
ADAIR COUNTY SB40
Developmental Disability Board

Table of Contents

Governance

BYLAWS OF
ADAIR COUNTY SB40 DEVELOPMENTAL DISABILITY BOARD.
A Political Subdivision of the State of Missouri

PREAMBLE

The Adair County SB40/Developmental Disability Board ("Political Subdivision") is dedicated to creating conditions that promote the wellbeing of persons with developmental disabilities. The Board seeks to enhance the care and/or employment of disabled persons as described in Revised Statutes for Missouri.

RSMo 178.900:
(2) "Disabled persons", a lower range educable or upper range trainable developmentally disabled or other disabled person sixteen years of age or over who has had school training and has a productive work capacity in a sheltered environment adapted to the abilities of persons with a developmental disability but whose limited capabilities make him or her non employable in competitive business and industry and unsuited for vocational rehabilitation training.

RSMo 205.9683:
(1) "Developmental disability" shall mean either or both paragraph (a) or (b) of this subsection:

a. A disability which is attributable to intellectual disability, cerebral palsy, autism, epilepsy, a learning disability related to a brain dysfunction, or a similar condition found by comprehensive evaluation to be closely related to such conditions, or to require habilitation similar to that required for intellectually disabled persons; and
    a. Which originated before age eighteen; and
    b. Which can be expected to continue indefinitely.
b. A developmental disability as defined in section 630.005;

(2) "Person with a disability" shall mean a person who is lower-range educable or upper-range trainable intellectually disabled or a person who has a developmental disability.

RSMO 630.005:
(9) "Developmental disability", a disability:

a. Which is attributable to:
    a. Intellectual disability, cerebral palsy, epilepsy, head injury or autism, or a learning disability related to a brain dysfunction; or
    b. Any other mental or physical impairment or combination of mental or physical impairments; and
b. Is manifested before the person attains age twenty-two; and
c. Is likely to continue indefinitely; and
d. Results in substantial functional limitations in two or more of the following areas of major life activities:
    a. Self-care;
    b. Receptive and expressive language development and use;
    c. Learning;
    d. Self-direction;
    e. Capacity for independent living or economic self-sufficiency;
    f. Mobility; and

(e) Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, habilitation or other services which may be of lifelong or extended duration and are individually planned and coordinated;

ARTICLE I
Corporate Office

The Political Subdivision's address and location of the principal office (if any shall exist) is located within Adair County and shall be designated by and may be changed from time to time by the Board of Directors by a majority vote. The address of record will be: Office of the Adair County Clerk, 215 North Franklin Street, Kirksville, Missouri 63501-2916.

ARTICLE II
Board of Directors

Section 2.1 General Powers.

(a) The board may engage in and contract for any and all types of services, actions or endeavors, not contrary to the law, necessary to the successful and efficient prosecution and continuation of the business and purposes for which it is created, and may purchase, receive, lease or otherwise acquire, own, hold, improve, use, sell, convey, exchange, transfer, and otherwise dispose of real and personal property, or any interest therein, or other assets wherever situated and may incur liability and may borrow money at rates of interest up to the market rate published by the Missouri division of finance.

(b) The board may contract to provide services relating in whole or in part to the services which the board may provide to handicapped persons as defined in this law and for such purpose may expend the tax funds or other funds.

(c) The board may contract with any not-for-profit corporation for any common services, or for the common use of any property of either group.

(d) The board may accept any gift of property or money for the use and benefit of the facility, and the board is authorized to sell or exchange any such property which it believes would be to the benefit of the facility so long as the proceeds are used exclusively for facility purposes. The board shall have exclusive control of all gifts, property or money it may accept; of all interest or other proceeds which may accrue from the investment of such gifts or money or from the sale of such property; of all tax revenues collected by the county on behalf of the facilities or services; and of all other funds granted, appropriated, or loaned to it by the federal government, the state, or its Political Subdivisions so long as these resources are used solely to benefit the facility or related services except those paid for transportation purposes under the provisions of RSMo 94.645.

Section 2.2 Number and Qualifications. The Adair County Commission shall appoint a board of directors consisting of a total of nine (9) members, two (2) of whom shall be related by blood or marriage within the third degree to a handicapped person as defined in RSMo 205.968, and four (4) of whom shall be public members. At least seven of the board members shall be residents Adair County, Missouri.

Section 2.3 Term of Office and Election: All board members shall be appointed to serve for a term of three years, except that of the first board appointed three members shall be appointed for one-year terms, three members for two-year terms and three members for three-year terms. Each director will hold office until the expiration of the term or until his/her successor is appointed. Directors may be re-appointed.

Section 2.4 Resignation. Any director may resign at any time by written notice of resignation to the Board of Directors and the Adair County Presiding Commissioner.

Section 2.5 Removal. Any board member may, following notice and an opportunity to be heard, be removed from office by a majority vote of the other members of the board for any of the following grounds:

1. Failure to attend five consecutive meetings, without good cause;
2. Conduct prejudicial to the good order and efficient operation of the facility or services; or

3. Neglect of duty.

The chairman of the board shall preside at such removal hearing, unless he or she is the person sought to be removed. In which case the hearing shall be presided over by another member elected by the majority vote of the other board members. All interested parties may present testimony and arguments at such hearing, and the witnesses shall be sworn by oath or affirmation before testifying. Any interested party may, at -his or her own expense, record the proceedings.

Section 2.6 Vacancies. Vacancies in the board occasioned by removals, resignations or otherwise shall be reported by the board chairman to the Adair County Commission and shall be filled in like manner as original appointments; except that, if the vacancy occurs during an unexpired term, the appointment shall be for only the unexpired portion of that term.

Section 2.7 Annual Meeting The Board of Directors shall meet annually in August. The first order of business at each Annual Meeting shall be the accepting the directors appointed by the Adair County Commission and the election of officers.

Section 2.8 Regular Meetings. The Board of Directors may provide by resolution for regular meetings of the Board for the transaction of business of the Political Subdivision. The time, place, and frequency of regular meetings shall be determined from time to time by resolution of the Board. Meetings will be held at least four times a year.

Section 2.9 Special Meetings. Special meetings of the Board of Directors shall be called by or at the request of the Chairman, or any two (2) members of the Board of Directors. The person or persons authorized to call special meetings of the Board of Directors shall fix the time and place of such meeting and shall notify all directors of the time and place of the meeting in the notice of meeting.

Section 2.10 Notice of Meetings. Notice of all meetings shall be posted as prescribed by RSMo 610.020. Notice of any special meeting shall be given by written notice deposited in the US Mail at least (5) days prior to the date of the meeting with postage prepaid for first class delivery to the directors' address as they appear on the records of the Political Subdivision, or by written notice at least two (2) days prior to the meeting date if hand delivered notice is given. Any director may waive notice of any meeting. The attendance of a director at any meeting shall constitute waiver of notice of the meeting except where a director attends a meeting for the express purpose of objecting to the transaction of any business thereat and asserts that the meeting is not lawfully called or convened.

Section 2.11 Place of the Meeting. The annual and all regular or special meetings of the Board of Directors shall be held at a place within Adair County, Missouri as may be designated by resolution of the Board of Directors or consented to in writing by all directors.

Section 2.12 Quorum. A majority of the directors in office immediately before a meeting begins shall constitute a quorum for the transaction of any business at any meeting of the board of directors.

Section 2.13 Conflict of interest. Each member of the Board of Directors and all management employees of the Political Subdivision shall be required to disclose fully and frankly to the Board any and all actual or potential conflict or duality of interest or responsibility and any financial interest whether individual, personal, or business which may exist or appear as the Political Subdivision or nay matter of business which may come before the Board or a committee thereof at any time prior to actions thereon. After disclosure of such interests and all material facts, and after any discussion with the interested person, the Board of Directors, absent the interested person, shall determine if a conflict of interest exists and what steps are appropriate.

Ordinarily the interested person will leave the meeting during the discussion of, and the vote on the transaction or arrangement involving the conflict of interest.

Individual board members shall not be eligible for employment by the board within twelve months of termination of service as a member of the board. No person shall be employed by the board who is related within the third degree by blood or by marriage to any member of the board.

Section 2.14 Compensation. The directors shall not receive compensation for their services, but may be reimbursed for their actual and necessary expenses.

ARTICLE III
Officers

Section 3.1 Number. The officers of the Political Subdivision shall be: Chairman, Vice Chairman, Treasurer, Secretary and such other officers as it deems necessary. All officers shall be duly appointed directors with the exception of the office of secretary which may be held by a non director. The offices of Secretary and Treasurer may be held by the same person.

Section 3.2 Election. The officers are elected by Board at the Annual Meeting of the Board or Directors for one year terms. Each officer shall be elected by a majority vote of the Board of Directors and shall hold office until his or her successor shall have been duly elected and shall have qualified of until he or she resigns or otherwise vacates the office or shall be removed in the manner provider herein.

Section 3.3 Chairman. The Chairman of the Board shall be the principal officers of the Board, The Chairman shall preside at all meetings of the Board of Directors. The Chairman shall be an ex officio member of all board committees. The Chairman shall perform all duties incident to the office of Chairman and all other duties as may from time to time be prescribed or designated .by the Board of Directors.

Section 3.4 Vice Chairman. The Vice Chairman shall perform such duties as may be assigned by the Chairman, the Board of Directors, or by these Bylaws. In the absence of the Chairman or in the event of the Chairman's inability or refusal to act, the Vice Chairman shall preside at Board meetings and shall perform the duties and exercise the powers of Chairman with the same force and effect as if performed by the Chairman.

Section 3.5 Treasurer: The Treasurer shall perform such duties as may be assigned by the Chairman, the Board of Directors, or these Bylaws. The Treasurer shall oversee and monitor the funds of the Political Subdivision and shall ensure that a full and accurate record of all receipts and disbursements is made. The Treasurer will oversee and monitor the disbursement of all funds, demanding and requiring proper vouchers for such disbursements. The Treasurer will ensure the rendering of an account of all transactions and the financial condition of the Political Subdivision that at such time or times as the Board of Directors may require.

Before taking office, the treasurer shall furnish a surety bond, in an amount to be determined and in a form to be approved by the board, for the faithful performance of his duties and faithful accounting of all moneys that may come into his hands. The treasurer shall enter into the surety bond with a surety company authorized to do business in Missouri, and the cost of such bond shall be paid by the Political Subdivision.
Adair County SB40/Developmental Disability Board Bylaws APPROVED Version 1.2 dated 7/28/05 page 6 of 8

Section 3.6 Secretary. The Secretary shall perform such duties as assigned by the Chairman, the Board of Directors, or these Bylaws. The Secretary shall ensure that a record is kept of attendance at all Board

meetings, shall ensure that all Board votes are recorded and ensure that minutes of all meetings are taken and kept. The secretary shall keep a register of the mailing addresses and contact telephone numbers of each Director. The Secretary will be the custodian of records as required by RSMo 610.023.1.

ARTICLE IV
Committees of the Board

Section 4.1 Board Committees. The Board of Directors, by resolution adopted by a majority of directors, may establish or designate one of more committees, each of which shall consist of not less than two (2) directors. The Board of Directors may designate that persons not appointed to the Board may serve on committees. Appointment to all committees and designation of Committee Chairs shall be made by the Chairman of the Board subject to ratification by the Board.

Section 4.2 Finance Committee. The Finance Committee will be a standing committee of the Board of Directors and shall be appointed by the Chairman of the Board and ratified by the majority of the Board each year at the Annual Meeting or the next regular meeting of the Board following the Annual Meeting. The Treasurer will serve as the Chairman of the Finance Committee. The Finance Committee shall review and make recommendations to the board regarding an annual budget, financial feasibility of all Political Subdivision activities and undertakings, compensation of any staff, annual audit of the Political Subdivision.

ARTICLE V
Contracts, Loans, Checks and Deposits

Section 5.1 Execution of. Instruments. All documents, contracts, agreements, instruments or writings of any nature shall be signed, executed, verified, acknowledged and delivered by such officer or officers, or by such other agent or agents of the Political Subdivision, and in such manner as the Board of Directors shall from time to time determine. Unless so authorized, no officer, director or employee shall have the power or authority to bind the Political Subdivision by contract, to pledge any asset of the Political Subdivision, or to render the Political Subdivision pecuniarily liable for any purpose in any amount.

Section 5.2 Loans. No borrowing or loan obligations shall be contracted on behalf of the Political Subdivision and no evidence of such indebtedness of the Political Subdivision shall issue in the name of the Political Subdivision unless authorized by resolution of the Board of Directors. No loan shall be made by the Political Subdivision to any of its directors.

Section 5.3 Authorized Signatories. All checks, notes, drafts and other instruments for the payment of money or disbursement of funds drawn, endorsed or executed in the name of the Political Subdivision shall be signed by the Treasurer and either the Chairman or the Vice Chairman. In the absence of the Treasurer, the Chairman and Vice Chairman will be the authorized signatories.

Section 5.4 Deposits. All funds of the Political Subdivision not otherwise employed shall be deposited from time to time to the credit of the Political Subdivision in such depositories as the Board of Directors may from time to time direct.

Section 5.5 Fiscal Year: The fiscal year shall be from July 1 until June 30.

ARTICLE VI
Notice

Whenever notice is required to be given under the provisions of these Bylaws waiver of notice in writing signed by the person or persons entitled to notice, whether before of after the event noticed, shall

be deemed to be equivalent to the giving of such notice except as may otherwise be specifically prohibited by RSMo Chapter 610 or by any other law.

ARTICLE VII
Dissolution

The Political Subdivision may be dissolved as prescribed by the laws of the State of Missouri, or in the absence of any such laws, as directed by the Attorney General of the State of Missouri.

ARTICLE VIII
Amendments

The Bylaws of the Political Subdivision, or any portion thereof, may be altered, amended, or repealed from time to time and new Bylaws, or new provisions thereof may be adopted in lieu hereof upon affirmative vote of a two-thirds of the directors then in office, provided that written notice of such alterations, amendment or repeal and restatement of the Bylaws shall have been given each director and the same having been discussed at not fewer than two (2) meetings of the Board, including the meeting a which the vote thereon is taken.

Certificate of Secretary

The undersigned, being duly elected, qualified and acting Secretary of the Political Subdivision, hereby certifies that the forgoing Bylaws consisting of seven (7) pages (not including this certificate), were approved and adopted by the Board of Directors of the Adair County SB40/Developmental Disability Board on the Twehty-Seventh day of July, 2005.

Printed Name: _____ _____

Title: Secretary

Dated: APPROVED Version 1.2 dated July 28, 2005

ADAIR COUNTY SB40/DEVELOPMENTAL DISABILITY BOARD
BYLAWS AMENDMENT #2
FIRST READING 01/10/06

AMEND ARTICLE I: CORPORATE OFFICE

REPLACE: % Adair County Ambulance District; 606 West Potter Avenue; Post Office Box 189; Kirksville, MO 63501-0189.

WITH: 1011 East George Street, Kirksville, Missouri 63501-4548

The article as amended would read:

ARTICLE I
Corporate Office

The Political Subdivision's address and location of the principal office (if any shall exist) is located within Adair County and shall be designated by and may be changed from time to time by the Board of Directors by a majority vote. The address of record will be: 1011 East George Street; Kirksville, Missouri 63501-4548.

ADAIR COUNTY SB40/DE'VELOPMENTAL DISABILITY BOARD

BYLAWS AMENDMENT #3
FIRST READING 3-17-09
SECOND READING 4-14-09

AMEND ARTICLE 1: CORPORATE OFFICE

REPLACE: 1011 E. George Street, Kirksville, Missouri 63501-4548
WITH: 1107 Country Club Drive, Kirksville, Missouri 63501-5355

The article as amended would read:

ARTICLE I
Corporate Office

The Political Subdivision's address and location of the principal office (if any shall exist) is located within Adair County and shall be designated by and may be changed from time to time by the Board of Directors by a majority vote. The address of record will be: 1107 Country Club Drive, Kirksville, Missouri 63501
APPROVED; Lk- ILA-O9

ADAIR COUNTY SB40 DEVELOPMENTAL DISABILITY BOARD
BYLAWS AMENDMENT #4
FIRST READING 3/8/16
SECOND READING 4/12/16

Amend PREAMBLE to reflect the changes in the Revised Statutes of Missouri. APPROVED 4/12/16

Adair County SB40 Developmental Disability Board

Mission:
The MISSION of the Adair County SB40 is to engage in ADVOCACY, promote INCLUSION, and provide essential RESOURCES to assist people with developmental disabilities to live self-determined lives.

Our Vision:
Our VISION is to see people's ABILITIES and change the world so that everyone can live their best life.

What We Value:

- SELF-DETERMINATION – Having opportunities, respectful support, and the authority to exert control in one's own life with decisions that are honored and the opportunity to succeed or learn from failure
- COMMUNITY – The importance of community in the lives of people with developmental disabilities and the importance of people with developmental disabilities in the life of the community with emphasis on collaboration and belonging.
- EQUALITY – Believing all people are of equal value and ensuring they are treated with equal dignity.
- EQUITY – Believing that no one should have poorer life chances because of their race, color, religion, sex, national origin, age, disability, or genetic information, ensuring systemic barriers are removed, and helping people meet their unique needs to make the most of their lives and talents.
- EXCELLENCE – Believing the organization must go *beyond compliance* in delivery of services to meet current needs and anticipate future needs of the people we support.

Key Focus Areas:

- Through trauma informed approaches, implement quality, effective Person-Centered Planning using proven life planning tools & *in-person* assessments supported by learning programs which improve life skills and social relationships.
- Promote Competitive and Integrated Employment; implementing initiatives throughout the transition to adulthood years resulting in students who are workforce ready upon graduation from High School and supports adults in their pursuit of jobs of their choice.
- Foster development of support networks for Advocacy/Self-Advocacy; small groups, education & information for people with IDD and their support(s).
- Advocate for *equity* in education, healthcare, employment, transportation, housing and other areas of home & community living.
- Ongoing promotion of *authentic* inclusion of people with IDD as valued members of our community.

Adair County SB40 Developmental Disability Board

Strategic Plan FY25

Mission:
The MISSION of the Adair County SB40 is to engage in ADVOCACY, promote INCLUSION, and provide essential RESOURCES to assist people with developmental disabilities to live self-determined lives.

Our Vision:
Our VISION is to see people's ABILITIES and change the world so that everyone can live their best life.

What We Value:

- SELF-DETERMINATION – Having opportunities, respectful support, and the authority to exert control in one's own life with decisions that are honored and the opportunity to succeed or learn from failure.
- COMMUNITY – The importance of community in the lives of people with developmental disabilities and the importance of people with developmental disabilities in the life of the community with emphasis on collaboration and belonging.
- EQUALITY – Believing all people are of equal value and ensuring they are treated with equal dignity.
- EQUITY – Believing that no one should have poorer life chances because of their race, color, religion, sex, national origin, age, disability, or genetic information, ensuring systemic barriers are removed, and helping people meet their unique needs to make the most of their lives and talents.
- EXCELLENCE – Believing the organization must go *beyond compliance* in delivery of services to meet current needs and anticipate future needs of the people we support.

Key Focus Areas:

- Through trauma informed approaches, implement quality, effective Person-Centered Planning using proven life planning tools & *in-person* assessments supported by learning programs which improve life skills and social relationships.
- Promote Competitive and Integrated Employment; implementing initiatives throughout the transition to adulthood years resulting in students who are workforce ready upon graduation from High School and supports adults in their pursuit of jobs of their choice.
- Foster development of support networks for Advocacy/Self-Advocacy; small groups, education & information for people with IDD and their support(s).
- Advocate for *equity* in education, healthcare, employment, transportation, housing and other areas of home & community living.
- Ongoing promotion of *authentic* inclusion of people with IDD as valued members of our community.

Key Performance Indicators #1: Ensure quality programs and services for people with intellectual/developmental disabilities (IDD) in accordance with the Mission and Vision of the organization.

- Provide individual and group information, education, and social programs to people with IDD through the Community Learning Center which aligns with DMH's Missouri Quality Outcomes.
- Provide information/education programs, at least one per quarter. (i.e. Project STIR, CIRCLES Relationships and Intimacy, Life Facts classes, etc.)
- Provide quality Targeted Case Management Services
- Quarterly and annual Audits by DMH and CMS yield no major areas of concern.
- Community inquiries for new referrals to the Division for Intake & Assessment (MAAS) will be tracked to be sure the MAAS assessments are completed, and referrals are sent to the Agency as appropriate.
- Provide individual grants to Adair County citizens for disability related expenses with no other source for payment.
- Agency budget includes reimbursement program for temporary residential supports to natural families.
- Provide agency grants to applicant Adair County agencies which adhere to the stated mission and values of Adair County SB40
- All agency grants approved by the Board of Directors will adhere to both the tax levy ballot language approved by taxpayers and the mission statement of Adair County SB40.
- Agency and individual grants from SB40 fund programs and services maximize the human potential of persons with a developmental disability.
- Provide ongoing administrative support to individuals that the agency serves. (i.e. Organizational Payee, Benefits Counseling, etc.)
- Develops and administers satisfaction surveys annually to measure the success of Adair County SB40 programs including but not limited to Service Coordination and the Community Learning Center.

Key Performance Indicators #2: Maintains positive work environment with highly trained staff who demonstrate commitment to excellence.

- Directors, Management and Staff practices are transparent and demonstrate positive communications.
- The Agency ensures competitive compensation plans.
- Maintain an employee benefits plan which assures the Agency is an 'employer of choice'.
- Management fosters a work environment which supports reasonable work/life balance of the staff.
- Management and Board support initiatives of the Agency which address Secondary Trauma experienced by staff and prevents compassion fatigue/burnout.
- The 360 Committee will host monthly employee social hours to discuss or have training on healthy living, self-care, and individual resiliency.
- Management provides ongoing training, development, and advancement opportunities for staff.
- Implements ongoing employee recognition for excellent performance.

Key Performance Indicators #3: Ensure an efficient and financially strong organization.

- Ensures clear and accurate accounting, purchasing and asset management systems.
- Develops and maintains an annual budget in cooperation with the Board of Directors.

- Coordinates, reviews, and evaluates local individual funding requests on a weekly basis.
- Coordinates, reviews, and evaluates agency funding requests with the Board of Directors each month.
- Actively researches and pursues funding sources and opportunities (e.g. grants, matching funds, partnerships, services) to supplement and enhance programs consistent with the organization's mission.
    - Routinely promote QR Code for donations to support the 501(c)3 organization, Adair DD Link, in all external and social media communications.

Key Performance Indicators #4: Develop positive and professional working relationships with interagency contacts to maximize synergy in meeting the needs of the IDD community.

- Advocates for people with IDD in the community
- The agency will provide Service Coordination for individuals with IDD in Adair County who are non-Medicaid eligible.
- Maintains positive and proactive working relationships with Service Providers for individuals served by the agency.
- The CLC programming will include Mandt Training and Certification for Service Provider staff to support positive behavioral supports in residential settings.
- The agency will organize and host an annual DSP recognition event for Service Provider staff.
- Cultivates effective relationships with community and business leaders, public officials, and potential funding sources and collaborates with community leadership to support programs impacting those we serve.
- The agency will maintain and promote a community online resource directory (NEMO Resources)
- Through an ongoing stakeholder survey and needs assessments tools, identifies gaps in services for people with IDD and initiates formation of workgroups to find resolution.
- Actively participates in community work groups formed to resolve pressing local issues impacting people with IDD.
- The agency will facilitate ongoing positive and productive working relationships with local school districts, Children's Division, Department of Health & Human Services, and other agencies that also service the people that the agency services.

Key Performance Indicators #5: Represents the interests of citizens with intellectual/developmental disabilities in Northeast Missouri through effective governmental relations efforts.

- Advocates for people with IDD in the community at local, county, state, and federal levels including participation in the local Chamber Government Affairs Committee, MACDDS Legislative committee and other government related entities.
- Ongoing regular contact with legislators to provides representatives with ongoing education/information on local issues impacting local citizens with IDD and includes hosting an annual legislative forum which assists legislators in identifying priority issues impacting people with IDD and potential resolutions.
- Agency staff, management and Directors maintain a strong knowledge of State plans, policies and resources.

Key Performance Indicators #6: Promotes the programs and services of the organization to citizens with intellectual/developmental disabilities, their families, and their supports, in Northeast Missouri

- Demonstrates attitude of sincere interest, concern and accessibility toward persons served by Adair County SB40, as well as toward their families and others supporting them.
- Maintains updated social media presence with platforms including Agency website, Online Resource Directory, Facebook page and Facebook Live.
- Maintains a positive and professional relationship with the local community through regular coffee chats and participation in local interagency workgroups.
- Participate in community events that promote awareness of services provided.
- Management represents the Agency in a positive and professional manner with the local media.
- The Agency distributes monthly newsletters and calendars to individuals served, their families and all agency stakeholders and shares occasional press releases with local media to promote agency initiatives.
- Management initiates frequent presentations and interactions with local service groups, civic organizations and governmental entities.
- The Agency will host community events that raise awareness of issues involving people with IDD such as the annual Community Engagement Conference, Spotlight Awards, March Developmental Disabilities Awareness month, etc.

Key Performance Indicators #7: Actively participate in professional development, training, and educational opportunities to continuously grow knowledge and understanding of community resources, disability issues and the best practices to assure quality services to the individuals served by the organization.

- All activities of the Staff and Board of the Agency demonstrate a commitment to the mission, vision, and values of the organization.
- Agency staff and management actively participate in regular meetings and training opportunities, including but not limited to those opportunities available through DMH, MACDDS and other advocacy groups at the state and national level.
- Develops partnerships through networking with other professionals in the field of developmental disabilities locally and abroad.
- Strives to uphold highest standards of professional integrity and accountability in fulfillment of commitment to Adair County SB40 Board members and employees, individuals/families served by Adair County SB40, and the citizens of Adair County.

ADAIR COUNTY SB40 DEVELOPMENTAL DISABILITY BOARD
STRATEGIC PLAN GOALS TO ACHIEVE BY END OF FISCALYEAR 2025

1) Recognizing that good processes produce good results - coordinate and implement internal information technology supports which increase the efficiency of operations and administrative oversight and which produce improved results as measured through data tracking of ISPs, Amendments, Due Process, Utilization Review and Benchmarks.
2) Through the addition of a full-time Community Resource Coordinator (CRC) to the staff,
    a. transfer Non-Medicaid Service Coordination to the CRC, relieving the case loads of Service Coordinators providing Targeted Case Management to the heavier weighted consumers eligible for Medicaid, allowing for 50% of the CRC time focused on this area, and.
    b. focus on employment, transportation and transition to adulthood planning services which result in a 5% increase in the number of adults engaged in competitive integrated employment and increases the number of school aged children with transition to adulthood planning included in their ISP and IEP no later than 14 years of age, and
    c. Through collaborations with area schools and local agencies, assist in the identification of potential referrals to MO-DMH for Agency Service Coordination and, to assure timely eligibility determination, initiate contact with the intake/referral coordinator within 30 days of referral.
3) The Agency will form a Disability Advisory Group which includes up to 10 parents and self-advocates to advise the Agency on programs, projects, and planning priorities.
4) Through active participation in the ongoing IEP process of all school aged children serviced by the Agency, assure ongoing collaboration between the TCM team and the Education Team which results in consistency between the specifics of the IEP and the ISP goals written into those plans.
5) While respecting rights to Self-Determination, all Agency services will assure that all adults over the age of 18 who are not under legal guardianship have been educated on the importance of planning for emergencies and have been helped in executing Medical and/or Durable Power of Attorney and/or Supported Decision-Making agreements if they choose to do so.
6) Prior to becoming a legal adult, all consumers at 17 to 18 years of age and their parents/natural support receive information and education on least restrictive alternatives to guardianship and the medical rights of adults with IDD.
7) All Agency services will include research and education for consumers on available Assistive Technology (AT) supports and ongoing developments which offer least restrictive alternatives with AT.
8) Increase Community Outreach
    a. The Agency will develop a strategic marketing plan for the Community Learning Center and its programs.
    b. The Agency website and social media content will be evaluated to identify areas of improvement which could increase community knowledge about and engagement with the Agency.

Board of Directors

Policy: It is the policy of Adair County SB40 to operate under the direction of the Board of Directors.

Procedure:

1. The Adair County SB40/Developmental Disability Board is a Political Subdivision in Adair County of the State of Missouri, providing essential resources for people with developmental disabilities.

