

910 KAR 3:030. Traumatic brain injury trust fund operations program.

RELATES TO: KRS 13B, 42.320(2)(d), 45A.075, 45A.080, 189A.050(3)(d)1, 205.900(3), 211.470-211.478, 314.011

STATUTORY AUTHORITY: KRS 211.474(1), EO 2009-541

NECESSITY, FUNCTION, AND CONFORMITY: EO 2009-541 transferred the functions and funds of KRS 189A.050(3)(d)1 to the Department for Aging and Independent Living. KRS 211.474(1) requires the Traumatic Brain Injury Trust Fund Board of Directors to promulgate administrative regulations necessary to carry out the provisions of KRS 211.470 through 211.478. This administrative regulation establishes the Traumatic Brain Injury Trust Fund Operations Program.

Section 1. Definitions.

(1) "Applicant" means a person:

- (a) Who applies for the program, including a legally responsible individual on behalf of an applicant;
- (b) Who participates in the development of, and agrees to, a service plan for the use of the program; and
- (c) For whom a completed service plan is submitted to the program.

(2) "Benefit" means financial assistance provided to a recipient to cover the cost of services approved by the service plan review committee.

(3) "Benefit management program" or "program" means the entity recommended by the board that provides case management services and facilitates distribution of trust fund monies.

(4) "Board" is defined by KRS 211.470(1).

(5) "Cabinet" is defined by KRS 211.470(2).

(6) "Case management" means a process, coordinated by a case manager, for linking a recipient to appropriate, comprehensive, and timely home or community based services as identified in the service plan by:

- (a) Planning;
- (b) Referring;
- (c) Monitoring; and
- (d) Advocating.

(7) "Case manager" means the individual employee responsible for:

- (a) Coordinating services and supports from all agencies involved in providing services required by the service plan;
- (b) Ensuring all service providers have a working knowledge of the service plan; and
- (c) Ensuring services are delivered as required.

(8) "Community residential services" means retraining and rehabilitation of a recipient in a nonemergency situation in a community setting.

(9) "Companion services" means nonmedical supervision and socialization services for the purpose of:

- (a) Preventing the need for institutionalization; and
- (b) Assisting a recipient in maintaining community placement based upon an approved service plan.

(10) "Conflict free" means a scenario in which an agency, including any subsidiary, partnership, not-for-profit, or other business entity under the control of the agency, is providing case management to an individual without providing any other waiver service.

(11) "Department" means the Department for Aging and Independent Living (DAIL).

(12) "Educational or experiential equivalent" means:

- (a) Two (2) semesters totaling at least twenty-four (24) hours of course work; and

- (b) At least 400 documented hours of experience assisting brain injured or other disabled individuals through:
 - 1. Practicum placement;
 - 2. Clinicals; or
 - 3. Volunteerism.
- (13) "Environmental modification" means a physical adaptation to a recipient's home:
 - (a) For the purpose of helping a recipient function with greater independence in the recipient's own home; or
 - (b) Which is necessary to accommodate medical equipment and supplies required for the recipient's welfare.
- (14) "Fund" or "trust fund" is defined by KRS 211.470(4).
- (15) "Good cause" means a circumstance beyond the control of a recipient that affects the recipient's ability to access an approved benefit, including:
 - (a) Illness or hospitalization of the individual that is expected to last thirty (30) days;
 - (b) Death or incapacitation of the primary caregiver; or
 - (c) Unavailability of a service provider that is expected to last thirty (30) days.
- (16) "Immediate family" is defined by KRS 205.8451(3).
- (17) "Integrated environment" means other individuals in a nonresidential setting integrated with those individuals who have a brain injury and in which both are being served to improve community living skills.
- (18) "KYTBI data system" means the internet based data system used to monitor, track, and maintain recipient information, annual and lifetime allocations, and case work performed on behalf of a recipient.
- (19) "Legally responsible individual" means an individual who has a duty under state law to care for another person and includes:
 - (a) A biological, adoptive, or foster parent of a minor child who provides care to the child;
 - (b) The legal guardian who is responsible for the care of the recipient; or
 - (c) A spouse of a recipient.
- (20) "Medical records" means records signed by a physician documenting an applicant's or recipient's traumatic brain injury including:
 - (a) Hospital records; or
 - (b) Diagnostic imaging reports as related to KRS 211.470(3).
- (21) "Natural supports" means a non-paid person, or community resource who can provide, or has historically provided assistance to the consumer or, due to the familial relationship, would be expected to provide assistance when capable.
- (22) "Noncrisis behavior programming" means an individually-designated nonemergency service plan intended to increase a recipient's adaptive social behavior that is provided by a behavioral therapist or clinical psychologist.
- (23) "Occupational therapist" is defined by KRS 319A.010(3).
- (24) "Occupational therapy" means the therapeutic use of self-care, work, and leisure activities to enhance independent functioning or skill development.
- (25) "Personal care assistance services" is defined by KRS 205.900(3).
- (26) "Physical therapist" is defined by KRS 327.010(2).
- (27) "Physical therapy" is defined by KRS 327.010(1).
- (28) "Prevocational service" means a service designed to develop a prerequisite skill necessary to prepare a recipient for paid or unpaid employment provided beyond other external program resources and provided by an occupational therapist or rehabilitation counselor.
- (29) "Psychological and mental health services" means services provided by a mental health professional licensed by the state which are:

