants work towards achieving, contributing to



their overall journey towards living independently. The sequential attainment of these milestones is integral to the program's success where each step/milestone builds upon the previous one, culminating in the attainment of comprehensive skill development, sustainment, and self-sufficiency.

While the program is structured to promote steady progress through each milestone, the Department acknowledges that individual circumstances may necessitate a different approach. Participants may encounter various factors which impact their ability to achieve milestone independence on the first attempt OR may need to repeat a milestone based on various factors. These factors can include, but are not limited to:

- **Health Issues:** Medical conditions or health crises that temporarily impede progress.
- **Personal Circumstances:** Significant life changes, such as housing instability, family emergencies, housing relocation, or other personal challenges, etc.
- **Learning Pace:** Variations in learning styles and paces which require additional time and practice to master certain skills.
- **Support System Changes:** Changes in the participant's support network, such as loss of a caregiver or transition to a new support team.

Recognizing these potential challenges, the Department has established an exception process which allows participants to repeat milestones when necessary. This process ensures the MAPs program remains flexible and responsive to individual needs, providing participants with the opportunity to fully develop their skills and achieve their goals without being penalized for circumstances beyond their control.

The exception process empowers ICs to advocate for their participants by submitting a formal request to repeat a milestone. This request is based on a thorough assessment of the participant's situation and a clear rationale for why repeating the milestone is essential for their continued progress. By allowing for milestone repetition, the Department upholds its commitment to person-centered planning and support, ensuring that each participant receives the individualized attention and resources they need to succeed.

This approach not only addresses immediate needs but also reinforces the program's overarching goal of fostering long-term independence. Through a structured and compassionate exception process, the MAPs program can adapt to the unique paths of each participant, facilitating their journey towards a more independent and fulfilling life.



b. Purpose of the Repeat Milestone Exception Request

The purpose of the Repeat Milestone Exception process is to provide a structured and compassionate mechanism within the MAPs program which allows participants to repeat specific milestones when necessary. This process is designed to accommodate individual circumstances which may impede a participant's ability to achieve milestone independence on the first attempt or require additional support to sustain milestone independence based on contributing influences. By doing so, the Repeat Milestone Exception process ensures:

1. **Person-Centered Support:** Participants receive tailored support that recognizes and addresses their unique challenges and needs, fostering a more individualized and effective pathway to independence.
2. **Continuous Progress:** Participants can maintain their engagement and momentum within the program, even when faced with setbacks/adversity, ensuring that they remain on track toward achieving long-term independence and self-sufficiency.
3. **Holistic Development:** The process supports the overall goal of the MAPs program by ensuring that each participant can fully develop their capabilities and reach their potential across all milestones, contributing to a comprehensive skill set by the end of the three years.
4. **Program Integrity and Quality:** By providing a formalized exception process, the MAPs program can maintain high standards of support and accountability, ensuring all participants are given a fair and equitable chance to succeed while having access to the necessary flexibility.

Overall, the Repeat Milestone Exception process is a critical component of the MAPs program, reinforcing its commitment to adaptability, person-centered care, and the goal of independent living for all participants.

Eligibility and Implementation Criteria

Eligibility Criteria: To qualify for a Repeat Milestone Exception within the MAPs program, participants must meet the following criteria:

1. **Demonstrated Effort:** The participant has shown a consistent and genuine effort to achieve the milestone, including active participation in related activities and engagement with support services.

2. **Documented Challenges:** There must be documented evidence of specific challenges or circumstances which have impeded the participant's progress or justification for repeating a milestone. These challenges can include, but are not limited to:
 - Health issues or medical emergencies
 - Significant personal or family circumstances
 - Changes in living situations or support network
 - Learning difficulties which require more time to master the skills associated with the milestone
3. **Support Team Recommendation:** The participant's support team, including their IC and other relevant staff, must recommend the milestone repeat based on a thorough assessment of the participant's needs and progress.
4. **Participant's Consent:** The participant and/or legal guardian, if applicable, must consent to the milestone repeat request and be willing to continue working towards the milestone.

Implementation Criteria: Once eligibility is established, the following implementation criteria will guide the Repeat Milestone Exception process:

1. **Submission of Request:** The IC will complete and submit a formal Repeat Milestone Exception request, including all necessary documentation and a detailed rationale for the request, to the MAPs Program Review Team.
2. **Review and Approval:** The MAPs Program Review Team will evaluate the request based on the documentation provided and the established eligibility criteria. The MAPs Program Review Team will determine within a specified timeframe, typically 30 days, and communicate the decision to the IC.
3. **Development of Action Plan:** If the request is approved, then the IC, in collaboration with the participant and their support team, will develop a detailed action plan outlining the steps to be taken during the milestone repeat period. This plan will include:
 - Specific Repeat Milestone selected with a potential amendment made to the PSCP.
 - Roles and responsibilities of the participant, support team, and other stakeholders (as applicable).
4. **Monitoring and Support:** Throughout the milestone repeat period, the IC will closely monitor the participant's progress, providing ongoing support and adjustments to the action plan, as needed. Regular monthly check-ins from the provider agency will be conducted to ensure the participant is on track.
5. **Evaluation and Feedback:** At the end of the milestone repeat period, the participant's progress will be evaluated to determine if the milestone has been achieved through the Pre-Claim Validation process. At that point, the

provider agency **WILL** be able to receive Value-Based payment for the successful completion of the Repeat Milestone implementation process.