2. The functions of the Board of Directors include, but are not limited to the following:
    a. Establishing by-laws
    b. Approving a mission statement and direction of the organization
    c. Approving core values
    d. Approving service lines and a strategic plan
    e. Reviewing and approving an annual budget that ensures financial solvency.
    f. Assuring that the agency's physical and financial resources are insured, and risk managed.
    g. Advocating for resources needed to meet the agency's mission.
    h. Complying with insurance and risk management requirements/practices
    i. Participating in accreditation/licensure processes as determined by the Directors.
    j. Supporting the activities of the quality improvement program
    k. Approving the organizational structure
    l. Reviewing program and administrative activities
    m. Assuming responsibility and accountability for programs/services offered
    n. Developing and implementing corporate responsibilities
    o. Appointing the Executive Director and establishing duties and responsibilities
    p. Annually evaluating the Executive director's performance
    q. Collaborating with the Executive Director
    r. Insuring that personnel and employment practices function in accordance with established law and regulatory requirements
    s. Insuring client rights
    t. Insuring adequate professional liability and hiring practices insurance protection for its Board of Directors and employees
    u. Documentation of Board of Director activities are found in meeting minutes kept on file by the Executive Director or designee.

Board of Directors Recruitment Process

Purpose

The purpose of this policy is to outline the process to be used to fill vacancies on the Board of Directors of Adair County SB40 Developmental Disabilities Board ('the Agency'). Nothing in this policy shall be construed to be in conflict with the Agency's existing By-Laws and where questioned, the content of the By-Laws shall supersede the content of this policy.

Process

In accordance with the authority of the Adair County Commissioners, any eligible citizen that is interested in appointment to the Agency's Board may notify the Commission of their interest at any time.

When there becomes a vacancy on the nine-member Board of Directors, due to the resignation of a member or because of an expiration of the term of a member, the Executive Director shall notify 1) the Chair of the Board of Directors and 2) the Adair County Commissioners. The notification shall be in writing and sent within three (3) business days of the vacancy. The notification may be communicated electronically.

In addition, a notice of Board vacancy shall be posted on social media, the Agency Website and on the front entrance of both Agency locations. The notice of vacancy shall be posted within three (3) business days of the vacancy. The notice of vacancy must contain details about how to apply for consideration for appointment to the Agency's Board and establish a deadline for submitting an application for that vacancy.

All applications submitted for that vacancy will be reviewed by the Board Recruitment Committee of the Agency. The Board Recruitment Committee will consist of the Executive Director and three members of the Agency staff as appointed by the Executive Director. This committee will review the applications and may request that any candidate meet with the committee to discuss their interests. Following this review, the Committee will submit all applications received to the Adair County Commissioners along with the Committee's recommendations for appointment.

The Adair County Commissioners are not bound by the recommendations of the Board Recruitment Committee.

Upon the Commission's appointment to the vacancy, the Executive Director shall notify the Chair of the Board and the new Board member of the appointment.

The Executive Director shall schedule Board member orientation within thirty (30) calendar days of appointment.

Board of Directors Orientation

Policy: It is the policy of Adair County SB40 to provide formal orientation for all new Board members during the first thirty (30) days of appointment.

Procedure:

1. All new Board members will complete an orientation that includes, but is not limited to, a review of the following:
    a. Agency mission statement
    b. Governing structure
    c. Board functions, duties, responsibilities, operations and annual reviews
    d. Strategic and annual plan, goals and objectives, services, hours of operation, and table of organization
    e. Quality improvement program and plan
    f. Summary of client rights activities
    g. All policies and procedures

2. Scheduling, completion, and documentation of each new Board member's orientation will be the primary responsibility of the Executive Director and shall occur within 30 days of the person's appointment to the Board.

Board Operations Manual

Policy: The Board of Directors shall maintain an Operations Manual reflective of all Board activity.

Procedures:

1. The Operations Manual of the Board will include, but not be limited to, the following:
    a. Agency By-Laws
    b. Governing policies, rules and regulations
    c. Board of Directors membership roster and terms
    d. Officer roster, responsibilities, and terms
    e. Committee membership roster
    f. Meeting minutes
    g. Annual reviews
    h. Strategic plan
    i. Annual goals and objectives
2. Board meeting minutes shall contain, at a minimum, the following:
    a. Date, time and place of the meeting
    b. Members in attendance
    c. Topics discussed and actions taken

Board of Directors Meetings and Meeting Minutes

Policy: It is the policy of the Board of Directors to conduct scheduled Board meetings on a monthly basis, but not less than quarterly, and to maintain minutes of each meeting.

Procedure:

1. The Executive Director or designee shall be responsible for notifying all Board members by email and/or postal mail of a scheduled meeting no less than 10 days prior to the scheduled board meeting.

2. The Executive Director or designee shall be responsible for maintaining the minutes of all meetings of the Board. A copy of all minutes shall be kept in chronological order in the Board of Directors Operational Manual.
3. All meeting minutes shall reflect the date, time, place, names of members present, topics discussed, actions taken and required follow-up.

Board of Directors Annual Reviews

Policy: It is the policy of the Board of Directors to perform scheduled Annual Reviews to fulfill the responsibilities of agency governance.

Procedures:

1. As scheduled, the Board of Trustees will conduct annual reviews to include the following:
    a. Mission statement
    b. Agency Vision and Values statements
    c. Strategic plan
    d. Annual goals and objectives
    e. Annual budget
    f. Annual independent fiscal audit
    g. Quality improvement plan
    h. Policies and procedures
    i. Executive Director's annual performance evaluation
    j. Summary of client rights activities
    k. Agency insurance program

2. Documentation of Board Annual Reviews will be reflected in the Board meeting minutes and records.

Board of Directors Conflict of Interest

Policy: The Board of Directors shall maintain a Conflict-of-Interest Policy for all members.

Procedure:

1. All Board members will be notified of the Conflict-of-Interest Policy as part of the new Board member's orientation process.
2. All Board members will complete and sign an annual Conflict of Interest Declaration to be stored in the Board of Directors Operational Manual.
3. If a Board member believes a conflict of interest pertaining to a specific issue exists, it will be presented to the Board for discussion.
4. If the Board determines that a conflict of interest exists for a member(s), the member(s) will abstain from discussion and vote on that specific issue.
5. Appropriate documentation will be maintained in the Board Meeting Minutes.

Conflict of Interest Policy

Each member of the Board of Directors and all management employees of the Political Subdivision shall be required to disclose fully and frankly to the Board any and all actual or potential conflict or duality of interest or responsibility and any financial interest whether individual, personal, or business which may exist or appear as the Political Subdivision or nay matter of business which may come before the Board or a committee thereof at any time prior to actions thereon. After disclosure of such interests and all material facts, and after any discussion with the interested person, the Board of Directors, absent the interested person, shall determine if a conflict of interest exists and what steps are appropriate. Ordinarily the interested person will

leave the meeting during the discussion of, and the vote on the transaction or arrangement involving the conflict of interest.

Individual board members shall not be eligible for employment by the board within twelve months of termination of service as a member of the board. No person shall be employed by the board who is related within the third degree by blood or by marriage to any member of the board.

Organizational Ethics

Policy: It is the policy of Adair County SB40 to maintain an Organizational Ethics Policy to guide the business practices and programming conduct of the organization.

Procedure:

1. Administration shall develop an Organizational Ethics Policy for review and approval of the Board.
2 Upon board approval, the Organizational Ethics Policy shall be communicated to all staff, persons served, and other stakeholders through existing communication channels.
3. The Organizational Ethics Policy shall be reviewed annually by the administration and the Board for approval.
4. The Organizational Ethics Policy will address professional responsibilities, personal behavior, business practices, marketing practices, programming practices, conflicts of interest, and human resources.
5. Adair County SB40 has a “no reprisal” policy for personnel reporting waste, fraud, abuse, and questionable activities and practices.

Organizational Ethics Policy

This policy shall apply to Board members of Adair County SB40 Developmental Disability Board ("the Agency").

1.0 Compliance

1.1 Maintain a high standard of personal and professional conduct in capacity or identity as a Board member of the Agency.

1.2 Act in compliance with and abide by the code of ethics and the compliance plan during the entire term as a Board member.

1.3 Report first-hand knowledge of unethical activity to the Board Chairperson or Vice-Chairperson for investigation and appropriate action.

2.0 Responsibility to Organization

2.1 Work to achieve the organization's mission, vision and values.

2.2 Support the integrity and reputation of the organization and represent the organization in a positive manner.

2.2.1 Respond responsibly to criticism from those outside the organization.

2.2.2 Fully support and promote the Board approved the Agency's Strategic Plan.

2.3 Work to accomplish the organization's goals and outcomes.

2.3.1 Accessibility: Immediacy of Service

2.3.2 Effectiveness: Services provide for positive persons served outcomes.

2.3.3 Efficiency: Services are cost-effective and competitive.

2.3.4 Satisfaction: Services meet needs & expectations.

2.3.5 Quality: Services promote wellness.

2.4 Respect organizational policies and Board decisions.

2.5 Be prepared for and faithfully attend all meetings and trainings as assigned and enrolled.

2.5.1 Attend all meetings for which per diem is received or registration fees are paid by the organization.

2.5.2 Be prepared to report to full Board on information obtained from conferences and meetings attended on behalf of the Board.

3.0 Persons served

3.1 Primary responsibility is to the community and person served.

3.2 Foster every effort to support the community and self-determination of the person served, including person-centered planning through policy and annual budget.

4.0 Confidentiality

4.1 Maintain the highest level of confidentiality by not disclosing any information identifying consumers to others, unless the disclosure is required by a court order.

4.2 Respect Board decisions as final and binding on the organization, including all Board members and staff. Actively participate in Board decision-making process. Once a decision is made, accept and support the Board decision.

5.0 Discrimination

5.1 Avoid discrimination against anyone on the basis of race, color, sex, gender, age, height, weight, national origin, LGBTQ status, religion, handicap, disability, marital status, financial status, or political affiliation.

6.0 Competency

6.1 Board members shall accurately represent their education, training, experience and competencies as they relate to the business of the Board.

6.2 Advise on problems within the boundaries and scope of any recognized competency.

6.3 Take responsibility for enhancing professional knowledge, skills and abilities, and actively improve Board member competency through documented development plan.

7.0 Conflict of Interest

7.1 Comply with Missouri Department of Mental Health, Division of Developmental Disability guidelines and agency policies and procedures regarding conflict of interest.

7.2 Avoid and abstain from activities or decisions that constitute a conflict of interest or the appearance of a conflict of interest.

7.2.1 All Board members shall sign an annual Declaration of Conflict of Interest.

7.2.2 An updated Declaration of Conflict of Interest shall be completed when a new Conflict of Interest arises.

7.3 Avoid using Board member relationship with the organization to further personal or professional interests.

7.4 Avoid relationships with the Executive Director, staff, and persons served that could impair professional judgment or exploit their trust and vulnerability.

8.0 Colleagues

8.1 Treat all Board members, Executive Director, and community partners with respect, fairness, courtesy, and good faith.

8.2 Avoid engagement in any form of harassment or discrimination, including sexual harassment.

9.0 Removal of Board Member

A Board member may be removed from office by the appointing board of commissioners for neglect of official duty or misconduct in office after being given a written statement of reasons and an opportunity to be heard on the removal.

Rights of the Public

POLICY
This policy shall apply to all Adair County SB40 services operated by or under contract with it.

1.0 Policy

All Adair County SB40Board/Committee Meetings are required to be open to the public unless a closed meeting is held.

1.1 All persons shall be permitted to attend any meeting except as discussed subsequently.
1.2 The right of a person to attend a meeting includes the right to audio record, video record, broadcast live on radio and television.
1.3 A person cannot be required, as a condition of attendance at a meeting, to register or otherwise provide his/her name or other information.
1.4 A person shall be permitted to address a meeting of Adair County SB40 Board providing the individual wishing to address the meeting identifies him/herself.
1.5 Public comments shall be limited to three (3) minutes per speaker.
1.6 Public comment shall be allowed only where so designated on the agenda.

2.0 Order of Business

Notice of all meetings shall be posted as prescribed by RSMo 610.020 and include a written agenda.

3.0 Closed Meeting

Upon a two-thirds roll call vote of Adair County SB40 Board members appointed and serving, Adair County SB40Board may meet in closed session utilizing a written agenda for any of the following reasons:

3.1 To consider the purchase or lease of real property up to the time an option to purchase or lease that real property is obtained. [not the sale of real estate owned by the Agency]

3.2 To consult with its attorneys regarding trial or settlement strategy in connection with specific pending litigation, but only if an open meeting would have a detrimental financial effect on the litigating or settlement position of the public body.

3.3 To review and consider the contents of an application for employment or appointment to a public office if the candidate requests that the application remain confidential. All interviews of a public body for employment or appointment to a public office shall be held in an open meeting pursuant to this Act except as otherwise provided in this subdivision.

3.4 To consider material exempt from discussion or disclosure by State or Federal statute. To hold a closed session for consideration of a written legal opinion within the attorney-client privilege. A closed session may not be held for consideration of an oral opinion.

3.5 Closed sessions may also be held by the Board for the following reasons without a two-thirds roll call vote:

3.5.1 To consider the dismissal, suspension, or disciplining of, or to hear complaints or charges brought against or to consider a periodic personnel evaluation of, a public officer, employee, staff member, or individual agent, if the named person requests a closed hearing. The named person requesting a closed hearing may rescind the request at any time, in which case the matter at issue shall be considered thereafter only in open sessions.

4.0 Disorderly Conduct

The chairperson shall call to order any person who is being disorderly by speaking or otherwise disrupting the proceedings, by failing to be germane, by speaking longer than the allotted time, or by speaking vulgarities.

4.1 Such person shall thereupon be seated until the chairperson shall have determined whether the person is in order.

4.2 If the person continues to be disorderly and to disrupt the meeting, the chairperson may ask the person to leave the meeting.

4.3 No person shall be requested to leave an open meeting except for an actual breach of the peace committed at the meeting.

4.4 The chairperson shall have the right to immediately declare a recess of the meeting for such time as may be, in the chairperson's discretion, necessary to deal with disruptive or disorderly behavior.

By-Laws

The Adair County Board of Directors shall conduct, at minimum, an annual review of the organizational by-laws in consultation with, as appropriate, the Executive Director. Documentation of the completion of the review will be reflected in the meeting minutes.

Board of Governance Policies

POLICY
This policy shall apply to all Adair County SB40 services operated by or under contract with it.

1.0 Board Leadership

The Adair County SB40 Board of Directors (Board) serves as the body representing the citizens of Adair County. Community representation is carried out in a manner that is intended to provide leadership of the organization that reflects person served and community-based values rather than popular opinion or special interest.

The fundamental purpose of the Board is to establish the vision, mission, values, and policies of the organization. The Board provides ultimate leadership to the organization by establishing the vision, mission, values, and policies.

The Board speaks as one voice through a deliberative decision-making process set forth in the by-laws and governance policies. No individual board member may act to influence or affect the Executive Director and Agency employees in any way that does not agree with the board's by-laws, policies, and decisions.

1.1 Board Responsibility Relative to Providing Leadership

The Board is responsible for their own self-governance. This responsibility includes the development of by-laws and a governing policy that details the responsibilities of the Board and the responsibilities and relationship with the Executive Director.

The Board is intended to hold the Executive Director accountable for the immediate leadership relative to the implementation of the Board-approved direction. This is accomplished through the development of a relationship with the Executive Director articulated through expectations established in the Board governance policy.

1.2 Board Responsibilities Relative to Organization Direction

As the formulators of the organization's direction, the Board is responsible for developing the vision, mission, and values.

1.2.1 Vision
The organization's vision statement is intended to provide the organization with long-term strategic direction. The vision is likened to a statement of where the organization plans to go and the organization's future mission statement. The organization's vision is as follows:

Our VISION is to see people's ABILITIES and
change the world so that everyone can live their best life.

1.2.2 Mission

The organization's mission statement, in comparison to the vision, speaks more directly to the immediate purpose of the organization. The mission is intended to

promote a strategic course consistent with the intent of the organization's vision. The organization's mission statement is as follows:

The MISSION of the Adair County SB40 is to engage in ADVOCACY, promote INCLUSION, and provide essential RESOURCES to assist people with developmental disabilities to live self-determined lives.

1.2.3 Values

The organization's value statements are intended to provide the parameters for the operation and practices of the organization. The values provide the ultimate boundaries for all organizational decisions and are intended to promote the operating practices consistent with the intent of the organization's mission. The organization's value statements are as follows:

What We Value:

- **SELF-DETERMINATION – Having opportunities, respectful support, and the authority to exert control in one's own life with decisions that are honored and the opportunity to succeed or learn from failure**
- **COMMUNITY – The importance of community in the lives of people with developmental disabilities and the importance of people with developmental disabilities in the life of the community with emphasis on collaboration and belonging.**
- **EQUALITY – Believing all people are of equal value and ensuring they are treated with equal dignity.**
- **EQUITY – Believing that no one should have poorer life chances because of their race, color, religion, sex, national origin, age, disability, or genetic information, ensuring systemic barriers are removed, and helping people meet their unique needs to make the most of their lives and talents.**
- **EXCELLENCE – Believing the organization must go *beyond compliance* in delivery of services to meet current needs and anticipate future needs of the people we support.**

Key Focus Areas:

- Through trauma informed approaches, implement quality, effective Person-Centered Planning using proven life planning tools & *in-person* assessments supported by learning programs which improve life skills and social relationships.
- Promote Competitive and Integrated Employment; implementing initiatives throughout the transition to adulthood years resulting in students who are workforce ready upon graduation from High School and supports adults in their pursuit of jobs of their choice.
- Foster development of support networks for Advocacy/Self-Advocacy; small groups, education & information for people with IDD and their support(s).
- Advocate for *equity* in education, healthcare, employment, transportation, housing and other areas of home & community living.
- Ongoing promotion of *authentic* inclusion of people with IDD as valued members of our community.

1.2.4 Policies

The Board is responsible for reviewing and acting on all organizational policies. This responsibility includes evaluating any deletions, additions, new, and/or modified policy proposals presented by the Executive Director in terms of their adherence to, consistency with, and relevance to promoting the vision, mission, and values of the organization.

2.0 Board-Executive Director Relationship

The Executive Director serves as the only employee of the Board. The Executive Director role as sole employee of the Board is to provide ethical and sound leadership within the organization, community, and state consistent with the directives, values, and policies developed by the Board.

The Executive Director recognizes the single voice of the Board. The Executive Director acts on the Board voice with the same integrity and intensity of effort regardless if an issue or item received a unanimous or single vote victory.

The Executive Director may not transgress into the scope of those responsibilities that are defined as the responsibilities of the Board.

The Executive Director is responsible for the administrative management of the organization's financial, human, technical, and physical resources.

2.1 Executive Director Responsibilities Relative To Organization Direction

As the implementer of the organization's direction and as the only employee of the Board, the Executive Director is ultimately held accountable and responsible for assuring that the vision, mission, and values are implemented in a manner consistent with the intent and scope established by the Board. In this role, the Executive Director is also responsible for assuring the development of all organizational policy proposals for presentation to the Board.

.

2.1.1 Vision

The Executive Director is responsible for keeping the Board informed of federal and state policy directions that may serve to influence the Board's ongoing evaluation of and decisions regarding the organization's vision statement. It is expected that the Executive Director will fulfill this obligation by adhering to the principles of honesty, completeness, accuracy, objectivity, critical relevancy, and integrity in keeping Agency's Board informed and providing the Board with any analysis of information.

2.1.2 Mission

The Executive Director is responsible for ensuring the implementation of the organization in a manner consistent with the intent and scope of the organization's mission statement. It is expected that the Executive Director will fulfill this obligation through a process of operationalizing the organizational values and ongoing reporting to the Board on the status of said values. The aggregate reporting of status of the organizational values serves as the method for the Board to evaluate implementation adherence and accomplishments relative to the organization's mission.

2.1.3 Values

The Executive Director is responsible for developing conceptual definitions for the organizational values and presenting said conceptualizations to the Board for their review and action. This process assures the most complete and best possible understanding of meaning of the organizational values. This also ensures that the steps necessary to operationalize the organizational values are complete.

Operationalization speaks to the implementation and the measurement of the organizational values.

The Executive Director is responsible for delivering a monthly report to the Board that provides detail regarding the status, accomplishments, and achievements relative to each of the organizational values. The substance of the report should include quantitative and qualitative information and analysis and reaction to said information that adheres to the principles of honesty, completeness, accuracy, objectivity, relevancy, and integrity.

In demonstrating a commitment to the organizational values, the Executive Director is responsible for conducting the practices of the organization in a manner that promotes the total wellness of persons served, provides for immediate access to services, maintains cost-effective and quality services, achieves person served and agency outcomes, and meets the needs of the community.

2.1.4 Policies
The Executive Director is responsible for developing and presenting draft board governance, finance, recipient rights, programming, and human resources policies for review and action by the Board. In developing proposed policies, the Executive Director is responsible for the following:

1. An assurance of need for the proposed policy.
2. An assurance that the proposed policy is not contradictory to any of the organization's values.
3. An assurance that the policy will serve to promote an organizational value or values; and
4. An assurance that the policy is legal.

2.1.5 Procedures

1) The Executive Director is responsible for implementing policies approved by the Board. It is expected that the Executive Director will faithfully and with honor fulfill the obligation of implementing and abiding with all Board approved policies.
2) Implementation is defined as the development of a corresponding set of standard operating procedures, practices, guidelines, and/or instructions that will comprehensively and accurately assure the instructive detail necessary to implement the policy. The Executive Director is solely responsible to issue a directive to the organizational members to implement the standard operating procedures, practices, guidelines, and/or instructions that correspond to an approved Board policy.

3.0 Organizational Evaluation

The Board is responsible for assuring that the Executive Director implements the vision, mission, values, and polices. This is to be accomplished through the development and use of valid, reliable evaluation and monitoring instruments. The ultimate evaluation of the organization involves an appraisal of the organizations' performance and outcomes compared to its identified vision, mission, values, and policies. The evaluation is intended to be reflective of the community who entrusts leadership to the Board and the individuals who are affected by the actions.

Selection of Executive Director

Policy: The Board of Directors assume primary responsibility for the recruitment and selection of the Executive Director, as well as establishing the duties and responsibilities of the position.

Procedure:

1. The Board of Directors shall write the position description for the position and be responsible for the annual evaluation of performance.
2. The Board of Directors shall recruit, interview, and select the Executive Director in accordance with agency and Board policies including EEO and Affirmative Action.
    a. When the Executive Director's position is vacant, the Board President shall appoint a Search Committee within 14 working days of the occurrence of the vacancy. Members shall be appointed from among the Board and Agency staff, if deemed appropriate.
    b. Recommendation of the candidate will be made to the Board of Directors as soon as a qualified candidate is identified. The qualifications of the Executive Director are contained in the Executive Director's job description.
    c. In the interim, the Board President may appoint an "Acting Director" from among the professional management staff of the organization.
3. The Executive Director's compensation will be determined by the Board of Directors based upon recommendations of the Search Committee. The Executive compensation should be reflective of market trends in order to attract and retain an Executive Director that can meet the functional demands of executive work and guide the organization.
4. The Board shall conduct the annual performance evaluation of the Executive Director using the position description and established performance indicators and competency requirements as benchmarks for this review.

Executive Compensation

The full Board retains authority for approving all executive compensation actions. The compensation and changes to the compensation will be based upon the recommendations of the Talent/Leadership Committee Chair who is tasked with conducting the annual evaluation of the Executive Director. The Chair will consider an analysis of functionally comparable positions, market comparator data, available salary surveys and/or salary consultants.

Succession Planning

Succession Planning is critical to assuring continuity of leadership due to planned or unplanned departure of the Executive Director and to affirm the principles of developing potential internal candidates for promotion at all levels of the organization.

It is the intention of the Agency to develop and promote internal candidates to supervisory and administrative positions whenever possible. This is necessary to encourage recruitment and retention of staff. Considerations shall be given based on skills, abilities, best fit for the position and demonstration of organizational values. The organization shall have in place a professional development plan for all staff to assist in this endeavor of developing depth of leadership potential within the organization. The Executive Director shall annually report on the status of succession development.

<u>Appointment of Interim Executive Director</u>
In the event of the premature departure or extended absence (30 days) of the Executive Director ("ED"), the Board shall appoint an interim ED for a specific period of time documented in a letter to the interim ED.

The interim ED shall be a current internal agency administrator.

1. A list of potential internal interim ED candidates shall be provided to the Board annually.
2. The interim ED may or may not be a candidate for the permanent ED position and the appointment to interim ED shall not implicitly or explicitly imply a permanent appointment.
3. A temporary salary adjustment shall be made, in the amount of 20% above that administrator's current base pay, while the administrator is serving in the role of the Interim ED.
4. The interim ED shall retain responsibility for their current position and job duties as well as the responsibility of interim ED.
5. During their tenure as interim ED the interim ED may not hire, terminate, contract with, or promote any internal or external person without formal approval of the Board.

No Reprisal

Adair County SB40 requires Directors and employees to observe high standards of business and personal ethics in the conduct of their duties and responsibilities. As employees and representatives of Adair County SB40, we must practice honesty and integrity in fulfilling our responsibilities and comply with all applicable laws and regulations.

Reporting Responsibility

This No Reprisal Policy is intended to encourage and enable employees and others to raise serious concerns internally so that Adair County SB40 can address and correct inappropriate conduct and actions. It is the responsibility of all board members, officers, employees and volunteers to report concerns about violations of Adair County SB40 Compliance Policy or suspected violations of law or regulations that govern Adair County SB40's operations.

No Retaliation

It is contrary to the values of Adair County SB40 for anyone to retaliate against any board member, officer, employee or volunteer who in good faith reports an ethics violation, or a suspected violation of law, such as a complaint of discrimination, or suspected fraud, or suspected violation of any regulation governing the operations of Adair County SB40. An employee who retaliates against someone who has reported a violation in good faith is subject to discipline up to and including termination of employment.

Reporting Procedure

Adair County SB40 suggests that employees share their questions, concerns, suggestions or complaints with their supervisor. If you are not comfortable speaking with your supervisor or you are not satisfied with your supervisor's response, you are encouraged to speak with the Executive Director or HR Coordinator. Supervisors and managers are required to report complaints or concerns about suspected ethical and legal violations in writing to Adair County SB40's Executive Director, who has the responsibility to investigate all reported complaints. Employees with concerns or complaints may also submit their concerns in writing directly to their supervisor or the Executive Director.

Compliance Officer

Adair County SB40's Executive Director, as the designated Compliance Officer, is responsible for ensuring that all complaints about unethical or illegal conduct are investigated and resolved. The Compliance Officer will advise Board of Directors of all complaints and their resolution and will report at least annually to the Finance Committee/Audit Committee on compliance activity relating to accounting or alleged financial improprieties.

Accounting and Auditing Matters
Adair County SB40's Compliance Officer shall immediately notify the Audit Committee/Finance Committee of any concerns or complaint regarding corporate accounting practices, internal controls or auditing and work with the committee until the matter is resolved.

Acting in Good Faith
Anyone filing a written complaint concerning a violation or suspected violation must be acting in good faith and have reasonable grounds for believing the information disclosed indicates a violation. Any allegations that prove not to be substantiated and which prove to have been made maliciously or knowingly to be false will be viewed as a serious disciplinary offense.

Confidentiality
Violations or suspected violations may be submitted on a confidential basis by the complainant. Reports of violations or suspected violations will be kept confidential to the extent possible, consistent with the need to conduct an adequate investigation.

Handling of Reported Violations
Adair County SB40's Compliance Officer will notify the person who submitted a complaint and acknowledge receipt of the reported violation or suspected violation. All reports will be investigated commencing within three business days and concluded within ten business days. Appropriate corrective action will be taken if warranted by the investigation.

Policies, Procedures and Standard Operating Practices

It is the intent of this policy for the Board to establish authority as related to the establishment and implementation of the policies, procedures, and standard operating practices of the organization.

The Board has sole authority to approve, rescind, and/or modify policies. Policy proposals, new and revised, may be developed within the organization and presented to the Board for review and disposition. Policies provide a conceptual description of the Board's intent relative to a specific issue, topic, and/or standard and serves as the framework for the Executive Director to develop operational guidelines and procedures. The policies of the organization are divided into seven major categories as identified and defined in the subsections that follow:

Governance
These policies address the role of the Board and the manner in which the Board governs itself, including the Board Bylaws, Code of Ethics, Organizational Planning, the Board's relationship with other organizations, Board member development, Corporate Compliance, Outcomes, Quality Improvement, and also establishes the relationship with the Executive Director.

Operations
These policies address the administrative support practices of the organization and includes guidelines for records management, care and maintenance of property, acquisitions and disposal of property and Emergency/Disaster planning.

