OHIO Administrative Code

3701-3-10 Approval of human immunodeficiency virus tests
(A) In approving tests to be used to determine whether an individual has human immunodeficiency virus infection under division (B)(l) of section 3701.241 of the Revised Code, the director of health shall consider:
(I) Whether the test has been approved by the United States food and drug administration, in the case of an enzyme immunoassay test,
(2) The recommendations of the United States centers for disease control and the association of state and territorial public health laboratory directors, in the case of other tests, including tests to confirm the results of an enzyme Immunoassay test. The director shall approve the "Western Blot Assay" confirmatory test.
(13) The director shall define a confirmed positive test result as two or more reactive enzyme immunoassay tests on the same specimen followed by a positive "Western Blot Assay" or other approved confirmatory test. The director may define other confirmed positive test results after consideration of the recommendations of the United States centers for disease control and the association of state and territorial public health laboratory directors,
(C) In developing guidelines for interpreting test results, the director shall:
(1) Require that the results of an enzyme immunoassay test approved by the United States food and drug administration be interpreted in accordance with the instructions of the manufacturer.
(2) Require that the "Western Blot Assay" confirmatory test be interpreted in accordance with the criteria set forth in the appendix to this rule, "Interpretation and Use of the Western Blot Assay for Serodiagnosis of Human Immunodeficiency Virus Type I Infections," as published in "Morbidity and Mortality Weekly Report," United States centers for disease control, volume 38, number 5-7, July 21, 1989.
(3) Consider interpretation criteria established by the United States centers for disease control and the association of state and territorial public health laboratory directors in developing guidelines for interpreting results of other tests that may be approved,

3701-3-11 Requirements relating to human immunodeficiency virus testing
(A) A human immunodeficiency virus (HIV) test shall be performed only if, prior to the test, informed consent is obtained either by the person or agency of state or local government ordering the test or by the person or agency performing the test. Consent may be given orally or in writing after the person or agency performing or ordering the test has given the individual to be tested or his guardian the following information:
(1) An oral or written explanation of the test and testing procedures, including the purposes and limitations of the test and the meaning of its results.

(a) The explanation of the test and testing procedures shall include a statement that the test is conducted on a blood sample taken from the individual tested and that the test determines the presence of antibodies to HIV. The explanation also shall include a statement that if the first test is positive, additional tests will be performed on the same blood sample.

(b) The explanation of the meaning of the test results shall include a statement that a positive test result means that the individual tested has been exposed to HIV and is infected but that a positive result does not mean necessarily that the individual has acquired immune deficiency syndrome (AIDS) or will contract AIDS in the future. The explanation also shall include a statement that if the individual has been exposed to HIV but presently has negative test results, future retesting is advisable because of the amount of time after exposure required for the body to produce antibodies to HIV,

(2) An oral explanation that the test is voluntary, that consent to be tested may be withdrawn at any time before the individual tested leaves the premises where blood is taken for the test and that the individual or guardian may elect to have an anonymous test: and

(3) An oral or written explanation about behaviors known to pose risks for transmission of HIV infection. This explanation shall focus on methods of transmission, such as anal, oral or vaginal sex, sharing of needles, transmission from a pregnant woman to a fetus or blood donation and transfusion, which the person or agency providing the information reasonably believes are possible ways that the individual to whom the information is given may have been exposed to HIV or may transmit HIV.

(B) In preparing the informed consent form referred to by division (A) of section 3701.242 of the Revised Code, the director of health shall include the information required by paragraph (A) of this rule. The director also may include in the form other information that may be useful to an individual seeking HIV testing. Use of the informed consent form prepared and distributed by the director under division (A) of section 3701.242 of the Revised Code and under this paragraph is not mandatory, but a person or government agency required by division (A) of section 3701.242 of the Revised Code and paragraph (A) of this rule to give information to an individual may satisfy the requirement by obtaining the signature of the individual on the form prepared by the director.

(C) A minor may consent to be given an HIV test. The consent is not subject to disaffirmance because of minority. The parents or guardian of a minor giving consent under this division are not liable for payments for an HIV test given to the minor without the consent of a parent or the guardian.

(D) The person or government agency ordering an HIV test shall provide counseling for the individual at the time he is told of the result of the test or informed of a diagnosis of AIDS or of and AIDS-related condition. If the test was performed on the order of the individual tested, the person or government agency that performed the test shall provide counseling. The individual shall be given an oral or written explanation of the nature of AIDS and AIDS-related conditions and the relationship between the HIV test and those diseases and a list of resources for further

counseling or support. When necessary, the individual shall be referred for further counseling to help him cope with the emotional consequences of learning the test result.

(E) Any individual seeking a HIV lest shall have the right, on his request, to an anonymous test. A health care facility or health care provider that does not provide anonymous testing shall refer an individual requesting an anonymous test to a site where it is available.

(F) The requirements of paragraphs (A) to (E) of this rule do not apply to the performance of an HIV test in any of the following circumstances:

(I) When the test is performed in a medical emergency by a nurse or physician and the test results are medically necessary to avoid or minimize an immediate danger to the health or safety of the individual to be tested or another individual, except that counseling shall be given to the individual as soon as possible after the emergency is over;

(2) When the test is performed for the purpose of research if the researcher does not know and cannot determine the identity of the individual tested;

(3) When the test s performed by a person who procures, processes, distributes, or uses a human body part from a deceased person donated for a purpose specified in Chapter 2108, of the Revised Code, if the test is medically necessary to ensure that the body part is acceptable for its intended purpose:

(4) When the test is performed on a person incarcerated in a penal institution under the control of the department of rehabilitation and correction if the head of the institution has determined, based on good cause, that a test is necessary;

(5) When the test is performed by or on the order of a physician who, in the exercise of his professional judgment, determines the test to be necessary for providing diagnosis and treatment to the individual to be tested, if the individual or his parent or guardian had given consent to the physician for medical
treatment; or

(6) When the test is performed on an individual after the infection control committee of a health care facility, or other body of a health care facility performing a similar function determines that a health care provider, emergency medical services worker, or peace officer, while rendering health or emergency care to an individual, has sustained significant exposure to the body fluids of that individual, and the individual had refused to give consent for testing.

(G) The consent of the individual to be tested is not required, and the individual or guardian may not elect to have an anonymous test, when the test is ordered by a court in connection with a criminal investigation.

3701-3-12 AIDS, ARC, and HIV test reporting

(A) Persons required to report cases of acquired immune deficiency syndrome (AIDS), AIDS-related conditions (ARC), and confirmed positive tests for the human immunodeficiency virus (HIV) under division (C) of section 3701.24 of the Revised Code and paragraph (B) of this rule are as follows:

(I) Cases of AIDS and AIDS-related conditions shall be reported

by the physician or dentist in attendance. In an institutional setting, a designated agent such as an infection control practitioner may make the report for the attending physician or dentist.
(2) Confirmed positive HIV tests, as defined in rule 3701-03-10 of the Administrative Code, shall be reported by the person in charge of the laboratory performing the test. If a second laboratory is used for additional or confirmatory testing, the person in charge of the laboratory first receiving the specimen shall report the confirmed positive test.
(B) The persons designated by paragraph (A) of this rule shall report promptly every case of AIDS, every AIDS related condition, and every confirmed positive HIV test to the department of health on forms and in a manner prescribed by the director. In each county the director shall designate the health commissioner of a health district in the county to receive the reports.

Chapter 3701-44 Ryan White Program

3701-44-01 Definitions

As used in this chapter:
(A) "Ryan White program" means the program established by Title II of the "Ryan White Comprehensive AIDS Resources Emergency Act of 1990," 1(14 Stat. 576, 42 U.S.C. 300ff, as amended, and administered by the director of health under division (D) of section 3701.241 of the Revised Code.
(B) "Director" means the director of health or his or her designee.
(C) "HIV" means human immunodeficiency virus.
(D) "Community-based HIV case manager" means an individual designated by the director to provide case management services for individuals and families affected by HIV infection, or the designee of a designated individual.
(F) "Family" means a group of individuals who are related by blood, marriage, or adoption.
(G) "Significant other" means an individual who is responsible for a significant portion of an HIV-infected individual's care or who is dependent upon an HIV-infected individual.