- (a) Designed to help a recipient to resolve personal issues or interpersonal problems resulting from a traumatic brain injury; or
- (b) Provided to a recipient's direct caregiver to preserve the stability of a recipient's community living situation, as part of an approved service plan.
- (30) "Recipient" means an eligible applicant who receives a benefit as defined by Section 1(2) of this administrative regulation.
- (31) "Respite care" means a skilled or unskilled service provided to a recipient on a short-term basis if there is an absence or need for relief of a recipient's caregiver.
- (32) "Service plan" means a document that itemizes the goals, services, equipment, or items which are subject to review by the service plan review committee.
- (33) "Service plan review committee" means a committee composed of persons with traumatic brain injuries or their family members and professionals in the field of brain injury as outlined in Section 4(5)(b).
- (34) "Specialized medical equipment and supplies" means items which are of direct medical or therapeutic benefit to a recipient and assist the recipient to maintain community placement.
- (35) "Speech-language pathologist" is defined by KRS 334A.020(3).
- (36) "Speech and language therapy" means an intervention designed to maximize a recipient's language, pragmatic, articulation, swallowing, and cognitive skills.
- (37) "Structured day program services" means a service:
 - (a) Provided by a certified or licensed entity; and
 - (b) Performed in a nonresidential setting which is designed to develop and improve a recipient's skills through activities and skill trainings in areas of:
 - 1. Personal well being;
 - 2. Social and community living; and
 - 3. Independent living management.
- (38) "Supported employment services" means supervision and training of a recipient in a work site at which persons without disabilities are employed and for a recipient who:
 - (a) Is unlikely to obtain competitive employment at or above minimum wage; or
 - (b) Needs ongoing support to perform competitive employment.
- (39) "Traumatic brain injury" is defined in KRS 211.470(3).
- (40) "Wrap-around service" means a service, equipment, or item, not excluded by KRS 211.474(2)(e), which will enhance a recipient's ability to live in the community, consistent with the recipient's overall service plan.

Section 2. Board Operating Procedures.

- (1)
 - (a) A board member shall adhere to the bylaws of the board and the confidentiality requirements as specified in KRS 211.474(3).
 - (b) If a member fails to act in accordance with the bylaws, the chair of the board shall recommend to the governor the dismissal of that member.
- (2) A board member shall not:
 - (a) Influence, discuss, deliberate, or vote on a decision if the member has a conflict of interest that is:
 - 1. Personal;
 - 2. Professional; or
 - 3. Financial; or
 - (b) Directly assist another individual, regardless of where the person resides, to apply for benefits from the fund, except a board member:
 - 1. May refer another individual but not directly assist another individual to apply for benefits from the fund; and

2. Shall not refer himself or an eligible family member or receive benefits from the fund at the same time as being a member of the board.
- (3) The board shall review a quarterly report of the program's activities in accordance with Section 4(8) of this administrative regulation.
- (4) The board shall direct the department to:
 - (a) Issue a request for proposal for the benefit management program in accordance with KRS 45A.080; or
 - (b) Operate the program within the department.

Section 3. Department Duties.