Fiscal Resources
These policies address standards to ensure the fiscal integrity and viability of the organization including Method of Accounting, Audits, Schedule of Rates, Assets, Liabilities, Contracts, Purchasing, Budgets, Internal Controls, as well as Information Systems.

Funding
These policies address the requirements of individual and agency funding request, fundraising practices and grant administration.

Consumer Services
These policies address the standards of providing service coordination and support, and/or Learning Center programming to consumers of the organization. It includes Best Practices, Eligibility and Access, Delivery of Supports and Services. These policies also address the choice of the person(s) served, inclusion, confidentiality and service recipient rights.

Information Systems Management
These policies will address the security and usage of organizational computers, internet and phones, address staff training requirements and responses to a data or security breach.

Human Resources
These policies will address policies found in the Employee Handbook such as employee Health and Safety, Recruitment, Employment at Will, Termination, Supervision, Personal and Professional Conduct, Training and Education, Compensation and Benefits, Hours of Work, Drug Free/Tobacco Free Workplace, Employee Records and standards regarding all human resource practices.

The policies of the organization will be subject to continuous review. A comprehensive annual review of all of the organization's policies shall be conducted and documented by the Board.

Adair County SB40 reserves the right to amend, modify or delete any of its Policies from time to time as it determines necessary or desirable, at its sole discretion.

The Executive Director is responsible for implementation of the Board's approval of a new or revised policy within 30 calendar days or unless otherwise specified by the Board.

The development of procedures is intended to provide operating guidelines necessary to implement Board approved policies. All procedures developed are to be consistent with both the letter and intent of the corresponding policy. The Executive Director is solely responsible for ensuring the development, continuous review, and modifications of all existing procedures.

Staff are responsible to maintain awareness and perform application of all organizational policies and procedures.

If any portion of any policy or procedure, or the application thereof to any person or circumstance is found to be invalid by legislation or case law, such invalidity shall not affect the remaining portions or application of the policies and procedures which can be given effect without the invalid portion or application, provided such remaining portions are not determined to be inoperable; and to this end, such policies and procedures are declared to be severable.

The Executive Director may temporarily waive any policy at his/her discretion, to maintain congruence with the organizational values and the policy direction and intent of the Board of Directors. Such action shall be reported at the next scheduled full Board meeting.

Emergent Business

This policy shall apply to Adair County SB40, Executive Director.

It is the intent of this policy to ensure that the daily operations of agency business continue in an uninterrupted manner and that the Executive Director has the authority to make urgent decisions affecting the ongoing operations and vitality of the organization when they emerge between regularly scheduled Board Meetings.

1. The Adair County SB40 Board of Directors empowers its Executive Director with the authority to act on its behalf in situations that require urgent or immediate action without pre-approval of the Board.

2. These actions shall be consistent with applicable Board policies and the organization's annual budget and in full compliance with all applicable regulatory standards.

3. The Executive Director shall notify the Chairperson of the Board as soon as possible to report the nature of the urgent business.

4. The Executive Director shall, within seven business days, prepare and disseminate a report to the full Board describing the nature of the emergent business, the consequences had the decision been delayed, the decision made, and supporting rationale.

Quality Improvement
Quality Improvement is a philosophy involving the ongoing process of monitoring, evaluating, and improving the quality, efficacy, and efficiency of organizational systems, processes, services, and outcomes; the accessibility of services; and the satisfaction of persons served and stakeholders. The scope of quality improvement encompasses all services and supports provided by Adair County SB40 either directly or by contract.

A continuous improvement plan (Quality Improvement Plan) will be developed and implemented in a manner consistent with the intent of this policy; in accordance with the Vision, Mission, and Values of the organization; and in keeping with the standards of the Missouri DMH/Division of Developmental Disabilities quality improvement initiatives.

Specific, measurable performance outcomes will be identified and developed in a manner consistent with the intent of this policy and in keeping with the agency Mission, Vision, Values, and strategic plan.

The authority for Quality Improvement Plan is vested by the Board in the Executive Director. The Executive Director will appoint members of Targeted Case Management and other staff to the QI Team. The Executive Director will submit the Quality Improvement Plan to the Board annually for review and approval. The Board will receive periodic reporting as to the progress of quality improvement efforts and process improvements throughout the fiscal year. Annually, the organization, with the input of staff, persons served, and providers, will evaluate the effectiveness of the quality improvement structure and processes and make recommendations to the Executive Director for revisions to the Quality Improvement plan and Agency Performance Outcomes.

Corporate Compliance Program
It is the intent of Adair County SB40 to comply with all applicable federal and state laws and regulations, affiliation policies and regulations, Federal and State contractual requirements and applicable accreditation standards. To ensure compliance, the Agency will enforce the Compliance Investigation, Reporting, Documentation & Resolution policy. It is the intent of the Board to implement the Corporate Compliance Program for the purpose of assuring ongoing compliance, reporting of potential violations, investigating reported compliance issues, resolving confirmed violations and addressing any areas of concern, as appropriate.

Authority is vested by the Board of Director in the Executive Director for overall implementation and oversight of compliance. The Executive Director is designated as the Compliance Officer. The Executive Director is responsible to review and evaluate compliance with the Board of Directors on an annual basis.

Compliance Investigation, Reporting, Documentation & Resolution

1.0 Intent
It is the intent of Adair County SB40 to establish and maintain mechanisms for the investigation, reporting, resolution, and documentation of suspected violations or potential misconduct with assurances for confidentiality and non-retaliation. It is the intent of Adair County SB40 to also ensure that all Board Members, employees, and contractors fulfill the requirements of the Deficit Reduction Act.

2.0 Deficit Reduction Act & Compliance
a. Adair County SB40 shall have internal processes to monitor for actions by providers to prevent fraud, abuse, and waste, and to identify actions likely to result in unintended expenditures.
b. Adair County SB40 Board members, employees and contractual providers will receive training or education on federal and state False Claims Acts and Whistleblower Provisions.
c. Adair County SB40 Board members, employees and contractual providers are required to report any suspected occurrences of fraud, abuse and waste. The designated Adair County SB40 Compliance Officer will investigate the allegations and will assure that appropriate reporting occurs.
d. Adair County SB40 Compliance Officer will inform the Board of Directors if incidents occur which require reporting to state or federal agencies or place Adair County SB40 in jeopardy.

3.0 HIPAA/HITECH Act Reporting, Investigation and Documentation
a. Adair County SB40 will comply with the Health Insurance Portability Accountability Act of 1996 (HIPAA), the Health Information
b. Technology for Economic and Clinical Health Act (HITECH Act), Subtitle D— Privacy, the Department of Health and Human Services (DHHS) security and privacy regulations, and Commission on Accreditation for Rehabilitation Facilities (CARF) accreditation standards, as well as our duty to protect the confidentiality and integrity of confidential medical information as required by law, professional ethics, and accreditation requirements. The following procedure will assist Adair County SB40 in fulfilling its obligation under DHHS privacy regulations to mitigate damages caused by breach of individual privacy.
c. **Reporting breaches:** The purpose of reporting health information breaches, and suspected breaches, is as follows:
    a. Minimize the frequency and severity of incidents.
    b. Provide for early assessment and investigation before crucial evidence is gone.
    c. Quickly take remedial actions to stop breaches, correct problems, and mitigate damages.

d. Implement measures to prevent recurrence of incidents.
    1. Facilitate effective disciplinary actions against offenders.
    2. Properly make required notifications.

d. **Duty to Report:** All employees, providers, contractors, persons served, interns, temporary staff of Adair County SB40 have a duty to report breaches and should feel free to report breaches without fear of retaliation.
e. **Protection for those who Report:** Adair County SB40 will not take any adverse personnel or other action against a person who reports actual or suspected breach of security, confidentiality or policies and procedures protecting the security and confidentiality of health information so long as the report is made in good faith.
    a. What are the risks to the subject(s) of the breach?
    b. What was the motive for the breach if not accidental?
    c. Does the potential for further harm exist?
    d. What can Adair County SB40 do to limit or eliminate further damage?
    e. What steps can Adair County SB40 do to prevent this type of breach in the future?
f. **HITECH Act:** If the breach qualifies as a breach under the HITECH Act definition of breach in Subtitle D – Privacy, Part I, § 13400, the data is unsecured, and the breach poses a significant risk to the affected individuals, Adair County SB40 must, without unreasonable delay and in no case later than 60 days after the discovery of the breach, notify the individual(s) whose protected health information (PHI) was involved in the breach.
g. **Documentation:** The report and recommendations will be discussed with appropriate personnel and appropriate action to prevent recurrence of the breach, mitigate any harm caused by the breach, and necessary disciplinary action(s) will occur.
    a. Provide copies of the report with an endorsement as to any corrective action taken, including suspensions of access, and recommendations for future action to all the following people and departments, as necessary and appropriate:
    b. Executive Director
    c. HR Director
    d. Directors, Managers and Supervisors
h. All reports will be kept for not less than 6 years from the date of the report.
i. No such report will be made a part of a patient's medical record. The report is a risk management tool.

Resolution

j. A breach notification must be provided without unreasonable delay, and in no case later than 60 days after the discovery of a breach. **The notice must include:**
    a. Description of the types of unsecured PHI that were involved in the breach (i.e. Name, SSN, Patient ID, insurance number, date of birth, home address, disability code, etc.)
    b. Brief description of what Adair County SB40 is doing to investigate the breach to mitigate losses, and to protect against further breaches.
    c. Contact information for individuals to ask questions or learn additional information, which will include a toll-free telephone number, an email address, and/or postal address. The HHIPAA Security Officer or HIPAA Privacy Officer shall respond to all such contacts.
    d. The notification, unless the contact information is insufficient or out-of-date, shall be sent by first class, certified mail to the individual, guardian, legal representative or next-of kin of the individual or, if specified as a preference the individual, by email.
    e. If the contact information is insufficient or out-of-date, Adair County SB40 will use a substitute form of notice, such as, if the breach involves 10 or more individuals for which there is insufficient or out-of-date information, a conspicuous posting on the home page

website or notice in major print or broadcast media in geographic areas in which the individuals affected by the breach likely reside as determined by the HIPAA Security Officer in conjunction with legal and risk management administration. Such notice will include a toll-free number where the individual can learn whether the individual's unsecured PHI was possibility involved in the breach

f. If the HIPAA Security or Privacy Officers, in consultation with the Executive Director or designee determines that the breach requires urgency because of the possible imminent release of unsecured PHI, immediate notification may also be made by telephone or other appropriate means.

k. If the breach involves 500 or more individuals' unsecured PHI, Adair County SB40 will provide notice, as required by HIPAA and the HITECH Act, to prominent media outlets in the state or jurisdiction of the individuals and immediately to DHHS.
    a. The HIPAA Security Officer must report breaches of fewer
        i. than 500 individuals to DHHS not later than 60 days from the end of the calendar year in the form of a log.
    b. Notifications may be delayed if law enforcement represents
        i. that the notification will impede a criminal investigation or damage
        ii. national security.

4.0 Reporting Other Compliance Violations

a. Employees, providers, contractors, persons served, and other individuals are to report suspected violations or potential misconduct to the Executive Director, or in situations involving the Executive Director, to the Compliance Officer by phone/voicemail, email, in person, in writing, or to one of the Board of Directors. A posting shall be placed at all Adair County SB40 offices with the applicable contact information of all Board of Directors Officers. A standard form shall be made available for individuals wanting to utilize a specific form to file a report in writing.
b. Reports made to the Board of Directors Officers will be forwarded for investigation and follow up to the Executive Director, or in situations involving the Executive Director to the organization's Compliance Officer in which the potential/suspected violation was to have occurred.
c. Staff are expected to cooperate in the investigation of an alleged violation of the Compliance Plan or related policies.
d. FRAUD AND ABUSE:
    a. Adair County SB40 employees, contractual providers and the provider network will report all suspected fraud and abuse to the Compliance Officer. The report will include the nature of the complaint and the name of the individuals or entity involved in the suspected fraud and abuse, including address, phone number and Medicaid identification number if applicable.
    b. The Compliance Officer will be immediately informed of any suspicion of Medicaid Fraud and Abuse prior to attempting to investigate or resolve the alleged fraud and/or abuse.
    c. The Compliance Officer will report suspected fraud and abuse to the Missouri Department of Mental Health Division of Developmental Disabilities.

e. Confidentiality:
    a. Individuals making a report are encouraged to disclose their identity, recognizing that anonymity may hamper complete and timely investigation. However, no anonymous report shall be refused or treated less seriously because the complainant/reporter wishes to remain anonymous.
    b. No promises will be made to any individuals making a report or witnesses providing supporting information about the report by the EXECUTIVE DIRECTOR, the Compliance Officer, or anyone else in regard to his/her culpability or what steps may be taken by Adair County SB40 in response to the report.

c. Confidentiality and anonymity of the individual making the report and the content of the report will be preserved to the extent permitted by law and by the circumstances. Information about reports, investigations, or follow-up actions shall not be disclosed to anyone other than those individuals charged with responsibility in investigation and investigative findings as well as legal counsel.

5.0 Non-Retaliation

a. No employee, provider, contractor, person served, or other individual making such a report in good faith shall be retaliated against by Adair County SB40 employees or agents and will be protected by the Whistleblower's Protection Act.
b. Discipline for engaging in acts that violate applicable laws and regulations, making knowingly false reports, failure to report known violations, or discipline for any other performance-related reason unconnected to reporting potential violations is not retaliation.

6.0 Investigation

a. Within five business days of receiving a report, the Compliance Officer shall provide a written acknowledgement of receipt (sample attached) to the individual making the report (if known) and conduct an initial assessment to determine whether the report has merit and warrants further investigation.
b. If it is determined that the matter does not constitute a violation of any applicable laws or regulations and warrants no further action, the issue will be closed following the appropriate documentation and reporting by the Compliance Officer.
c. If it is determined that the matter does not constitute a violation of any applicable laws or regulations but does identify an area for improvement or raises concern for potential future violations, the matter will be referred to the Quality Improvement Director for appropriate assignment and follow-up action.
d. If it is determined that the matter requires further investigation, the Compliance Officer shall take the necessary steps to assure that documents or other evidence are not altered or destroyed through the following possible means:
    a. Suspending normal record/documentation destruction procedures.
    b. Taking control of the files of individuals suspected of wrongdoing.
    c. Limited access of files, computers, and other sources of documents by individuals suspected of wrongdoing; and/or
    d. Placing individuals under investigation on temporary suspension.
e. If the Compliance Officer concludes that reporting to a governmental agency (DMH, CMS, MMAC, County Commissioners) or a third party, may be appropriate, the Executive Director shall be informed immediately. Upon recommendation by legal counsel and with notice to the Board, the Executive Director shall make such report to the appropriate government agency within 30 days after the determination that a violation has occurred.
    a. Documentation retention and destruction must take place in accordance with the established Adair County SB40 Record Retention procedures. Adair County SB40 must retain all potentially responsive documents if it has been served with a government investigation. If Adair County SB40 is served with a subpoena or search warrant or has reason to believe a subpoena or search warrant may be served, the Executive Director is responsible for immediately directing staff to retain all documents that may be potentially responsive to the subpoena or search warrant.
f. When corporate compliance issues arise involving an investigation and potential legal consequences, the following questions should be asked:
    a. Should an internal investigation be conducted?
    b. Should legal counsel be contacted?

c. Should disclosure be made to the appropriate government agency?
d. Does the staff person need separate counsel?
e. If the Executive Director is the subject of a subpoena or search warrant the Executive Director OR Corporate Compliance Officer shall each contact the chairperson of the Board who will be responsible for the administration of this procedure.

g. A full investigation shall be completed within 90 days from the date of the initial report. An extension may be granted by the Compliance Committee.

7.0 Documentation

A record shall be maintained by the Compliance Officer or designee for all reports of potential/alleged violations utilizing the attached Compliance Investigation Report form. The record may also include copies of interview notes and documents reviewed and any other documentation as appropriate.

8.0 Resolution

Following the investigation, the Compliance Officer shall document and report the findings of the investigation to the Executive Director and Compliance Committee. In cases where actions of the Executive Director are investigated, the report of findings is made to the Board Chairperson. If appropriate, a remedial action plan shall be developed to address any confirmed violations or address areas of concerns raised during the investigation. If appropriate, disciplinary action shall be taken in accordance with the organization's disciplinary policies and procedures.

Measuring Effectiveness

By improving both performance and quality, Adair County SB40 improves quality of living, cuts costs and gets better results.

In practice, performance management often means actively using data to improve performance, including the strategic use of performance standards, measures, progress reports, and ongoing quality improvement efforts to ensure an agency achieves desired results.

1. At least once every year, Adair County SB40 will review its goals and objectives toward achieving its mission and will complete a performance and effectiveness assessment of its programs based on that review.
2. The Adair County SB40 Board of Directors will receive a written report of this assessment
    a. Describing the activities that Adair County SB40 undertook in the prior year to achieve its goals and objectives,
    b. Identifying the measures used to assess Adair County SB40's effectiveness in achieving its goals and objectives,
    c. Analyzing the effectiveness of Adair County SB40's programs in achieving Adair County SB40's goals and objectives,
    d. Recommending future actions Adair County SB40 might take to increase effectiveness based on the findings.
3. At the conclusion of this process, Adair County SB40 will revise the goals and objectives for Adair County SB40, as needed, for the upcoming term and will suggest means of measuring them. This process will be integrated with the agency's on-going strategic planning process.

Fraud and Abuse Compliance

It is the policy of Adair County SB40 (the "Agency") to consistently and fully comply with all laws and regulations pertaining to the delivery of and billing for services which apply to the Agency on account of its participation in Medicaid and other government programs.

INTRODUCTION

The Agency has developed this fraud and abuse compliance program to be a comprehensive statement of the responsibilities and obligations of all employees regarding submissions for reimbursement to Medicaid, and other government payers for services rendered by the Agency. In addition, this policy is intended to apply to business arrangements with personnel, vendors and other persons which may be impacted by federal or state laws relating to fraud and abuse.

EMPLOYEE PARTICIPATION AND REPORTING

It is the responsibility of every employee in the Agency to abide by applicable laws and regulations and support the Agency's compliance efforts.

All employees are required to report their good faith belief of any violation of the compliance program or applicable law. The Agency, at the request of the employee, will provide such anonymity to the employee(s) who report as is possible under the circumstances in the judgment of the Agency, consistent with its obligations to investigate employee concerns and take necessary corrective action. There shall be no retaliation in the terms and conditions of employment as a result of such reporting.

Employees will report their good faith belief of violations of the compliance program or applicable laws (1) either orally or in writing to their supervisor; or (2) either orally or in writing to the Agency's Executive Director or HR Coordinator OR (3) to the Chairman of the Board of Directors.

RESPONSIBLE OFFICER

The Agency has designated the Executive Director as the Compliance Officer, the individual within the Agency responsible for overall implementation and operation of the compliance program. The Compliance Officer shall be responsible for ensuring that:

1. Standards and manuals are reviewed and updated as necessary;
2. Employee and vendor screening mechanisms are in place and are operating properly;
3. Employees are receiving adequate education and training and that such education and training are documented;
4. Audit procedures are implemented in accordance with the Agency's audit policies;
5. Employee complaints and other concerns regarding compliance are promptly investigated; and
6. Adequate steps are taken to correct any identified problems and prevent the recurrence of such problems.

REPORT TO THE BOARD

The Compliance Officer will report in writing at least annually to the Agency's Board of Directors on the status of compliance within the Agency, and at other times as appropriate. This report shall include any other information requested by the Board.

Enforcement and Prevention

The purpose of this policy is to set forth the procedures that will be used by Adair County SB40 (the "Agency") to respond to reports by employees or others that a program or individuals employed by a program are engaging in activity which might violate the standards describes in the Compliance Plan and which may be contrary to applicable Medicaid laws or regulations or that such persons or business units may be submitting claims in a manner which does not meet the Medicaid program requirements, as applicable**.**

INVESTIGATION

Purpose of Investigation.

The purpose of the investigation shall be to (1) identify those situations in which the laws, rules and standards of the Medicaid program may not have been followed; (2) to identify individuals who may have knowingly or inadvertently caused claims to be submitted or processed in a manner which violated Medicaid laws, rules, or standards; (3) to facilitate the correction of any practices not in compliance with the Medicaid laws, rules and standards; (4) to implement those procedures necessary to ensure future compliance; (5) to protect the Agency in the event of civil or criminal enforcement actions, and (6) to preserve and protect the Agency's assets.

Control of Investigations.

All reports received by agency management shall be forwarded to the Agency's Compliance Officer. The Agency's Compliance Officer will be responsible for directing the investigation of the alleged problem or incident. In undertaking this investigation, the Agency's Compliance Officer may, with the permission of the Executive Committee, solicit the support of external legal counsel, consultants and auditors, and internal and external resources with knowledge of the applicable laws and regulations and required policies, procedures or standards that relate to the specific problem in question. These persons shall function under the direction of legal counsel and shall be required to submit relevant evidence, notes, findings and conclusions to legal counsel.

Investigative Process.

Upon receipt of an employee complaint or other information (including audit results) which suggests the existence of a pattern of conduct in violation of compliance policies or applicable laws or regulations, an investigation under the direction and control of legal counsel shall be commenced. Steps to be followed in undertaking the investigation shall include, at a minimum:

1. Notification to the Board Executive Committee of the nature of the complaint.
2. The investigation shall be commenced as soon as reasonably possible but in no event more than 10 days following the receipt of the complaint or report. The investigation shall include, as applicable, but need not be limited to:
    a. An interview of the complainant and other persons who may have knowledge of the alleged problem or process and a review of the applicable laws and regulations which might be relevant to or provide guidance with respect to the appropriateness or inappropriateness of the activity in question, to determine whether a problem actually exists.
        i. If the review results in conclusions or findings that the complained of conduct is permitted under applicable laws, regulations or policy or that the complained of act did not occur as alleged or that it does not otherwise appear to be a problem, the investigation shall be closed and a written report filed with the Agency's Compliance Officer.
        ii. If the initial investigation concludes that there is improper billing occurring, that practices are occurring which are contrary to applicable law, that inaccurate claims are being submitted, or that additional evidence is necessary, the investigation shall proceed to the next step.

b. The identification and review of representative bills or claims submitted to the Medicaid program to determine the nature of the problem, the scope of the problem, the frequency of the problem, the duration of the problem, and the potential financial magnitude of the problem.
c. Interviews of the person or persons in the departments who appear to play a role in the process in which the problem exists. The purpose of the interview will be to determine the facts related to the complained of activity, and may include, but shall not be limited to:
    i. Individual understanding of the Medicaid laws, rules and regulations;
    ii. The identification of persons with supervisory or managerial responsibility in the process;
    iii. The adequacy of the training of the individuals performing the functions within the process;
    iv. The extent to which any person knowingly or with reckless disregard or intentional indifference acted contrary to the Medicaid laws, rules or regulations;
    v. The nature and extent of potential civil or criminal liability of individuals or the Agency; and
    vi. Preparation of a summary report which (a) defines the nature of the problem, (b) summarizes the investigation process, (c) identifies any person whom the investigator believes to have either acted deliberately or with reckless disregard or intentional indifference toward the Medicaid laws, rules and policies, and (d) if possible, estimates the nature and extent of the resulting overpayment by the government, if any.

ORGANIZATIONAL RESPONSE

1. Possible Criminal Activity.

In the event the Agency uncovers what appears to be criminal activity on the part of any employee or program, it shall undertake the following steps:

i. In the event Medicaid is involved, Missouri Department of Mental Health, Division of Developmental Disabilities, including the Director of Kirksville Regional Center, shall be notified, as counsel for the Agency deems appropriate. The Agency, through its counsel, shall attempt to negotiate a voluntary disclosure agreement prior to the disclosure.
ii. Initiate appropriate disciplinary action against the person or persons whose conduct appears to have been intentional, willfully indifferent or undertaken with reckless disregard for the Medicaid laws. Appropriate disciplinary action shall include, at a minimum, the removal of the person from any position with oversight for or impact upon the claims submission or billing process and may include, in addition, suspension, demotion, and discharge.

2. Other Non-Compliance.

In the event the investigation reveals billing or other problems which do not appear to be the result of conduct which is intentional, willfully indifferent, or with reckless disregard for the Medicaid laws, the Agency shall nevertheless undertake the following steps:

a. Improper Payments. In the event the problem results in duplicate payments by Medicaid, or payments for services not rendered or provided other than as claimed, it shall:
    i. Correct the defective practice or procedure as quickly as possible;
    ii. Calculate and repay to the appropriate governmental entity duplicate payments or improper payments resulting from the act or omission;
    iii. Initiate such disciplinary action, if any, as may be appropriate given the facts and circumstances. Appropriate disciplinary action may include, but is not limited to, reprimand, demotion, suspension and discharge; and
    iv. Promptly undertake a program of education at the appropriate program to prevent future similar problems.

b. No Improper Payment.

In the event the problem has or does not result in an overpayment by the Medicaid program, the Agency shall:

i. Correct the defective practice or procedure as quickly as possible.
ii. Initiate such disciplinary action, if any, as may be appropriate given the facts and circumstances. Appropriate disciplinary action may include, but is not limited to, reprimand, demotion, suspension and discharge.
iii. Promptly undertake a program of education at the departmental unit to prevent future similar problems.

DISCIPLINE

Employees may be subject to discipline for failing to participate in the Agency's compliance efforts, including, but not limited to:

1. The failure of an employee to perform any obligation required of the employee relating to compliance with the program or applicable laws or regulations;
2. The failure to report suspected violations of compliance program laws or applicable laws or regulations to an appropriate person; and
3. The failure on the part of a supervisory or managerial employee to implement and maintain policies and procedures reasonably necessary to ensure compliance with the terms of the program or applicable laws and regulations.

Discipline should follow the Agency's existing employee discipline policies and procedures.

Sunshine Law

It is the policy of the Adair County SB40 Developmental Disability Board to comply with sections 610.010 to 610.030, RSMo, the Sunshine Law, as now exist or hereafter amended, and that meetings, records, votes, actions and deliberations of this body shall be open to the public unless otherwise provided by law.

The Executive Director is designated as the "Custodian of Records" for the Adair County SB40 Developmental Disability Board and is located at 314 E McPherson St, Kirksville, MO 63501. Such designation does not mean that the Custodian will necessarily have all the records in possession, but simply is an indication to whom requests for copies of records and information regarding the public governmental body shall be directed. Requests for records made to persons other than the Custodian of Records may not be considered to be requests that are made pursuant to the Missouri Sunshine Law, Chapter 610 of the State Statutes. Nonetheless, any official of the public governmental body who receives a request is directed to inform the Custodian of the request in a timely fashion, so that a response may be made to the request.

The Custodian shall respond to all requests for access to or copies of a public record within the time period provided by statute except in those circumstances authorized by statute. The fees to be charged for access to or furnishing copies of records shall be as hereinafter provided: to be determined on an as needed basis not to exceed 10 cents per page for paper, plus an hourly fee for duplicating time not to exceed the average hourly rate of pay for clerical staff of the public governmental body.

Operations

Organizational Chart
It is the policy of Adair County SB40 to maintain an up-to-date Organizational Chart listing all agency positions and illustrating the line of reporting. This Organizational Chart shall be posted at all agency locations, distributed to the Board of Directors and made available in an electronic file to all employees of the organization. The Executive Director will review and update this Organizational Chart as needed, but no less than annually.

Organizational Planning Calendar
It is the intent of the Agency Management and Board to follow an organizational planning calendar in line with the beginning of each Fiscal Year, which is July 1st through June 30th of each year. In preparation for the beginning of each Fiscal Year, the Agency will schedule the following activities:

- April – Staff Retreat – Activities to include review of and recommendations for the Strategic Plan updates of the Board.
- May – Board Retreat – The Board will review and confirm the Mission, Vision and Values of the Agency. In addition, the Strategic Plan will be updated, along with updated Goals and Objectives of the Agency for the coming Fiscal Year.
- June – Budget Review and Approval – The Financial Committee of the Board will review the proposed Budget for the coming Fiscal Year. The Committee will propose the Budget to the full Board for approval.
- August – Annual Meeting – The August monthly meeting will be scheduled as the Annual Meeting of the Agency in accordance with Agency Bylaws.

Accessibility
The Adair County SB40 Developmental Disability Board respects and intends to promote the dignity and independence of all people with disabilities.

Consistent with this commitment and in accordance with federal law, the organization shall insure full compliance with the Americans with Disabilities Act and the Americans with Disabilities Amendment Act as these acts pertain to people with disabilities and accessibility requirements including those which pertain to accessible customer service, information and communications, employment practices, transportation, and the design of all public spaces and facilities owned and operated by Adair County SB40.