3701-44-02 Establishment of HIV care consortia

(A) The director shall designate HIV care consortia for purposes of the Ryan White program. The director shall establish geographic areas to be served by consortia and shall designate one consortium for each geographic area. The geographic areas may include one or more counties, but the director is not required to include all counties in the state in a geographic area to be served by a consortium.
(B) To be designated as an HIV care consortium, an applicant shall submit an application to the director that contains documentation showing that the applicant meets all of the following criteria:
(1) The consortium will have no fewer than seven and no more than twenty members, unless the director determines that a larger number of members is needed to appropriately represent affected

individuals and organizations in the geographic area. The membership of the consortium shall be approved by the director and shall include agencies and community-based organizations that meet both of the following criteria:

(a) The agencies or organizations have a record of service to populations and subpopulations with HIV disease requiring care in the community to be served; and

(b) The agencies or organizations are representative of populations and subpopulations reflecting the local incidence of HIV and that are located in areas in which the populations reside;

(2) The consortium will include at least one representative of a public health care provider, one representative of a private, non-profit health care provider, and one representative from a local community-based organization. The director also may consider whether the consortium will include representatives of rural areas, affected subpopulations, an individual with HIV infection, and a representative of a drug and alcohol treatment organization;

(3) The consortium will include a community-based HIV case manager;

(4) The applicant has carried out an assessment of service needs within the geographic area to be served and, after consultation with the entities described in paragraph (C) of this rule, has established a plan to ensure the delivery of services to meet the identified needs that shall include all of the following:

(a) Assurances that service needs will be addressed through the coordination and expansion of existing programs before new programs are created;

(b) Assurances that, in metropolitan areas, the geographic area to be served by the consortium will correspond to the geographic boundaries of local health and support services delivery systems to the extent practicable;

(c) Assurances that, in the case of services for individuals residing in rural areas, the applicant consortium shall deliver case management services that link available community support services to appropriate specialized medical services. Case management under this paragraph shall be provided through community-based HIV case managers; and

(d) Assurances that the assessment of service needs and the planning of the delivery of services will include participation by individuals with HIV disease; and

(e) Assurances that the full continuum of health and social services needed for individuals with HIV disease has been considered;

(5) The applicant demonstrates that adequate planning has occurred to meet the special need, of families with HIV disease, including family centered care. As used in this paragraph "family centered care" means the system of services described in paragraph (B) of rule 3701-44-03 of the Administrative Code that is targeted specifically to the special needs of infants, children, women, and families. Family centered care shall be based on a partnership between parents, professionals, and the community designed to ensure an integrated, coordinated, culturally sensitive, and community-based continuum of care for

children, women, and families with HIV disease;
(6) The applicant demonstrates that the consortium has created a mechanism to periodically evaluate the success of the consortium in responding to identified needs and the cost-effectiveness of the mechanisms employed by the consortium to deliver comprehensive care. The consortium shall provide for this evaluation by establishing an independent peer review committee consisting of at least three but no more than six individuals who are not members of the consortium but who have experience in quality assurance review. The committee shall meet at least every six months to review services provided to individuals affected by HIV disease with special attention to quality based on availability, appropriateness, timeliness, and access;
(7) The applicant demonstrates that the consortium will report to the director the results of the evaluations described in paragraph (Is)(6) of this rule. The consortium shall make this report by authorizing the peer review committee established under that paragraph to provide the results of its evaluations directly to the director. The consortium also shall make available to the director or the secretary of the United States department of human services, on request, such data and information on the program methodology that may be required to perform an independent evaluation; and
(8) The consortium provides the following assurances:
(a) Within any locality in which the consortium is to operate, the populations and subpopulations of individuals and families with HIV disease have been identified by the consortium;
(b) The service plan established under paragraph (B)(4) of this rule by the consortium addresses the special needs of the populations and subpopulations identified under paragraph (B)(8)(a) of this rule; and
(c) The consortium will be a single coordinating entity that will integrate the delivery of services among the populations and subpopulations identified under paragraph (B)(8)(a) of this rule.
If more than one applicant seeks designation as an HIV care consortium, the director shall determine which applicant appears to be most capable of effectively serving the needs of individuals and families in the area who are affected by HIV disease.
(C) In establishing the plan required under paragraph (B)(4) of this rule, the consortium shall consult with either an agency described in paragraph (C)(l)(a) of this rule or an agency described in paragraph (C)(l)(b) of this rule. The consortium also shall consult with an organization described in paragraph (C)(2) of this rule.
(I) The consortium shall consult with either of the following:
(a) The public health agency that provides or supports ambulatory and outpatient HIV-related health care services within the geographic area to be served; or
(b) In the case of a public health agency that does not directly provide HIV-related health care services, the agency shall consult with an entity or entities that directly provide ambulatory and outpatient HIV-related health care service, within the geographic area to be served.
(2) The consortium also shall consult with not less than one

community-based organization that is organized solely for the purpose of providing HIV-related support services to individuals with HIV disease. The organization to be consulted under this paragraph shall be at the discretion of the applicant consortium. If there is no organization in the area that is organized solely for the purpose of providing HIV-related support services to individuals with HIV disease. the consortium shall consult with a unit of a community-based organization that is organized solely for that purpose.

(D) The director may request any additional information necessary to determine whether the applicant meets the requirements for designation established by this rule. The applicant shall provide the requested information within the time and in the manner specified by the director.

(E) The director shall provide written notification of his or her decision whether or not to designate an applicant as an HIV care consortium under this rule. If the director does not designate the applicant, the notice shall state the reasons for the decision and inform the applicant of the reconsideration process under paragraph (G) of this rule.

(F) The director ma) revoke the designation of an HIV care consortium upon a determination that the consortium is not adequately discharging its responsibilities under this chapter. The director shall provide written notice of the revocation which shall state the reasons for the decision and inform the consortium of the reconsideration process under paragraph (G) of this rule.

(G) If the director denies or revokes a consortium's designation under paragraph (E) or (F) of this rule, the consortium may request reconsideration of the decision by submitting a written request for reconsideration. The request shall be filed with the director within fifteen days after the date of mailing of the denial or revocation of designation. The request shall be accompanied by any written information that the consortium wishes to have considered. The director shall render a written decision on reconsideration, which shall be final.

3701-44-03 Operation of HIV care consortia; establishment of list of services covered by the Ryan White program

(A) An HIV care consortium designated under rule 3701-44-02 of the Administrative Code shall not use any money allocated by the director for provision of services to individuals and families in the consortium's geographic area to pay for the consortium's personnel or administrative costs.

(B) The consortium shall list which of the services specified in this paragraph may be authorized for payment under the Ryan White program. The list shall apply to services requested by eligible individuals, or families that include eligible individuals, who reside in the area served by the consortium. The consortium may list any or all of the following services, and may revise the list when it considers revision to be appropriate:

(1) Home health services such as durable medical equipment, home health aide and homemaker services, home intravenous therapy, day treatment, and routine diagnostic tests, and hospice services, such as social work and counseling, nursing services, and home health aide services;

(2) Transportation by cab, bus, or contracted transportation service or by mileage reimbursement, but not including ambulance or airplane transportation;
(3) Child welfare and family services, such as legal services (excluding litigation), individual and family mental health counseling, child care short-term foster care, and emergency supplies;
(4) Physician's services including gynecological examinations;
(5) Diagnostics and monitoring, such as T-cell counts and complete blood counts;
(6) Housing referral and placement, such as rental deposits (limited to once per twelve months), moving expenses (limited to once per twelve months), and utility bills;
(7) Nutrition services, such as food vouchers, oral nutritional supplements, one-time nutritional consultations, baby formula, and food for an infected child;
(8) Dental services, such as office visits and cleanings (limited to twice per year); and
(9) Rehabilitation services, such as physical therapy, speech therapy, adaptive equipment, and vocational rehabilitative services.
Inpatient hospital and nursing home services are not covered under the Ryan White program.
(C) Each consortium shall establish and may revise dollar limitations or other limitations on each category of services, as specified in paragraph (B) of this rule, that it lists for purposes of payment by the Ryan White program. Alternatively, a consortium may establish a dollar limitation on total services for which payment may be authorized for each individual or family. The director may establish additional limitations on services for which payment may be authorized because of program fiscal constraints.
(D) The consortium shall provide copies of the list prepared under paragraph (B) of this rule and any revisions to the director and the community-based HIV case manager serving the area. The director shall prepare a list of covered services that shall apply to counties that are not included in a geographic area served by a consortium.

3701-44-04 Payment for services under the Ryan White program
(A) The director shall make payments for services under the Ryan White program in accordance with the requirements specified in this rule.
(B) The director shall allocate specific amounts of the money available for the consortia portion of the Ryan White program to pay for services to individuals and families residing in each of the geographic areas served by HIV care consortia. The director also shall allocate a specific amount for any counties not included in any geographic area served by a consortium. The director may revise these allocations as he or she considers appropriate. The director shall ensure that at least fifteen per cent of the money available for the consortia portion of the Ryan White program is expended for services to infants, children, women, and families with HIV disease.
(C) The director shall contract with a third-party administrator

to make payments under this rule. The administrator shall pay the usual, customary, and reasonable charges in the area for the services at issue. If there is no usual, customary, and reasonable charge for a given service, the administrator shall pay an amount specified for the service by the HIV care consortium serving the geographic area where the services are provided. If there is no consortium serving the area, the administrator shall pay an amount specified by the director.