6. **Documentation and Reporting:** All aspects of the milestone repeat process, including the initial request for progress monitoring, and final validation, will be thoroughly documented and reported to ensure transparency and accountability.

NOTE: *Repeated Milestones will NOT be credited to the progression toward the Person Supported Establishment Incentive Payment. To qualify for the Person-Supported Establishment Incentive, the participant must complete 6 distinct and MAPs validated milestones over the course of the 3 years.*

By adhering to these eligibility and implementation criteria, the Repeat Milestone Exception process will provide a fair and supportive framework which enables MAPs participants to overcome obstacles and achieve their goals, ultimately fostering greater independence and success.

Procedures for Milestone Report Request

Step 1: Initial Assessment

1. Identify Need: The IC, in conjunction with the provider agency, identifies the need for a repeat Milestone based on the participant's circumstances.
2. Gather Documentation: Collect all relevant documentation, including evidence of the participant's effort, the challenges encountered, and any other pertinent circumstantial information supporting the need for a milestone repeat.

Step 2: Preparing the Request

1. Complete Request Form: Fill out the official Milestone Repeat Exception Request form. Ensure all sections are completed, including:
 - Participant's name and all applicable identifying information
 - Description of the milestone to be repeated.
 - Detailed rationale for the request. This should include specific details related to the actual justification to repeat a milestone.
 - Recommendations from the support team
2. Attach Supporting Documents: Include all supporting documentation as applicable (PSCP, Amendments, Pre-Claim Validation Confirmation, Budget Analysis, etc.).



Step 3: Submission of Request

1. Submit to MAPs Program Review Team: Submit the completed Repeat Milestone Exception Request form and all supporting documents to the designated MAPs Program Review Team via the specified submission channel (e.g., online portal as primary).

Step 4: Review Process

1. Preliminary Review: The MAPs Program Review Team conducts a preliminary review to ensure the request is complete and all necessary documentation is provided.
2. Request for Additional Information: If needed, the MAPs Program Review Team may request additional information or clarification from the Innovation Coordinator in collaboration with the provider agency.

Step 5: Detailed Evaluation

1. Evaluation by Panel: The request is evaluated by the MAPs Program Review Team including regional MAPs Transition Guides, Director of MAPs, members of the Division of Innovation, etc. The MAPs Program Review Team assesses the request based on the established eligibility criteria and the participant's documented needs.
2. Decision Making: The MAPs Program Review Team decides to approve or deny the request. The decision is based on the evidence provided and the anticipated benefits for the participants.

Step 6: Notification of Decision

1. Communicate Decision: The IC is notified of the decision in writing, including any conditions or limitations associated with an approved request. If the request is denied, and, if applicable, any possible alternatives to the requested exception.
2. Inform Participant: The participant and his/her support team are informed of the decision and any subsequent steps required to implement the exception.

Step 7: Implementation of Approved Request

1. Develop PSCP Plan (amendment if applicable): For approved requests, the IC, in collaboration with the participant and their support team, updates the PSCP to ensure selected milestones are a confirmed function of the annual plan.
2. Provide Support: The IC provides ongoing support and adjustments to the action plan, as needed. Regular check-ins are conducted to ensure the participant is on track toward milestone achievement.

Step 8: Monitoring and Evaluation

1. Monitor Progress: Throughout the milestone repeat period, the IC monitors the participant's progress, providing support and adjusting the plan, as necessary.
2. Final Evaluation: At the end of the milestone repeat period, the participant's progress is validated through the Milestone Pre-Claim validation process to determine if the milestone has been achieved.

Step 9: Documentation and Reporting

1. Document Process: Thoroughly document all aspects of the milestone repeat process, including the initial request, action plan, progress monitoring, and final evaluation.
2. Report to the Department: Submit a final report to the Department through the MAPs Pre-Claim Portal to confirm validation OR denial, ensuring transparency and accountability in the implementation of the Repeat Milestone Exception.

By following these specific procedures, the Repeat Milestone Exception Request process ensures participants receive the necessary support and flexibility to achieve their milestones, fostering a person-centered approach and promoting overall program success.

Milestone Repeat Request Frequently Asked Questions

What is a Milestone Repeat Exception Request?

A Repeat Milestone Exception Request is a formal petition submitted by an IC on behalf of a participant in the MAPs program, seeking approval to repeat a milestone due to specific challenges or circumstances that have prevented the participant from achieving the milestone on the first attempt or due to unforeseen circumstances where a participant would benefit from repeating the milestone completion.