Particularly, Adair County SB40 shall:

- Provide, upon request, accessible formats and communication supports, including websites and electronic communications, to individuals with disabilities in a manner that takes into account each individual's specific limitation;
- Provide accessible transportation to individuals with disabilities in a manner that takes into account each individual's specific limitation and promotes full inclusion, when transportation is included in the service or program provided by the organization to eligible individuals;
- Exercise regard to the accessibility needs of individuals when designing, purchasing or acquiring buildings, vehicles, equipment and furnishings, and when making changes or additions to existing structures and facilities;
- Ensure notification of the availability of accommodation for employment applicants with disabilities, as well as supports for staff with disabilities.
- Provide training to Board Directors and employees regarding the ADA and the ADAA as it applies to Board-owned property, Board decisions, employee supports, and the provision of services by the organization.

Community Learning Center Visitor Policy

Policy Background
The Community Learning Center is owned and operated by the Adair County SB40 Developmental Disability Board and intended primarily for use by persons with developmental disabilities, their families, friends, and support providers. However, the public at large are welcome to participate in all programs and services of the Learning Center.

The Center is open Monday through Friday and designated Saturdays with a variety of activities scheduled each week, some at the Center and some at other locations. A monthly calendar is available free of charge which explains upcoming classes and recreational/social events along with listing times and locations for the events.

The Center's goal is to provide a safe, friendly environment where people may come to have fun, make friends, and learn skills that will carry over into their own homes, communities, and employment, enabling them to lead fulfilling lives and assume valued roles.

The Center is staffed at any given time by one to three employees who are present to coordinate activities, supervise volunteers, and assist Center visitors to participate in activities as they are able. Many community members and students also volunteer at the Center to teach classes and share their skills with Center visitors.

All employees and volunteers are required to submit to a background screening through the Missouri Family Care Safety Registry (at no charge to themselves) prior to working with visitors at the Center. Anyone interested in volunteering at the Center should notify one of the Center employees of his/her interest—we LOVE volunteers!

Assistance to and Supervision of Guests
Because the Center may often have a large number of visitors at any given time, employees and volunteers are not able to provide consistent one-to-one assistance and/or supervision to visitors. Staff and volunteers may not provide any personal care assistance with actions such as feeding, toileting, or hygiene, nor are they allowed to physically restrain or direct individuals as a behavioral support.

Therefore, anyone who requires ongoing one-to-one assistance and/or supervision due to issues including but not limited to communication barriers, behaviors, or personal care needs must bring a family member, friend or support provider to the Center with him/her in order to assure his/her comfort, safety and full participation in activities. The sufficiency of, or need for, such assistance will be left purely within the discretion of the Adair County SB40 Board and staff. SB40 employees and volunteers are unable to transport individuals.

Use Agreement
Persons are allowed to utilize the Community Learning Center at the discretion of the Adair County SB40 Developmental Disabilities Board, and the Board reserves the right to refuse use of the Center for any reasons it deems sufficient.

Actions which are deemed to be sufficient grounds for exclusion (temporary or permanent) from the Center are those which interfere with the safe and efficient use of the Center or which are dangerous or offensive to the person acting or the Center staff, volunteers and/or visitors. The following are examples of such actions, but this is not meant to be an inclusive list:

- Possessing or using alcohol or illegal drugs on the premises
- Concealing a weapon of any kind on the premises
- Smoking on CLC premises or during CLC programming
- Aggressive behaviors (threatening speech, gestures and/or touching others in a threatening manner)
- Destructive behavior (intentionally breaking, damaging or stealing property of the Center)

- Foul, obscene or offensive language
- Neglect of an individual by caretaker or guardian, such as leaving an individual at the Center for long periods of time without prior approval of Center staff, leaving an individual at the Center who requires one-on-one supports, or failing to pick up an individual at the Center within twenty minutes following a call/voice message from a Center employee stating that individual needed to be picked up
- Failure of the visitor to have sufficient support provided

Appeal Procedure
Should a Center visitor feel that he/she has been unfairly excluded from the Center, he/she may request a meeting with the Executive Director of the Adair County SB40 to discuss the situation. Should the Executive Director choose to uphold the decision to exclude, a written appeal (description of incident and reason decision was unfair) may be submitted to the Adair County SB40 Board of Directors. Any decision

Meeting Room Usage Policy
Policy Purpose
The Adair County SB40 Developmental Disability Board desires to be good stewards of the taxpayer funded resources made available through the organization. All requests for use of either the Learning Center or Office Conference Rooms will be considered in light of the mission and purpose of the organization.

Adair County SB40 allows outside uses of the agency facilities when such use by the outsider does not conflict with regular or scheduled activities of the organization. Consideration for usage is based on the following priority list:

AUTHORIZED BY THE EXECUTIVE DIRECTOR (or designee)
1. Non-profit organizations holding activities for the direct or indirect benefit of persons with developmental disabilities. (No charge.)
2. One time use by individuals or families of individuals with developmental disabilities for social purposes. (No charge.)
3. Non-profit organizations.
4. Usage by staff, management or Directors of the organization.

AUTHORIZED BY THE BOARD OF DIRECTORS
1. Other individuals or families for social use only *(does not include any activities regarding sales or in which fees are charged to attendees).*
2. For profit organizations.
3. Individuals who charge fees or attempt sales.

Adair County SB40 reserves the right to decline usage requests from any individual or group.

NOTICE: Individuals or groups who wish to rent the facility must contact the Executive Director no less than seven working days prior to the planned meeting date. All proposed renters must state their purpose for the meeting.

Fees
Rental fees will be assessed at the rate of $25 for up to two hours of use. The minimum rental fee is $25. Additional time beyond two hours will be pro-rated in quarter hour increments at $3.75 per quarter hour.

Post Use Requirements
All trash and other debris associated with the meeting must be picked up and disposed of properly. Tabletops and chairs must be wiped clean prior to leaving the premises. Anyone renting the meeting room who does not follow these procedures will be assessed an additional cleanup charge of $25. Key must be returned within 24 hours after the event.

Care and Maintenance of Organization Property

Policy Purpose
Adair County SB40 has sought to provide employees with high quality equipment and technology needed to perform their duties to the best of their abilities.

Employees are therefore expected to demonstrate responsibility and respect toward property entrusted to their use and care.

Policy Rules

- Exercise proper caution and use good judgment when using Adair County SB40 property to ensure that it is not lost, stolen, damaged or wasted. Report equipment found to be functioning improperly for repair.
- Report immediately to supervisor or management any theft or destruction of property which comes to employee's attention.
- Use any keys/key fobs issued to employee only according to Adair County SB40 policy and safeguard building security at all times.
- Deliver all keys and other property to supervisor or management before ending employment.
- DO NOT REMOVE SUPPLIES OR PROPERTY FROM SB40 PREMISES WITHOUT AUTHORIZATION AND DO NOT UTILIZE SB40 PROPERTY (INCLUDING STATIONARY, POSTAGE, SUPPLIES, COPIER, FAX MACHINE, ETC.) FOR PERSONAL USE.
- Know and follow the Adair County SB40 Computer Usage Policy

Violation of the above rules may result in disciplinary action.

Record Keeping and Retention

Purpose
The human resources (HR) department retains and destroys personnel records in accordance with Adair County SB40 ('the Agency') policies on business records retention, as well as federal and state laws governing record retention. Below is an outline of the HR department's operating procedures for personnel record retention and destruction of documents when such retention periods have passed. If the Agency's retention procedure is not of sufficient duration for any state in which the company does business, this procedure will be superseded by state requirements.

The HR department maintains both employee record information and government compliance reports. Both are subject to the following retention requirements and destruction procedures.

Maintenance of Employee Records
The following employee information records are maintained in segregated personnel files:

1) Pre-employment testing results and background check information.
2) I-9 forms.
3) Benefits plan and employee medical records.

4) Health and safety records.
5) General employee personnel records.

Government compliance reports are maintained in reverse chronological sequence and filed separately from the above employee information records.

Destruction of Employee and Applicant Records

All paper personnel records and confidential employee data maintained by the HR department will be destroyed by shredding after retention dates have passed; this procedure pertains to all personnel records, not just those governed by the Fair and Accurate Credit Transactions Act (FACTA).

Employment application materials submitted by applicants who were never employed are also to be shredded. When a confidential record must be discarded or destroyed, it shall be placed in a locked documents holding bin, to be destroyed by contracted confidential shredding service. Alternatively, hardcopy confidential records may be shredded using a locked shredder on the Agency premises.

In the case of remote employees, employees are discouraged from printing out or creating hard copies of confidential records where possible. If hard copies must be printed, created or kept, they should be stored in a locked cabinet, drawer or other secure location until they are no longer needed, or until the maximum retention period has ended. Remote employees must then destroy all confidential files by shredding them in a locked shredder on the Agency premises, or otherwise rendering the documents unusable or unreadable.

Personnel records include electronic as well as paper records. The HR department will work with the IT department periodically but no less than twice annually to review and ensure that the HR department's electronic records relating to employee information and compliance reports are properly purged.

Litigation Hold

When the Agency is involved in or anticipates that it may be involved in litigation, Legal Counsel may issue a litigation hold. This means that all documents relating to the litigation matter must be kept in order to preserve any potential evidence. If we fail to do so, the Agency can be sanctioned by the court for destroying evidence. A court has broad authority to impose these sanctions, which may include anything from unfavorable procedural rulings during a trial to payment of monetary damages.

In the event that Counsel announces a litigation hold on any or all Adair County SB40 records as a result of pending or anticipated litigation, all records covered by such litigation hold MUST NOT be discarded, deleted or destroyed. Further, the IT department will suspend the automatic deletion of emails for all individuals covered by the litigation hold. Any questions about the litigation should be directed to the Counsel.

Retention of Terminated Employees' Records
Record Types and Retention Periods

Health & Benefits Records	
Health & Benefits Beneficiary Forms	Termination + 3 yrs.
Medical, Dental/Vision Plan Elections	Termination + 3 yrs.
Drug Test Results	Termination + 3 yrs.
Education Assistance Program Records	Termination + 3 yrs.
FMLA Leave Reports	Termination + 3 yrs.
USERRA Leave Records	Permanent
Toxic & Bloodborne Pathogens Records	Termination + 30 yrs.
Job Related Injuries & Illnesses Records	Termination + 5 yrs.
Reasonable Accommodation Records	Termination + 3 yrs.
Pre-Employment/Employment Documents*	
Job Description	Termination + 3 yrs.
Position Requisition	Termination + 3 yrs.
Recruitment Notice/Job Ads	Termination + 3 yrs.
Employment Application/Resume	Termination + 3 yrs.
Interview Evaluation	Termination + 3 yrs.
Assessment Results	Termination + 3 yrs.
Background Check Information	Termination + 3 yrs.
References/Verifications	Termination + 3 yrs.
New-Hire Action Form	Termination + 3 yrs.
Offer Letter	Termination + 3 yrs.
Form I-9	Termination + 3 yrs.
EEO Data Form	Termination + 3 yrs.
Employee Policy Acknowledgements	Termination + 3 yrs.

Conflict of Interest Statement	Termination + 3 yrs.
Intellectual Property Ownership/Nondisclosure	Termination + 5 yrs.
Employee Change Action Documents	Termination + 3 yrs.
Disciplinary Records	Termination + 3 yrs.
Employee Development Records	Termination + 3 yrs.
Position/Pay History Records	Termination + 3 yrs.
Employee Performance Reviews	Termination + 3 yrs.
International Assignment Documents	Termination + 3 yrs.
Relocation Agreement	Termination + 3 yrs.
Resignation Letter	Termination + 3 yrs.
Termination Action Form	Termination + 3 yrs.
COBRA Election Notice	Termination + 3 yrs.
Separation Agreement	Termination + 5 yrs.
Exit Interview Form	Termination + 3 yrs.
Unemployment Claim Records	Termination + 4 yrs.
* *Note:* If an applicant is ultimately not hired, the above records should be retained for three (3) years after the no-hire decision is made.	
Payroll/Tax	
Paychecks/stubs, W-2s, W-4s	4 yrs.
Earnings Register	4 yrs.
Employee Withholding	4 yrs.
Expense Reports	3 yrs.
Federal & State Payroll Tax Forms	4 yrs.
Federal Forms 1099	4 yrs.
Time Sheets/Cards	4 yrs.

Other Payroll Records	
Computer Loan Agreement	Termination + 5 yrs.
Direct Deposit Records	Termination + 4 yrs.
Garnishment Records	Termination + 4 yrs.
Final Payroll Deduction Checklist	Termination + 4 yrs.
HR Policies & Reports	
HR Policies	While current + 3 yrs.
State New-Hire Reports	3 yrs.
Form 5500	6 yrs.
OSHA 300/300A	Posting date + 5 yrs.
VETS-4212 Reports	5 yrs.
Adair County SB40 Ethics Hotline Reports*	3 yrs.

***Note:** If an Adair County SB40 ethics hotline report is related to an employee disciplinary matter or other type of record listed herein, then staff should follow the retention period for that particular type of record.

Security of Files

All files retained by the Adair County SB40 Developmental Disability Board shall be secured in locked areas to ensure the confidentiality of all individuals.

All areas containing files shall be kept locked at all times unless a staff person is physically present to ensure the confidentiality of the information contained in each of the files.

Employees must comply with the records management requirements set forth by HIPAA and Division Directive 1.060 from the Division of Developmental Disabilities.

Protected Health Information

It is the policy of the Adair County SB40 Developmental Disability Board to protect the privacy of individually identifiable health information in compliance with federal and state laws governing the use and disclosure of protected health information (PHI). To accomplish this, Adair County SB40 will uphold the following guidelines:

All PHI shall be created, stored, handled, transmitted, transported, shared, and disposed of in strict accordance with current Health Insurance Portability and Accountability Act (HIPAA) guidelines, as set forth by the U.S. Department of Health and Human Services.

All Adair County SB40 employees and office workers shall receive training and testing on HIPAA-compliant procedures and regulations within one week of beginning employment, and at least once annually thereafter. Once trained and having passed testing with a minimal score of 90%, all employees and office workers are required to know and follow procedures outlined in training.

All Adair County SB40 employees and office workers are required to report any possible breaches of PHI, or any security incidents involving computers, to their immediate supervisor as soon as the possible breach or incident is discovered. Intentionally choosing NOT to report a breach of PHI, whether committed by oneself or another person within the organization, may be grounds for termination.

- Prior to disclosing PHI to third parties, the Privacy Officer shall verify the proper release has been signed and that the individual requesting the information has the proper authority to do so.
- Adair County SB40 will document all information released.
- Adair County SB40 will ensure that the records of PHI are as accurate and complete as possible.
- Individuals are able to amend their PHI if they believe that information is incomplete or incorrect as allowed by law.
- All records will be retained for a minimum of 6 years in a filing system that protects confidentiality and provides reasonable protection from fire, water, etc.

Individuals have the right to request specific restrictions on the use or disclosure of PHI as requested in written form. In accordance with federal regulations, Adair County SB40 is not required to agree to restriction requests on the use or disclosure of PHI.

Case records should not be removed from the Adair County SB40 office except under extenuating circumstances such as when required due to court subpoena or when a service coordinator is approved for work from a secondary site. Care shall be taken that all PHI is fully protected while in transport or use outside of the office. Records transported outside of the office must be kept in approved sturdy locked containers where no person other than the service coordinator may access them at all times.

Service coordinators who work from home or another secondary work site on a regular basis must demonstrate that all due care is regularly exercised to protect PHI. A service coordination supervisor and either the Executive Director or Business Manager of Adair County SB40 shall visit each site on at least an annual basis to document full HIPAA compliance using PHI Checklist for Secondary Worksite (see Forms section).

Employees who access, receive, or transmit PHI via mobile devices are required to exercise all precautions as prescribed in the annual HIPAA training, including but not limited to: Using secure approved remote access process; using secure Internet connections; having and using password protection and encryption capability on all mobile devices; deleting PHI regularly from mobile devices.

Storage of PHI on mobile devices is strongly discouraged due to the risk of theft, loss, and/or access by third parties through other applications on the devices.

Adair County SB40 shall create and maintain a HIPAA compliant Notice of Privacy Practices which shall be: provided at the first meeting of an Adair County SB40 employee with an individual, guardian of individual, or parent of minor child served by the Adair County SB40; posted on the agency website; posted near the entrance to each agency facility where PHI is used or stored; provided at the request of any individual, guardian of an individual, or parent of a minor child served by Adair County SB40; offered at least once yearly to every individual, guardian of an individual, or parent of a minor child served by Adair County SB40.

A signed proof of receipt or proof of refusal for the Notice of Privacy Practices should be obtained no less often than annually, and filed in the case record of each individual served by Adair County SB40. This signed receipt may be included in the annual ISP.

All assurances and statements found in the HIPAA compliant Notice of Privacy Practices shall be upheld by Adair County SB40 and its employees and office workers.

All organizations and businesses which meet the HIPAA definition of “business associate” shall be responsible to comply with all applicable rules of HIPAA and shall sign a contract annually with the ACSDDB to guarantee compliance.

Emergency & Disaster Preparedness

It is the policy of Adair County SB40 to maintain an up-to-date Emergency & Disaster Plan Book detailing emergency response of the agency and its staff with regard to a variety of types of emergencies and/or disasters. This Plan Book shall be distributed to all staff annually, attached to the Policy & Procedure Handbooks (Attachment C) as well as made available in an electronic file to all employees of the organization. The Executive Director will review and update the Emergency & Disaster Plan Book as needed, but no less than annually.

The Plan Book will include the details for executing emergency drills on both scheduled and unscheduled basis no less than monthly. Emergency drills conducted will be documented by the HR Coordinator.

Incident Reporting

POLICY:
All situations which occur and meet the requirement of a major incident, are to be documented in the form of an Incident Report. At any time, however, that staff is aware of risks or have concerns regarding safety concerns for staff and/or clients, staff are expected to inform their supervisor to allow appropriate review and examination of the concern.

Major Incident Criteria
Adair County SB40 Targeted Case Management ('TCM') staff will immediately notify Adair County SB40's Director of Service Coordination (DSC) or designee if any of the following occur:

1. Allegation of abuse or neglect to include physical, sexual verbal, neglect and/or fraud or misappropriation by any of the following: agency employee, foster parent, respite provider, member of foster family, biological family member or others.
2. Death of a client.
3. Elopement of a client or missing client.
4. Emergency medical treatment or any hospitalization of a client, this includes bodily injury: (even if used in the place of routine medical care);
5. Expulsion from school.
6. Any alleged delinquent or criminal activity of a client.
7. Any situation in which the client is a victim of alleged delinquency or criminal activity.
8. Suicide attempts.
9. Physical restraint.
10. Sexual Assault.
11. Medication errors likely to result in serious consequences.
12. Any adverse reaction to a life-threatening degree due to an administered drug to a client.
13. Disruption of Placement due to Fire, Flood, Tornado.
14. "Significant" events involving clients will be documented per DMH requirements and reported to TCM Team Lead
    a. Significant events include: falls, bruises/marks found, contraband found, harming animals, minor injuries (requiring first aid only), lice or other infestations, physically aggressive (not causing major harm to others), property damage (not criminal), school bus suspension, school truancy, school detention, sexual behaviors between minors, theft with no legal involvement, verbally menacing or threatening.
15. Additional events involving clients to be reported as "major" incidents that will be documented per DMH requirements and reported to the Director of Service Coordination or designee include:
    a. Biohazard accident,
    b. communicable disease,
    c. infection control (exposure to infectious diseases),
    d. death caused by a client,
    e. fire setting,
    f. Involuntary termination of treatment,
    g. police involvement,
    h. possession of illicit substances or weapons,
    i. suicidal ideation,
    j. threats to kill others,
    k. vehicle accidents,
    l. victim of a crime
    m. client rights violation

n. Removal of a child from the home by any person or agency other than the placing agency, or attempts at such removal

16. Adair County SB40 will ensure that any employee, college intern or volunteer who knows of or suspects any physical or mental abuse or neglect, or threatened abuse or neglect of a child by any person, including another youth, will immediately report the situation **as per mandated reporting of abuse or neglect requirements.**

PROCEDURE

An Incident Report is completed for all incidents involving a client or staff member meeting the criteria above.

1. The incident report must include the date and time of the incident, the involved client's identifier (as appropriate), an objective description of the circumstances that led up to the incident, the incident itself (injury, illness, emergency, acting-out behavior, etc.), the interventions by staff and steps taken to prevent a reoccurrence of the incident. The report should be signed by all staff completing the report and by any staff identified as having witnessed the event.
2. For incidents involving TCM Clients, the Director of Service Coordination (or designee) will be responsible for reviewing and ensuring the timeliness and accuracy of incident reports, which they are written in compliance within expected standards, and are sent to the appropriate authorities, custodial agent, such as children services, and others as appropriate.
3. For incidents involving Agency staff, the Executive Director and HR Coordinator will be responsible for reviewing and investigating the incident reports.
4. Within 24 hours, a copy of the client incident reports will be mailed or faxed to the required external agency or agencies as follows:
    a. For foster youth, the referring Child Custodial Agency.
    b. For youth receiving mental health services, a copy of all shall be sent to the community mental health liaison and KRO (as designated).
    c. It is expected that every effort will be made to contact the assigned caseworker prior to the routing of any written Incident Report. <u>All Incident Reports should be reviewed by the DSC prior to sending to external agencies</u>. Incidents will also be reviewed by designated Quality Assurance Team Support as designated.
5. The original Incident Report is filed in electronic health records ("Filebound") for clients and in HR files for staff.
6. In the event of allegations of abuse and neglect of a client, the appropriate contact with the Kirksville Regional Office will be immediately notified.
7. In the event a supervisor is reporting a client related incident for a Service Coordinator or other staff person, the supervisor is listed as the reporter AND becomes responsible that the notification, report distribution, and follow-ups are completed.
8. Unresolved incidents will require follow-up and documentation within 14 days of the incident. All follow up documentation will be maintained in the files.
9. All incident reports involving clients will be reviewed by the Director of Service Coordination to address completion of documentation, resolution status and logging of incidents.
10. All Major Incidents shall be reviewed by the Executive Director for feedback on appropriateness of intervention and if need for follow-up.
11. At least quarterly, SB40 will provide an analysis of written incident reports and corrective action taken, if any, within the agency's quality assurance activities.
12. A written analysis of all critical incidents shall be reviewed by leadership at least annually addressing causes, trends, action for improvement, results of performance improvement plans, education and training of employees, prevention of recurrence, and internal and external reporting requirements.

Vehicle Usage Policy

The purpose of this policy is to ensure the safe and proper use of Adair County SB40 ("Agency") owned vehicles and/or personal vehicles driven by the employees for the purpose of conducting Agency business.

VEHICLE SAFETY
All employees driving a vehicle for Agency business **must** adhere to standard safety rules as well as all local and state laws regulating motor vehicle operation. Any employee who drives for the purpose of Agency business, and has their motor vehicle license revoked or suspended shall immediately notify the Human Resources Department and discontinue operation of any vehicle for business reasons.

MOTOR VEHICLE LICENSE
All employees who drive for the purpose of Agency business must maintain an appropriate valid driver's license, (CDL, Operators, etc.) and drive in accordance to any restrictions attached to same license. Motor Vehicle Records will be obtained on all employees prior to employment and no less than every 12 months. A driving record that fails to meet reasonable safety criteria may result in a any of the following: Loss of the privilege of driving an Agency vehicle, discontinuance of vehicle allowance and/or further disciplinary action including termination.

ACCIDENT REPORTING
All accidents in Agency vehicles, regardless of severity, must be reported immediately in accordance to incident reporting guidelines which includes notification to Human Resources. Accidents in personal vehicles while on Agency business must follow these same accident procedures. Failing to stop after an accident and/or failure to report an accident may result in disciplinary action. Employees operating a vehicle, and have been involved in an accident during Agency business and/or while operating an Agency vehicle are subject to post accident drug and alcohol testing.

AGENCY OWNED VEHICLES

- Agency owned vehicles should be driven for the purpose of conducting agency business.
- Agency owned vehicles are to be driven by authorized employees only. Spouses, other family members, or other non-employees are not authorized to drive company vehicles.
- Personal use should be limited and restricted to during the work day and on the way to and from work.
- Agency vehicles should not be used during non work hours without prior authorization from the Executive Director.
- Passengers are generally limited to those individuals who need to ride in the vehicle to conduct agency business, such as other employees, program participants, etc. Non-employee family members may be passengers during the above defined restricted, need based use. Employees who use the vehicle to transport non-employees (ex: child from day care) should be aware that such use indicates acceptance of any liability not covered by company insurance.
- It is the responsibility of the driver to inform Vehicle Maintenance of any vehicle maintenance needs or safety problems with the assigned vehicle.
- Drivers must report all ticket violations received during the operation of a company vehicle within 72 hours to their supervisor.
- The vehicle color, options and equipment shall not be altered, except as authorized by the Executive Director.

PERSONAL VEHICLES

- All employees driving their personal vehicle for Agency business must maintain current insurance at minimum level as determined by the State of Missouri on vehicle driven, unless otherwise stipulated by an agreement between the individual employee and the Agency.
- Maintenance of the vehicle is the sole responsibility of the employee.

Fiscal

Operating Reserve Fund
The purpose of this Operating Reserve Policy for the Adair County SB40 Developmental Disability Board is to build and maintain an adequate level of unrestricted net assets to support the organization's day-to-day operations in the event of unforeseen shortfalls. The reserve may also be used for one-time, nonrecurring expenses that will build long-term capacity, such as staff development and investment in infrastructure. Operating reserves are not intended to replace a permanent loss of funds or eliminate an ongoing budget gap. The organization intends for the operating reserves to be used and replenished within a reasonable period of time.

This Operating Reserve Fund Policy will be implemented in conjunction with the other financial policies of the organization and is intended to support the goals and strategies contained in those related policies and in strategic and operational plans.

The target minimum Operating Reserve Fund is equal to six (6) months of average recurring operating costs, and the target maximum is equal to twelve (12) months of average recurring operating costs, as calculated based upon the approved annual budget for the organization. If the organization is not in compliance with this policy, management will report it at the next regular meeting of the Directors.

Audit Procedure
The Adair County SB40 Developmental Disability Board of Directors shall select and contract with an independent external accounting firm or individual licensed by the Missouri Board of Accountants to perform an audit at the end of each fiscal year. The contract will be for a three-year engagement of services, subject to yearly evaluations. Engagements beyond three-years shall be as Board approved.

This audit shall provide a complete accounting for all receipts and expenditures. This audit report shall be examined in accordance with Generally Accepted Accounting Principles as promulgated by the American Institute of Certified Accountants.

Upon completion, a copy of the completed audit will be forwarded to the Missouri State Auditor in accordance with RSMo. 105.145.

Bid Protocol
The Adair County SB40 Developmental Disability Board (the 'Agency') shall comply with statutes governing bidding RSMo. 50, which are then in effect.

1. For any purchase of equipment, supplies, or administrative service estimated to cost between $4,500 and $25,000 the Executive Director, or designee, shall make reasonable effort to obtain competitive bids from no fewer than three providers, preferably based within Adair County. The Executive Director of the Agency shall be responsible for soliciting all bids under $4,500.

2. The Agency may waive the requirement of competitive bids or proposals for supplies when the Executive Director has determined in writing and entered into the Board's minutes that there is only a single feasible source for the supplies. Immediately upon discovering that other feasible sources exist, the Executive Director shall rescind the waiver and proceed to procure the supplies through the competitive processes. A single feasible source exists when:
    a) Supplies are proprietary and only available from the manufacturer or a single distributor; or
    b) Based on past procurement experience, it is determined that only one distributor services the region in which the supplies are needed; or
    c) Supplies are available at a discount from a single distributor for a limited period of time.

3. The Agency may waive the requirement of competitive bids or proposals for supplies when the Executive Director has determined that there exists a threat to life, property, public health, or public safety or when immediate expenditure is necessary for repairs to Agency property in order to protect against further loss of, or damage to, Agency property, to prevent or minimize serious disruption in Agency services or to ensure the integrity of Agency records. Emergency procurements shall be made with as much competition as is practicable under the circumstances. After an emergency procurement is made by the Executive Director, the nature of the emergency and the vote of the Board of Directors approving the procurement shall be noted in the minutes of the next regularly scheduled meeting.