(D The administrator shall make payments only for services for which payments are authorized by the appropriate community-based HIV case manager. Upon request of an eligible individual, the case manager shall determine whether or not to authorize payment for the requested services in accordance with paragraph (E) of this rule. Authorization may be given orally or in writing.

(E) The community-based HIV case manager shall authorize payment for services only after making all of the following determinations:

(1) That the individual receiving services or a member of the service recipient's family is eligible under rule 3701-44-05 of the Administrative Code;

(2) That the provider is eligible under rule 3701-44-06 of the Administrative Code;

(3) That the service is needed as the result of the service recipient's HIV disease or is needed because of the HIV disease of a member of the recipient's family;

(4) That the HIV care consortium designated by the director to serve the area where the individual or family receiving services resides or the director, as applicable, has included the service in the list of covered services established under paragraph (B) or (D) of rule 3701-44-03 of the Administrative Code;

(5) That the service does not exceed any of the limitations established under paragraph (C) of rule 3701-44-03 of the Administrative Code. A case manager may authorize services in excess of those limitations if he or she obtains prior approval from the director; and

(6) That the recipient of services is not covered by any third-party payment source, including the medicaid program established by Chapter 8111. of the Revised Code, for the service at issue. A recipient shall be considered to be covered by a third-party payment source if such a source will provide any payment for the service, even if the payment does not cover the provider's charges fully.

(F) If a community-based case manager denies authorization of payment for a requested service, he or she shall provide written notification of the denial to the person requesting authorization. The notice shall state the reasons for the denial and inform the person of the reconsideration process under rule 3701-44-07 of the Administrative Code.

(G) After providing authorized services, the provider shall bill the recipient of the services and send a copy of the bill to the community-based case manager within forty-five days after the services were provided. The case manager, after verifying that the services were authorized, shall forward the bill to the third-party administrator for payment.

(H) In addition to the requirements of paragraph (D) of this

rule, the third-party administrator shall make payments under this rule for authorized services only if both of the following conditions are met:

(1) The amount to be paid does not cause the total payments for the geographic area where the service recipient lives to exceed the amount that the director has allocated to provide services in that area under paragraph (B) of this rule: and

(2) The bill identifies the individual or family for whom the services were provided and itemizes the charges for all services for which payment is requested.

(3) The third-party administrator shall send the director biweekly written reports that identify, by number, the recipients of services for which payments were made during the preceding period, the providers to whom the payments were made, the amounts of the payments, the types of services for which the payments were made, and the geographical areas involved. The administrator also shall provide any other information required by the director.

3701-44-05 Eligibility for benefits under the Ryan White program

(A) To be eligible for benefits under the Ryan White program, an individual shall meet all of the following requirements:

(1) The individual shall be an Ohio resident;

(2) The individual or a member of the individual's family shall have a verified HIV infection, or the individual shall be a significant other of an individual who has a verified HIV infection; and

(3) The individual's or family's monthly gross income, excluding taxes and any mandatory retirement deduction, does not exceed three hundred per cent of the currently applicable supplemental security income payment under Title XVI of the Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended. The director may lower this eligibility standard if he or she determines that it is necessary because of program fiscal constraints.

(B) The community-based HIV case manager for the area where the applicant for program eligibility resides shall determine whether the applicant meets the requirements specified in paragraph (A) of this rule. Upon determining that the applicant is eligible, the case manager shall assign the applicant an identification number and shall report the applicant's name and number to the third-party administrator responsible for making payments under rule 3701-44-04 of the Administrative Code. Upon request by the director, the case manager also shall report the applicant's identification number and date of birth to the director.

(C) The community-based case manager shall give the applicant for program eligibility written notification of the decision on eligibility. If eligibility is denied, the case manager shall state in the notice the reasons for denial and the process for reconsideration under rule 3701-44-07 of the Administrative Code.

3701-44-06 Eligibility of providers for the Ryan White program

(A) An individual or entity that wishes to receive payments for

services under the Ryan White program shall meet the eligibility criteria specified in tht\ m[c.

(B) The provider shall possess any license or other regulatory approval required by law to practice in Ohio.

(C) If the provider is not required to have a license or other regulatory approval to practice in Ohio, the provider shall have a current federal tax identification number, except as otherwise provided in this paragraph. A community-based HIV case manager may authorize payment for services provided by an individual or entity that does not have a federal tax identification number. In such a case, the agency that employs the community-based HIV case manager shall pay the individual or entity. That agency shall enter into a provider agreement with the director under paragraph (D) of this rule and shall bill the third-party administrator for reimbursement, under rule 3701-44-04 of the Administrative Code, for payments made under this paragraph.

(D) The provider shall execute an agreement with the director which includes, but is not limited to, the following provisions:

(I) A requirement that the provider accept as payment in full for the service the following applicable payment, as determined under paragraph (C) of rule 3701-44-04 of the Administrative Code:

(a) Usual, customary, and reasonable charges, as determined by the third-party administrator for the service in question; or

(b) The payment rate established by the applicable HIV care consortium or the director for the service.

The provider shall not bill the recipient of services or any other person for any services for which payment is made under the Ryan White program; and

(2) A requirement that the provider comply with all applicable provisions of state and federal law regarding confidentiality of information about individuals with HIV infection.

(E) The community-based HIV case manager serving the geographic area where the provider provides services shall determine the provider's eligibility. Once a provider has been determined to be eligible, the provider shall be eligible to provide services to individuals and families residing in any geographic area in the state unless the director has terminated the provider's eligibility under paragraph (F) of this rule.

(F) The director may terminate a provider's eligibility upon determining that the provider no longer meets the eligibility requirements specified by this rule or has violated the provider agreement required by paragraph (D) of this rule.

(G) The community-based HIV case manager or the director, as applicable, shall provide written notification of any decision regarding eligibility of a provider. If the case manager or director denies or terminates eligibility, he or she shall state in the notice the reasons for denial or termination and the process for reconsideration under rule 3701-44-07 of the Administrative Code.

3701-44-07 Reconsideration of eligibility and authorization decisions

(A) The following persons may seek reconsideration of the specified decisions pertaining to the Ryan White program:

(I) An individual who has applied for eligibility for benefits and whose application has been denied by the community-based HIV case manager;
(2) An individual or entity that has applied for eligibility as a provider and whose application has been denied by the community-based HIV case manager;
(3) An individual or entity whose eligibility as a recipient or provider has been terminated by the community-based HIV case manager or the director, as applicable; and
(4) An individual or entity that has sought authorization of payment for services from the community-based HIV case manager and whose request has been denied.
(B) A person seeking reconsideration shall file a written request for reconsideration with the director within fifteen days after the date of mailing of the notice of denial or termination of eligibility or authorization. The request shall be accompanied by any written material that the person making the request wishes to present. The director shall provide the person with written notice of his or her decision on reconsideration, which decision shall be final.

3901-1-49 Aids model consent form
(A) Purpose. The purpose of this rule is to establish the form and content of the written consent form an insurer must use in order to obtain an applicant's consent to an HIV test.
(B) Authority. This rule is issued pursuant to the author it) vested in the superintendent under section 3901.041 of the Revised Code.
(C) Applicability. This rule applies to all insurers permitted b) Chapter 3901 of the Revised Code to require applicants for life or sickness and accident insurance cover-age to submit to an HIV test.
(D) Definitions.
I. "AIDS" means the illness designated as acquired immunodeficiency syndrome.
2. "HIV" means the human immunodeficiency virus identified as the causative agent of AIDS.
3. "HIV TEST" means an) test for the antibody or antigen to HIV that has been approved b) the director of health under division (13) of section 3701.241 of the Revised Code.
4. "Insurer" means an) person authorized to engage in the business of life or sickness and accident insurance under Title XXXIX of the Revised Code or any person or governmental entity providing health services coverage for individuals on a self-insurance basis.
(E) Written consent to HIV test. Division (B)(I) of section 3901.46 of the Revised Code, provides that an insurer that requests an applicant to take an HIV test shall obtain the applicant's written consent for the test and shall inform the applicant of the purpose of the test.
In obtaining the applicant's written consent to an HIV test, the insurer must use the exact form set forth in appendix I.
(F) Severability. If any section, term or provision of this rule be adjudged invalid for any reason, such judgment shall not affect, impair or invalidate any other section, term or provision

of this rule, but the remaining sections, terms and provisions shall be and continue in full force and effect.

5101:1-39-78" ADC-related medicaid: earmarked income

(A) If an individual under twenty-one receives earmarked income, the individual must be given the option of being included or excluded from the assistance group for ,ADC-related medicaid coverage. If the individual wishes to be included, the earmarked income is considered in deter-mining the family’s countable income and the individual is counted in determining the family size. "Earmarked income" is defined as income specifically designated by court order or law for the sole needs of an individual. An example of earmarked income is social security (RSDI) if paid for a member of the assistance group other than a parent or caretaker/relative.