Who is eligible to submit a Milestone Repeat Exception Request?

Participants who have demonstrated genuine effort to achieve the milestone, but have faced documented challenges, such as health issues, personal circumstances, or are eligible. The request must be recommended by the participant's support team and consented to by the participant or their legal guardian.

What documentation is required to submit a Milestone Repeat Exception Request?

The request must include a completed Repeat Milestone Exception Request form, a detailed rationale for the request, and supporting documentation such as progress notes, and other relevant records that demonstrate the participant's circumstances.

How do I submit a Milestone Repeat Exception Request?

The completed request form and supporting documents should be submitted to the designated MAPs Program Review Team via the specified submission channel, such as email or an online portal.

How long does the review process take?

The MAPs Program Review Team typically decides within 30 days of receiving the request. The Innovation Coordinator will be notified of the decision in writing.

What happens if the request is denied?

If the request is denied, then the notification will include the reasons for denial.

How will the participant's progress be monitored during the milestone repeat period?

The IC will closely monitor the participant's progress, provide ongoing support and make necessary adjustments to the PSCP, as necessary. Regular monthly check-ins will ensure the participant is on track to achieve the milestone.

Can a participant request to repeat more than one milestone?

Yes, participants can request to repeat multiple milestones if they meet the eligibility criteria for each request. Each request will be evaluated individually based on the participant's documented needs and circumstances.

How does the Repeat Milestone Exception process support person-centered planning?

The process is designed to accommodate individual circumstances and provide the necessary flexibility to ensure each participant receives tailored support. By allowing milestone repeats, the program promotes a person-centered approach, helping participants achieve their goals at their own pace and according to their unique needs.

Who can I contact for assistance with the Repeat Milestone Exception Request process?

For assistance, you can contact the designated Department Regional Transition Guide or your IC. They can provide guidance on the submission process, required documentation, and any other questions you may have.

These FAQs provide clarity and guidance on the Repeat Milestone Exception Request process, ensuring that ICs and participants understand the requirements and procedures involved in requesting and implementing a repeat milestone request exception.

11.5 Family Members Delivering Direct Support

Background

In many support programs, policies typically prohibit immediate family members from providing direct services to their loved ones to maintain objectivity, reduce conflicts of interest, and ensure professional standards of care. However, the MAPs program recognizes that, in certain circumstances, having a family member deliver support may be in the best interest of the participant. These circumstances might include cultural preferences, unique medical and/or behavioral needs, or the availability of qualified providers in remote areas. Allowing family members to deliver direct support can ensure continuity of care, foster stronger trust and communication, and leverage the intimate understanding of the participant's needs and preferences that only a family member can provide. Therefore, the Exception Request process enables ICs to formally request the approval of a family member as a service provider, ensuring that such arrangements are carefully considered and appropriately managed.

Purpose

The purpose of the Family Member Direct Support Exception Request is to provide a structured and equitable process within the MAPs program that allows for the possibility of family members delivering direct support to participants. This exception recognizes and accommodates unique circumstances where family involvement may be the most effective and beneficial option for the participant's well-being and progress. The key purposes include:

1. **Ensuring Continuity of Care:** In situations where continuity and consistency in care are critical, allowing a family member to deliver direct support can provide a stable and familiar environment for the participant.
2. **Addressing Unique Needs:** Participants with specific medical, behavioral, or cultural needs may benefit from the intimate understanding and personalized care that a family member can provide.
3. **Overcoming Provider Shortages:** In areas where there is a shortage of qualified service providers, permitting family members to step into this role can ensure that participants receive the necessary support without interruption.
4. **Enhancing Trust and Communication:** The strong, pre-existing relationship between a participant and a family member can enhance trust, improve communication, and foster a more effective support dynamic.
5. **Promoting Person-Centered Care:** This exception aligns with the MAPs program's commitment to person-centered planning by respecting the participant's preferences and optimizing their support network to best meet their individual needs.

By formalizing the process through an exception request, the MAPs program can ensure that the involvement of family members in direct support roles is appropriately evaluated, justified, and monitored, maintaining high standards of care and program integrity.

Eligibility and Implementation Criteria

Eligibility Criteria: To qualify for the Family Member Direct Support Exception within the MAPs program, the following criteria must be met:

1. **Demonstrated Need:** The request must demonstrate that having a family member provide direct support is in the best interest of the participant. This could be due to unique medical, behavioral, or cultural needs that a family member is best suited to address.
2. **Documentation of Circumstances:** Provide thorough documentation of the specific circumstances which justify the need for a family member to deliver direct support. This could include:
 - Medical or behavioral assessments
 - Statements from healthcare providers or other professionals

- Evidence of cultural preferences or practices
- 3. **Lack of Available Providers:** Show there is a shortage of qualified service providers in the participant's area, making it challenging to find appropriate support outside the family.
- 4. **Participant and Family Consent:** Obtain documented consent from the participant and/or legal representative, if applicable, and the family member who is proposed to provide the direct support. This ensures that all parties are fully aware of and agree to the arrangement.
- 5. **Support Team Recommendation:** The participant's support team, including their IC and other relevant staff, must support the request based on a thorough assessment of the participant's needs and the proposed family member's ability to meet those needs.