4. Projects can move forward with less than 3 bids if approved by the Board of Directors.

5. Any purchase of equipment, supplies, or administrative service in excess of $25,000 shall be formally bid.
    a) Formal bidding shall be defined as inviting bids by advertising on the Adair County SB40 Developmental Disability board website and/or by social media release. Said notice shall be published at least ten days preceding the last day set for the receipt of proposals.
        a. Public notice shall include a general description of the requirements to be met and shall state where bid blanks and specifications may be secured, and the time and place for opening of bids.
    b) When deemed necessary, bid deposits or surety bonds, or both such deposits and bonds shall be entitled to the return of surety bonds or deposits. A successful bidder shall forfeit any deposit or surety required by the failure on his part to enter into a contract within ten (10) days after the award.
    c) All formal bids shall be submitted sealed to the Agecny unless otherwise specified and shall be identified as “Bids” on the envelope. All bids shall be opened and read aloud by the Director.

6. The Agency shall have the authority to reject all bids or part of any bid when the public interest would be served thereby and require the filing of new bids.

7. The bids should be awarded to the lowest responsible bidder, preferably within the County. In addition to price, the Board shall consider the ability, capacity, or skill of the bidder to perform the contract or to provide the service required, and:
    a) The ability of the bidder to perform the contract or to provide the service promptly or within the time specified without delay or interference;
    b) The character, integrity, reputation, judgment, experience, and efficiency of the bidder;
    c) The quality of performance of previous contracts or services;
    d) The previous and existing compliance by the bidder with all laws regarding contract services;
    e) The sufficiency of the financial resources and the ability of the bidder to perform the contract or provide the services;
    f) The quality, availability, and adaptability of the supplies or contractual services for the particular use required;
    g) The ability of the bidder, if applicable, to provide for the maintenance and service for the use of the subject of the contract; and
    h) The fully submitted bid complies with the minimum requirements of bid specifications.

8. When the award is not given to the lowest bidder, a full and complete statement of the reasons for not awarding the contract shall be prepared by the Director with the Board’s approval and entered into the minutes of the Board meeting. Such papers are to be filed with other papers relating to the transaction.

9. If, after consideration of all the above criteria, two or more bids are deemed by the Board to be equal, the award shall be determined in accordance with the following procedures:
    a) If one or more of the tying responsible bidders is a person, firm or corporation residing or having places of business outside the county, it shall be excluded from consideration; if the bid is divisible so that the contract may be apportioned among the tying bidders without increasing the cost to the County, it shall be recommended that the bid be divided equally among the tying bids.
    b) If the contact is not divisible, it shall be recommended that the bid be awarded by lot. The lot shall be drawn at a public meeting of the Board.

10. If required by the Board, the successful bidder shall furnish, at his own expense, a corporate surety bond, in a sum equal to the full amount of the contract running to insure the faithful performance of the contract.

11. When the nature of the contract or purchase is such that the Board deems a performance bond necessary, it shall be indicated in specifications for bids. The Board can assume that any bid submitted shall be deemed to include an understanding on the bidder's part of furnishing such a bond at no further charge to the Board.

Budget
The Adair County SB40 Developmental Disability Board shall approve a written organization operation budget prior to the beginning of each fiscal year in order to disburse any funds. Budget development shall include reasonable projection of revenues and expenditures and comparisons to historical performances as well as consideration of financial trends, challenges, and opportunities.

Input from The Adair County SB40 Developmental Disability Board of Directors shall be included.

The final revised budget shall be approved prior to the fiscal year end in order to ensure that more funds have not been spent than have been appropriated.

The Adair County SB40 Developmental Disability Board and leadership will regularly monitor its performance against the proposed budget. Monitoring shall include comparison of revenue and expenditures to the annual approved budget, consideration of financial trends, and consideration of emerging financial challenges and opportunities.

Authorized Signatories
It is the intent of the Agency to assure that financial practices offer separation of duties as much as possible in order to minimize risk to the Agency. Therefore, all checks, notes, drafts, and other instruments for the payment of money or disbursement of funds drawn, endorsed or executed in the name of the Adair County SB40 Developmental Disability Board shall be signed by at least two members of the Board. Signatures are the Treasurer, Chairman, Vice Chairman or other appointed signatory from the Board.

The Accounting Manager shall not be authorized as a signor on any bank account, nor be issued any Agency credit cards. The Accounting Manager will have responsibility for maintaining the associated financial records regarding any expenditures. The Executive Director shall reconcile bank statements, balance sheet accounts and review all financial statements no less than monthly.

Insurance Requirements
The Adair County SB40 Developmental Disability Board shall obtain appropriate insurance to protect the organization from acts of theft from staff, acts of omission of the Directors and Officers and/or acts of

negligence/liability by staff/agents. The Agency will also have and maintain all necessary comprehensive property insurance, liability insurance and workers' compensation insurance.

Purchasing Procedures

All purchases exceeding $100 must have the prior approval of the Executive Director. Final authorization to purchase goods or services for the Agency may only be given by the Executive Director.

No reimbursements shall be made to employees for purchases made without the preauthorization of the Executive Director. Requests for reimbursement for purchases paid for by employees of the Agency must be submitted with the original receipt on the appropriate Agency Expense Reimbursement form. The form must be reviewed and approved by both the Supervisor and the Executive Director prior to reimbursement.

For instructions and policies regarding purchases by employees using an Agency issued credit card, please refer to the Credit Card Usage Policy. The ultimate authority and responsibility for maintaining and providing oversight of the purchasing shall reside with the Executive Director.

Billing Process:

Targeted Case Management services provided by the Agency will be invoiced electronically to MO HealthNet Division based on the Medicaid approved rate in effect for the date of service and in accordance with Federal and State Medicaid rules and regulations.

The Agency will receive from MO HealthNet the full reimbursement for TCM services paid by MO HealthNet Division in accordance with their stated business cycles. The Agency shall be responsible for the accuracy of billings submitted to MO HealthNet Division. The Agency shall be liable for any denials or recoupment for failure to comply with applicable Medicaid rules and regulations.

The Agency's Accounting Manager, working in conjunction with TCM management, will be responsible for reviewing all denials or recoupment for payment. The Accounting Manager will resolve and resubmit required information necessary to request the reinstatement of the denied funding. This accounting review process will be completed and re-submitted on a monthly basis.

Credit Card Usage Policy

Designated Cardholders
The Executive Director may designate up to five Cardholders at any given time within the organization, each of whom will have the authority to make purchases according to the specific purposes, guidelines, restrictions and limits applicable to each Designated Cardholder. The Executive Director may also end the designation of any or all Designated Cardholders without prior notice if such action is believed to be warranted.

Each Designated Cardholder will be assigned a spending limit which he/she may not exceed. This limit will be enforced for each Designated Cardholder by the Bank which administers the ADAIR SB40 Credit Card, so that any charges in excess of the limit for each Designated Cardholder will be declined. The Executive Director will prepare a written agreement for each Designated Cardholder which specifies the monthly spending limit for that Designated Cardholder as well as the types of purchases which may be made by each Designated Cardholder. The agreement will also contain a statement that the Designated Cardholder has reviewed the ADAIR SB40 Credit Card policy and agrees to be bound by the requirements specified as long as he/she has possession and authorized use of the ADAIR SB40 Credit Card.

Restrictions on Use by Designated Cardholders
The Designated Cardholder is liable for all access and utilization of the ADAIR SB40 Credit Card. Authorization of usage by anyone other than the Designated Cardholder remains the full responsibility of the Designated Cardholder.

1. Absolutely NO PERSONAL PURCHASES may be made with an ADAIR SB40 Credit Card by any Designated Cardholder. All purchases must be for the use or benefit of the ADAIR SB40 to carry out its business and purposes. Any Designated Cardholder found to have used an ADAIR SB40 Credit Card for personal purchases will be subject to disciplinary action, up to and including termination of employment.
2. No Designated Cardholder may exceed the spending limit specified in his/her Designated Cardholder agreement.
3. No Designated Cardholder may purchase items with an ADAIR SB40 Card which are outside of those categories specified in his/her Designated Cardholder agreement.
4. No Designated Cardholder may purchase alcoholic beverages, firearms, tobacco products, ammunition and/or hazardous materials with the ADAIR SB40 Card.
5. No Designated Cardholder may utilize an ADAIR SB40 Card for a cash advance.

Cardholder Responsibilities
1. Ensure the physical security of the ADAIR SB40 Card assigned to his/her custody, and protect the account number. Immediately notify ADAIR SB40 Executive Director or Accounting Manager when the card has been lost, stolen or misused.
2. Follow strict adherence that the only person to use the ADAIR SB40 Card is the Designated Cardholder whose name appears on the front of the card. Under rare circumstances as approved by the Executive Director, the Designated Cardholder may allow another employee of the agency to use his or her card.
3. Verify availability of funds, verify that purchase is an allowable charge as per Designated Cardholder's specifically approved categories, and verify that the amount does not exceed the spending limit approved as per Designated Cardholder's agreement.
4. Ensure that Missouri sales tax is not charged on qualifying purchases.
5. Obtain original itemized receipts for all purchases and payments made to the card as well as any other required documentation to support the purchase. An original receipt must be provided for every ADAIR SB40 Credit Card Purchase.
6. Maintain a Monthly Transaction Log (using template provided) containing:
    a. amount and date of each transaction,

b. documentation of the valid and clear business purpose for each transaction, explaining why the purchase is necessary to conduct ADAIR SB40 business,
c. assignment of each transaction to a particular expense category for budget tracking,
d. running total of transactions made throughout the month,
e. signature of Designated Cardholder attesting to accuracy of information contained on the log, and
f. signature line for Executive Director or Business Manager attesting to review and approval of log with matching itemized receipts for all purchases. The Executive Director and Accounting Manager cannot approve their own Designated Cardholder monthly logs so will either review and approved each other's logs or will request Designated Board Check Signer to review and approve their logs.

7. Compile all required supporting documentation, obtain proper approval signatures, and submit to Accounting Manager by the 4th day of each month for ALL transactions made by the Designated Cardholder to the ACSCCB card for the prior month.

Management/Board Responsibilities

All Monthly Transaction Logs must be reviewed and approved by either the Executive Director or Accounting Manager, prior to submission to Accounting on the 4th day of the month. The Director or Accounting Manager will review and match the amount of each transaction to the accompanying original itemized receipt, assure that all original itemized receipts are included, assure that the purchase was made for the use and purpose of the ADAIR SB40 within a category of purchase assigned to the particular Designated Cardholder, assure that the category assigned to the purchase is correct, and assure that the total of the transactions does not exceed the limit for that Designated Cardholder.

Any abuse or misuse of an ADAIR SB40 card identified through the review of the Monthly Transaction Logs or at any other time must be reported to the Executive Director and the Accounting Manager immediately, so that they may take appropriate measures to stop payment on any transactions and/or remove Designated Cardholder from approved users listed with the Bank issuing the card and/or invoke any and all disciplinary and legal measures required to prevent or limit losses to the ADAIR SB40. Cardholder privilege may be revoked at the discretion of the Executive Director at any time with no advance warning required. The Executive Director's Designated Cardholder privilege may be revoked at the discretion of the Chairman of the Board of Directors at any time with no advance warning required.

Accounting will review charges weekly to the ADAIR SB40 Credit Card account through online access, in order to monitor and question any unusual spending by a Designated Cardholder. Accounting will make certain that all Monthly Transaction Logs are turned in containing complete and accurate information and accompanied by all appropriate documentation of transactions. Accounting will reconcile the Bank Transaction statement each month, ensuring that any disputed charges are addressed and resolved with issuing Bank, and submitting payment in full to issuing Bank each month on or before payment deadline.

Designated Board Check Signers will review the itemized bank transaction statement and individual Monthly Transaction Logs with documentation before signing monthly payment checks to the Bank Card Account. The logs, documentation, and bank statements will become a part of the organization's financial records, subject to the same annual audit and retention requirements.

Method of Accounting

The Adair County SB40 Developmental Disability Board fiscal records, chart of accounts, operating practices shall be consistent with General Accepted Accounting Principles (GAAP) and Governmental Accounting Standards Board (GASB). The Agency's fiscal records shall be maintained on a full accrual basis within a computerized general ledger system. The Agency's fiscal year shall remain July 1- June 30 as stated in the organization's bylaws.

Contracts
Any contracts that Adair County SB40 Developmental Disability Board enters shall be reviewed and approved by the Executive Director prior to the signing of any contracts. Agency contracts shall be within the approved annual plan and operating budget. Contracts shall be procured based on assessment of persons served and agency needs.

The Adair County SB40 Developmental Disability Board empowers its Executive Director to enter into contracts that are $20,000 or less per fiscal year without formal approval by the Board. All contracts shall be evaluated before contracts are renewed.

The Agency will not discriminate against contract providers due to race, color, religion, national origin, age, sex, handicap, disability, height, weight, marital status, or political affiliation.

All contracted providers shall comply with all applicable local, state, and federal laws, rules and regulations, and the Agency's policies, procedures, standards, and guidelines.

No contracts are considered valid contracts without the Executive Directors signature.

ASSETS

Board Owned Real Estate
Buildings constructed or purchased by the Board shall remain the property of the Board unless specific Board action designates otherwise. Buildings may be leased for specific purposes, by written agreement formally agreed to by the Board, with program intentions and maintenance provisions identified therein.

All leases shall be net leases: That is, lessees will pay all expenses of the property, except major renovation, refurbishing, and repairs on the property. The Board shall determine what constitutes “major” renovation. The amount of the lease shall be determined on an annual basis unless specific Board action designates otherwise.

The Board shall maintain property and general liability insurance coverage on buildings, grounds and Board-owned equipment. The lessee organization shall be responsible for its own organizational liability and property coverage.

Lease agreements shall represent a contract for service and shall specify Board action in the event of lessee default or failure to operate the building or program adequately.

Maintenance of Board-owned property, or property maintained by the Board according to grant provision, shall be specified and outlined by contract.

Fixed Assets Management
The Agency's general fixed assets should be reported by asset class. The most common classes used to categorize fixed assets in the public sector are as follows:

- Buildings – by location
- Vehicles
- Office Equipment – by location

Asset records will be reviewed on an annual basis for any additions or deletions due to purchases or disposals.

The asset records are recorded and maintained in an Excel spreadsheet at the original date of purchase or disposal. Currently, the following information is documented in the Excel spreadsheet on each asset, as information is available for an asset:

- The asset category and location
- Type of depreciation used
- Vendor Name
- Check Date and Check Number
- Model Number
- Serial Number

The Agency reports only a single number for fixed assets on the face of the combined statement of net assets. The Executive Director will reconcile the detailed asset ledgers to the financial statements on a monthly basis.

Cost of the asset, for this purpose, includes not only the purchase price or cost of construction, but also any other charges incurred "to place the asset in its intended location and condition for use.” Examples of capitalizable costs include the following:

- Legal and title fees
- Closing costs
- Appraisal and negotiations fees

- Surveying fees
- Damage payments
- Land-preparation costs
- Demolition cost
- Architect and accounting fees
- Insurance premiums during the construction phase
- Transportation charges

Interest capitalization is permitted, but not required, for general fixed assets. In practice, interest capitalization on general fixed assets is uncommon and is not recommended.

Donated assets should be reported at their estimated fair value at date of acquisition. This rule applies only to donations made from outside the Agency. When this is not available, an estimate of the historical cost is used but may not be used for financial reporting purposes. The method used to estimate the historical cost of fixed assets for which invoices and similar documentation of historical cost are no longer available is to use old vendor catalogs to establish the average cost of obtaining the same or similar asset at the time of acquisition.

Depreciation of assets will be calculated by the Agency's accounting software and in accordance with the Governmental Accounting and Financial Reports Standards.

Fixed Assets Disposal
It is the intent of the Agency to establish a process for disposal of assets whose net economic value has been exhausted. When it has been recommended that an Agency asset should be disposed of, the disposal of that asset may be arranged through the Executive Director. Generally, the plans for disposal of the asset will be determined by Accounting Manager with the approval of the Executive Director. All assets exceeding the current book value of $1,000 must also have approval of the Board prior to disposal.

Process:

- A determination shall be made by the Executive Director and/or Accounting Manager that the asset has been exhausted through obsolescence or is deemed unrepairable.
- Arrangements shall be made for disposal.
- Adjustments shall be made to the asset inventory database and the asset inventory dollar value to record the disposal of the asset.
- The insurance company shall be notified when the item is of significant cost, such as a car, van, building, etc.
- Guidelines established for governmental entities shall be followed in the sale of real estate.

Funding

Fundraising

The Adair County SB40 Developmental Disability Board may solicit donations to further the mission of the organization through our non-profit Adair County DD Link.

Funds shall be solicited in a respectful manner and without pressure. All third parties not directly affiliated with Adair County DD Link who wish to solicit funds on behalf of the organization must acquire written permission from the Adair County SB40 Developmental Disability Board Executive Director prior to beginning any fundraising activities.

Adair County DD Link is a nonprofit 501 C3 organization and contributions made to the organization are tax deductible to the fullest extent of the law. Written tax receipts will be issued upon request and if the donor receives anything in exchange for their donation, such as dinner or event admission, the tax receipts shall clearly state what portion of the donation is tax deductible.

Any information supplied to the Adair County Developmental Disability Board or Adair County DD Link by donors will be used solely to fulfill their donation and shall not be shared for any reason unless permission is granted by the donor to share such information. All requests to remain anonymous shall be honored. Neither Adair County Developmental Disability Board or Adair County DD Link will sell or share donor lists.

Availability of Funds

Policy Background

In 1969, the Missouri Legislature passed legislation (Senate Bill 40) to allow Missouri Counties and cities not a part of counties to approve local property taxes to generate locally controlled funds for the delivery of services to persons who are developmentally disabled.

Policy Purpose

Adair County SB40 Developmental Disability Board (hereafter referred to as the "Board") has the responsibility for the administration and management of special tax revenues generated from a county-wide property tax currently set at 0.15 cents per $100 of assessed valuation.

Policy Procedures

The Board's fiscal year is from July 1 through June 30. The Board adopts an annual budget in June/July of each year which establishes an allocation plan by which funds are budgeted by administrative and service areas in accordance with priorities set by the Board's goals and objectives. Agencies seeking funds from the Board should be aware that its funds are limited, and the competition for them is great.

Statement of Basic Principles of Funding
The following are basic principal statements of the Adair County SB40 Developmental Disability Board concerning the funding of services:

1. The Board desires to enhance, initiate and/or expand services utilizing its funds, without the possible commensurate loss of other sources of funding.
2. The Board recognizes that persons with developmental disabilities of all ages are in need of some type of service. The Board believes that for the service delivery system to be truly comprehensive in meeting the needs of people with developmental disabilities, funding responsibilities must be shared. Within the service delivery system, there are defined areas of responsibilities pursuant to local, state, and federal statutory mandates. It is not the intent of the Board to function as a substitution, either in determination of eligibility, delivery, or funding, for those services which are provided by mandate through other governmental agencies (examples include but are not limited to: Dept. of Elementary and Secondary Education, Dept. of Social Services, Dept. of Mental Health, MO Healthnet, Social Security, Vocational Rehabilitation, Housing Authority, etc.). The Board's funding policy concentrates on services that are not a primary mandate or focus of other major public funding resources.
3. The Board may, at its discretion, expend its funds through contractual agreement with not-for-profit agencies, provide direct provision of services, or utilize a combination of either method. This includes additional, forfeited or unused funds during each fiscal year.
4. Adair County levy funds shall be used to supplement, not to supplant, all other public and private expenditures. All other potential resources for funding shall be explored and accessed prior to approval of funding through the Adair County SB40.
5. With respect to funding requests for the establishment of new or substantially expanded services, all applicants must demonstrate the need/demand for the proposed service by means of a waiting list verified by the referring or sponsoring entity (i.e., Dept. of Mental Health, Division of Vocational Rehabilitation) and, if applicable, a needs survey should be conducted within Adair County.
6. In the case of projects for which the applicant is requesting partial funding, applicants must demonstrate the availability and source of other funds other than those requested from the Board for the development and/or continued operation of the proposed service.
7. In order to serve the maximum number of persons with developmental disabilities, the Board desires to use its available funds to leverage other funding sources. To this end, the Board may, at its discretion, request that applicants seeking Board funds consider using their own financial resources and/or other resources in partnership with Board funds.
8. The Board will not utilize funds to assist agencies in retiring their long-term debts. To be considered for funding, the debt must be incurred within the last twelve (12) months.
9. The Board will not, except under special circumstances, approve funds for services rendered/expenses incurred prior to the date of Board approval of the application. No contracts are considered valid contracts without the Executive Director’s signature.
10. The Board reserves the right to establish the conditions and requirements of the funding agreement between the applicant and the Board for approved applications.
11. An applicant that has failed to perform in accordance with the contractual agreement with the Board on any one project shall therefore be considered by the Board to be in default on all other projects, and no further funds shall be disbursed until the problem has been resolved to the satisfaction of the Board.
12. Agencies must demonstrate an ongoing effort toward publicizing its programs, functions, and location to all segments of the community utilizing all feasible media. It is expected that public education materials and media information state that funding is being received from the Adair County SB40 DD Board.
13. Agencies are required to submit a Board of Directors membership list showing names, addresses, telephone numbers, occupation, term of office including identification of officers.
14. Agencies requesting funds from the Board shall comply with all requirements as stated in the Board's Agency Funding Policies and Procedures unless the Board in its discretion waives any requirements.

Use of Funds

The funds of the Adair County SB40 Developmental Disability Board shall not be used to supplant or take the place of funds received by organizations from other funding sources.

In approving proposals received from organizations which are eligible under law, it is the intent of the SB40 Board that County funds be spent for services above and beyond the organization's current program, with the goal of assisting organizations to expand, improve, and upgrade the quality of their services to persons with developmental disabilities. However, the Board may make exceptions to this policy if said organizations can demonstrate need for assistance in operations funding.

Guiding Principles

The purpose of our Guiding Principles is to articulate, affirm, and promote the characteristics of quality services and partnerships, to which we are committed and toward which we strive. These principles will guide our implementation of the Board's approach, processes, and tools and will be used to foster reflection and self-assessment for ourselves and our partners granted Board funding.

- *People-Focused* - We and our partners acknowledge the individuality and dignity of those we serve by including, respecting, and responding to their voices and needs as we plan and deliver our services.

- *Culturally Responsive* - We and our partners value the unique cultures of those we serve and seek to understand and respect those cultures by supporting people to express their identities freely.

- *Well-Founded* - We and our partners support programs, processes, and services that are founded on research, best practices, and our own learning. We can articulate the rationale and justification for our approaches.

- *Goal-Directed* - We and our partners ensure that our work is designed to meet specific, measurable goals and is implemented in the ways necessary to achieve results.

- *Continuous Improvement* - We and our partners gather, reflect on, and use information to continually learn and improve.

- *Thoughtful Stewardship* - We and our partners recognize that we are entrusted with taxpayer resources and aim to work in efficient and accountable ways that deliver the best possible return on our investments.

- *Forward-Thinking* - We and our partners strive to spark and support innovation that responds to the changing needs of those we serve and the changing environments in which we operate.

- *Trusting and Trustworthy* - We and our partners communicate honestly, presume positive intent, and follow-through on our commitments.

Outcomes

Within the funding application of each funded service, individuals and agencies will describe the intended impact of the funding relative to the desired outcomes of the Board. Outcomes described will answer the question "What are we trying to accomplish?". Further, the funding application will identify in specific and measurable terms what the funded service or support will look like.

Desired outcomes of the Adair County SB40 Board funding include:

Community Living: Support individuals with establishing, developing and maintaining skills needed to live in the community.

Outcome: Individuals have life skills necessary to live independently.

1. Individuals improve/maintain their ability to manage belongings, financial and community resources.
2. Individuals gain/maintain skills for interaction with persons necessary to maintain independent living.
3. Individuals gain/maintain skills for housekeeping.
4. Individuals gain/maintain skills for health and self-care tasks.

Outcome: Individuals have the skills to ensure their safety in their homes and community.

1. Individuals gain/maintain skills to ensure personal safety and healthy boundaries.
2. Individuals gain/maintain skills for following safety procedures.
3. Individuals gain/maintain skills to safely navigate their community.

Outcome: Individuals live independently in the community.

1. Individuals remain living independently in the community. (ISLD services only)
2. Individuals transition to living independently in the community.

Community Integration: Services support individuals in accessing community and social life in self-directed, safe, and inclusive ways.

Outcome: Individuals have meaningful and self-directed experiences in the community.

1. Individuals report that their experiences in the community were meaningful.
2. Individuals report that their experiences in the community were self-directed.

Outcome: Individuals experience positive and self-directed social lives.

1. Individuals report increased frequency of positive interactions with people of their choosing.
2. Individuals report increased number of relationships with people of their choosing.
3. Individuals gain/maintain skills for self-advocacy.

Outcome: Individuals have the skills necessary to access and succeed in community and social life.

1. Individuals gain/maintain communication skills.
2. Individuals gain/maintain social skills.
3. Individuals gain/maintain skills for self-management.
4. Individuals gain/maintain "hard" skills.

Outcome: Individuals have skills to ensure their safety in the community.

1. Individuals gain/maintain skills to ensure personal safety and healthy boundaries.
2. Individuals gain/maintain skills for following safety procedures.
3. Individuals gain/maintain skills to safely navigate their community.

Professional Services: Services are provided by qualified professionals and support the physical and/or emotional well-being of the individual and their caregiver(s).

Outcome: Individuals and their caregivers experience improved emotional well-being
1. Individuals report experiencing fewer emotional and/or behavioral symptoms.
2. Individuals report improved ability to cope with stress.
3. Individuals report improved satisfaction with relationships.
4. Individuals are free from substantiated reports of abuse or neglect.

Outcome: Individuals experience improved physical well-being.
1. Individuals demonstrate improved strength, stability, or motor skills.
2. Individuals experience improved self-regulation and/or sensory processing.
3. Individuals are free from substantiated reports of abuse or neglect.

Outcome: Individuals increase independence.
1. Individuals navigate home and community settings more safely and independently.
2. Individuals complete daily tasks more independently.
3. Individuals increase their skills to communicate their wants and needs.

Support Systems: Services strengthen the individual's natural and formal support systems.

Outcome: Individuals and/or their caregivers are able to meet their needs.
1. Participants gain skills for stress management.
2. Participants report less overall stress.
3. Participants report increased confidence in their ability to advocate for and/or seek out services and community supports.
4. Participants increase understanding of their or others' developmental disabilities.
5. Participants gain caregiving skills.
6. Individuals report increased satisfaction with family relationships.
7. Individuals remain in their home.
8. Individuals gain/maintain skills to navigate formal support systems.
9. Individuals gain/maintain skills to pursue their academic and professional interests.

Outcome: Individuals have the skills to ensure their safety in their homes and community.
1. Individuals gain/maintain skills to ensure personal safety and healthy boundaries.
2. Individuals gain/maintain skills to safely navigate their community.
3. Individuals are free from substantiated reports of abuse or neglect.

Outcome: Individuals have necessary supports.
1. Individuals develop/maintain natural supports.
2. Individuals develop/maintain connections to necessary formal supports.

Employment Training: Services support an individual, who may or may not be employed, to develop skills necessary to obtain and maintain employment in the community.

Employment Training projects must report on all the Outcomes and Indicators listed below. However, the Board recognizes that each individual's goals and abilities are unique and that service providers tailor services to meet those individual needs. As such, not every Indicator within the list below will be applicable to every individual participating in the project.

Youth Employment Training

Outcome: Individuals have the skills necessary to become employed in the community.
1. Individuals gain/maintain “hard” skills necessary for employment.
2. Individuals gain/maintain “soft” skills necessary for employment.

Outcome: Individuals progress toward employment.
1. Individuals gain employment.
2. Individuals who are unemployed at the program’s end are connected to opportunities supporting future employment.

Adult Employment Training

Outcome: Individuals have the skills necessary to become employed in the community.
1. Individuals gain/maintain “hard” skills necessary for employment.
2. Individuals gain/maintain “soft” skills necessary for employment.

Outcome: Individuals who are employed have skills necessary for career development and/or advancement.
1. Individuals accept and manage increasing responsibilities.
2. Individuals demonstrate increasing productivity.
3. Individuals gain skills for career development and/or advancement.
4. Individuals secure employment that utilizes newly developed skills.

Outcome: Individuals progress toward employment.
1. Individuals gain employment.
2. Individuals who are unemployed at the program’s end are connected to opportunities supporting future employment.

Employment: Services support individuals with developing and maintaining the skills needed for competitive, integrated employment.

Employment projects must report on all the Outcomes and Indicators listed below. However, the Board recognizes that each individual’s goals and abilities are unique and that service providers tailor services to meet those individual needs. As such, not every Indicator within the list below will be applicable to every individual participating in the project.