(B) If the individual wishes to be excluded, the earmarked income is not considered in determining the family's countable income, nor is the individual counted when determining the family size. Choosing to be excluded from the assistance group does not automatically result in the individual's ineligibility for ADC-related medicaid. However, a separate financial eligibility determination must be made for the excluded individual. The ADC pa)ment standard for one person is used. The individual's income and the parent/spouse's income must be considered. The amount of the parent/spouse's income considered available to the individual is the amount remaining after the work-related expense deduction if earned income and the one hundred per cent ADC standard for the other household members has been deducted from the gross monthly income. The parent/spouse's income is not considered if the parent/spouse is a recipient of ADC, GA, SSI, or medicaid,
The income available from the parent/spouse plus the earmarked income of the individual is then compared to the SDC payment standard for one person.

C.) financial eligibility determination for the excluded child with earmarked income is calculated according to the following:

(I) Determine the gross income of the parent(s).

(2) Subtract the standard work deduction(s) of ninety dollars, if applicable.

(3) Subtract the one hundred per cent SDC-related medicaid standard for the nonexcluded family members.

(4) Prorate the amount remaining by the number of eligible excluded individuals, if necessary.

(5) any amount remaining is countable income for the excluded child.

(6) Add the countable income of the excluded child.

(7) Compare the total countable income of the excluded child to the payment standard for one person. If there is a deficit, eligibility for ADC-related medicaid exists. If there is no deficit, eligibility does not exist.

(D) A financial eligibility determination for the remaining family members is calculated according to the following:

(I) Determine the gross income of the parent(s).

(2) Subtract all appropriate income exemptions and disregards; i.e., ninety-dollar work expense, thirty-dollar and one-third of

earned income, etc.
(3) Any amount remaining is countable income.
(4) Determine the gross income of the remaining dependent children.
(5) Subtract all appropriate income exemptions and disregards; i.e. fifty dollars of child support, student earnings, etc.
(6) Any amount remaining is countable income.
(7) Compare the total of paragraph (D)(3) plus paragraph (D)(6) of this rule to the appropriate payment standard. If there is a deficit, eligibility for ADC-related medicaid exists. If there is no deficit, eligibility does not exist.
The natural/adoptive parent(s) cannot be eligible unless there is a dependent child in the home. The dependent child must also be eligible for .ADC cash assistance if the child with earmarked income was not in the home. For instance, if the remaining child in the home was nineteen and not in school, the parent(s) could not be eligible.

5101:1-39-79 Objective of the human immunodeficiency virus (HIV) program
(A) The HIV program, formerly identified as the AZT/ retrovir program, is a special program designed to assist low-income individuals, who have been diagnosed with acquired immunodeficiency syndrome (AIDS) or AIDS related complex (ARC), with the cost of certain specified covered drug treatment.
(B) The HIV program funds are used to purchase or assist with the purchase of drugs and associated medical equipment which have been both determined by the Food and Drug Administration (FDA) to prolong the life of a person with AIDS or ARC and have been approved by CDHS. The drugs covered under the HIV program are:
(I) Zidovudine (AZT/retrovir),
(2) Alpha interferon,
(3) Pentamidine,
(4) Ganciclovir,
(5) SMZ/TMP, and
(6) Aerosolized Pentamidine and associated equipment.
(C) Additional drugs and associated equipment may be added from time to time as determined by the FDA and approved by ODHS. The HIV program is dependent upon federal grant(s) and/or state appropriated monies for its funding. The program will continue providing such funds are available.
(D) The HIV program covers low-income individuals who are not eligible for medicaid, general assistance medical (GAM) coverage, and are not fully covered under any other third-party pay or. Individuals eligible for medicaid under the spend-down provision outlined in rule 5101:1-39-11) of the Administrative Code, may be covered under the HIV program until such time as they reach their monthly spend-down amount.
(E) The HIV program is administered by ODHS and eligibility is determined by the bureau of public assistance policy.
(F) Priority will be given to qualified individual who received AZT/retrovir under the treatment investigational new drug program.

5101:1-39-791 HIV program application process

(A) To apply for assistance under the HIV program, the individual must complete the ODHS 7328 "HIV Program Application." Included in the application is a section to be completed by the individual's physician. The physician's section must accompany each application to confirm and verify the medical indicators or other medical circumstances that require the use of the FDA/ODHS approved drug(s).

(B) Applications for the HIV program can be obtained by contacting:

Ohio Department of Human Services
Bureau of Public Assistance Policy 30 East Broad Street, 27th Floor Columbus, Ohio 43266-0423
Telephone: (614) 466-6024 or toll free at 1-800-686-I 581 ext 6-6024

(C) The completed HIV program application (ODHS 7328) may be mailed to the above address along with all required verification (including income and physician's statement).

(D) The date of application is the date on which a signed and dated ODHS 7328 is received by ODHS.

(E) The HIV program is subject to all hearing rights and notice requirements of Chapter 5101:1-35 of the Administrative Code. Appropriate notices shall be sent by the bureau of public assistance policy. All hearing requests concerning the HIV program shall be sent to the bureau of state hearings, which shall forward copies to the CDHS and the bureau of public assistance policy within one working day of receipt. The bureau of public assistance policy shall complete an ODHS 4067 - Appeals Summary" and shall forward it to the CDHS. CDHS staff shall act as agency representative at the hearing.

5101:1-39-792 HIV program eligibility periods

(A Individuals approved for the HIV program will receive an HIV program identification card which will indicate their eligibility period.

(1) Individuals with no potential eligibility for medicaid or G~~ shall be approved for a period of six months from the date of application.

(21 Individuals in receipt of medicaid under the spend-down provision outlined in rule 511)1:1-39-11) of the Administrative Code, shall be approved for a period of six months from the date of application.

(3) Individuals with potential eligibility for medicaid or GA shall he referred to the CDHS and will initially be approved for the HIV program for a period of sixty days. A follow-up contact will be made with the CDHS and/or with the individual within sixty days to determine the individual's eligibility for medicaid or GA.

(a) If the individual has been unable to make an application within the original sixty days or if the determination of Medicaid or GA eligibility is pending, the individual's HIV program eligibility period with be extended for an additional sixty days.

(b) If the individual is approved for medicaid on a regular monthly basis or for GA, the individual is no longer eligible under the HIV program, as treatment is a covered expense under

medicaid and CAM.
(c) If the individual is approved for medicaid under the spend-down provision, as stated in rule 5101:1-39-I0 of the Administrative Code, the individual's HIV program eligibility period will be extended for an additional four months.
(I) The HIV program coverage may be used each month until the individual meets his spend-down amount as described in rule 5101:1-39-10 of the Administrative Code.
(ii) Since the cost of the drug treatment is covered by the HIV program, the cost of the covered drug(s) cannot be used to help meet the spend-down amount.
(d) For individuals whose medicaid or GA application has been denied but who meet the HIV program requirements, the HIV program eligibility period will be extended for an additional four months.
(B) Prior to the end of the six-month HIV program eligibility period. the individual must reapply for any additional assistance under the HIV program by completing the ODHS 328 "HIV Program Application"

5101:1-39-793 HIV program eligibility requirements
(1) Ti~c £~llo,v in defi nit 1i~n JPl-~l) ;~i ; hc III \ program.
"child” means an unemancipated individual under twenty-one years of age.
(2) Emancipated” means those individuals under age twenty-one who have married or have been (or are) members of the armed forces. Divorced individuals under age twenty-one are also considered to be emancipated. If an individual under age twenty-one has married and subsequently had that marriage annulled, the individual is not considered to be emancipated due to the annulled marriage.
(3) "Families" means the natural and adoptive parent(s), and all children and stepchildren of such parents under twenty-one living in the home. A childless married couple is also considered a family. Emancipated individuals are excluded from the family for purposes of determining the family’s eligibility for the HIV program.
(B) To be eligible for the HIV program the individual must be a resident of the state of Ohio. As a condition of eligibility, individuals with potential eligibility for medicaid or GA must apply for assistance at the local Cf)HS.
(C) The individual must cooperate with ODHS in obtaining any third party payments. Refusal to cooperate in and obtaining third party payment will result in ineligibility for the HIV program.
(D) When an individual resides in the same household with his spouse, or a child under age twenty-one resides in the same household with his parent(s), the individual’s income and the income of such spouse and/or parent(s) shall be included in determining the individual's eligibility.
(E) Financial eligibility is determined by comparing countable income to the appropriate individual income standard based on the individual's circumstances. The income standards are as follows;
(I) For an individual not residing with other family member(s); three hundred per cent of the current SSI payment payable to a

single individual living independently.
(2) For an eligible individual(s) residing with other family members: three hundred percent of the current SSI payment payable to a single individual living independently plus an additional amount for each ineligible family member, equal to one hundred per cent of the current SSI payment payable to a couple living independently.
(F) The amount of monthly gross earned income is determined by subtracting taxes and any mandatory retirement deduction. Self-employment earnings are determined as stated in rule 5101;I-39-15 of the Administrative Code.
(G(Resources will only be evaluated to determine possible medicaid or GA eligibility.