Implementation Criteria: Once eligibility is established, the following implementation criteria will guide the Family Member Direct Support Exception process:

1. **Submission of Request:** The IC must complete and submit a formal Family Member Direct Support Exception Request form, including all necessary documentation and a detailed rationale for the request, to the MAPs Program Review Team.
2. **Review and Approval:** The MAPs Program Review Team will evaluate the request based on the documentation provided and the established eligibility criteria. The MAPs Program Review Team will decide within a specified timeframe, typically 30 days, and communicate the decision to the IC.
3. **Training and Certification:** The family member must complete any required training or certification to ensure they are adequately prepared to provide direct support according to MAPs program standards.
4. **Monitoring and Support:** Throughout the period in which the family member provides direct support, the IC will closely monitor the situation (in conjunction with the provider agency) providing ongoing support and adjusting the support plan, as needed. Regular monthly check-ins will be conducted to ensure the arrangement remains beneficial for the participant.
5. **Evaluation and Feedback:** Periodically, the participant's progress and the effectiveness of the family member's support will be evaluated. Feedback from the participant, the family member, and the support team will be gathered to assess the arrangement and inform any necessary adjustments.
6. **Documentation and Reporting:** All aspects of the family member's direct support process, including the initial request, support plan, monitoring, and evaluations, will be thoroughly documented and reported to the Department to ensure transparency and accountability.

By adhering to these eligibility and implementation criteria, the Family Member Direct Support Exception process ensures participants receive personalized, high-quality care while maintaining program integrity and standards.

Procedures

Step 1: Initial Assessment

1. Identify the Need: The IC identifies the need for a family member to provide direct support based on the participant's unique circumstances.
2. Gather Preliminary Information: The Department will collect preliminary information, including the participant's medical, behavioral, or cultural needs, and discuss the potential benefits and challenges with the participant and their support team.

Step 2: Preparing the Request

1. Complete the Exception Request Form: Fill out the Family Member Direct Support Exception Request form. Ensure all sections are completed, including:
 - Participant's full name and identification number
 - Description of the specific direct support needed
 - Detailed rationale for why a family member should provide these supports
 - Documentation of the participant's needs and circumstances
 - Statements of consent from the participant (or legal guardian) and the family member
2. Submit Supporting Documents: Include all relevant supporting documentation, such as medical reports, behavioral assessments, cultural justification, evidence of provider shortages, and recommendations from healthcare providers or professionals.

Step 3: Submission of Request

1. Submit to MAPs Program Review Team: Submit the completed Exception Request Form and support documents to the MAPs Program Review Team via the specified submission channel (e.g., online portal).

Step 4: Review Process

1. Preliminary Review: The MAPs Program Review Team conducts a preliminary review to ensure the request is complete and all necessary documentation is provided.

2. Request for Additional Information: If needed, the MAPs Program Review Team may request additional information or clarification from the IC.

Step 5: Detailed Evaluation

1. Evaluation by MAPs Program Review Team: The request is evaluated by a panel of experts (chosen by DDA) including program managers, clinical advisors, and other relevant stakeholders. The Department assesses the request based on the established eligibility criteria and the participant's documented needs.
2. Decision Making: The panel decides to approve or deny the request. The decision is based on the evidence provided and the anticipated benefits for the participant.

Step 6: Notification of Decision

1. Communicate Decision: The IC is notified of the decision in writing, including any conditions or limitations associated with an approved request. If the request is denied, then the notification will include the reasons for the denial and, if applicable, any possible alternatives to the requested exception.
2. Inform Participant: The participant and his/her support team are informed of the decision and any subsequent steps required to implement the exception.

Step 7: Implementation of Approved Request

1. Provide Training and Certification: Ensure the family member completes any required training or certification to prepare them to provide direct support according to MAPs program standards.

Step 8: Monitoring and Support

1. Monitor Progress: Throughout the period in which the family member provides direct support, the IC will closely monitor the situation, provide ongoing support and adjusting the support plan, as needed.
2. Conduct Regular Check-ins: Regular monthly check-ins will be conducted to ensure the arrangement remains beneficial for the participant.

Step 9: Evaluation and Feedback

1. Periodic Evaluation: Periodically evaluate the participant's progress and the effectiveness of the family member's support. Gather feedback from the participant, the family member, and the support team to assess the arrangement and inform any necessary adjustments.
2. Document and Report: Thoroughly document all aspects of the family member's direct support process, including the initial request, support plan, monitoring, and evaluations.

By following these procedures, the Family Member Direct Support Exception Request process ensures participants receive personalized, high-quality care while maintaining program integrity and standards.