- (1) The department may issue a request for proposal:
 - (a) If directed by the board; and
 - (b) In accordance with KRS 45A.080.
- (2) The department may rescind all or part of an awarded benefit if the recipient does not utilize all or part of the benefit within a twelve (12) month plan period.

Section 4. Duties of the Program. The program shall:

- (1) Establish a toll free telephone number for the purpose of enabling individuals with a traumatic brain injury to apply for benefits from the fund;
- (2) Engage in public information activities for the purpose of informing individuals with a traumatic brain injury about the availability of case management services and benefits from the fund and other sources;
- (3) Review an applicant's documentation of the applicant's diagnosed brain injury and Kentucky residency to determine eligibility as specified in Section 5 of this administrative regulation;
- (4) Assign a case manager within two (2) business days of the determination;
- (5) Establish a service plan review committee:
 - (a) For the purpose of reviewing proposed service plans for approval or denial;
 - (b) Which shall:
 1. Include a minimum of one (1) person with a traumatic brain injury or the guardian or advocate of a person with a traumatic brain injury;
 2. Include a minimum of one (1) professional with expertise in the field of traumatic brain injury; and
 3. Not have two (2) individuals from the same agency or family serve consecutive terms; and
 - (c) In which a member shall be limited to serve twelve (12) consecutive months but may be reappointed to the service plan review committee twelve (12) months after the date of the expiration of the member's most recent term of service on the committee;
- (6) Accept a request for benefits from the fund;
- (7) Distribute benefits to a recipient based upon an approved service plan;
- (8) Submit a list of approved or denied service plans in a quarterly report to the department;
- (9) Provide conflict free case management services:
 - (a) To applicants and recipients statewide, including the provision of assistance in accessing a needed support or service, regardless of funding source; and
 - (b) By a case manager who:
 1. Possesses a bachelor's degree in a health or human services profession from an accredited college or university with:
 - a. One (1) year experience in health or human services; or
 - b. The educational or experiential equivalent in the field of brain injury or physical disabilities;
 2. Is a currently licensed RN as defined by KRS 314.011(5) who has at least two (2) years of experience as a professional nurse in the field of brain injury or physical

disabilities;

3. Is a currently licensed LPN as defined by KRS 314.011(9) who has:

a. At least three (3) years of experience in the field of brain injury or physical disabilities; and

b. An RN to consult and collaborate with regarding changes to the service plan; or

4. Has a master's degree from an accredited college or university;

(10) Be certified by the DAIL beginning July 1, 2015; and

(11) Be supervised by a case management supervisor who shall have four (4) years or more experience as a case manager.

Section 5. Eligibility.

(1) An applicant shall be eligible for a benefit from the fund:

(a) In accordance with:

1. KRS 211.470(3); and

2. KRS 211.472(2)(a) and (c); and

(b) If the applicant is a legal resident of Kentucky.

(2) A resident of an institution or hospital shall not be eligible for benefits from the fund:

(a) Unless the resident is anticipated to be within two (2) weeks of discharge and the benefits facilitate a discharge to the community; and

(b) If funding is available.

(3) An applicant shall provide medical records of the applicant's traumatic brain injury to the program.

(4) An applicant shall document that the applicant has no other public or private payor source, other than the trust fund, which covers the type of service the applicant is requesting.

Section 6. Procedures for Obtaining a Benefit From the Fund.

(1)

(a) A benefit for assistance from the fund shall be directly related to an applicant's brain injury or care of the applicant.

(b) A referral for benefits may be made by, or on behalf of, an eligible person by contacting the program in the following manner:

1. Telephone;

2. In person;

3. In writing;

4. Facsimile;

5. Email; or

6. Online.

(2) Upon receipt of referral, the program shall notify the applicant or referral source of the documentation needed to determine eligibility as specified in Section 5 of this administrative regulation.

Section 7. Benefits Available from the Fund.