5101:1-39-80 Alien emergency medical assistance (AEMA)
(A) The following individuals, if otherwise eligible, may qualify to receive AEMA which provides medicaid coverage for treatment of an emergency medical condition:
(I) Unlawfully admitted aliens in the United States.
(2) Aliens who arc not permanently residing under color of law (PRUCOL).
(3) Aliens who are legalized under the Immigration Reform and Control Act of I986 (IRCA-86) who do not meet the criteria for full medicaid benefits.
(B) Aliens may be eligible to receive AEMA to assist in the payment of medicaid-eligible cost, which arose as a result of an emergency.
(C) Eligibility for AEMA is not ongoing and will only cover costs associated with an emergency medical condition. In many instances, the eligibility period will only be one day.
(1) An "emergency medical condition" is defined as the sudden and unexpected onset of a serious medical condition with symptoms so severe as to cause a person to seek immediate medical attention, regardless of the hour of the day or night, and when failure to obtain immediate medical care would cause serious harm to the patient's health or jeopardize his or her life.
(2) "Acute medical emergency services" refers to those professional services necessary to stabilize the patient's condition and which are rendered within twenty-four hours of the onset of a medical emergency.
(3) Examples of an emergency medical condition include, but are not limited to, the following;
(a) Emergency labor,
(b) Broken arm or leg,
(c) Heart attack,
(d) Kidney failure,
(e) Convulsions,
(4) Medicaid will cover those services necessary to stabilize the patient experiencing an emergency medical condition.
(D) AEMA applicants must meet the income, resource and categorical eligibility requirements for either aid to dependent children (ADC) or medicaid, and the definition of emergency medical condition to be eligible for AEMA.
(I) The following categorical requirements shall be waived when determining AEMA eligibility;

(a) Enumeration as stated in rules 5101:1-3-09 and 5101:1-39-09 of the Administrative Code.
(b) Citizenship as stated in rules 5101:l-3-07, 5101:1-3-22, and 5101:1-39-091 of the Administrative Code.
(c) School attendance as stated in paragraph (B) of rule 5101:l-3-083 of the Administrative Code.
(d) Child support cooperation as stated in rules 5101;l-3-10 and 5101;l-39-752 of the Administrative Code.
(e) Work registration as stated in rule 5101:1-3-083 of the Administrative Code.
(2) When the county department of human services (CDHS) refers an application to the Ohio department of human services (ODHS) disability determination unit (DDU) to determine physical and/or mental disability in accordance with rule 5101:1-39-03 of the Administrative Code, a statement of denial by the social security administration for supplemental security income (SSI) is not required.
(3) All other ADC or medicaid eligibility requirements as stated in Chapters 5101:1-3 and 5101:1-39 of the Administrative Code must be met.

Chapter 5101:3-33 Home and Community-Based Services Waiver II Program
5101:3-33-01 Abbreviations and definitions
(A) "A&R" means assessment and referral, the process whereby a multidimensional assessment is completed by the assessor(s) to determine the applicant's long-term care needs and to identify appropriate community and institutional resources. The assessment and referral process is set forth in rules 5101:3-33-03 and 5101:3-33-04 of the Administrative Code, and includes the level 0 need assessment, the home care management assessment, service plan development, and referral to initiate services.
(B) "A&R unit" means a unit within ODHS or a local agency or CDHS under contract with ODHS which performs assessment and referral services.
(C) "AIDS" means acquired immune deficiency syndrome.
(D) “ARC" means AIDS-related complex.
(E) "Assessors" means registered nurses, qualified social workers, and qualified mental retardation professionals (QMRPs) trained by ODHS to perform all assessment and referral functions for applicants and enrollees of the HCBS waiver II program.
(F) "Authorized representative" means an adult age eighteen or older who has enough knowledge of the situation of the applicant or enrollee to act on behalf of the applicant or enrollee, including signing the service plan. The representative may be, but is not limited to, a parent of a minor child, spouse, relative, friend, or representative from another public or private agency who is authorized by the individual, or a legal guardian.
(G) "Caregivers" mean relatives, friends and/or significant others who voluntarily provide assistance to the client.
(H) "Case manager" means a registered nurse who provides case management.
(I) "Case management" means services provided by a registered

nurse employed by the qualified provider agency of the client's choice, which include coordinating and monitoring all home and community-based services, and authorizing any allowable changes in the amount, scope or duration of covered services. Case management is more fully set forth in rule 5101:3-33-06 of the Administrative Code.
(J) "CDC" means center for disease control, the federal agency which is responsible for monitoring trends and patterns of infectious and chronic disease.
(K) "CDHS" means county department of human services.
(L) "Cost cap" means the maximum allowable dollar amount for waiver services and medicaid-covered noninstitutional long-term care state plan services for a six-month period, as specified by ODHS.
(M) "Enrollee" means an individual who has been accepted for enrollment and is receiving HCBS waiver II services.
(N) "Enrollment" means the receipt by an enrollee in the HCBS waiver II program of services set forth in rule 5101:3-33-06 of the Administrative Code in accordance with rule 5101:3-33-04 of the Administrative Code.
(0) "HCBS waivers" are home and community-based service programs designed by the state and submitted to HCFA for time-limited approval that allow the state to waive certain regulations of medicaid concerning eligibility and service coverage in order to provide home and community-based services to a limited number of persons who would otherwise require institutionalization, if provision of such services is cost-effective.
(P) "HCBS waiver 11" means home and community-based services waiver II, an Ohio waiver approved by HCFA designed for medicaid-eligible hospitalized PWAs.
(Q) "HCFA" means health care financing administration, the federal agency which administers the medicaid program and approves home and community-based services waivers.
(R) "HIV" means human immunodeficiency virus.
(5) "ICF" means intermediate care facility as defined in rule 5101:3-3-06 of the Administrative Code.
(T) "ICF/MR" means intermediate care facility for the mentally retarded and/or developmentally disabled as defined in rule 5101:3-3-07 of the Administrative Code.
(U) "Licensed community alternative home" means a facility licensed by the director of the department of health pursuant to authority set forth in section 33 of Sub. H.B. 231 of the 117th General Assembly to provide accommodations, personal assistance, and administration of oral medications prescribed by a physician, to three or more individuals diagnosed with AIDS or ARC.
(V) "LOC" means level of care.
(W) "LTCF" means long-term care facility.
(X) "Medicaid-covered noninstitutional long-term care state plan services" mean nonwaivered services provided under the Ohio medicaid state plan which provide home and community-based long-term care and includes home health services, medical equipment and supplies.
(Y) "ODHS" means Ohio department of human services.
(Z) "PWA" means persons with AIDS or ARC.

(AA) "Service plan" means a written document outlining an individualized package of home and community-based services as set forth in rule 5101:3-33-05 of the Administrative Code.
(BB) "QMRP" means qualified mental retardation professional as defined in 42 CFR 442.401.
(CC) "SNF" means skilled nursing facility as defined in rule 5101:3-3-05 of the Administrative Code.
(DD) "551" means supplemental security income.
(EE) "Treatment plan" means a written document outlining the specific tasks and activities to be carried out by a specific service provider as set forth in rule 5101:3-33-05 of the Administrative Code.
(FE) "Waiver service provider" means an agency or person with a signed medicaid provider agreement with ODHS to provide HCBS waiver II services, and that meets the HCBS waiver II certification standards as determined by ODHS.

5101:3-3302 Eligibility for the HCBS waiver 11 pro-gram

(A) Eligibility for the HCBS waiver 11 program is limited to persons who complete the ODHS 2305 "Application for Home and Community-Based Services Waiver II," and who meet all of the following criteria:
(I) Are determined by the CDHS to be financially eligible for medicaid according to the special income level as specified in rule 5101:1-39-225 of the Administrative Code, or according to the noninstitutional need standard as specified in rule 5101:1-39-21 of the Administrative Code;
(2) Have a diagnosis of AIDS or ARC;
(3) Are certified by the local or state A&R unit and a physician as having an SNF level of care or an ICF level of care;
(4) Are receiving inpatient hospital care at the time of assessment for and acceptance into the HCBS waiver II program;
(5) Will receive services in a residence with no more than one unrelated resident who is eligible for supplemental security income (SSI), unless the residence is a licensed community alternative home;
(6) Are determined by the assessors to be able to participate without presenting a threat to personal health or safety;
(7) Have needs for service, as documented by the A&R unit, which cannot be readily addressed by other community resources;
(8) Have a service plan in which the total cost of HCBS waiver II services and other medicaid-covered noninstitutional long-term care services is less than or equal to the cost cap specified by ODHS;
(9) Have the service plan, as developed by the A&R unit, verbally approved by the applicant's physician; and
(10) Agree to receive HCBS waiver II services from authorized providers only, and to work with the assigned case manager in reviewing the need and ongoing eligibility for services.
(B) As a condition of federal financial participation, enrollment in the HCBS waiver II program is subject to an annual limit equal to the number of unduplicated program participants approved by HCFA. For example, an individual who is served under the HCBS waiver II program on multiple occasions during the year is only counted as one unduplicated participant. Applicants who meet the

eligibility criteria specified in paragraph (A) of this rule are enrolled only if the annual limit of unduplicated program participants has not been exceeded for the current waiver program year. For the purpose of the HCBS waiver 11 program, the waiver program year begins on January first and ends on December thirty-first.