Family Members Delivering Supports Frequently Asked Questions (FAQs)

What is a Family Member Direct Support Exception Request?

A Family Member Direct Support Exception Request is a formal petition submitted by an IC to allow a family member to provide direct support to a participant in the MAPs program. This request is made in recognition of unique or extraordinary circumstances where a family member is deemed the most suitable provider of care.

Who can submit a Family Member Direct Support Exception Request?

The request will be submitted by an IC on behalf of a MAPs program participant. The request must include thorough documentation and be supported by the participant's support team.

Under what circumstances can a family member provide direct support?

Family members may provide direct support in cases where there are documented medical, behavioral, or cultural needs, a shortage of qualified service providers, or other unique circumstances that justify the need for a family member's involvement.

What documentation is required for the request?

Required documentation includes a completed Exception Request Form, medical or behavioral assessments, cultural justification, evidence of provider shortages, recommendations from healthcare providers or professionals, and consent statements from the participant (or legal guardian) and the family member.

How is the request evaluated?



The MAPs Program Review Team conducts a preliminary review to ensure completeness, followed by a detailed evaluation by a panel of experts (as selected by DDA). The panel assesses the request based on eligibility criteria and the participant's documented needs before making a decision.

How long does the review process take?

The review process typically takes 30 days from the submission of the request. The IC will be notified of the decision in writing.

What happens if the request is denied?

If the request is denied, then the notification will include the reasons for denial and, if applicable, any possible alternatives to the requested exception. The participant and their support team can consider these alternatives and may choose to address the identified issues and resubmit the request if appropriate. There is no appeal process.

What are the responsibilities of the family members providing direct support?

The family member must complete any required training or certification, follow the detailed PSCP developed by the IC and support team, and participate in regular check-ins and progress evaluations to ensure the effectiveness of the support provided.

Can a family member provide direct support for multiple participants?

Each request is evaluated individually. If a family member wishes to provide direct support for multiple participants, separate requests must be submitted and approved for each participant.

Who can I contact for assistance with the Family Member Direct Support Exception Request process?

For assistance, you can contact the designated MAPs Program Review Team or your IC. They can provide guidance on the submission process, required documentation, and any other questions you may have.

Additional Resources and Supports

For more information, send inquiries to DDA.Maps@tn.gov.

Chapter 12:

Program Modifications and Updates

The MAPs program, administered exclusively by the Department of Disability and Aging (DDA), is a dynamic initiative designed to evolve in response to the changing needs of participants, providers, and communities and as the program evolves. As a pilot program, MAPs embraces a culture of continuous improvement, where modifications and updates are not only anticipated but essential to refining operational protocols, enhancing user experiences, and advancing equitable outcomes. The program's foundation is built on a commitment to collaboration, innovation, and transparency—values that ensure every stakeholder has a voice in shaping its future.

From its inception, MAPs has been guided by a set of core expectations, chief among them the principle that meaningful progress requires active partnership. Providers, community organizations, and participants are integral to identifying opportunities for growth. To this end, all MAPs partners are expected to engage in collaborative efforts to drive program developments, including participating in subcommittees, attending strategic development meetings, and sharing insights with agencies statewide to design and implement improvement protocols. These partnerships ensure that modifications are informed by on-the-ground expertise, participant feedback, and emerging best practices in disability and aging services.

While collaboration is central to the program's evolution, DDA retains ultimate responsibility for stewarding MAPs' integrity and effectiveness. The Department reserves the right to implement modifications, whether to policies, procedures, or service frameworks—when necessary to align with regulatory requirements, address systemic gaps, or amplify participant outcomes. Such changes will be communicated proactively to all partners through formal channels, including training sessions, policy bulletins, and the MAPs Provider Information Sessions. By balancing collective input with decisive leadership, DDA ensures that the program remains responsive, sustainable, and true to its mission of fostering independence and dignity for all participants.

This section outlines the processes for proposing, reviewing, and enacting program updates, as well as the mechanisms for maintaining open dialogue between DDA and its partners. Together, we advance a shared vision: a program that adapts, grows, and thrives in service of its community.

12.1: Changes in MAPs Service Definitions and Payment Models

The MAPs program's service definitions and payment models are grounded in stakeholder collaboration, and evidence-based practices, ensuring alignment with the program's mission to advance participant independence. These frameworks have been thoroughly tested and are currently active for implementation, providing stability and predictability for providers, participants, and partners. The Department of Disability and Aging (DDA) does not anticipate major modifications to these core structures unless necessitated by regulatory compliance mandates, shifts in federal or state funding requirements, or legal directives (e.g., court orders).

Commitment to Stability & Transparency

While the DDA prioritizes continuity to minimize disruptions to service delivery, the program must remain adaptable to evolving legal, fiscal, or systemic realities. Any proposed changes to service definitions or payment methodologies will follow a structured, transparent process:

1. Notification of Proposed Changes:

- Providers will receive written notice of significant modifications via formal policy bulletins, the MAPs Provider Portal, and mandatory virtual briefings.
- Changes will be categorized as major (e.g., revised billing codes, overhauled milestone criteria) or minor (e.g., clarifications to existing definitions).