(1) An applicant may apply for one (1) or more benefits from the fund as follows:

(a) Noncrisis behavior programming;

(b) Case management;

(c) Community residential services, which shall include at least the following:

1. Dressing;

2. Oral hygiene;

3. Hair care;

4. Grooming;

5. Bathing;

6. Housekeeping;

- 7. Laundry;
- 8. Meal preparation;
- 9. Shopping;
- 10. Room and board; and
- 11. Twenty-four (24) hour supervision of a recipient;
- (d) Companion services;
- (e) Environmental modification to the recipient's residence if:
 - 1.
 - a. The recipient is listed on the deed and a copy is provided to the case manager;
 - b. The recipient is a minor residing in a home owned by his parent; or
 - c. The recipient is an adult residing in a home owned by his legal guardian and provides:
 - (i) Written documentation, by the owner, approving the modification;
 - (ii) A copy of the legal documents verifying parental status or guardianship;
 - (iii) A copy of the deed documenting the owner who has provided the written approval for modification; and
 - (iv) Written documentation that the dwelling is safe and free of structural defect; and
 - 2. The recipient or owner provides:
 - a. At least two (2) estimates of cost and scope of modification;
 - b. A copy of the chosen contractor's license and liability insurance policy or a signed release of liability that no contractor is available within thirty (30) miles of the recipient's residence; and
 - c. Documentation from a health care professional that the requested modification is necessary;
- (f) Occupational therapy provided by an occupational therapist;
- (g) Physical therapy provided by a physical therapist;
- (h) Prevocational service, which shall include at least the following:
 - 1. Assisting a recipient to understand the meaning, value, and demands of work;
 - 2. Assisting a recipient to learn or reestablish skills, attitudes, and behaviors necessary for employment; or
 - 3. Assisting the individual to improve functional capacities;
- (i) Psychological and mental health services, which may include the following:
 - 1. Training to improve interpersonal skills;
 - 2. Social skills;
 - 3. Problem-solving skills;
 - 4. Training to remediate a cognitive problem resulting from the traumatic brain injury;
 - 5. Treatment for a substance abuse problem related to the traumatic brain injury;
 - 6. Psychological assessment; and
 - 7. Neuropsychological evaluation;
- (j) Respite care in:
 - 1. The recipient's own home;
 - 2. Another personal residence; or
 - 3. Another setting, if approved by the program;
- (k) Specialized medical equipment and supplies with written documentation of need from a:
 - 1. Physician;
 - 2. Licensed health care provider; or
 - 3. Licensed therapist;
- (l) Speech and language therapy provided by a speech-language pathologist which may include the following:

1. Articulation therapy;
 2. The design of and instruction in the use of augmentative communication strategies or devices;
 3. Cognitive retraining strategies; or
 4. Swallowing therapy;
- (m) Structured day program services, which shall include at least the following:
1. Direct supervision of the recipient;
 2. Specific training to allow a recipient to improve functioning and to reintegrate into the community;
 3. Social skills training;
 4. Sensory skill development;
 5. Motor skill development;
 6. Teaching of concepts and skills necessary for the increased independence of the recipient; and
 7. Other services to increase:
 - a. Adaptive behavioral responses; and
 - b. Community reintegration;
- (n) Supported employment services; or
- (o) Wrap-around services, which may include the following:
1. Assistance in transporting a recipient, such as to and from:
 - a. A medical appointment;
 - b. A therapy appointment;
 - c. A counseling appointment; or
 - d. Other destinations in the community as specified in the recipient's service plan;
 2. Dental services by a licensed professional;
 3. Vision services by an optometrist, ophthalmologist, or optician;
 4. Modification to the recipient's vehicle for accessibility if the:
 - a. Recipient is listed on the vehicle title and a copy is provided to the case manager; or
 - b. Owner provides written documentation:
 - (i) Approving the vehicle modification;
 - (ii) That the vehicle is for the use of the recipient;
 - (iii) That the vehicle is safe and mechanically sound; and
 - (iv) That the vehicle is insured.
- (2) Program funds shall not be expended to pay for:
- (a) Attorney fees;
 - (b) Court costs or fines assessed as a result of a conviction for a criminal offense;
 - (c) The cost of incarceration;
 - (d) Other court ordered monetary judgments;
 - (e) Insurance premiums, copays, or deductibles;
 - (f) The purchase or leasing of vehicles;
 - (g) The purchase or renting of homes;
 - (h) Home owner association fees;
 - (i) Vacations;
 - (j) Recreational activities;
 - (k) Food, including groceries or eating out;
 - (l) Utilities;
 - (m) Immediate family; or
 - (n) Natural supports.

Section 8. Case Management Services.