5101:3-33-03 Application process for the HCBS waiver 11 program

(A) To apply for the HCBS waiver II program, the client, the client's caregiver or authorized representative, representatives of a hospital, or other interested parties may request that the client receive an assessment by the A&R unit. The client must be an inpatient of an acute care hospital at the time of assessment and have received a verbal pending authorization for an ICF or SNF LOC. from the ODHS preadmission unit.

(B) The .A&R unit shall document all requests for assessment, recording the client's name, hospital, source of referral, and other information as specified by ODHS.

(C) The A&R unit shall supply the ODHS 2305 "Application for Home and Community-Based Services Waiver II" to each applicant who is seeking enrollment into the HCBS waiver II program.

(D) Each ODHS 2305 completed by an applicant shall be processed by the A&R unit within Sixty days of application.

(1) If the applicant fails to meet any of the eligibility criteria specified in rule 5101:3-33-02 of the Administrative Code, the .A&R unit shall document the failure, discontinue the application process and deny the application.

(2) If an applicant decides to withdraw the ODHS 2305 prior to a determination of eligibility, the A&R unit shall discontinue the application process and maintain documentation of the applicant's withdrawal request.

(E) The A&R unit shall take the following steps in processing applications;

(I) Contact ODHS to determine if the annual limit of unduplicated program participants has been reached;

(2) Contact the CDHS in the county in which the applicant resides to ascertain the status of medicaid eligibility of the applicant. An applicant may have eligibility for medicaid established by the CDHS and eligibility for the HCBS waiver II program established by the .A&R unit concurrently.

(3) Confirm the LOC which has been verbally authorized by the ODHS preadmission unit. The LOC shall be confirmed through a level of need assessment, which is conducted face-to-face by an assessor who is a registered nurse and examines areas of the applicant's or enrollee's personal functioning, including, but not limited to, activities of daily living, physical health, and mental health/cognitive functioning.

(a) If the applicant has an established or suspected diagnosis of mental retardation and/or developmental disability, the QMRP assessor will evaluate the information requested by the nurse assessor and identify any CF/MR level of care needs of the applicant. Applicants determined to have an ICF/MR level of care are not eligible for the HCBS waiver II program.

(b) The A&R unit shall act in behalf of ODHS in processing the ODHS 3670 "Level of Care Authorization" for ICE and SNF levels of

care.
(4) Complete a home care management assessment, which is conducted face-to-face by an assessor who is a qualified social worker and examines the applicant's social and economic resources, environmental matters, and level of demand on the caregiver.
(5) Develop a service plan as set forth in rule 5101:3-33-05 of the Administrative Code.
(6) Compare service plan costs to the cost cap.
(7) Determine if services identified on the service plan are readily available through nonwaiver resources in the community.
(8) Assess whether implementation of the service plan allows the applicant to be discharged from the hospital to a home care setting without jeopardizing personal health or safety.
(9) Determine whether the applicant's planned residence is appropriate according to rule 5101:3-33-02 of the Administrative Code.
10) Contact the applicant’s physician to obtain verbal authorization of the service plan.
(Fl If the client is determined by the A&R unit to be eligible, the A&R unit makes a referral to ODHS, as is further detailed in rule 5101:3-33-04 of the Administrative Code.
(0) .Applicants to the [CBS waiver II program v hose applications are denied shall be offered information, referral, and limited assistance in securing alternative services by the local or state .A&R unit.

5101:3-33-04 Enrollment in the I{CBS waiver 11 pro-gram
(A) Prior to approval of an application for enrollment, the A&R unit shall obtain confirmation from the applicant in writing that the applicant has voluntarily chosen to enroll in the program in lieu of institutional care. The applicant may withdraw the application prior to final action.
(B) Approval for enrollment in the HCBS waiver II pro gram occurs when:
(I) The A&R unit notifies ODHS that an applicant has been determined to meet the eligibility requirements of rule 5101:3-33-02 of the Administrative Code;
(2) ODHS authorizes approval for enrollment if space in the program is available, by recording the applicant's name and medicaid case number on the list of HCBS waiver II participants;
(3) The A&R unit gives the applicant or authorized representative the ODHS 2307 Notice of Approval of Your Application for Home and Community-Based Services" as set forth in rule 5101:3-33-23 of the Administrative Code;
(4) The A&R unit notifies the authorized case management agency of the approval for enrollment and forwards assessment and service plan information; and
(5) The .A&R unit notifies the CDHS responsible for determining the applicant's financial eligibility for medicaid of the approval for enrollment.
(C) The effective date of approval shall be the date ODHS records the applicant's name on the list of waiver participants. The effective date of approval can be no earlier than the date the applicant was admitted into the hospital and no later than

the day the applicant is discharged from the hospital.
)D) The effective date of enrollment shall be the date HCBS waiver II services other than case management are first received by the client.
)E) Prior to the effective date of enrollment, the .A&R unit or assigned case manager shall complete the referral process by contacting each of the service providers cited in the service plan to:
(I) Initiate or to confirm continual ion of services;
(2) Provide a verbal explanation of the goals listed on the service plan; and
(3,) Request that, if required by rule 5101:3-33-05 of the Administrative Code, specific treatment plans be formulated and submitted to the case manager and to the client's physician within ten days of the service provider's initial visit.
(F) Within three working days of the effective date of enrollment, the A&R unit shall provide ODHS and the authorized case manager with a copy of the multidimensional assessment tool and service plan and any other pertinent information.

5101:3-33-05 Service and treatment plans
(A) Medicaid will not reimburse for waiver services which are furnished without a written service plan.
(B) The written service plan is subject to final approval by ODHS.
(C) The service plan shall be developed by the A&R assessors and adjusted by the case manager in collaboration with the applicant or enrollee, authorized representative, caregivers, physician, and other involved health care professionals.
(D) The service plan is a written document which out lines an individualized package of home and community-based services suitable to the client's needs and values. The service plan utilizes available community resources whenever possible and supports, but does not supplant, the caregivers' role. The service plan includes, but is not limited to, the following elements.
(I) The identified needs and service objectives based on the multidimensional assessment.
(2) The client's responsibilities.
(3) The responsibilities of any available caregiver(s).
(4) The responsibilities of any available and appropriate nonmedicaid-reimbursed service providers.
(5) The responsibilities of each waiver service provider, including, but not limited to:
(a) The type of service to be provided (e.g., homemaker, respite care).
(b(The amount of service to be provided in units per month.
(c) The unit cost per service.
(d) The total cost per month per service.
(e) The authorized provider agency of the client's choice.
(6) The medicaid-reimbursed noninstitutional long-term care slate plan service provider's responsibilities, including all items from paragraphs (D)(5)(a) to (D)(5)(e) of this rule.
(7) The total service plan cost projected for six months, including costs projected from paragraphs (D)(5) and (D)(6) of

this rule.
(E) The service plan is to be signed by the applicant/enrollee or authorized representative, any caregivers cited in the service plan, and members of the assessment team. The physician must provide at minimum verbal authorization of the service plan prior to acceptance for enrollment. The signature of the client's physician is required within thirty days of enrollment.
(F) A formal reassessment and updated service plan must be completed at least once every six months from the effective date of enrollment, as set forth in rule 5101:3-33-l 9 of the Administrative Code.
(G) The case manager is responsible for monitoring the delivery of services identified in the service plan to determine continued appropriateness of services to meet client needs.
(l) Changes in the service plan may include addition of services, replacement of one service by another, modification of intensity of service, or termination of a service.
(2) Changes in the service plan affecting the following services require approval of the physician caring for the client, as evidenced by verbal authorization followed by signature on the service plan within thirty days:
(a) Personal care;
(b) Respite care;
(c) Nutrition consultation; and
(d) Respiratory therapy.
(3) Changes in the service plan must be relayed to ODHS within one working day and are subject to final approval by ODHS.
(H) For the purpose of establishing eligibility, the total service plan cost cannot be reduced by deducting the applicant or enrollee's spend-down as set forth in rule 5101:l-39-10 of the Administrative Code, or patient liability as set forth in rule 5101:1-39-225 of the Administrative Code.
(I) When the total cost of the service plan exceeds the cost cap, ODHS may consider the enrollee's continued eligibility status on a case-by-case basis, but only if intensive services of forty-eight hours or less, which result in a temporary increase of the cost cap, are needed to resolve a crisis situation which threatens the health and safety of the enrollee.
(J) The following HCBS waiver 11 services must be delivered according to physician-approved treatment plans:
(l) Personal care;
(2) Respite care;
(3) Nutrition consultation; and
(4) Respiratory therapy.
(K) The treatment plan is a service-specific written document which outlines;
(l) All pertinent diagnoses;
(2) Functional limitations and activities permitted;
(3) Nutritional requirements;
(4) Medications;
(5) Mental status;
(6) Client-specific goals and objectives;
(7) Detailed description of the service's interventions;
(8) Frequency of visits;
(9) Timeframes of expected outcomes;

(10) Any safety measures to protect against injury;
(11) Degree of supervision of the direct service provider by the health care professional, if applicable; and
(12) Any other appropriate items.
(L) The treatment plan must be signed by the physician responsible for the care of the client and must be reviewed, evaluated and signed by the physician as the enrollee's condition requires but not less than once every sixty days.
(M) Copies of the initial and each subsequent physician approved treatment plan must be submitted to the case manager.