Outcome: Individuals have the skills necessary to maintain employment.
1. Individuals gain/maintain “hard” skills necessary for employment.
2. Individuals gain/maintain “soft” skills necessary for employment.

Outcome: Individuals who are employed have skills necessary for career development and/or advancement into competitive and integrated employment.
1. Individuals accept and manage increasing responsibilities.
2. Individuals demonstrate increasing productivity.
3. Individuals gain skills for career development and/or advancement.

Agency Supports: Agency grants funded by the Board are invested into the requesting Agency as a support for the development and effectiveness of partner organizations.

Outcome: The investment provides the agency with the capacity to better serve individuals and their families.

1. The agency completes project activities and deliverables.
2. The agency achieves project goals/objectives.

Outcome: The investment provides the opportunity for individuals to live in the home/environment that meets their needs.

1. The agency completes project activities and deliverables.
2. The agency achieves project goals/objectives.

Sheltered Employment Funding

The Adair County SB40 Developmental Disability Board ('The Agency') may elect to pay a monthly stipend to sheltered workshops employing Adair County Citizens based upon the following contingencies:

1. The employee is eligible for Adair County SB40 services under the State's definition of Developmental Disability.
2. The employee is a citizen of Adair County.
3. The annualized total of the monthly stipend will be established each year based upon projected available tax levy funds.
    a. The Agency will establish annual caps for both number of employees and amount granted per employee.
    b. The annualized total will be reviewed and approved by the SB40 Board each Fiscal Year due to the frequent changes in tax levy rates.
4. The workshop must provide sufficient documentation which demonstrates that the employee did work a substantial number of work hours[*1] in the previous month.
    a. The monthly DESE report submitted by the workshop, with details on each individual's monthly work hours, must be shared with the SB40 Board for use in the calculation of the stipend.

The Agency reserves the right to deny eligibility of any individual for SB40 funding if it is the determination of the SB40 Board that employment at the workshop does not align with an individual's person-centered planning process.

Sheltered Workshops employing eligible Adair County citizens are not required to submit grant request to the Agency for this source of funding. The monthly stipend will be calculated and paid in accordance with the policy upon receipt of the requested documentation.

DESE reports are due by 10th of each month following the previous month documenting each individual's hours worked. The monthly stipend would be calculated off of that report and paid prior to the end of each subsequent month.

[*1] *'Substantial number of work hours' is defined as average monthly work hours per eligible individual exceeds at least 50% of the average number of work hours per all employees of the workshop.*

Agency Funding

Policy Purpose
The following policies describe Adair County SB40 ('the SB40 Board') guidelines for funding agency requests and the procedures to be followed by agencies making applications for funding.

Interested agencies may access funding policies and application materials at the SB40 Board website or by contacting the SB40 Board office. Applications may be submitted to the SB40 Board office at any time during business hours; however, applications will not be reviewed by the Board until all requested information has been provided (see "checklist" below).

Agency Eligibility

1. The Agency must be registered as a not-for-profit corporation in the State of Missouri. In the case of not-for-profit corporations in existence for a period exceeding one year, the corporation must be recognized as being in "Good Standing" with the State of Missouri.

2. The Agency shall not discriminate in the hiring or employment of staff on the basis of race, color, national origin, sex, religion, familial status or disability.

3. The Agency shall establish and maintain a system of client rights as provided by Chapter 630, Sections 630.110 through 630.200, RSMo, and the Department of Mental Health's rules and regulations.

4. The Agency services shall be available to persons without regard to sex, race, color, creed or national origin.

5. The Agency shall have a *Conflict of Interest* policy consistent with the Missouri Ethics Commission Chapter 105, RSMo. If a conflict of interest should be identified, a statement of full disclosure should be on record with the Agency.

6. The Agency representatives shall demonstrate that they have a sound financial management system with fiscal management controls and record keeping in accordance with generally accepted accounting principles as promulgated by the American Institute of Certified Public Accountants.
   - *The Agency Application must provide financial information, including a copy of the Independent Financial Audit from the last fiscal year.*
   - *The Agency must be able to document at least a 60 day operational reserve fund in liquid assets*

7. The Agency representatives must demonstrate that they have the programmatic, technical expertise, and facilities to accomplish the Agency's stated goals.

8. The Agency shall meet, at a minimum, those mandatory standards promulgated pursuant to Local, State and Federal statutes. Agencies are encouraged to strive to a level of excellence in service beyond that viewed as minimum/mandatory.

9. The Agency and/or its services must be located within Adair County.

Any agency submitting a request for funding will be notified in advance of the date of the ACSDD Board meeting where the agency's application will be reviewed so that the agency may send representatives to the meeting to answer questions and provide further information regarding their request.

Project/Service Eligibility

1. Target population for proposed projects or services must be individuals with developmental disabilities or who qualify as persons with disabilities as defined:

"Developmental Disability" - shall mean either or both paragraph (A) or (B) below:

A. “A disability which is attributable to intellectual disability, cerebral palsy, autism, epilepsy, a learning disability related to a brain dysfunction or a similar condition found by comprehensive evaluation to be closely related to such conditions, or to require habilitation similar to that required for intellectually disabled persons; and,

1) Which originated before age eighteen; and,

2) Which can be expected to continue indefinitely.” (RSMo 205.968 to 205.972)

B. “A disability

(a) Which is attributable to:

a. Intellectual disability, cerebral palsy, epilepsy, head injury or autism, or a learning disability related to a brain dysfunction; or

b. Any other mental or physical impairment or combination of mental or physical impairments; and

(b) Is manifested before the person attains age twenty-two; and

(c) Is likely to continue indefinitely; and

(d) Results in substantial functional limitations in two or more of the following areas of major life activities:

a. Self-care;

b. Receptive and expressive language development and use;

c. Learning;

d. Self-direction;

e. Capacity for independent living or economic self-sufficiency;

f. Mobility; and

(e) Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, habilitation or other services which may be of lifelong or extended duration and are individually planned and coordinated.” (RSMo 630.005)

" Person with a disability" - shall mean either or both paragraph (A) or (B) below:

A. “A person who is lower range educable or upper range trainable intellectually disabled or a person who has a developmental disability” (RSMo 205.968 - 205.972)

B. “A lower range educable or upper range trainable developmentally disabled or other disabled person sixteen years of age or over who has had school training and has a productive work capacity in a sheltered environment adapted to the abilities of the mentally retarded but whose limited capabilities make him or her nonemployable in competitive business and industry and unsuited for vocational rehabilitation training” (RSMo 178.900)

2. Target population for proposed projects or services must be residents of Adair County (refer to the SB40 Board Residency Requirements Policy).

3. The SB40 Board may, at its discretion, impose limitations with respect to individuals to be served and services to be provided. Such limitations shall be reasonable in the light of available funds, needs of the persons and community to be served as assessed by the Board and the appropriateness and efficiency of combining services to persons with various types of disabilities.

4. The SB40 Board reserves the right to establish the conditions of the funding agreement when funding is provided for a project and/or service on a seasonal basis.

Agency Application Process

Interested agencies may access funding policies and application materials at the SB40 Board website or by contacting the SB40 Board office. Applications may be submitted to the SB40 Board office during business hours no less than 10 calendar days prior to the upcoming Board meeting. Applications will not be reviewed by the Board until all required information has been provided.

Any agency submitting a request for funding will be notified in advance of the date of the SB40 Board meeting where the agency's application will be reviewed so that the agency may send representatives to the meeting to answer questions and provide further information regarding their request.

Appeal Procedure

If the agency requesting funds disagrees with the funding decision of the Board, the following procedures are to be used by the agency for appealing such decisions:

a. The Board of the agency requesting funds must vote in an open session of a Board meeting to appeal the decision of the SB40 Board.
b. Within 30 days of the SB40 Board's decision, a letter must be received by the SB40 Board from the presiding officer of the agency's Board, stating the agency's decision to appeal, along with a copy of the minutes of the agency's Board meeting minutes documenting the vote of the agency Board to appeal.
c. The letter from the presiding officer of the appealing agency's Board must state, in specific terms, the reason(s) for the appeal.
d. The SB40 Board will review the appeal and provide a written response within 30 days from receipt of the letter requesting appeal.

Funding Agreement

All Agency grants approved by the SB40 Board will be detailed in a written Funding Agreement delivered to the Board of Directors of the requesting Agency. The Funding Agreement shall include the terms and conditions of the grant. Terms and conditions will include the date by which the funds must be utilized, what the funds may be utilized for and the conditions for which unused funds must be returned the SB40 Board. Disbursement of grant funds approved will occur in accordance with the Funding Agreement upon return of the signed Funding Agreement accepting the terms and conditions of the grant.

Reporting & Monitoring

In order to ensure that the SB40 Board is carefully and effectively investing taxpayer dollars in services that demonstrate a positive impact on the lives of those they serve, the Board collaborates with agencies to enhance agency and project performance. Through processes of self-assessment, appreciative inquiry, and thought partnership, the Board and its funded grantees: 1) ensure that grantees and projects are demonstrating the SB40 Board's standards, 2) identify and share promising practices, and 3) build our collective capacity. Funded projects will be assessed and progress reports submitted to the SB40 Board in accordance with the Terms and Conditions of the Funding Agreement related to the grant. Such reporting requirements may include budget variance analysis, financial projections, detailed expense reports, service utilization data, demands for services, waitlists, successes, challenges and data documenting outcome measurement. Self-Assessment by the Agency will be reviewed by the SB40 Board for each funded project, and will be used by the Board to ensure project standards and terms of the Funding Agreement are met. For specific information regarding the reporting and monitoring requirements of the grant, the Grantee should refer to the Funding Agreement.

The SB40 Board or designated staff may visit the grantee operations to observe the funded project(s).

Unused Funds
Any funds unused at the end of the grant period will be returned to the Adair County SB40 Board.

In the case of the dissolution of the funded grantee within 24 months of grant distribution, the grantee agrees to reimburse the Grantor for dollars granted in cash payment or through proceeds generated from the sale of Grantee assets. The amount to be reimbursed will be prorated according to time lapsed following distribution of the grant. 100% of funds will be returned if dissolution occurs within 12 months of disbursement; 50% of funds will be returned if dissolution occurs after 12 months and before 24 months of grant distribution.

Adair County SB40 Developmental Disability Board
AGENCY APPLICATION FOR FUNDING

CHECKLIST

The following items should accompany any applications for agency funding through the Adair County SB40 Board.

Forms:
( ) Completed Agency Application for Funds
( ) Signature of Board Chair to authorize application for funding (on application form)

Corporate Information:

( ) Board Member List
( ) Copy of Agency By-Laws
( ) Certificate of incorporation as a non-profit
( ) Copy of Agency charter

Agency Financial Information:

( ) Copy of Current Year operating budget
( ) Copy of Proposed operating budget
( ) Copy of most recent report on Income and Expenses
( ) Copy of most recent Balance Sheet
( ) Copy of Audit from last full fiscal year

Please return completed application and all accompanying documents to the ACSDDB at least 10 work days prior to the next scheduled board meeting.

Adair County SB40
314 E McPherson
Kirksville, MO 63501

Individual Funding

Policy Purpose

The Individual Funding Program is designed to assist Adair County individuals with developmental disabilities and their families to address unique habilitative and support needs that cannot be met with other revenue sources. The Individual /Family Funding Program is designed to complement, not take the place of, existing funding sources, including such sources as Dept. of Mental Health, Vocational Rehabilitation, Dept. of Elementary and Secondary Education, Medicaid/Medicare/private insurance, local civic clubs and churches, local Community Action Agencies, etc. In addition, natural supports within the family as well as within the community should be identified prior to seeking financial assistance through the Adair County SB40 Board ('the Board').

Policy Procedures

The Board may, in its discretion, impose limitations with respect to individuals to be served and services to be provided. Such limitations shall be reasonable in the light of available funds, needs of the persons and community to be served as assessed by the Board, and the appropriateness and efficiency of combining services to persons with various types of disabilities.

Should an individual age 18 years or over (or his/her guardian) apply for funding in excess of $2000/plan year, the individual will be instructed (and assisted by service coordinator if necessary) to submit application to MO Health-Net (Medicaid) in order to access funding for TCM, waiver services and/or other available services through Medicaid. If the individual is determined ineligible for MO Health-Net due to excess income and/or resources, he/she will be expected to utilize the excess income and/or resources to pay for services or meet spenddowns in order to gain MO Health-Net eligibility.

Should an individual choose NOT to apply for MO Health-Net or choose NOT to expend excess resources and/or income to gain MO Health-Net eligibility, funding to that individual shall be limited to $2000 per plan year. An exception to this policy may be granted by Board vote when such exception is recommended to the Board by the Utilization Review Committee.

The Board will not consider any requests for funding in cases where reimbursement is requested for previously-conducted transactions or agreements. All services or items must be approved prior to delivery.

Requests for funding for individuals shall be submitted to the Board office during business hours on the Individual/Family Application for Funding form, with signature by the applicant or legally responsible party (parent, guardian, etc.). Service coordinators are expected to assist families and individuals as needed with completion and submission of the applications.

Recurring support expenses shall be authorized to coincide with the individual's person-centered plan year, and the need for continuation as well as the possibility of accessing other funding sources for the support expense shall be reviewed when the person-centered plan is renewed annually. Should additional funding be needed prior to the end of the plan year, an additional request for funding will be necessary.

Individual Eligibility

1. **Eligibility determination**: In order to qualify for service coordination and/or any other services or items funded through the Board, the individual must be evaluated and determined eligible for Division of Developmental Disabilities services through the established MO-DMH intake and referral process (with the exception of Learning Center programs which are specifically designated to be open to the public and/or to include family members/caregivers/support staff for persons with developmental disabilities).

2. **Residency Requirement:**

With regard to Individual Funding requests which are submitted in accordance with the Board's funding policy and where the funding is provided through either the Adair County SB40 Tax Levy or DMH payments received for TCM services delivered, the residency qualifications are:

For Board funding generated through revenue from the *Adair County SB40 tax levy* or TCM services delivered to residents of Adair County, the person with developmental disabilities must reside in Adair County.

For Board funding generated through revenue from *TCM services* delivered by the Board to residents of Putnam, Schuyler, Scotland, or Sullivan County, the person with developmental disabilities must reside in Putnam, Schuyler, Scotland, or Sullivan County.

For the purposes of this policy, the term *'reside in'* is defined as 'the place of domicile; meaning living in that locality with the intent to make it a fixed and permanent home.'

Waiver Requirements:

The Board may waive the eligibility requirements as set forth above for the applicants on a case-by-case basis, if the Board finds:

The person to be served has a unique or unusual relationship to a particular county which warrants such waiver;

or

Orderly operation of a Board administered or funded program warrants the waiver of residency requirements for such person.

Utilization Review and Funding Decisions

The Agency's Utilization Review ('UR') Committee shall meet at least once per week, with special sessions to be convened as required for emergency needs. The UR Committee shall be made up of: the Board's Executive Director, Business Manager, and the Service Coordination Supervisors, with a minimum of 3 voting members required to review funding requests.

Requests for funding of services and support which include (or may potentially include) state or federal funding MUST be submitted by the service coordinator to his/her supervisor using the standard authorization request form. These requests are subject to review and approval by the DSC or Executive Director before submission to the Utilization Review Coordinator at the Regional Office or satellite Regional Office.

All individual/family requests for funding solely through the Board shall be reviewed by the Board's Utilization Review Committee no later than ten working days following the receipt of the signed application for funding by the service coordinator or other Board personnel. The service coordinator assigned to the individual/family shall submit the request form along with a completed Priority of Need form to the Service Coordination Supervisor.

Utilization Review Guidelines

The following questions shall be considered in making decisions to fund individual requests:

a. Is the service/item requested directly related to the person's disability? Is it something that would not be a need if the person did not have a disability, or is it something that persons without disabilities also need and that families typically provide for their children? (Examples: medical insurance, routine dental care, generic shelter/food/clothing expenses, daycare for children up to the age of 12, routine school expenses, etc.)

b. Is the provision of the needed service or item typically the responsibility of another governmental agency? (Examples: Social Security Administration, Division of Social Services, MO Healthnet, DESE, Vocational Rehabilitation, Housing Authority, Comprehensive Psychiatric Services, etc.) In these cases, the service coordinator shall assist the individual/family to contact and access the appropriate agency(ies) to obtain the needed service, support, or item, including utilization of the agency's appeal process when appropriate.

c. Is the service/item for which funding is requested a "need" rather than a "want"? To answer this question, consider the severity of consequences which may result if the service/item is NOT provided. Prescriptions for medical needs such as therapies, supplies, durable medical equipment and adaptive clothing/devices should be provided. (Documentation that a service or item has been approved through the Utilization Review process and placed on the Regional Office waiting list is considered sufficient indication of need.)

d. Is the service or item requested consistent with the individual's person-centered plan? Are the reasons and objectives for this service or item clearly documented in the person-centered plan? Is the Priority of Need (PON) score clearly supported by information in the plan?

e. Have natural supports or other ways to meet the need been fully explored and accessed? Is the proposed solution the most cost-effective way to meet the need? It is the service coordinator's responsibility to insure that all other potential support and resources are explored and accessed prior to submission of an application for funding through the Board.

f. What is the priority of need as determined by the Utilization Review Committee? (May be determined by the Regional Office or Board's Utilization Review Committee, depending on whether or not state or federal funding is included in the funding request.) Are there other funding requests with higher PON scores that need to take precedence in light of available funding?

g. How much funding has the individual received from the Board in the past? Are there other individuals with comparable level of need of supports who have received minimal funding through the Board in the past? (In cases where funding is limited, persons who have received minimal past funding should take precedence over persons who have received significantly higher past funding when priority of need is the same for both.)

h. If a request involves renewal of a service funded in the past year, is reapproval of the funding at the same rate for the same service clearly justified? Were all authorized services for the past year fully utilized? If not, why not? Were the funded services effective in accomplishing the established objectives?

<u>Utilization Review Decisions</u>
The Board's UR committee, after thorough review of a request, may take any one of the following actions by majority vote of persons present:

a. Approve a request of up to $2000 for a specific item or service, and for up to $3000 total for a combination of services for one individual. This includes approval of a qualified individual for a Partnership for Hope Waiver ('PfH') slot, since the County Board match for a slot should not exceed $3000 (20% of maximum exception cap allowed to PfH waiver at $15,000) and a combination of services may be accessed through a Partnership slot.

b. Recommend approval of a request to the Board of Directors if the amount of the request exceeds the limits set forth in "a" above. In this case, the request shall be presented to the Directors at the next scheduled meeting.

In case of emergency need for approval, the Executive Director shall e-mail a summary of the individual's circumstances and request (containing no identifying information to protect the individual's privacy) to the Directors for their review and approval/denial vote via return e-mail.

c. Refer a request back to the service coordinator for revision of person-centered plan to better support the request, to explore additional resources suggested by UR to meet the need, or to discuss alternative solutions or revised level of supports with the individual/family. In this case, the service coordinator shall carry out the UR committee's instructions and resubmit the revised request and/or plan to the UR committee within ten business days of the initial UR review.

d. Deny a request based upon the Utilization Review Guidelines set forth above. In this case, a letter shall be sent by the Executive Director or her designee to the individual/legally responsible party explaining the reasons for denial of the service within 5 working days of the UR committee decision. The individual/legally responsible party will have thirty days from the date of the letter to appeal the decision to the Board of Directors as per the appeal process stated below.

Waitlists

If a request is approved by the UR committee but the Board has insufficient funds available to address the need, the request shall be documented on the agency waitlist with the name of the individual, the service/item requested, the amount requested, the date approved by the UR committee and the PON score. The requests on the agency waitlist shall be reviewed at least once per month to determine if any other funding may have become available or any other resources may have been discovered to meet the need. As funding becomes available, priority should first be given to those needs with the highest PON scores, and then to those needs which have been on the waitlist for the longest period of time.

The decision of the Board on a request submitted to the Board of Directors by the UR Committee shall be the final decision and is not subject to appeal. The decision to place a request on the Waitlist due to a lack of available funding is not subject to appeal.

Appeal Process

Should a request for individual/family funding be denied or the level of support be reduced by decision of the Board's Utilization Review Committee, a letter shall be sent to the individual/legally responsible party by the Executive Director or her designee within 5 working days of the decision, explaining the reason(s) for the denial. The individual or legally responsible party shall have 30 days from the date of the letter to appeal the Committee's decision, either by a written or verbal request for appeal delivered directly to the Executive Director or Business Manager.

When a request for appeal of a UR decision is received, the Executive Director shall schedule a closed session for the next regular Board of Directors meeting during which the Directors will hear the appeal. The Executive Director shall inform the individual/legally responsible party in writing of the time and location for the meeting and of his/her right to attend this closed session in order to present the request to the Board of Directors directly. The Executive Director will also present the UR Committee's reasons for denying the request or reducing the level of support. The Board of Directors' decision on the matter will be final and not subject to further appeal.

Ability to Pay

As a Public Entity, it is incumbent upon Adair County SB40 ('the Agency') to make a concerted effort to collect fees for services from clients or spouses, and/or parents or clients who have an ability to pay. Individuals and their families have the obligation to pay for the cost services within their capacity, without imposition of long-term financial obligation and/or material disturbance of their standard of living for necessities.

Fees may be charged to clients of the Agency based upon a determination by the Agency's Utilization Review Committee of their ability to pay based upon the current rate structure for the type of service provided.

No client will be denied services because of an inability to pay. Clients will be charged the full cost per unit of service based on the current rate structure, and will be billed an amount up to their ability to pay. The liability of the client shall not exceed the full cost of services provided.

Ability to pay determinations shall be in effect for the service year commencing on the date of the client's first service, rather than a calendar year. The determination of financial liability shall be made by the Agency prior to the admission of the individual to any Agency funded program.

Agency clients, or their responsible parties, shall be requested to make available to the Agency any relevant or pertinent financial information which the Agency deems essential for the purpose of determining eligibility to pay.

Consumer Services

TARGETED CASE MANAGEMENT

QUALITY ASSURANCE MONITORING

COMMUNITY LEARNING CENTER

TARGETED CASE MANAGEMENT

Requirements for Case Management Eligibility

Adair County SB40 provides Targeted Case Management ('TCM') services to individuals with developmental disabilities in Adair, Putnam, Schuyler, Scotland and Sullivan counties. To qualify for TCM, a person must be determined to be eligible for the services through the State Division of Developmental Disabilities as defined in Missouri Statute RSMo 630.005.

RSMO 630.005:

(9) "Developmental disability", a disability:

e. Which is attributable to:
   - c. Intellectual disability, cerebral palsy, epilepsy, head injury or autism, or a learning disability related to a brain dysfunction; or
   - d. Any other mental or physical impairment or combination of mental or physical impairments; and

f. Is manifested before the person attains age twenty-two; and

g. Is likely to continue indefinitely; and

h. Results in substantial functional limitations in two or more of the following areas of major life activities:
   - g. Self-care;
   - h. Receptive and expressive language development and use;
   - i. Learning;
   - j. Self-direction;
   - k. Capacity for independent living or economic self-sufficiency;
   - l. Mobility; and

(e) Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, habilitation or other services which may be of lifelong or extended duration and are individually planned and coordinated;

Adair County SB40 shall meet the requirements specified in the Targeted Case Management Contract with the Missouri Department of Mental Health, State Division of Developmental Disabilities.

If the person has Medicaid, the service coordinators' time spent providing TCM services will be billed to his or her Medicaid; if the person does not have Medicaid, no charges for TCM shall be billed.

Intake/Application Process

Individuals with disabilities and their families who believe that they meet the eligibility criteria for receiving Adair County SB40 Support Coordination services must first be determined eligible for those services by the Intake Coordinator of the Missouri Department of Mental Health, Division of Developmental Disabilities. Once eligibility is confirmed, the DMH Intake Coordinator will electronically transmit the completed referral packet to Adair County SB40. Upon Agency acceptance, Adair County SB40 will assign a Support Coordinator within five (5) business days.

Each person eligible to receive TCM services through Adair County SB40 will be assigned a Support Coordinator. The Director of Service Coordination, or designee, will determine assignment of the Support Coordinator to each individual based upon individualized criteria that best meets the needs of each person and the knowledge, experience or background of each Service Coordinator. Disputes over assignment of the Service Coordinator will be reported to the Executive Director. All disputes will be reviewed within five (5) business days. Upon review of the dispute, the Executive Director shall make final determination of the assignment.

Consumer Rights

Support Coordinators will ensure that each individual and their family members, as appropriate, are informed of and understand their rights to the best of our ability. This includes but is not limited to:

- The right to due process for before any rights and services can be limited or taken away.
- The right to be treated with respect at all times, to be treated as a person like everyone else under the law.
- The right to be free from abuse and/or neglect.
- The right to lead the planning process.
- The right to confidentiality with regard to all contact and interaction with the Agency and Agency Staff.
- The right to privacy, spending time alone and interacting with others privately.
- The right to have a safe, clean home; to choose where to live, whom to live and associate with, have meals that are healthy and the right to accessible, equitable medical care.
- The right to free and appropriate public education.
- The right to have maximum independence and the least restrictive environment, including access to the community, participation in community organizations of choice and access to media.
- The right to choose someone to assist with making decisions and/or act on individual's behalf.
- The right to have a job and make money.
- The right to control your personal money, pay your bills and manage your money.
- The right to keep and control personal possessions.
- The right to see files, data, information in a way that the individual can understand and kept private.
- To understand how to make a complaint and be helped without fear of repercussions.

Furthermore, Adair County SB40 Service Coordinators are committed to advocating for the protection of the rights of individuals by:

- Ensuring individuals served are free from abuse, neglect, and exploitation; reporting suspected abuse or neglect in accordance with specified procedures; and providing follow-up as necessary.
- Ensuring that incidents are reported in a timely manner in accordance with policy and follow-up Responsibilities are identified and completed.
- Notifying the individual, planning team, and service provider and revising the ISP whenever services are changed, reduced, or services are terminated.
- Reporting any suspected violations of contract, certification or monitoring/licensing requirements to the Director of Service Coordination and the State Division as required.
- Entering required information into the electronic health records in an accurate and timely manner.
- Ensuring that individuals/families are offered informed choice of service provider.

TCM Management Review Process

Agency Service Coordinators (SCs) will submit all Individual Plans, Addendums to the plans, Utilization Review requests and Due Process documentation to Agency's review email (reviews@sb40life.org). All submissions will be reviewed by the Director of Service Coordination or the Assistant Director of Service Coordination, or their designee. The submission will be returned for corrections and updates as needed. Submissions are to be filed by the DSC or designee.

On-Call, 24/7 Access

The Agency will provide the individuals/guardians information regarding how to contact the Support Coordinator/TCM office for assistance, including what to do in cases of emergencies and/or after hours. The afterhours contact number will be for the Kirksville Regional Office, who will be provided emergency contact information for the Agency for use in emergency situations requiring immediate information or assistance from the Agency.

Residency Requirements for Targeted Case Management (TCM) Intakes and Transfers:

As self-advocates say "Nothing about us without us" and "The mission of the Adair County SB40 is to engage in ADVOCACY, promote INCLUSION, and provide essential RESOURCES to assist people with developmental disabilities to live self-determined lives."

Adair County SB40 resolves people with developmental disabilities are best able to advocate for themselves, be included in their communities, and be connected to resources in their communities with the aid of Service Coordinators who have a strong connection to their same communities.

Furthermore, as it is required per the Department of Mental Health Division of Developmental Disabilities (DMH-DD) to conduct assessments and Individual Support Plan meetings in-person except when DMH-DD has modified requirements due to health emergencies; and

As "Individual Support Plan Monitoring and Review includes interaction with individuals in services. This monitoring and review include talking with the individual, observation, and review of documentation." (Individual Support Plan Monitoring and Review, Division Directive Number 3.020); and

As DMH-DD has established a minimum frequency of in person visits/contacts except when DMH-DD has modified requirements due to health emergencies and stated "It is expected that Support Coordinators exercise professional judgement and increase visits according to the individual needs of people. Unannounced visits may occur." (Individual Support Plan Monitoring and Review, Division Directive Number 3.020, p. 3),

Therefore; Adair County SB40 will accept intake and transfers for Service Coordination only for those people with intellectual/developmental disabilities who reside in Adair, Putnam, Schuyler, Scotland, or Sullivan Counties. For the purposes of this policy, the term 'reside in' is defined as 'the place of domicile; meaning living in that locality with the intent to make it a fixed and permanent home.'