(1) Following the program's determination of eligibility, the assigned case manager shall contact a recipient no later than three (3) business days and complete the following responsibilities:

- (a) Conduct an independent assessment;
- (b) Identify the recipient's needs for service and supports;
- (c) Identify potential resources to meet the applicant's need for services and supports;
- (d) Assist the applicant in obtaining needed services and supports regardless of funding source;
- (e) Determine that the fund is the payor of last resort;
- (f) Coordinate, arrange, and document identified service needs of the recipient;
- (g) Develop an individualized service plan that shall:
 - 1. Relate to assessed needs;
 - 2. Identify a source of service utilized in this administrative regulation; and
 - 3. Be signed by the recipient or recipient's representative and case manager, with a copy provided to the recipient;
- (h) Assist in the identification of local resources for individuals with traumatic brain injury;
- (i) Document all face-to-face contacts with the recipient in the KYTBI data system including time in and out, if applicable;
- (j) Maintain caseload as assigned:
 - 1. Upon available funding, at a minimum one (1):
 - a. Face-to-face contact at least every other month;
 - b. Face-to-face at place of residence at least annually; and
 - c. Phone contact during any month a face-to-face contact does not occur; and
 - 2. Document in the KYTBI data system each contact made with the recipient including the face-to-face visit's time in and out and mileage, if applicable; and
- (k) Complete a proposed service plan which shall specify:
 - 1. The name, address, and telephone number of the applicant;
 - 2. The TBI Trust Fund identification number;
 - 3. A clinical summary of the recipient's traumatic brain injury;
 - 4. An explanation of needed services and supports;
 - 5. The requested benefit from the fund;
 - 6. Documentation of the recipient's lack of a payor source for the requested service including:
 - a. An explanation of circumstances leading to the need to request funding; and
 - b. Attempts to find other funding such as:
 - (i) An agency denial or documentation of a noncovered service by insurance or other entity;
 - (ii) Department for Medicaid Services denial; or
 - (iii) Denial from other community programs;
 - 7. The signature of the applicant, or the applicant's legal representative, indicating agreement with the terms of the service plan; and
 - 8. The mechanism for distribution of benefits from the fund.

(2) The case manager shall submit the proposed service plan in the KYTBI data system upon completion of all supporting documents.

(3) The program designee shall verify completion of the service plan and place the case on the service plan review list in chronological order of receipt.

Section 9. Service Plan Review Committee Duties.

(1) The service plan review committee shall:

- (a) Verify the trust fund is payor of last resort of the submitted service plan specified in Section 8(1)(h) of this administrative regulation, based upon supplemental documents

- outlined in Section 5(3) and (4) of this administrative regulation;
 - (b) Verify eligibility of an applicant or recipient's service plan in accordance with Section 5 of this administrative regulation;
 - (c) Consider a service plan in the chronological order in which the completed service plan is received;
 - (d) Review the service plan to determine if the benefit requested from the fund meets the requirements of KRS 211.474(2)(d);
 - (e) Approve or deny an applicant or recipient's service plan;
 - (f) Approve reimbursement for the delivery of services according to a recipient's approved service plan; and
 - (g) Notify the program of an approved or denied service plan.
- (2) The service plan review committee may:
- (a) Approve the proposed service plan, for a period not to exceed twelve (12) months;
 - (b) Amend the proposed service plan; or
 - (c) Deny the proposed service plan and may provide recommendations to the applicant and the applicant's assigned case manager about other available resources or means to meet the applicant's need for services and supports.
- (3) If the applicant disagrees with the decision made by the service plan review committee, the applicant may appeal the decision in accordance with Section 15 of this administrative regulation.
- (4) The service plan review committee shall not approve the distribution of a benefit to a recipient in excess of \$15,000 within any twelve (12) month period and \$60,000 per lifetime pursuant to KRS 211.474(2)(c).
- (5) The service plan review committee shall not approve the distribution of benefits to an applicant:
- (a) Who does not meet the eligibility requirements established in Section 5 of this administrative regulation;
 - (b) If the requested benefits are intended for a purpose other than the direct health, safety, and welfare of the applicant;
 - (c) If the applicant fails to demonstrate a good faith effort that no other payor source is available to obtain the requested benefit;
 - (d) If other resources are available to the applicant to substantially meet a reasonable need for which the benefit is requested, including trusts, settlements, or restitution; or
 - (e) If the benefit requested is for the purpose of reimbursing the recipient for expenses incurred prior to approval of a service plan by the service plan review committee.
- (6) A service plan shall be signed by the director of the program or the director's designee, and the applicant or the applicant's legally responsible individual.