2. Opportunity for Feedback:

- For major modifications, the DDA will open a 30-day comment period, during which providers may submit questions, concerns, or suggestions.
- Feedback will be reviewed by the MAPs Advisory Council, with responses published in a follow-up bulletin.

3. Final Implementation:

- Adjustments based on provider input will be incorporated where feasible.
- Finalized changes will include clear guidance, training resources, and (if applicable) phased timelines for adoption.

Provider Responsibilities

- Timely Response: Agencies must review proposed changes and submit feedback within the 30-day window. Failure to respond may result in forfeiture of the opportunity to influence adjustments.
- Compliance Readiness: Providers are expected to update internal policies, train staff, and adjust documentation practices prior to the effective date of modifications.

Exceptions for Urgent Modifications

In rare cases requiring immediate implementation (e.g., court-ordered changes, critical regulatory mandates), the DDA will:

- Provide expedited notifications with detailed rationales.
- Offer post-implementation feedback sessions to address operational challenges.

DDA recognizes that trust in the MAPs program hinges on consistency, clarity, and collaboration. By engaging providers in the modification process and honoring their expertise, the Department ensures that changes strengthen—rather than undermine—service quality and participant outcomes. Providers are urged to actively participate in comment periods and leverage DDA support tools to navigate transitions seamlessly.

12.2: Notification and Implementation of Program Changes

The Department of Disability and Aging (DDA) is committed to ensuring that MAPs providers are informed of program modifications in a timely, transparent, and collaborative manner. Recognizing that changes to protocols, policies, or service frameworks require clear communication and preparation, the DDA will use a multi-channel approach to notify partners and outline expected implementation timelines. This structured process ensures continuity, minimizes disruption, and upholds the program's integrity.

Notification Methods

1. Written Communication

- Policy Bulletins: Formal updates will be disseminated via email detailing the nature of the change, rationale, and compliance requirements.



- Revised Manuals: Updated program manuals or appendices will be distributed digitally, with highlighted revisions for ease of reference.

2. Virtual Meetings

- Team/Video Meetings: Mandatory briefings for provider leadership will be held to review significant changes, answer questions, and clarify expectations.
- Development Trainings: Live or recorded training sessions will be provided to equip staff with the knowledge and tools needed to adopt new processes.

3. Direct Engagement

- 1:1 Sessions: The DDA Program Coordinators will offer individualized consultations for providers requiring tailored support to implement complex changes.
- Subcommittee Updates: Representatives from provider agencies will receive advance notifications through MAPs subcommittees to facilitate feedback loops.

Implementation Timelines

DDA will prioritize realistic timelines that account for provider readiness and participant impact:

- Urgent Changes (e.g., regulatory compliance, critical safety updates): Implemented immediately upon notification, with DDA support available within 24–48 hours.
- Standard Updates (e.g., revised reporting tools, service definitions): A minimum 30-day transition period, beginning on the date of formal notification.
- Complex Modifications (e.g., new technology platforms, funding model shifts): Phased rollouts over 60–90 days, including pilot testing, staff training, and progress check-ins.

By leveraging clear communication and collaborative timelines, the DDA and MAPs providers can ensure that program modifications enhance service quality without compromising participant care. Open dialogue, flexibility, and shared accountability remain central to this process.

12.3: Provider Responsibilities for Staying Informed

The success of the MAPs program relies on provider agencies' unwavering commitment to staying informed about program expectations, updates, and resources. As active partners in service delivery, agencies bear a direct responsibility to ensure all staff—both new and existing—are thoroughly familiar with current protocols, policies, and materials. This obligation is critical to maintaining compliance, delivering high-quality participant care, and upholding the integrity of the program. The Department of Disability and Aging (DDA) provides tools and updates to support this effort, but ultimate accountability rests with agencies to integrate these resources into daily operations and staff training.

Staying Informed: Agency Obligations

1. Proactive Monitoring of Communications

- Regularly review DDA communications, including Policy Bulletins, emails, etc.
- Designate a staff member (e.g., Compliance Officer) to monitor and disseminate updates to relevant teams.

2. Engagement with DDA Channels

- Participate in mandatory development meetings, webinars, and subcommittees to discuss changes and provide feedback.
- Access recorded training and resource libraries on the Provider Portal for self-paced learning.

3. Internal Review Processes

- Conduct quarterly audits to ensure all materials (e.g., service definitions, reporting templates) are current and accessible.
- Cross-reference operational practices with the latest MAPs manuals to identify gaps or misalignments.

Onboarding New Staff: Ensuring Compliance from Day One

Provider agencies must prioritize comprehensive onboarding to equip new staff with the knowledge and tools required for MAPs service delivery. Key steps include:

1. Mandatory Review of Materials

- Require new hires to review the MAPs Program Manual, Service Definitions, and Data Security Protocols before starting direct service.
- Provide access to the DDA's online training modules, with completion documented in personnel files.