5101:3-33-06 HCBS waiver II covered services
(A) HCBS waiver II services covered by medicaid are limited to;
(1) Adult day care;
(2) Case management;
(3) Homemaker:
(4) Personal care;
(5) Respite care;
(6) Adaptive and assistive equipment;
(7) Home-delivered meals;
(8) Medical supplies;
(9) Nutrition consultation;
(10) Respiratory therapy;
(11) Social work/counseling; and
(12) Nonemergency medical transportation.
Service definitions, descriptions of approved provider agencies, qualifications and certification standards for all HCBS waiver II services are outlined in appendix A of this rule.
(B) HCBS waiver II services are reimbursable by Ohio's medicaid program provided that:
(I) The billing provider is eligible as defined in appendix A of this rule and has a current signed agreement with ODHS to provide HCBS waiver II services.
(2) The service is not payable by other third-party payers, including but not limited to Title XVIII (medicare), Title XIX (medicaid) as defined in the state plan, private insurance, workers' compensation, or the veterans administration.
(3) The type of service and allowable service units per month are included on the client's service plan which has been approved by ODHS.
(4) Services, excluding nonemergency medical transportation, are delivered in the enrollee's personal residence, a licensed community alternative home, or an adult day care center. Services are not covered if delivered to enrollees who are inpatients of hospitals or residents of a rest home, LTCF, or board and care facility other than a licensed community alternative home.
(C) Providers of services will receive notices from ODHS indicating assigned ODHS prior-authorization numbers for each approved service giving the approved units of service as authorized by the enrollee's ODHS approved service plan. When subsequently billing for services delivered as authorized, the provider must use the assigned prior-authorization numbers for that service on the claims submitted for medicaid payment.
(D) Providers of services as defined in appendix A of this rule shall submit claims for payment using the ODHS 6780 "Medicaid

Claim Form to ODHS according to rules 510l:3-1-191 and 5101:3-l-l93 of the .Administrative Code.

(E) Medicaid maximum reimbursement amounts were determined from regional surveys within Ohio of prevailing charges for similarly defined services by potential or actual HCBS waiver service providers. Services are reimbursed at the lesser of medicaid maximum reimbursement amounts or usual and customary charges.

5101:3-33-19 Eligibility redetermination for the HCBS waiver II program

(A) The .A&R unit shall redetermine the LOC of each client according to paragraph).A)(3) of rule 5101:3-33-02 of the .Administrative Code at least once every six months from the effective date of enrollment, and more frequently if indicated by a change in the client's health status. The local or slate .A&R unit shall forward the reassessment information for each client to ODHS for approval of the LOC determination.

(B) The .A&R unit shall redetermine eligibility for HCBS waiver II enrollment every six months, according to paragraphs (.A)(l). (.A)(2) and (.A)(5) to (A)) 10) of rule 5101:3-33-02 of the Administrative Code. The local or state A&R unit shall forward the reassessment information and updated service plan to ODHS for approval of the HCBS waiver 11 eligibility redetermination.

(C) The A&R unit and case manager are responsible for establishing procedures to monitor the enrollee's ongoing eligibility for waiver services.

5101:3-33-20 Disenrollment from the HCBS waiver II program

(A) Failure to meet the eligibility criteria according to paragraphs (A)(l) to (A)(3) and (A)(5) to (.A)(I0) of rule 5101:3-33-02 of the Administrative Code shall be sufficient cause for disenrollment from the HCBS waiver II program.

(B) The physician's signature on the service plan is not required to initially enroll the applicant, but if not received within thirty days, is basis for disenrollment.

The effective date of disenrollment shall be the last day HCBS waiver It services other than case management were received by the client.

(D) The A&R unit or case manager shall notify the enrollee, in writing, of the disenrollment and the right to a state hearing, no less than fifteen calendar days prior to the processing of the proposed action. The ODHS 4065 "Prior Notice of Right to a State Hearing" shall be used to provide this notice.

(E) An enrollee may voluntarily withdraw from participation in the HCBS waiver II program at any time by providing written notice to the case manager or .A&R unit. ODHS shall maintain documentation of the enrollee's withdrawal request.

5101:3-33-21 State hearings: HCBS waiver II program

All rules contained in Chapter 5101:1-35 of the Administrative Code which govern access to and procedures surrounding state hearings, including adequate notice, continuation of benefits, state hearing decision, and corrective action, apply equally to applicants for and enrollees of the HCBS waiver II program in addition to the specific requirements set forth in rules 5101:3-

33-22 to 5101:3-33-29 of the Administrative Code.

5101:3-33-22 Notice of right to a state hearing
Applicants for or clients of the HCBS waiver II program shall be given notice of the right to a state hearing whenever appropriate and in the manner described in rules 5101:1-35-02 and 5101:3-33-23 to 5101:3-33-25 of the Administrative Code.

5101:3-33-23 Notice of approval of application for the HCBS waiver II program
When the A&R unit approves an application for the HCBS waiver II program, the A&R unit shall provide the affected individual prompt written notice of the decision.
(A) The notice must contain a statement of the action the .A&R unit has taken, a clear and understandable statement of the reasons for the action, the specific regulations supporting such action, the beginning date of enrollment, the amount of all assistance authorized, the right to and method by which the individual may obtain a hearing, and a telephone number to call concerning free legal services. It must also inform the individual of the opportunity to informally discuss this action at the local level through a county conference.
(B) In all instances, the .A&R unit shall use the ODHS 2307 "Notice of Approval of Your Application for Home and Community-Based Services.

5101:3-33-24 Notice of denial of HCBS waiver II program enrollment
When the A&R unit denies HCBS waiver II program enrollment, the A&R unit shall promptly provide the affected individual written notice of the action.
(A) The denial notice must contain a statement of the action the A&R unit has taken, a clear and understandable statement of the reasons for the action, the specific regulations supporting such action, an explanation of the individual's right to a hearing, the method by which the individual may obtain a hearing, and a telephone number to call concerning free legal services. 11 must also inform the individual of the opportunity to informally discuss the action at the local level through a county conference.
(B) In all instances, the ODHS 7334 "Notice of Denial of Your Application for Assistance" must be used.

5101:3-33-25 Prior notice of adverse action
(A) When the HCBS waiver II case manager intends to withhold, reduce or suspend services without the client's consent or the A&R unit or case manager intends to terminate HCBS waiver II services because the client no longer meets the requirements for HCBS waiver 11 services or enrollment as defined in rule 5101:3-33-02 of the Administrative Code, the HCBS waiver II program administrator or the A&R unit shall provide the affected individual prior written notice of the action in accordance with rule 5101:1-35-02 of the Administrative Code.
(I) The HCBS waiver II program administrator or the A&R tin it shall send a copy of the prior notice to the CDHS.

(2) The CDHS shall file the notice in the recipient's case record.
(B) When the CDHS intends to terminate medicaid eligibility for a recipient who is also enrolled in the HCBS waiver 11 program because the recipient no longer meets the eligibility requirements for medicaid as defined in Chapter 5101:1-39 of the Administrative Code, the CDHS shall contact the recipient's HCBS waiver II case manager.
(I) The CDHS shall notify the recipient that both Medicaid eligibility and HCBS waiver It enrollment are being terminated.
(2? Copies of all prior notices of adverse action involving an HCBS waiver II client shall be sent by the CDHS to the client's case manager and to ODHS.
(C) In all instances, the ODHS 4065 "Prior Notice of Right to a State Hearing" shall be used.