Section 10. Approved Service Plan.

- (1) A recipient shall receive notification of an approved benefit based upon the following types of services:
- (a) Individual;
 - (b) Purchased goods; or
 - (c) Contractors.
- (2) A recipient with an approved service plan may change a service provider within an approved service category if there is no increased cost of the service.
- (3) A recipient may make a permitted change by informing the case manager by:
- (a) Telephone;
 - (b) Email;
 - (c) Facsimile; or
 - (d) In writing.

(4) The case manager may approve a service provider change in a service plan made without review by the service plan review committee.

(5) Involuntary termination and loss of approved benefits shall be initiated if an individual fails to access the approved benefits as outlined in the service plan within ninety(90) calendar days of notification of approval of the service plan without good cause shown.

(a) The recipient or his designee shall have the burden of providing documentation of good cause as to the reason services cannot be accessed within ninety (90) calendar days, including:

1. A statement signed by the recipient or legal representative;
2. A copy of letters to providers;
3. A copy of letters from providers; and
4. A copy of documentation from physicians or other health care professionals.

(b) Upon receipt of documentation of good cause, the program shall grant one (1) sixty (60) day extension in writing.

Section 11. Service Provider Requirements.

(1) A service provider may be:

(a) An employee of the recipient who shall provide:

1. A completed I-9;
2. A completed W-9;
3. A signed service agreement;
4. A criminal background check as required by law;
5. Verification of abuse, neglect, and fraud training; and
6. Completed timesheets submitted bi-weekly;

(b) A licensed or certified agency that shall provide a:

1. Copy of the agency's license or certification;
2. Signed service agreement; and
3. Completed W-9; or

(c) A licensed and insured contractor who shall provide:

1. A copy of the business license;
2. A copy of the liability insurance;
3. A completed W-9;
4. A signed service agreement;
5. Pictures before work begins; and
6. Pictures of the completed work.

(2) Upon notification of an approved service plan, the service provider shall:

(a) Accept the reimbursement approved in Section 9(1)(f) of this administrative regulation as payment in full;

(b) Not require additional payment from a recipient;

(c) Submit an invoice for payment to the program entity within forty-five (45) days from date of service; and

(d) Not attempt to recoup from the service plan review committee beyond an approved reimbursement without prior written agreement by the recipient or legal representative.

(3) A request for payment submitted after forty-five (45) days of the date of service delivery shall not be:

(a) Reimbursed by the Benefit Management Program; or

(b) Billed to the board or recipient.

Section 12. Procedures for Distribution of Benefits from the Fund.

(1) The program shall distribute the fund to a service provider, contractor, or retailer for services rendered.

(2) The payment terms shall be specified in the service agreement.

- (3) The service provider or recipient shall provide to the program documentation of the delivery of a service or benefit to a recipient according to the terms of the service agreement.
- (4) A service shall be reimbursed or paid if it is delivered in accordance with a recipient's approved service agreement.
- (5) An expenditure not included in an approved service agreement shall not be paid by the provider, board, or cabinet.
- (6) The cost of providing case management services to an applicant or recipient shall be exempt from the benefit limits established in Section 9(4) of this administrative regulation.

Section 13. Procedures for Placement on a Waiting List.

- (1) The program may establish a waiting list for benefits from the fund if it determines that no further funding is available.
- (2) The waiting list shall be implemented as follows:
 - (a) An applicant or recipient shall be placed on the waiting list upon receipt, completion, and verification of a service plan by a program designee.
 - (b) The order of placement on the waiting list shall be determined chronologically by date and time of verification.
 - (c) A recipient shall be notified by his case manager of verification of placement on the waiting list.
- (3) The applicant shall be removed from the waiting list if:
 - (a) The applicant secures requested benefit through another resource;
 - (b) The applicant refuses a benefit in an approved service plan, unless the individual has made a permitted change in accordance with Section 10(2) through (4) of this administrative regulation; or
 - (c) The applicant is deceased.
- (4) The removal from the waiting list shall not prevent the submission of a new application at a later date for the applicant.
- (5) If the applicant is removed from the waiting list, the program shall notify the applicant, or his legal representative, in writing within ten (10) business days from the removal.