Exception: Adair County SB40 will provide Courtesy Service Coordination for people who have documented plans to move to Adair, Putnam, Schuyler, Scotland, or Sullivan Counties within thirty (30) calendar days and will begin providing Service Coordination after the person has completed the DMH-DD Transfer Process as allowed per the current TCM Contract.

The Agency reserves the right to reject services if the transfer packet is incomplete upon audit review or if the individual does not plan to permanently reside in the Agency's service area.

Waiver Requirements:

The Board may waive the eligibility requirements as set forth above for the applicants on a case-by-case basis, if the Board finds:

The person to be served has a unique or unusual relationship to a particular county which warrants such waiver;

or

Orderly operation of a Board administered or funded program warrants the waiver of residency requirements for such person.

At the discretion of Agency management, individuals transferring out of the Agency service area may remain in our services for a reasonable period of time to assure the transition is successful for the individual involved.

Residency Requirements for Individual Funding Requests

With regard to Individual Funding requests which are submitted in accordance with the Board's funding policy and where the funding is provided through either the Adair County SB40 Tax Levy or DMH payments received for TCM services delivered, the residency qualifications are:

For Board funding generated through revenue from the *Adair County SB40 tax levy* or TCM services delivered to residents of Adair County, the person with developmental disabilities must reside in Adair County.

For Board funding generated through revenue from *TCM services* delivered by the Board to residents of Putman, Schuyler, Scotland, or Sullivan County, the person with developmental disabilities must reside in Putman, Schuyler, Scotland, or Sullivan County.

For the purposes of this policy, the term *'reside in'* is defined as 'the place of domicile; meaning living in that locality with the intent to make it a fixed and permanent home.'

Waiver Requirements:

The Board may waive the eligibility requirements as set forth above for the applicants on a case-by-case basis, if the Board finds:

The person to be served has a unique or unusual relationship to a particular county which warrants such waiver;

or

Orderly operation of a Board administered or funded program warrants the waiver of residency requirements for such person.

At the discretion of Agency management, individuals transferring out of the Agency service area may remain in our services for a reasonable period of time to assure the transition is successful for the individual involved.

Role and Responsibilities of Support Coordinator

Adair County SB40 Support Coordinators shall provide TCM services to Medicaid eligible participants as follows:

a. Assessment - identifying the need for medical, social or other services and completing related documentation, and gathering information from other sources.

b. Development of an individual support plan - Based on information collected through the assessment, develop service goals and identify a course of action to address the medical, social, and other services the eligible individual needs, with active participation of the eligible individual (or authorized healthcare decision makers) and others to respond to assessed needs.

c. Referral and related activities to help eligible individuals obtain needed services - This includes activities that help link with medical, social or educational providers or other programs that are capable of providing needed services to address identified needs and achieve goals in the individual support plan.

d. Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the individual support plan is effectively implemented and is adequately addressing the individual's needs, which may include contacting the individual's family members or service providers, or other entities or individuals to help determine whether:

1. Services are being furnished in accordance with the individual support plan;
2. The services in the individual support plan are adequate;
3. Changes in the individual's needs or status exist;
4. Proper documentation is maintained;
5. Individual's rights are protected.

Adair County SB40 Support Coordinators will also provide Service Coordination services to non-Medicaid eligible persons as follows:

a. Assessment - identifying the need for specific services, including through Parent Advisory Council (PAC) and/or General Revenue (GR) funding.

b. Development of an Individual Support Plan (ISP) based on information collected through the assessment, develop service goals and identify a course of action to initiate and maintain identified services through PAC and/or GR funding.

1. ISPs for individuals receiving Service Coordination only will not require UR Review or submission of documentation of service need, may be held by phone or in person, and consent may be obtained via email, phone, electronic signature, or written signature.

c. Referral and related activities to initiate and maintain identified services through PAC and/or GR funding.

d. Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the identified funded services are effectively implemented and adequately addressing the individual's needs.

Selection and Assignment of Support Coordination

Adair County SB40 Support Coordinators who provide Targeted Case Management Contract ('TCM') services shall meet qualifications and competencies as described in the TCM Agency contract with the Missouri Division of Developmental Disabilities.

Upon referral of an eligible individual, the Director of Service Coordination, or designee, will identify a Support Coordinator within its agency. The individual can inform the Agency of any preference they may have in Support Coordinator, but there is no guarantee that the Support Coordination Agency will be able to assign the preferred Support Coordinator to the individual.

Once assigned, the Support Coordinator will contact the individual to be served within five (5) business days of the agency's receipt of a complete referral packet. The assigned Support Coordinator will meet to begin the planning process within thirty (30) days. The initial individual support plan will be completed within sixty (60) calendar days of the agency's receipt of a complete referral packet. The individual support plan shall be updated at least annually and submitted to Utilization Review at least 30 days prior to the implementation date or when warranted by changes in the waiver participant needs.

Changing Support Coordinator

If an individual wishes to change Support Coordinators, he/she may request a change in Support Coordinator by contacting the Director of Service Coordination, designee, or the Executive Director of the Agency. The Agency will make every effort to accommodate the request and assign a new Support Coordinator to the individual, but is not obligated to do so.

Typically, Support Coordination reassignments are conducted on the 1st of the month. As soon as the new Support Coordinator is assigned, information already gathered and developed – including contact and demographic information, planning documents such as the Individual Support Plan ('ISP'), monitoring tools, etc. – will become available to the newly assigned Support Coordinator through the electronic records maintained by the Agency.

In the event that a Support Coordinator leaves the Agency's employment, the DSC, or designee, will assign a new Support Coordinator within five (5) business days.

Every effort will be made to assign the most appropriate and qualified Service Coordinator to meet the person-centered needs of each individual. The DSC, or designee, will notify the individual and their families once the new Support Coordinator is assigned. Any conflicts or complaints arising from the assignment of Support Coordinator to individuals will be resolved by the Executive Director, who is assigned full and final authority.

Planning Meetings

The Support Coordinator assigned to each individual is responsible for scheduling and facilitating planning meetings when developing each Individualized Support Plan. These planning meetings will take place no less than annually, and as frequently as necessary in order to meet the changing needs of the individual served. Planning supports involves:

- Interviewing the individual and ensuring he/she is at the center of the planning process and in determining the outcomes, services, supports, etc. that he/she desires.
- Also interviewing, if appropriate, the family or other involved individuals/agency staff; reviewing/compiling various assessments or evaluations to make sure this information is understandable and useful for the planning team to assist in identifying needed supports; and facilitating completion of discovery tools, if applicable.
- Scheduling and facilitating planning team meetings in collaboration with the individual; informing the individual and parent/guardian that the service provider(s) can be part of the planning team, asking the individual and parent/guardian if they would like to include the service provider(s) at the ISP meeting, and inviting the service provider(s) to the ISP meeting; writing the ISP; and distributing the ISP to the individual, all team members, and the identified service providers; and reviewing the ISP through monitoring conducted at specified intervals.
- Ensuring that there has been a discussion regarding a behavior plan for individuals with behavioral concerns and that a positive behavior plan is in place as needed, particularly when the individual is assigned acuity due to behavior. This shall be documented in the individual's ISP.
- Ensuring that there has been a discussion regarding the medical needs of the individual and that these needs are documented in the ISP. This is to include the need for data collection of bowel movements, urine output, seizure activity, etc. Should the planning team agree that such data collection is medically necessary, and the individual's primary care physician provides a prescription for it, this shall also be documented in the ISP along with the responsible party who will record and store the information.
- Monitoring and following up to ensure delivery of quality services, and ensuring that services are provided in a safe manner, in full consideration of the individual's rights. This includes ensuring that for individuals residing in provider-owned or controlled residential settings (i.e., ISLs, Host Homes, etc.) and/or attending day habilitation programs, pre-vocational programs and group supported employment programs.
- Following the rights to due process with any program that implements any restrictions (Examples include, but are not limited to: Inability to access food at any time due to a medical disorder; Inability to have access to items due to PICA). That the due process review is supported by a specific assessed need and justified in the person-centered service plan.

Resolving Differences of Opinion among Planning Team Members

It is the intent of the Agency to resolve disputes in the most conciliatory manner possible, consistent with the best interests of recipients, the organization and the community it serves. In the event of the development of any dispute regarding the individual planning process for any person served, any and all parties are encouraged to contact the Director of Services Coordination ('the DSC'), or designee, for mediation.

Should the issue remain unresolved after it has been addressed by the DSC, any and all parties involved are encouraged to contact the Executive Director of the Agency. The Executive Director of the Agency is

responsible for ensuring that all stakeholders are engaged in solution planning, including referral(s) to an advocacy group or individual from outside of the organization to assist with the mediation process.

The Executive Director is assigned full and final authority for resolution. Nothing in this policy shall conflict with the right to due process before any rights and services can be limited or taken away.

Changes to the Service Plan

It is the expectation that Service Coordinators will engage in continuous person-centered planning processes that result in integrated and comprehensive annual plans that are reflective of and responsive to the strengths, interests, needs, and desired outcomes of the individuals served. The Service Coordinator will work collaboratively with the individual and all stakeholders to assure this process.

The Service Coordinator will encourage and respond to any suggestions for updates and necessary changes to the Service Plan. In other words, individuals will ***never*** need to wait until the annual planning process is scheduled in order to respond changes in the needs or identification of unmet needs of individuals. Through monthly and quarterly service monitoring, each Service Coordinator is expected to understand the needs of individuals and the appropriateness of the current plan for those individuals. Changes to that plan can be requested at any time and should be responded to by the Service Coordinator in a timely manner.

The specific procedures to be followed to request and implement changes to the Service Plan will be determined by the Director of Service Coordination (the DSC), or designee. These procedures may be adapted as necessary, and as approved by the DSC, or designee, due to agency or regulatory evolving requirements.

Discharge from Case Management Services

Discharge from TCM Services, (‘Case closure’), involves terminating a person from the service delivery system. The assigned Support Coordinator (‘SC’) will complete discharge summaries or other forms for recording the individual's removal from the services delivery system. Sometimes this is done as a result of the individual's death. The required documentation, including the discharge summary, will be submitted to TCM Management by the SC. The Director of Service Coordination, or designee, shall forward the required documentation to the appropriate Division staff for case closure. Although case closure services provided after the date of death should be logged, the SC should prevent the service being billed to MO HealthNet by logging as a non-billable activity. Documentation will include a case note, the discharge summary, quality assurance review and all relevant communications (email, written notices, etc.), in the individual's file

Remote Monitoring – Pandemic Response

Adair County SB40 services and programs play an integral part in the community’s health care system, including supporting people during viral or infectious disease. However, we know that isolation, lack of service monitoring and loss of essential supports also harms the individuals that we serve, including during an infectious disease outbreak. Therefore, Adair County SB40 essential programs and services will be continued to the maximal extent possible with appropriate modifications to assure the safety and security of all involved.

Service Coordinators are expected to take all necessary precautions to keep themselves safe while still providing quality service monitoring which ensures the health and well-being of everyone that we serve. For more information, please refer to the Infectious Disease or Pandemic plan in the Agency’s current *Emergency & Disaster Plan*.

Provider Relations

Provider Choice

Persons receiving services from the Agency shall be offered fully informed choice of providers of services and supports identified in the individual planning process. An up to list of providers for each type of service and support shall be maintained by the Agency and presented to the individual during the planning process. The Service Coordinator will support maximum control and the self-determination of each person during planning.

The choice of the persons served in service providers will at all times be respected and, whenever possible, accommodated. When choice of providers cannot be accommodated, mutually acceptable alternatives will be negotiated. All requests and rationale for accommodating the request shall be documented in the file of the person served. Potential alternatives, choice of alternative or reason for not accepting the alternate provider shall also be identified and documented.

If an acceptable alternative cannot be negotiated, the Service Coordinator will inform the person of their right to contact the Director of Service Coordination (the DSC), or designee. The DSC may consult, mediate and/or intervene as necessary. The Executive Director will render the final determination on all disputes of provider choice.

Service Monitoring

Service Coordinators (the SC) will conduct monitoring of services and supports offered by providers in accordance with the plan. The SC shall assess services delivered by the provider and problem solve any identified issues regarding service provision in collaboration with the person served, guardians/authorized representatives, provider representatives and other stakeholders. The SC will facilitate the sharing of information between providers of medical services, behavioral health services, social, educational, vocational, housing and community services as needed. The SC is responsible for adhering to the established procedures for service monitoring and documentation of such monitoring as determined by the Agency's DSC, or designee, in accordance with the TCM Contract and Medicaid requirements.

In the event of an unresolved issue between a Service Provider and individual, the SC will report the situation to the DSC. The DSC, or designee, will direct the SC in responding to the situation. All communications will be documented by the SC. All contact with the Service Provider is expected to be conducted in a positive and professional manner.

Service Provider / Agency Communications

The DSC will assure ongoing communications between Agency staff and Service Provider staff. In addition, the DSC, and/or designee, will meet with Service Provider Management as needed and on a routine basis to address any and all unresolved issues arising out of the provision of the Agency's TCM services and service monitoring.

It is the intent of the Agency to maintain positive and professional working relationships with all individuals outside of the organization who are involved with the delivery of services and supports to persons served.

QUALITY ASSURANCE MONITORING

Adair Count SB40 services are founded upon a value of Excellence. The staff of this organization have committed to go *beyond compliance* in delivery of services, to meet current needs and anticipate future needs, of the people we support.

Performance & Outcome Measures

Adair County SB40 (the Agency), in compliance with the TCM Contract with the State Division, shall ensure that

- Individuals that are Medicaid eligible are provided due process and an opportunity for a fair hearing.
- Services support of each individual's Individualized Service Plan (ISP) based on a person-centered planning process.
- Support Coordinators sign a Confidentiality Statement to safeguard the use or disclosure of information concerning applicants and eligible individuals and county and state records and information.
- Fully cooperate with the State Division and share all information related to abuse/neglect investigations at the time when they are initiated, quality assurance, and enhancement plans and any other information necessary for the Agency to properly carry out its TCM service responsibilities.
- Support Coordinators employed by the Agency **are mandated reporters of suspected abuse or neglect under State law** and shall report to the Kirksville Regional Office such suspected abuse/neglect as occur in Department contracted settings as required by State law and regulation.
- When the Agency determines that services are not being furnished in accordance with the plan of care or that services provided are inadequate in terms of quality, the Agency shall intervene to address the problem. The Agency shall submit findings into the State Department's approved electronic systems as required so that the Agency and the Department may jointly address issues through the Quality Enhancement process.
- The Agency shall participate in the collection and evaluation of outcomes data, including consumer satisfaction survey data, performance measure trend reports, and annual TAC review reports, as required by the State Department.
    - If requested by the State, the agency shall establish, implement, and monitor a plan of action to improve outcomes and consumer satisfaction.
- In accordance with Health, Safety and Rights assurances set forth by the Centers for Medicaid and Medicare Services (CMS) for 1915c waivers operated by the Division of Developmental Disabilities, TCM Support Coordinators shall ensure completion of health risk screenings using the Department's approved computerized systems as required.
    - The TCM Support Coordinator shall ensure that needed supports identified through the health risk screening process are incorporated into the Individual Support Plan (ISP) and monitored accordingly.
    - The TCM Support Coordinator shall ensure that identified areas through the HRST process requiring a plan of action are developed and issues remediated.
- The TCM support coordinator shall ensure that identified services and support needs are incorporated into the individual support plan and shall monitor progress to ensure identified needs are being addressed through support monitoring.
- The TCM support coordinator shall ensure that any identified need for nursing services and supports are requested through Utilization Review (UR).

- The Agency shall ensure that the TCM support coordinator reviews the provider's monthly documentation, to include reviewing the Community RN (Registered Nurse Oversight) Monthly Health Summary in the Department's approved electronic system utilized for health risk screenings for individuals receiving DD residential placement services, as required.
- The Agency shall comply with and meet performance requirements in accordance with the Centers for Medicare and Medicaid Services (CMS) 1915 (c) Waiver Sub-Assurances as listed in Attachment C of the TCM Contract between the Agency and DMH/Division of DD.
- The Agency shall provide the Division a report of provider outcomes and continuous quality improvement efforts at the end of each fiscal year quarter.

Performance Measures

Performance Measures in accordance with the TCM Contract between the Agency and DMH/Division of DD require that:

1. The Agency assign a Support Coordinator for the individual to be served within five (5) business days.
2. The Agency shall develop an initial, individual support plan within thirty (30) calendar days of the contractor's receipt of a complete referral packet.
3. The Agency update the individual's support plan on, at least, an annual basis.
4. That the Agency maintain a written performance measure report which shall be available for review or submitted to the Department upon request. Performance measures are:
    a. Upon acceptance of an eligible individual, a Support Coordinator shall be assigned for the individual to be served within five (5) business days.
    b. An initial individual support plan shall be developed within thirty (30) calendar days of the contractor's acceptance of the referral.
    c. For plans that must be submitted for Utilization Review, the individual support plan shall be updated at least annually and submitted to the UR Committee at least 30 days prior to the implementation date, or when warranted by changes in the waiver participant needs.
5. Information from the quarterly waiver performance measure reports will be communicated to the Agency when applicable in relation to the Agency's role. The information shared supports remediation of identified areas for improvement to meet the established CMS waiver assurances.
6. Adair County SB40 shall meet CMS assurance requirements related to the TCM Contract between the Agency and DMH/Division of DD (Attachment C).

BEST PRACTICES

Adair County SB40 is committed to assuring the greatest possible positive outcomes for individuals served through implementation of Best Practices in the provision of TCM services. Staff will be provided the training and resources necessary to grow their knowledge and understanding of the following practices. The responsibility for implementation of these Best Practices fall to every employee of the Agency, with the primary oversight of the Director of Service Coordination, Assistant Director of Service Coordination and the Quality Assurance Team Support.

Motivational Interviewing

Motivational interviewing is a method of interviewing which will be used in the Agency's TCM Services to help people change challenging behaviors that have become barriers to making positive life decisions. It is a practical, short-term, person-centered process in which the Support Coordinator recognizes individual strengths and brings them to the forefront whenever possible. Support Coordinators demonstrate strategies that:

1. Express empathy for each individual, using reflective listening skills.
2. Help individuals to identify gaps between their goals and values and their current behaviors.
3. Avoid direct confrontation, arguments, persuasion, manipulation or coercion.
4. Grow each individual's belief in their capacity to act in the ways necessary to reach specific goals.
5. Incorporate Positive Behavior Supports into the individual plans which will increase the quality of life, teach new skills and lead people to achieving their goals.
6. Resolve ambivalence and develop internal motivation to change behavior.

Person Centered Planning

Adair County SB40 Support Coordination Services are committed to the principals of Person-Centered Planning with all individuals served. In designing the plan, the planning team should consider the unique characteristics and needs of the individual as expressed by the individual and others who know the person, such as family, friends, service providers, etc. Outcomes, services, and providers identified in the plan should:

- Recognize and respect each individual's rights;
- Encourage independence;
- Recognize and value competence and dignity;
- Respect cultural/religious needs and preferences;
- Promote employment and social inclusion;
- Preserve integrity;
- Support strengths;
- Maintain the quality of life;
- Enhance all domains/areas of development;
- Promote safety and economic security;

Support Coordinators and approved service providers must include the individual in problem-solving and decision-making, and ensure that services are provided in a non-intrusive manner. Thus,

1. Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.
2. The Agency monitors service plan development in accordance with its policies and procedures.
3. Service plans are updated/revised at least annually or when warranted by changes in the waiver participant needs.
4. Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.
5. Participants are afforded choice between waiver services, between/among waiver services and between/among service providers.

Self Determination

A core value of the Agency's services is to advocate for each individual's right to Self-Determination.

Self-Determination promotes people choosing and setting their own goals, being involved in making life decisions, self-advocating, and working to reach their goals. Self-Determination is about people taking action in their life to get the things they want and need.

People with intellectual and developmental disabilities have the same right to Self-Determination as all people and are entitled to the freedom, authority, and supports to exercise control over their lives.

Support Coordinators will work to assure that

- Individuals receiving agency services have opportunities, respectful support, and the authority to exert control in their own life, with decisions that are honored and the opportunity to succeed or learn from failure.
- Services will include information and education that assists those served to understand that they direct and influence circumstances that are important to them.
- Self-Determination contributes to positive outcomes in areas like employment, education, community living, and an improved quality of life.

Trauma Informed Approach

A Trauma Informed Approach seeks to serve a person based on a kind and compassionate 'What happened to you?' rather than the 'What's wrong with you?' approach. All staff will be supported in a manner that prevents and/or addresses secondary trauma to the maximum extent possible. The agency will promote self-care and the well-being of staff. In addition, all Agency services will be provided to individuals using a trauma-informed approach. All staff of the agency will be trained and informed on the key elements of a trauma-informed approach based upon the following principles:

1. Safety – providing services and supports that foster a sense of physical, emotional and spiritual safety through healthy boundaries and communication.
2. Trustworthiness and transparency – all communications are consistent, have clarity, and reflect positive and professional collaboration.
3. Peer Support – Peer support throughout the Agency staff and management is strongly encouraged and enhance interventions such as advocacy, crisis response and recovery, education and resource development.
4. Collaboration and mutuality – Individuals served, staff and stakeholders are encouraged to participate in the shaping of agency policy and programs.
5. Empowerment, voice and choice – staff and management build an agency culture that appreciates the knowledge and expertise of everyone involved, listening to each individual voice and encouraging all individuals served to make their own choices.
6. Cultural, historical and gender issues – staff and management of the agency will receive appropriate tools and training necessary to provide culturally competent and gender responsive services.

Support Coordinators will incorporate these elements into the TCM services of all individuals served, and:

1. Realize the prevalence of trauma in individuals with Intellectual and Developmental Disabilities;
2. Recognize how trauma affects all individuals involved with the program, organization, or system, including its own workforce; and
3. Respond by putting this knowledge into practice, including
    a. All individuals served will be screened for trauma as early in the intake process as possible, taking measures so that program participants minimize the need to retell their trauma story.
    b. Respecting individuality by using the person's preference of person-first or identity-first language.
    c. Minimizing practices that may trigger emotions due to past traumas.
    d. Respecting that each person's experience is unique.
    e. Offering choice with regard to services and supports.
    f. Providing multiple and diverse opportunities for individuals to provide feedback about services received.

Least Restrictive Approach

Least restrictive approach is a principle that guides the services of Adair County SB40. All staff of the agency are expected to perform duties in a way that demonstrates a commitment to providing life settings and services in the least restrictive way.

The Least Restrictive Approach for each person may look different because people are unique. In agreement with Federal Law, (IDEA, 1975), the Agency maintains the right of every individual to be educated, to live, work and play, to the maximum extent appropriate, in settings that are inclusive alongside individuals without disabilities in their own communities.

In the delivery of Support Coordination services and Agency programming, the Agency will take every measure available to assure that services are provided only be as restrictive as the individual's needs require.

Employment

Adair County SB40 is committed to promoting the employment of individuals with intellectual and developmental disabilities in competitive and integrated employment settings in their communities.

Individuals will be supported and encouraged to seek opportunities which offer transition planning, skill development and career exploration which keeps them on an ever-progressing pathway to vocational success.

All policies, procedures and practices of the Agency will support this vision and promote this vision with the communities served.

Assistive Technology

The Agency recognizes the independence and cost efficiencies that advancements in Assistive Technology provides for persons served. All activities of the Agency will endeavor to promote the use of Assistive Technology through individual planning processes whenever possible.

The Agency will maintain updated information about Assistive Technology, funding mechanisms and AT Service Providers to be shared with Service Coordinators, individuals served and other stakeholders involved in the planning processes.

Transition Planning

The Agency will be proactive in approaching the transitional planning needs of individuals served and is committed to begin planning transitions of persons starting at an early age.

The Agency will assure that Service Coordinators are trained in various transition planning strategies to be implemented during the person-centered planning process.

The Agency is committed to collaborating with schools and other service providers to support students with intellectual and developmental disabilities to be productive citizens of their community, work-force ready and able to live as independently as possible when they graduate out of the Public School System.

Positive Behavioral Supports

The Agency will remain in full support and compliance of the Positive Behavioral Support planning process as outlined by the Missouri Department of Mental Health, Division of Developmental Disabilities, including:

- Support Coordinators will approach the coordination of supports for an individual with a positive, person-centered focus and will facilitate the individual's support team to understand and utilize this approach when supporting all persons.
- Support Coordinators will work with families, the individual and contracted providers to develop and maintain adequate and appropriate methods of observation and evaluation of the plan and strategies to ensure objectives are being met.
- Support Coordinators will ensure a plan for restrictive supports, is limited to health and safety reasons, and a functional plan is in place to remove restrictions and restore rights when such restrictions are no longer necessary.
- Support Coordinators will understand the process for securing additional supports and services including behavior analysis, counseling, consultation with other professionals to develop a comprehensive individual support plan with positive, person-centered strategies.

Inclusion

The Agency will design their services and supports to be congruent with the norms of the community. Whenever possible, first consideration will be given to linking to established conventional resources before attempting to develop new ones that exclusively or predominantly serve only people with developmental disabilities.

The Agency will promote inclusion by establishing processes that assure that

a. All persons served will be treated with dignity and respect.
b. Assure that all recipients, including those who have advocates or guardians, have genuine opportunities for client choice and self-determination.
c. Provide for a review of recipient outcomes
d. Provide opportunities for representation on planning committees, work groups and agency service evaluation committees.
e. Invite and encourage persons served to participate in community events and activities of their choice.

All policies and procedures of the Agency will

- support the principle of normalization through delivery of services and supports that address the social, cultural, and ethnic aspects of the life experience of the persons served.
- be trauma-informed
- ensure people are assisted to gain social integration skills
- support people to become more self-reliant and to maintain competitive, integrated employment in the labor markets of their communities, irrespective of their disabilities.
- support people to maintain permanent homes in residential neighborhoods in their communities
- develop informal and interpersonal community-based networks which promotes stable, permanent family and unpaid relationships.

Consumer Satisfaction Measures

The Agency will maintain a TCM satisfaction survey process for the individuals it serves to determine the individuals' level of satisfaction with the services provided. At least 30% of individuals, randomly chosen, receiving TCM services shall receive an annual satisfaction survey. The survey results shall be shared with the staff, management, Board of Directors and Kirksville Regional Office on an annual basis.

Crisis Response - Stop Light Report

To manage the collective caseload of the Agency, the management of the Targeted Case Management services will maintain a weekly Stop Light Report which prioritizes individuals at-risk in the following areas:

- Placement Status
- Family Supports
- Behavioral Supports
- Medical Status
- Provider Services
- Law Enforcement Involvement as a Victim or Alleged Perpetrator
- Sexual Misconduct as a Victim or Alleged Perpetrator
- Abuse/Neglect Concerns
- Psychiatric Treatment
- Hotlines with Children's Division, DHSS or others

Each week the Director of Service Coordination or designee will work with the Service Coordinators to designate the risk level of each individual served in each of the above areas. Tier 1 risk, or green light status, is an indicator of no concerns. Tier 2 risk, or yellow light status, is an indicator that there are some concerns which management should be aware of for future planning. Tier 3 risk, or red-light status, indicates that the individual is in crisis within the identified area and requires immediate crisis response attention from management.

Any individual deemed at Tier 2 or Tier 3 level of risk will have a comment included on the report with an overview of the situation. The report will be updated weekly and forwarded confidentially to the Kirksville Regional Office (KRO). The TCM Management Team will review the report with the staff of KRO in regularly scheduled monthly meetings to discuss potential resolution to the issues.

The TCM Management Team will utilize the weekly report to prioritize approaches to working with individuals identified at-risk.

Peer Reviews

On a regular basis, no less than monthly, the Director of Service Coordination or designee will facilitate an internal inter-professional peer review meeting with TCM staff of the Agency to address at-risk situations of any individuals who have been determined at-risk for more than 90 days.

Selected members of the staff may be asked to participate in these meetings based upon their individual knowledge, experience or background regarding the issues at-risk. The intent of the review meetings is to offer the Support Coordinators solutions and support with problem solving on behalf of the individual served.

Community Resources

The staff of the agency are expected to have universal knowledge and understanding of supports and resources available in the community at large.

The Agency will have representation at the System of Care interagency meetings held monthly. The participant will share information obtained in that meeting with the applicable staff of the Agency.

The Agency will maintain an online directory of available community supports and resources for staff to refer to while providing person-centered planning services and program planning.

The Agency will proactively collaborate with other community support groups and organizations to advocate in the best interests of the people that we serve, to promote inclusion of people with developmental disabilities within that collaboration and to link individuals within and outside of the Agency for assurance of best outcomes.