5101:3-33-26 Procedure prior to a state hearing
(A) When the hearing request is made to the HCBS waiver 11 program administrator, the A&R unit, or the HCBS waiver II case manager, that agency or person shall date stamp the request, retain a copy of the request, and send the request to "ODHS, Bureau of State Hearings, 30 East Broad Street, 32nd Floor, Columbus, Ohio 43266-0423" within one workday from the date of receipt. Because of the time limit for issuing a decision on the request, forwarding the hearing request to ODHS shall not be delayed for any reason.
(B) When the hearing request is about HCBS waiver II enrollment or services, the bureau of state hearings shall also send a copy of the request to the HCBS waiver II program administrator and the A&R unit.

5101:3-33-27 Appeal summary
(A) When the hearing request is about denial or delay in determining eligibility for HCBS waiver II services, or disenrollment or termination of services initiated by the A&R unit, the A&R unit shall complete the appeal summary and send it to the district hearings section and to the local CDHS.
(B) When the hearing request is about reduction of services, disenrollment or termination of services initiated by the case manager, or failure to provide the covered service or authorized provider of the enrollee's choice, the HCBS waiver 11 program administrator in the bureau of community services shall complete the appeal summary and send it to the district hearings section and to the local CDHS.

5101:3-33-28 Stale hearings procedure
(A) The district hearings section shall send written notice of the lime, date, and place of the hearing to the appellant, to the authorized representative, if any, to the CDHS, to the HCBS waiver II program administrator in the bureau of community services and, if the hearing is about denial or delay in determining eligibility for HCBS waiver II services or disenrollment or termination of service initiated by the A&R unit, to the A&R unit.
(B) When the hearing is about denial or delay in deter

mining eligibility or disenrollment or termination of services initiated by the A&R unit, the agency representative shall be a member of the A&R unit.
(C) When the hearing is about reduction of services, disenrollment or termination of services initialed by the case manager, or failure to provide the covered service or authorized provider of the enrollee's choice, the agency representative shall be the HCBS waiver II program administrator.

5101:3-3329 Corrective action pursuant to decision
(A) When the hearing is about denial or delay in determining eligibility for HCBS waiver II services or disenrollment or termination of services initiated by the A&R unit, the A&R unit is responsible for promptly and fully implementing the slate hearing decision.
(B) When the hearing is about reduction of services, disenrollment or termination of services initiated by the case manager, or failure to provide the covered service or authorized provider of the enrollee's choice, the HCBS waiver II program administrator in the bureau of community services is responsible for promptly and fully implementing the state hearing decision.
(C) The reason for the rules in Chapter 5101:3-33 of the Administrative Code being adopted is to implement the HCBS waiver II program.

Chapter 5101:3-59 Human Immunodeficiency Virus Program
5101:3-59-01 The human immunodeficiency virus (HIV) program
(A) Definitions.
(1) "Durable medical equipment" is equipment which can stand repeated use, is primarily and customarily used to serve a medical purpose, is not useful to a person in the absence of illness or injury, and is appropriate for use in the home as defined in rule 5101:3-10-20 of the Administrative Code.
(2) "Eligible individuals" are low-income individuals diagnosed with acquired immunodeficiency syndrome (AIDS) or aids-related complex (ARC) as defined in rules 5101:1-39-79 to 5101:1-39-793 of the Administrative Code.
(3) "Eligible providers" include both eligible providers of pharmacy services and eligible providers of medical supplies and durable medical equipment.
(4) "Eligible providers of medical supplies and durable medical equipment" are those providers eligible for reimbursement for medical supplies, durable medical equipment, orthoses, and prostheses as defined in rule 5101:3-10-01 of the Administrative Code.
(5) "Eligible providers of pharmacy services" includes "pharmacy providers" and "practitioners" with a "prescribed drugs" category of service as defined in rules 5101:3-9-01 of the Administrative Code.
(6) "HIV identification card" is an identification card issued to individuals who meet income, medical, and residence requirements for the HIV program as defined in rule 5101:1-39-792 of the Administrative Code.
(7) "Medical supplies" are items which are consumable, disposable, or have a limited life expectancy as defined in rule

5I01:3-l0-02 of the Administrative Code.
(8) "Direct delivery provider" is a pharmaceutical provider that supplies drugs, supplies, and equipment through a mail order program to eligible individuals and is selected under the competitive bid process as defined in sections 125.09 and 125.11 of the Revised Code.
(B) Scope of coverage.
(I) The Ohio department of human services (ODHS) human immunodeficiency virus (HIV) program (formerly known as the AZT/retrovir program) is a special program which purchases or assists with the purchase of drugs and associated medical equipment determined by the food and drug administration (FDA) and approved by ODHS to prolong the life of individuals with acquired immunodeficiency syndrome (AIDS) or aids-related complex (ARC). These individuals are low-income persons not covered under the medicaid program, general assistance medical program, or any other third-party payor. These individuals may be eligible for medicaid under the spend-down provisions set forth in rule 5101:1-39-10 of the Administrative Code.
(2) The HIV program provides zidovudine, pentamidine, alpha interferon, SMZ/TMP, ganciclovir, and aerosolized pentamidine and its associated equipment to eligible individuals. Additional drugs and associated equipment may be added from time to time as determined by the FDA and approved by ODHS. The HIV program is dependent upon federal grant(s) and/or state appropriated monies for its funding. Contingent upon such funds being available, the expanded HIV program commences February 1 1990.
(C) Eligible providers.
The HIV program, as defined in rule 5101:1-39-79 of the Administrative Code, provides covered drugs primarily through a state-term contract for mail order pharmaceuticals. When a state-term contract is not in effect or if the contractor is unable to provide drug(s), supplies, and/or equipment, other providers are eligible for reimbursement. To be an eligible provider, one must:
(I) Have a valid ODHS provider agreement; and
(2) Be an eligible provider of pharmacy services; and/or
(3) Be an eligible provider of medical supplies and durable medical equipment.
(D) Prior authorization.
In order to be reimbursed under the HIV program for drugs and/or equipment not covered under the state-term contract, eligible providers must:
(I) Call the ODHS HIV program coordinator to receive prior authorization to dispense the drug or equipment. The program coordinator will give verbal approval to dispense the drug and/or equipment if:
(a) It is dispensed only to individuals with a current HIV identification card;
(b) Physician instructions are followed in dispensing drugs or equipment and no more than the maximum prescribed units of the covered drug are dispensed.
(2) Following the telephone call, the HIV program coordinator will send a letter authorizing payment for the drug or equipment dispensed.
(E) Reimbursement.

(I) ODHS will reimburse eligible pharmacy services, in accordance with rule 5101:3-9-06 of the Administrative Code, the billed charge or the contracted charge, whichever is less.

(2) ODHS will reimburse eligible medical equipment suppliers for approved home delivery systems for the administration of aerosolized pentamidine when prescribed by the attending physician. Equipment and supplies are covered as specified in rule 5101:3-10-03 of the Administrative Code.

(3) Reimbursement for supplies and equipment will be the lesser of the medicaid maximum allowable fee, as set forth in rule 5101:3-1-60 of the Administrative Code, the billed charge, or the contracted charge.

(4) Claims must be submitted on a universal claim form and sent with the ODHS prior approval letter to "HIV Program, Ohio Department of Human Services, P.O. Box 1858, Columbus, Ohio 43266-0423." Claims must include the provider's federal identification number, medicaid provider number, name of the recipient, recipient's HIV program number, prescribing physician's name, name of drug dispensed, date dispensed, number of units dispensed, and/ or itemized charges for components of the aerosolized pentamidine delivery system and date equipment was dispensed. Claims must be submitted within ninety days after the drug and/or supplies and equipment were dispensed. Providers of both the drug and delivery systems may bill on one claim form, if they so choose.

Department of Rehabilitation and Correction

5120-9-58 Acquired immune deficiency syndrome

(A) In conjunction with the Ohio department of health, the department of rehabilitation and correction shall utilize a questionnaire to survey all inmates received by the department of rehabilitation and correction for activities believed by the Ohio department of health to correlate with a high risk of infection with the human immunodeficiency virus (hereafter referred to as "HIV"). Those individuals who are determined to be at high risk shall be counseled. If Its determined to be medically appropriate, such individuals shall be offered the opportunity to be given an HIV test approved by the director of health pursuant to section 3701.241 of the Revised Code.

)B) Testing for HIV can be required of an inmate when ordered by a judge of appropriate jurisdiction or when the head of the institution has determined, based on good cause, that a lest is necessary.

(C) The results of an HIV lest or a diagnosis of AIDS or an AIDS-related condition may be disclosed to institution or department staff members or contractors. Such disclosure shall only be made to staff and contractors who have a medical need to know and who are participating in the diagnosis, care or treatment of the individual on whom the test was performed or who has been diagnosed as having AIDS or an AIDS-related condition. Disclosure shall be made consistent with the appropriate protocol developed as required by division (B)(3) of section 3701.243 of the Revised Code.

(D) Inmates who have tested positive for the HIV virus or who have been diagnosed as having AIDS or an AIDS-related condition

shall be assigned to such housing within the department of rehabilitation and correction as meets the medical and security needs of the inmate.