2. Structured Training Programs

- Pair new staff with experienced mentors to reinforce understanding of program standards.
- Host internal orientation sessions to clarify agency-specific workflows and DDA expectations.

Consequences of Non-Compliance

Failure to stay informed or adequately train staff may result in:

- Corrective Action Plans: Mandated by the DDA to address knowledge or procedural gaps.
- Audit Findings: Non-compliance documented in program evaluations, impacting contract renewals or funding.
- Service Disruptions: Misapplication of outdated practices that jeopardize participant safety or program eligibility.

By embracing their role as stewards of the MAPs program, provider agencies ensure that every team member—regardless of tenure—operates with the most accurate, up-to-date information. This commitment fosters a culture of excellence, minimizes risk, and aligns all partners with the DDA's mission to advance participant independence. Agencies are encouraged to institutionalize these practices through internal policies, continuous learning opportunities, and open dialogue with the DDA.

Chapter 13:

Data Security and Confidentiality

Protecting the privacy and security of participant information is a foundational obligation of the MAPs program, rooted in both legal mandates and ethical responsibility. The Department of Disability and Aging (DDA), MAPs providers, and all affiliated staff are collectively accountable for safeguarding sensitive data—including medical records, service plans, and personally identifiable information (PII)—in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable regulations. Breaches of confidentiality not only jeopardize participant trust but also expose individuals to risks of discrimination, identity theft, and harm. This section outlines the non-negotiable standards and protocols that ensure data integrity across all formats, from physical documents to digital platforms, while emphasizing proactive measures to mitigate risks.

The following subsections detail critical components of MAPs' data security framework: Protecting Participant Information defines roles and best practices for handling sensitive data; Data Security Standards for Digital Services mandates encryption, access controls, and secure communication tools; and Reporting Data Breaches establishes clear procedures for incident response, notification, and remediation. Adherence to these protocols is mandatory, with non-compliance resulting in disciplinary action, legal penalties, or termination of provider contracts. By prioritizing rigorous data stewardship, the MAPs program affirms its commitment to participant safety, transparency, and dignity.

13.1: Protecting Participant Information

The MAPs program is committed to safeguarding the privacy, dignity, and rights of all participants by rigorously protecting their personal and medical information. Compliance with the Health Insurance Portability and Accountability Act (HIPAA) and other relevant privacy laws is non-negotiable. Participant data—including medical records, service plans, progress notes, and personally identifiable information (PII) is highly sensitive and must be secured against unauthorized access, breaches, or misuse. Failure to protect this information not only violates legal and ethical obligations but also erodes trust between participants, providers, and the Department of Disability and Aging (DDA). All MAPs providers, Independence Coaches (ICs), and DDA staff are collectively accountable for maintaining confidentiality and implementing robust data security measures.

Accountability Across Roles

- MAPs Providers: Agency leadership must establish clear protocols for data handling, staff training, and compliance monitoring.
- Innovation Coordination Staff (ICs): Direct service staff are responsible for securing physical and digital records during participant interactions.
- DDA Staff: Oversee compliance audits, provide guidance on HIPAA standards, and address reported vulnerabilities.

Best Practices for Data Security

Organizations are empowered to adopt agency-specific protocols aligned with HIPAA and DDA requirements. Below are essential best practices for all personnel:

1. Access Controls:

- Limit access to participant data to authorized personnel only.
- Use role-based permissions in digital systems (e.g., EHR platforms).
- Require strong, unique passwords and multi-factor authentication (MFA).

2. Encryption:

- Encrypt electronic Protected Health Information (ePHI) both at rest and in transit.
- Ensure secure transmission via encrypted email or HIPAA-compliant platforms.

3. Training & Awareness:

- Conduct annual HIPAA training for all staff, emphasizing penalties for violations.
- Include phishing simulations and guidance on identifying suspicious activity.

4. Physical Security:

- Store paper records in locked cabinets; shred documents when no longer needed.
- Prohibit unattended devices (e.g., laptops, tablets) in public areas.

5. Secure Communication:

- Avoid discussing participant details in unsecured settings (e.g., public spaces, non-secure apps).

6. Device Management:

- Install remote-wipe capabilities on mobile devices containing participant data.
- Regularly update software and firewalls to guard against cyber threats.

7. Audit Trails:

- Maintain logs of data access, modifications, and transfers for accountability.
- Review audit trails quarterly to detect anomalies.

8. Data Minimization:

- Collect only information necessary for service delivery.
- Anonymize data in reports or case studies used for training or advocacy.

Enforcement & Incident Response

- **Breach Reporting:** Any suspected or confirmed data breach must be reported to the DDA Privacy Officer within 24 hours. Providers must also notify affected participants per HIPAA guidelines.
- **Consequences for Non-Compliance:** Violations may result in disciplinary action (e.g., termination), legal penalties, or termination of provider contracts.
- **Post-Incident Protocols:** Conduct root-cause analyses, update security measures, and retrain staff to prevent recurrence.