Section 14. Discharge Criteria.

- (1) A recipient shall be discharged from the Brain Injury Trust Fund Program if:
 - (a) The recipient reaches the maximum \$60,000 lifetime benefit, except if the board waives the expenditure in accordance with KRS 211.474(2)(c);
 - (b) The recipient is noncompliant with program requirements;
 - (c) The recipient chooses to be terminated from participation in the program;
 - (d) The recipient, caregiver, family, or guardian threatens or intimidates a case manager or other program staff;
 - (e) Services accessed are referred and provided by another agency for continued service, if applicable;
 - (f) There is a substantiation of fraud related to the program involving:
 - 1. The recipient; or
 - 2. Both the recipient and the service provider;
 - (g) The recipient is no longer eligible pursuant to KRS 211.470(3)(a) through (f); or
 - (h) The recipient is deceased.
- (2) A recipient may be discharged from the Brain Injury Trust Fund Program if:
 - (a) A service plan is completed for an approved timeframe and no other service is needed;
 - (b) A requested service plan is denied;

- (c) Contact cannot be made with the recipient by the program within three (3) months of last case management contact; or
- (d) No case management services have been provided within a six (6) month period.
- (3) Recipients may reapply to the program without submittal of medical records except in accordance with subsection (1)(a) of this section.
- (4) All discharges shall be appealable in accordance with Section 15, except in accordance with subsection (1)(a) or (f) of this section.

Section 15. Procedures for Appealing the Denial of an Application for Benefits from the Fund.

- (1) If an applicant is determined to be ineligible for benefits from the fund because medical records do not provide documentation of a traumatic brain injury, the applicant may submit:
 - (a) Medical documentation to support the diagnosis of the injury; or
 - (b) Additional medical opinions about the disability.
 - (2)
 - (a) The program shall notify the applicant in writing if the service plan review committee does not approve a requested benefit.
 - (b) Notification shall be made within five (5) business days of the committee's decision.
 - (3) The program or the board shall not be liable for the cost of:
 - (a) A medical opinion obtained by an applicant; or
 - (b) An appeal.
 - (4) An applicant who wishes to appeal the denial of eligibility or benefits shall notify the program, in writing, within thirty (30) days of notification of the denial.
 - (5) Upon receipt of a written appeal, the program shall encumber funds if applicable and available in the amount requested until final resolution of the appeal.
 - (6) The program shall acknowledge receipt of a written appeal to the applicant, in writing, within three (3) business days of receipt.
 - (7) The program shall provide an opportunity for an informal dispute resolution for an applicant or his representative:
 - (a) To appear before the program director or designee and the benefits management program administrator to present facts or concerns about the denial; and
 - (b) Within ten (10) business days of receipt of written appeal.
 - (8) The program shall inform an applicant, in writing, of the decision resulting from the informal dispute resolution within ten (10) business days of the review.
 - (9) An applicant dissatisfied with the result of the informal dispute resolution may appeal to the Division of Administrative Hearings of the Office of Communications and Administrative Review. The appeal shall be:
 - (a) In writing;
 - (b) Made within thirty calendar (30) days of receipt of the decision by the program; and
 - (c) Submitted to the Department for Aging and Independent Living, 275 East Main Street, Frankfort, Kentucky 40621.
 - (10) The department shall request the Division of Administrative Hearings of the Office of Communications and Administrative Review to conduct a hearing pursuant to KRS Chapter 13B.
- (27 Ky.R. 2017; Am. 2829; eff. 4-9-2001; 29 Ky.R. 1145; 1659; eff. 12-18-2002; 2779; 30 Ky.R. 47; eff. 7-16-2003; 31 Ky.R. 1450; 1675; eff. 4-22-2005; Recodified from 908 KAR 4:030; eff. 6-19-2009; 36 Ky.R. 1535; 2068-M; eff. 4-2-2010; 41 Ky.R. 1455; 1994; eff. 4-3-2015; Certified to be amended, filing deadline 5-17-2023.)