Protecting participant data is a shared responsibility that demands vigilance, transparency, and continuous improvement. By adhering to HIPAA standards and adopting proactive security practices, MAPs providers and staff uphold participant trust and ensure the integrity of the program. Agencies are encouraged to tailor these best practices to their operational needs while maintaining alignment with DDA's overarching compliance framework.

13.2: Data Security Standards for Digital Services and Reporting

To ensure the security and integrity of participant data in digital/remote service delivery, MAPs providers and staff must adhere to the following standards:

1. Encryption Requirements

- All electronic Protected Health Information (ePHI) must be encrypted using AES-256 or higher standards, both at rest (stored data) and in transit (data being transmitted).
- Use secure, encrypted platforms (e.g., HIPAA-compliant cloud storage, EHR systems) for storing records.

2. Access Controls

- Implement role-based access to limit data visibility to authorized personnel only.
- Require multi-factor authentication (MFA) for accessing systems containing participant data.
- Automatically log out inactive users after 15 minutes of inactivity.

3. Secure Storage Solutions

- Use HIPAA-compliant cloud services (e.g., Microsoft Azure, Google Workspace with BAA agreements).
- Prohibit storing ePHI on personal devices, unsecured USB drives, or public cloud storage (e.g., personal Dropbox).

4. Data Retention & Disposal

- Retain records only for the period required by law or program guidelines (e.g., 6 years post-service termination).
- Permanently delete ePHI using software that overwrites data to prevent recovery.

5. Remote Work Protocols

- Require staff to use VPNs and secure Wi-Fi networks (no public Wi-Fi) when accessing participant data remotely.
- Ensure home workspaces are physically secure (e.g., screens not visible to others, locked devices when unattended).

6. Regular Audits & Updates

- Conduct quarterly security audits of digital storage systems.
- Install software updates and patches immediately to address vulnerabilities.

13.3 Protocols for Reporting Data Breaches

All personnel must promptly report suspected or confirmed breaches to mitigate harm and comply with legal obligations.

1. Immediate Response Steps

Step 1: Detect & Contain

- Identify the breach source (e.g., hacked account, lost device).
- Disconnect affected systems to prevent further data exposure.

Step 2: Notify Leadership

- Report the breach to the agency's Privacy Officer and the DDA Privacy Office within 1 hour of discovery.

2. Formal Reporting

Within 24 Hours: Submit a written incident report to DDA, including:

- Nature and scope of the breach.
- Type of data exposed (e.g., medical records, contact details).
- Initial corrective actions taken.
- Within 72 Hours: Notify affected participants via phone, email, or mail, per HIPAA's Breach Notification Rule.

3. Regulatory Compliance

- If the breach impacts 500+ individuals, notify the U.S. Department of Health and Human Services (HHS) and local media within 60 days.
- Smaller breaches require annual reporting to HHS.

4. Documentation & Follow-Up

- Maintain detailed records of the breach, response actions, and communications for 6 years.
- Conduct a root-cause analysis within 14 days and update security protocols to prevent recurrence.

5. Post-Breach Support

- Offer affected participants identity theft monitoring or credit protection services if sensitive data (e.g., SSNs) is exposed.
- Provide a dedicated contact (e.g., agency Privacy Officer) to address participant concerns.

Consequences for Non-Compliance

- Staff: Disciplinary action up to termination, mandatory retraining, or legal liability.
- Providers: Fines, contract termination, or exclusion from the MAPs program.

Chapter 14:

MAPs Emergency Continuity Plan

To ensure uninterrupted delivery of services to MAPs participants during emergencies or staff unavailability, safeguarding progress toward milestone independence.

Leadership & Responsibilities

- Director of MAPs Program: Primary authority for executing coverage plans. Regularly reviews and updates contingency protocols.
- Division of Innovation (DDA): Assumes responsibility if the Director is unavailable. Implements temporary support strategies and finalizes long-term solutions.

Backup Support Protocols

- Critical Role Identification: Crosstrain staff to fulfill essential duties during absences.
- Temporary Supports: Pre-identified backup personnel or partner agencies step in immediately.
- Coverage Execution: Director approves contingency plans; Division of Innovation intervenes if Director is unavailable.

Provider Agency Responsibilities

- Staffing Strategies: Implement flexible schedules, on-call staff, or inter-agency partnerships to maintain participant support.
- Progress Reporting: Notify DDA within 24 hours of disruptions and document mitigation steps.
- Autonomy: Agencies are empowered to adjust tactics but must align with DDA's continuity goals.

Communication Plan

- Internal: Updates shared via email, secure messaging, and emergency briefings.
- External: Participants and families are notified through pre-approved channels (e.g., phone trees, agency portals).

Documentation & Review

- Annual plan reviews and updates by the Director.