Work- Life Balance

Having a clear and separate work-life balance will facilitate the restoration staff needs from managing workloads, experiencing secondary trauma and other work-related stressors. Management will encourage staff to practice methods of self-care, such as limiting work hours and managing expectations of the organization. A healthy, balanced routine, both at work and in staff personal lives, will help to build resilience and positivity in working with others.

- Staff are expected to inform management if work-related stressors are interfering daily functioning.
- Staff will work a regular work week schedule, except on rare occasions, to meet the needs of individuals and families served. This includes evenings, weekends and holiday time periods off.
- Staff will adjust their work schedules to assure minimal hours of overtime worked.
- Staff will take regular paid time off (PTO) as earned through employee benefits.
- Staff will not work during PTO or leave.
    - Staff will not take computers or paperwork home or with them during PTO or leave.
    - Staff will not accept phone calls or read emails during PTO leave, except in emergencies when approved the management.

Technical Assistance – Audit Compliance

With regard to TCM Services provided in accordance with the Agency's contract with the State of Missouri Department of Mental Health, the Agency will work to assure full compliance with all contractual obligations of those services. Each employee is expected to have full knowledge and understanding of the terms of the contract for those services. Each employee is assigned their responsibilities associated with that compliance through their written job description. TCM Management staff and the Quality Assurance Team Support will assure all relevant staff are adequately trained. It is the goal of the Agency to demonstrate excellence in the delivery of those services, as evidenced by positive outcomes of DMH, MMAC or any other independent audits of the Agency's work. The Agency TCM Management staff will participate in the monthly Technical Assistance calls with the State to remain informed of current policy. The Agency will comply with the requirements of each quarterly and annual audit requests, coordinated by the Quality Assurance Team Support under the oversight of the Director of Service Coordination. The Executive Director will be immediately advised of any identified discrepancies, along with the plan for remediation. The TCM Management Team, including the Executive Director, will participate in the annual Audit Review meetings with the State representatives.

COMMUNITY LEARNING CENTER

Program Planning

Program Planning of the Community Learning Center will be based upon assessed of needs of citizens with intellectual and developmental disabilities and their families living in Adair County. Approaches to the assessment of needs will include

- Annual Assessment Survey
- Consumer advisement and participation, including from Self-Advocates and family work groups
- Community leadership input from work groups such as System of Care and other interagency groups
- Legislative input and collaboration with community Government & Legislative Affairs work groups
- Priorities of the Board of Directors as identified through the Agency's Strategic Planning process

The Executive Director of the Agency will oversee an annual community needs assessment process and share the outcomes of those surveys with the Community Engagement Specialist (CES). Working with the CES, programming needs will be identified and prioritized, to be shared during the Strategic Planning process with the Board. The Executive Director will oversee the development of the annual Strategic Plan each year prior to budget preparation for the coming Fiscal Year.

Following Board approval of the annual Strategic Plan, the CES will be tasked with the responsibility to coordinate and schedule specific programs to be offered through the Community Learning Center. The CES will coordinate and schedule needed programming, determining which program content will be provided by Agency staff and which programs require support from outside sources.

Monthly program calendars will be broadly distributed to Adair County citizens through USPS, email, mass media, social media and presentations to the community. The CES will develop data tracking systems to determine level of participation and level of satisfaction for the programs offered, to be reviewed by the Executive Director and Board periodically.

Community Engagement & Outreach

The Executive Director, the Community Engagement Specialist and the Community Engagement Board Committee will work together to identify strategies for Community Engagement and Outreach efforts of the Agency. The goals of this effort will be to

- To advocate for the citizens of Adair County with intellectual and developmental disabilities and assure their representation in community planning processes.
- To raise awareness of issues impacting people with developmental disabilities among the leadership of the community.
- To promote inclusion of citizens of Adair County throughout their community so that they may live, work and play with the same rights and opportunities as the general population.
- To advocate for equitable health care, education, employment and other community supports and services for citizens of Adair County with disabilities.

Specific methodologies to address these goals will be contained within the annual Strategic Plan of the Agency and may include event planning, interagency collaboratives, community work groups and inter-professional education.

Mandt Training

The Mandt System Copyright Agreement specifically states that certified instructors are authorized to share and teach the material to individuals covered by the agreement, and that certified instructors are not authorized to instruct this course, or any part of this course to anyone not covered by the liability insurance of the organization which sponsored the instructors' certification or their organization without prior written approval of the Mandt System.

It is the intention of the ACSDDB to provide Mandt System training through the Learning Center to its own employees (permanent and temporary) and to the qualified staff of any DMH contracted provider of services to persons with developmental disabilities operating in Adair County.

Any other professionals or provider employees applying to be trained in Mandt through the Learning Center will need to be approved for the training by the Executive Director of ACSDDB, and will need to provide payment for the training as required by the Mandt System, along with proof of liability insurance coverage and verified results of a current (within past 30 days) screening through the Missouri Family Safety Registry showing no convictions or pending actions related to abuse, neglect, or other crimes against persons. Costs of MOFCSR screenings are the responsibility of the applicants or their employers.

Parents and caretakers of persons with developmental disabilities served by the ACSDDB may apply to be trained in the relational (first three chapters) portion of the Mandt System curriculum, as per the recommendation of the Mandt System Trainer Information and Guidelines. Parents of children with developmental disabilities may be trained in the skills involving physical restraint **ONLY** with the unanimous approval of the certified Learning Center Mandt trainers and the Executive Director.

The following stipulations must be met before a parent or caretaker relative may receive any level of Mandt System training through the Learning Center: The person to be trained

- is the parent or caretaker relative of an individual receiving service coordination through the ACSDDB;
- has completed and provided results of a screening through the Missouri Family Safety Care Registry within the 30 days preceding the training date;
- has never been convicted of severe neglect, abuse (physical, sexual, or emotional), or any other physical crime against a person, and is not currently the subject of court proceedings and/or any allegations or investigations of possible abuse (physical, sexual or emotional), neglect or any other physical crime against a person;
- has been recommended for the specified level of Mandt System training by the support planning team of the individual served by the ACSDDB, and the recommendation is documented in the individual's current Individual Support Plan.

The cost of the MOFCSR screening may be paid by the Adair County SB40 if approved as a support need for the individual by the ACSDDB Utilization Review committee.

Information Systems Management

Unique User ID
It is the policy of Adair County SB40 Developmental Disability Board ('the Agency') to comply with HIPAA Security Rule regulations in regards to the Unique User ID as outlined below.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that access to Protected Health Information (PHI) shall be managed to guard the integrity, confidentiality, and availability of electronic PHI (ePHI) data. According to the law, the Agency must preserve the integrity and the confidentiality of individually identifiable health information (IIHI) pertaining to each patient or client.

The purpose of this policy is to comply with HIPAA's Security Rule requirements pertaining to the unique user identification. User identification is a way to identify a specific user of an information system, typically by name and/or number. A unique user identifier allows an entity to track specific user activity when that user is logged into an information system. It enables an entity to hold users accountable for functions performed on information systems with EPHI when logged into those systems.

All users that require access to any network, system, or application will be provided with a unique user identification.

Users shall adhere to the Agency 's Password Management policy. Users shall ensure that auto-complete or password remembering features of software and applications is disabled. Users will not share their unique user identification or password with anyone. Users must ensure that their user identification is not documented, written, or otherwise exposed in an insecure manner. If a user believes their user identification has been comprised, they must report that security incident to the HIPAA Security Officer.

Emergency Access Procedures
The Agency strives to protect the confidentiality, integrity and availability of ePHI by taking reasonable and appropriate steps to establish and implement documented integrity controls.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that access to Protected Health Information (PHI) shall be managed to guard the integrity, confidentiality, and availability of electronic PHI (ePHI) data. According to the law, the Agency must preserve the integrity and the confidentiality of individually identifiable health information (IIHI) pertaining to each patient or client.

The Agency will take reasonable and appropriate steps to establish, implement, and document an emergency access procedure delineating the necessary steps to enable authorized workforce members to obtain access to necessary ePHI during a disaster or other emergency.

The Agency will provide appropriate workforce members with a current copy of the emergency access procedure and keep an appropriate number of copies at a secure off-site location in conjunction with the Disaster Recovery Plan, as set forth in the Disaster Recovery Plan, and the Emergency Mode Operation Plan.

Appropriate workforce members shall be provided with separate emergency access log-in credentials. An electronic and auditable log of will be maintained indicating who, when and purpose for using the emergency access credentials.

Automatic Logoff

It is the policy of the Agency to comply with HIPAA Security Rule regulations in regards to Automatic Logoff as outlined below.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that access to Protected Health Information (PHI) will be managed to guard the integrity, confidentiality, and availability of electronic PHI (ePHI) data. According to the law, the Agency must preserve the integrity and the confidentiality of individually identifiable health information (IIHI) pertaining to each patient or client.

Automatic Logoff implementation standard of the Rule requires covered entities to implement policies and procedures to ensure user or entity authorized access to ePHI is not left unsecured during extended idle time [45 CFR 164§.312(b)(2)(iii)]. Covered entities that implement the Automatic Logoff specification will increase the security of their ePHI.

The purpose of this policy is to comply with HIPAA's Security Rule requirements pertaining to automatic logoff procedures. As a general practice, users should logoff the system they are working or when their workstation is unattended. However, there will be times when workers may not have the time, or will not remember to log off a workstation. Automatic logoff is an effective way to prevent unauthorized users from accessing ePHI on a workstation when it is left unattended for a period of time.

Any server or workstation that stores or access PHI will have the password protected screensaver turned on. The system will be configured to lock the server or workstation after 15 minutes of inactivity. Any servers or workstations that are located in locked or secure environments need not implement inactivity timers.

Encryption and Decryption

It is the policy of the Agency to comply with HIPAA Security Rule regulations in regards to the Access Control Standard as outlined below.

The Health Insurance Portability and Accountability Act of 1996 *(HIPAA)* requires that access to Protected Health Information (PHI) will be managed to guard the integrity, confidentiality, and availability of electronic PHI *(ePHI)* data. According to the law, the Agency must preserve the integrity and the confidentiality of individually identifiable health information *(IIHI)* pertaining to each patient or client. Encryption and Decryption can be used as a form of Access Control.

The purpose of this policy is to comply with HIPAA's Security Rule requirements pertaining to encryption and decryption.

The Agency will abide by encryption and decryption policies and procedures as outlined elsewhere in its Security policies and procedures. The Agency will ensure encryption and decryption is reasonable and appropriate as related to its security risk analysis, to be conducted or reviewed on an annual basis. Media which cannot be protected by other methods of access control shall utilize encryption and decryption to protect ePHI from unauthorized disclosure. Encryption and Decryption may also be utilized in combination with other access controls where indicated by risk analysis.

The Agency will seriously review the viability of securing critical database, file servers as well as ePHI on mobile devices such as laptops and PDAs. The Agency will need to balance the challenge of protecting "data at rest" such as that defined in the Access Control standard of the HIPAA Security Rule against the increase in security technology complexity and administrative overhead including performance considerations and usability.

Proven, standard algorithms such as DES, Blowfish, RSA, RC5 and IDEA should be used as the basis for encryption technologies. These algorithms represent the actual cipher used for an approved application. Symmetric cryptosystem key lengths must be at least 56 bits. Asymmetric crypto-system keys must be of a length that yields equivalent strength. The Agency 's key length requirements will be reviewed annually and upgraded as technology allows. All keys generated will be securely escrowed. The Agency will consider the use of automated encryption tools as recommended by their IT vendor.

The Agency will identify systems that require ePHI to be encrypted.

Data Backup Plan
It is the policy of the Agency to comply with Data Backup Plan as outlined below:

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that access to Protected Health Information (PHI) shall be managed to guard the integrity, confidentiality, and availability of electronic PHI (ePHI) data. According to the law, the Agency must preserve the integrity and the confidentiality of individually identifiable health information (IIHI) pertaining to each patient or client.

The purpose of this policy is to comply with the HIPAA Security Rule's requirements pertaining to Data Backup.

The Agency shall create and maintain retrievable exact copies of the following systems: a. Essential Servers b. Virtual Servers c. Network Storage Servers d. Workstations not networked e. Mobile devices

Responsibility of creating and maintaining retrievable exact copies of the Agency 's ePHI systems:
a. HIPAA Security Officer b. Disaster Recovery Team c. Information Systems Department or Business Associate

Backup Schedule:

- Daily incremental back up
- Weekly full back up

Backup media will be stored and maintained in multiple cloud-based locations by the IT Vendor.

Complete periodic testing of restoration procedures to confirm the effectiveness of those procedures and that the ePHI can be restored in the event that ePHI systems are damaged by or during a disaster or other emergency a. Conduct annual testing of procedures and provide feedback to its successes and failures to the appropriate management and/or workforce members b. Ongoing monitoring of system backup shall be conducted by IT Vendor. Any issues are to be brought to the immediate attention of the appropriate management and/or workforce members.

Document the retention period for backup media and contain backup copies of ePHI

- The Agency shall determine when to retire external hard drives. This should be a time that is pre-determined in an effort to protect the stored ePHI's confidentiality, integrity and availability

- External hard drives, though not commonly used, will be retired after a period of no longer than 3 years.

- Retired external hard drives shall be stored for a period of 6 years at the offsite storage facility

Disaster Recovery Plan
It is the policy of the Agency to comply with Disaster Recovery Plan as outlined below:

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that access to Protected Health Information (PHI) will be managed to guard the integrity, confidentiality, and availability of electronic PHI (ePHI) data. According to the law, the Agency must preserve the integrity and the confidentiality of individually identifiable health information (IIHI) pertaining to each patient or client.

The purpose of this policy is to comply with the HIPAA Security Rule's requirements pertaining to Disaster Recovery

The Agency in partnership with their IT provider will take reasonable steps to maintain a documented and detailed disaster recovery plan to recover ePHI that is lost, damaged, or corrupted in the event of a disaster or other disaster.

The conditions under which the Disaster Recovery Plan may be activated a. Environmental Factors such as fire, tornado, earthquake, lightning strike, extreme winter weather and other acts of God causing loss of data access b. Data storage failure or Server Failure c. Criminal Activity such as theft or vandalism d. Sudden, unexpected loss of staff e. Loss of Data access due to network outage, power outage, denial of service attacks, or compromised accounts

Define workforce members' roles and responsibilities in executing the Disaster Recovery Plan:

All workforce members:

1. Are responsible for reporting to the HIPAA Security Officer any condition triggering this Disaster Recovery Plan
2. Taking necessary and reasonable steps to protect ePHI's confidentiality, integrity, and availability

HIPAA Security Officer:

1. Entire process oversight
2. Notify necessary clients of issues
3. Interview employees to ensure all time keeping methods for payroll are intact and accurate, make necessary adjustments

Timeframes for recovery are documented on the Agency 's Application and Data Criticality Analysis.

Emergency Mode of Operations

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that access to Protected Health Information (PHI) will be managed to guard the integrity, confidentiality, and availability of electronic PHI (ePHI) data. According to the law, the Agency must preserve the integrity and the confidentiality of individually identifiable health information (IIHI) pertaining to each patient or client.

The purpose of this policy is to comply with the HIPAA Security Rule's requirements pertaining to Emergency Mode of Operations.

It is the policy of the Agency to comply with Emergency Mode of Operations as outlined below:

In an effort to ensure the continuation of operation, the Agency will take reasonable steps to ensure the confidentiality, integrity, and availability of ePHI by continuing operations and protecting ePHI during and immediately following a disaster or other emergency.

Define and Categorize Reasonable and Foreseeable Emergencies

- Environmental factors such as fire, tornado, earthquake, lightening strike, extreme winter weather, and other acts of God causing loss of data access.
- Data Storage failure or Server Failure
- Criminal Activity such as theft or vandalism
- Sudden, unexpected loss of staff
- Loss of Data Access due to network outage, power outage, denial of service attacks, or compromised accounts

Testing to be performed annually

- Classroom style and unannounced testing will be performed at a time that will not affect services to individuals
- Revisions will be made appropriately as a result of the testing procedures. It is possible that each site will have different Emergency Mode of operations after testing is performed

Testing and Revision

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that access to Protected Health Information (PHI) shall be managed to guard the integrity, confidentiality, and availability of electronic PHI (ePHI) data. According to the law, the Agency must preserve the integrity and the confidentiality of individually identifiable health information (IIHI) pertaining to each patient or client.

This policy reflects the Agency's commitment to effectively prepare for and respond to emergencies or disasters in order to protect the confidentiality, integrity and availability of its information systems.

It is the policy of the Agency to comply with HIPAA Security Rule regulations in regards to Testing and Revision as outlined below:

The Agency must conduct periodic, at least annual, testing of its contingency plan to ensure that it is current and operative.

Paper Test: A detailed walk through of the plan including tasks such as validating notification call lists of both key workforce members and vendors. The paper test will also include reviewing end user procedures of the data backup plan, disaster recovery plan, and the emergency mode of operations, ensuring the application and criticality analysis is complete and up to date.

Limited Scope Test: A test of one or more components of the disaster recovery plan. This should include using the data back up to restore selected information systems at in a test environment. The limited scope test should also include a testing of communications.

Simulated Full-Scale Disaster: A complete test of the disaster recovery plan. The test will likely interrupt the Agency's operations and should only be attempted after a significant limited scope testing and after determination that such a test would not impact care. The simulated full-scale disaster requires planning and should only be conducted when deemed crucial to the testing process.

Document the Results of Testing: The Agency must formally document the testing procedures and results of the test. A plan must be derived for addressing any identified gaps or issues in the contingency plan.

The Agency's contingency plan must be kept current through a formal change management process. Examples of events that must result in an update of the plan include, but are not limited to:

1. Change in disaster recovery plan personnel or vendors
2. Change in contact information for disaster recovery personnel
3. Significant changes to the Agency's technical or physical infrastructure

Application and Data Critical Analysis

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that access to Protected Health Information (PHI) shall be managed to guard the integrity, confidentiality, and availability of electronic PHI (ePHI) data. According to the law, the Agency must preserve the integrity and the confidentiality of individually identifiable health information (IIHI) pertaining to each patient or client.

The purpose of this policy is to implement an application and criticality analysis process of evaluating the Agency's information systems and the data contained within them.

The purpose of this analysis is to prioritize information systems based on the impact to the Agency's services, processes, and business objective if disasters or emergencies cause specific information systems to be unavailable for periods of time. The criticality analysis must be conducted at least annually or with every change or anticipated change to the information systems.

It is the policy of the Agency to comply with Application and Criticality Analysis as outlined below:

The Agency must have a formal, documented process for defining and identifying the criticality of its information systems and the data contained within them.

inventory of all the Agency information systems is maintained in partnership with the IT provider:

- Servers
- Workstations
- Mobile Media
  - Laptops
  - USB Drives
  - Smart Phones
  - Cassette Tapes
  - Any other portable media
- Scanners or Copiers with hard drives
- Software
  - Operating Systems
  - Electronic Medical Records
  - Practice Management Systems
  - Other Software

The prioritization of the Agency information systems must be based on an analysis of the impact to the Agency services, processes, and business objectives if disasters or emergencies cause specific information systems to be unavailable for particular periods of time. The documentation of the systems prioritization can be incorporated into the inventory or maintained separately.

The criticality analysis must be conducted with significant involvement from the administrators, users and owners of the Agency information systems and processes.

The criticality analysis can be conducted by either the Agency employee(s) or by a qualified third-party firm. Those conducting the analysis should understand the inter-dependencies among the Agency's information systems and processes.

The criticality analysis must be conducted at least annually. Results from the analysis must be documented and presented to appropriate the Agency's management. The criticality analysis report must be securely maintained. Any change in status of information systems and/or the data contained within them must be reflected in the Agency's disaster recovery plan.

Disposal
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that access to Protected Health Information (PHI) shall be managed to guard the integrity, confidentiality, and availability of electronic PHI (ePHI) data. According to the law, the Agency must preserve the integrity and the confidentiality of individually identifiable health information (IIHI) pertaining to each patient or client.

The Agency shall dispose of unused, retired, or otherwise non-essential media through the following methods: Degaussing; Shredding.

The Agency strives to protect the confidentiality, integrity, and availability of ePHI by taking reasonable and appropriate steps to establish and implement documented media disposal policies and procedures, ensuring that electronic media containing ePHI is rendered unusable and/or inaccessible.

Media disposal procedures are established to prevent the loss of confidentiality, integrity, or availability of ePHI. The destruction of the media depends on many factors, including types and classification of data, the quantity of media, and the Agency's environment.

The Agency will ensure a complete backup, exact, and retrievable replica of all ePHI and essential business information is made prior to the destruction of media.

The Agency may use Business Associates or subcontractors to assist with the disposal of unused electronic media. If using a Business Associate or subcontractor for media destruction, the Agency shall request a certificate of destruction from the Business Associate or subcontractor.

The Agency shall dispose of electronic media as outlined below.

A log of destroyed media shall be kept for a period of 6 years. The log shall include: name of media destroyed, method of destruction, date of destruction, person or organization destroying media, location of backup.

Media Re-Use
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that access to Protected Health Information (PHI) shall be managed to guard the integrity, confidentiality, and availability of electronic

PHI (ePHI) data. According to the law, the Agency must preserve the integrity and the confidentiality of individually identifiable health information (IIHI) pertaining to each patient or client.

The Agency strives to protect the confidentiality, integrity and availability of ePHI by taking reasonable and appropriate steps to establish and implement documented media disposal policies and procedures, ensuring that electronic media containing ePHI is rendered unusable and/or inaccessible.

Media disposal procedures are established to prevent the loss of confidentiality, integrity, or availability of ePHI. The destruction of the media depends on many factors, including types and classification of data, the quantity of media, and the Agency's environment.

The Agency shall dispose of electronic media as outlined below.

The Agency may reuse retired, unused, or otherwise non-essential media. ACSDDB shall ensure that all data and ePHI is removed from the media prior to reuse through the following methods: Degaussing; Shredding. The Agency may use Business Associates to assist with the disposal of unused electronic media. If using a Business Associate for media destruction, the Agency shall request a certificate of destruction from the Business Associate.

A record of how the media is being re-used, as well as if it is being reused within a different location, client's office, or for personal use will be maintained for a period of 6 years. No record of re-use will be maintained if the media is being re-used for internal purposes.

Accountability
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that access to Protected Health Information (PHI) shall be managed to guard the integrity, confidentiality, and availability of electronic PHI (ePHI) data. According to the law, the Agency must preserve the integrity and the confidentiality of individually identifiable health information (IIHI) pertaining to each patient or client.

Identify portable media that contains ePHI Laptops; External Hard drives; Thumb Drive; Cassette Tapes; Back Up Tapes; Any other portable media that stores, access, or processes ePHI.

The Agency strives to protect the confidentiality, integrity, and availability of ePHI by taking reasonable and appropriate steps to establish and implement documented accountability policies, and procedures that ensure an accurate record of the movement of electronic media containing ePHI is maintained and monitored. Media accountability procedures are established to prevent the loss of confidentiality, integrity, or availability of ePHI. All portable media will be accounted for at all times.

Portable media would be defined as media that is transferred between users in a facility, transferred between facilities, and/or is transferred out of the practice setting to a personal setting.

Maintain a Check Out/In log for portable media. Periodically review the log to ensure all portable media is properly accounted for.

The Agency shall account for portable electronic media as outlined below.

Data Backup and Storage
It is the policy of The Agency to comply with Data Backup and Storage as outlined below.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that access to Protected Health Information (PHI) shall be managed to guard the integrity, confidentiality, and availability of electronic PHI (ePHI) data. According to the law, the Agency must preserve the integrity and the confidentiality of individually identifiable health information (IIHI) pertaining to each patient or client.

In the event that equipment containing ePHI is being moved, the Agency shall: Document the movement according to the Accountability Policy of the Agency's Device and Media Controls, Backup the data according to the procedures outlined in the Data Backup policy of the Agency's Contingency Plan, Store the backup according to the procedures outlined in the Data Backup policy of the Agency's Contingency Plan.

The Agency strives to protect the confidentiality, integrity, and availability of ePHI by taking reasonable steps to backup and store ePHI prior to the movement of equipment.

In the event the data needs to be restored after the equipment has been moved, the Agency will restore the data according to the Disaster Recovery Plan. Data back-up and restoration services provided by Huber and Associates.

Mechanism to Authenticate ePHI
The Integrity Standard of the Security Rule requires that covered entities protect the integrity of electronic protected health information by implementing proper electronic mechanisms to ensure that ePHI is not inappropriately destroyed or altered. EPHI that is improperly altered or destroyed can result in clinical quality problems for a covered entity, including patient safety issues.

The purpose of this policy is to establish procedures for protecting ePHI from being compromised regardless of the source by implementing electronic mechanisms to authenticate ePHI.

In order to determine which electronic mechanisms to implement to ensure that ePHI is not altered or destroyed in an unauthorized manner, the Agency must consider the various risks to the integrity of ePHI identified during the risk analysis. Once the Agency has identified risks to the integrity of their data, they must identify security measures that will reduce the risks.

Electronic mechanisms used to protect the integrity of ePHI accessed on the Agency's systems must ensure that the value and state of the ePHI is maintained, and it is protected from unauthorized modification and destruction.

Mechanisms must also be capable of detecting unauthorized alteration or destruction of ePHI. Such mechanisms might include: System memory, hard drives, and other data storage devices with error-detection capabilities; File and data checksums; Encryption; Audit log reviews.

Security Reminders
Security reminders are to be communicated at least quarterly to all workforce members. Security reminders should be sent out more frequently in the following events:

1. Substantial revisions are made to the Agency's security policies or procedures
2. Substantial new security controls are implemented at the Agency
3. Significant changes are made to existing the Agency security control
4. Substantial changes are made to the Agency's legal or business responsibilities
5. Substantial threats are perceived or risks arise against the Agency's ePHI systems or network

All security reminders and security trainings must be documented. 1. Who distributed the reminder/training 2. Who attended or received the reminder/training 3. What topics were covered in the reminder/training 4. What date was the reminder/training 5. What was the purpose of the reminder/training

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that access to Protected Health Information (PHI) shall be managed to guard the integrity, confidentiality, and availability of electronic PHI (ePHI) data. According to the law, the Agency must preserve the integrity and the confidentiality of individually identifiable health information (IIHI) pertaining to each patient or client.

The Agency's Security Officer shall be responsible for the taking reasonable steps to ensure that the Agency's workforce members receive security information, awareness reminders, and training on the Agency's security policies and procedures periodically and as needed.

Workforce members and others with access to the Agency's PHI will be formally trained on information security risks and how to follow the Agency's security policies and procedures as well as how to use ePHI systems in a manner that reduces security risks and on selected security topics including:

The Agency security policies and procedures the Agency security controls and processes significant risks to ePHI systems Legal and business responsibilities of the Agency for protecting ePHI systems Security Best Practices Basic HIPAA principles, although important, are not sufficient. The Agency must train workforce members and other entities with access to the Agency's PHI on specific policies and procedures adopted by the Agency

The purpose of this policy is to comply with the HIPAA Security Rule’s requirements pertaining to Security Reminders.

The Agency will ensure security reminders are provided to workforce members and other entities with access to the Agency's PHI. Security reminders may be in written or verbal. Security reminders are to be sent through electronic methods, distributed in newsletters, discussed at staff meetings, displayed on posters, displayed on screen savers, or any other method approved by the Agency's Security Officer.

1. Security training is to be conducted at least annually to all workforce members.
2. All new workforce members must be trained on the Agency's security policies and procedures prior to being granted access to systems containing PHI.
3. All workforce members with a change in position requiring higher level of access to PHI must be retrained on the Agency's security policies and procedures prior to the change in access being granted.
4. Any workforce member found in violation of a security safeguard implemented by the Agency must be retrained on the Agency's policies and procedures, if required by the Sanction Policy.

It is the policy of the Agency to comply with Security Reminders as outlined below:

The Agency will ensure security training is provided to all workforce members. Security training is required prior to granting access to PHI to any new workforce member, business associate, or subcontractor. Security training may be delivered in an in-person classroom style learning session, webinars, electronic portals, or any other method approved by the Agency 's Security Officer, so long as the delivery method chosen complies with the content requirements listed within this policy.

Protection from Malicious Software
The purpose of this policy is to comply with the HIPAA Security Rule's requirements pertaining to Protection from Malicious Software. Anti-virus and anti-malware installed and updated on ePHI systems.

The Agency 's workforce members shall not bypass or disable anti-malware or anti-virus software installed on ePHI systems unless properly authorized to do so. Sanctions will apply to any workforce member attempting to or successfully disabling anti-malware or anti-virus software.

Procedures for the Agency workforce members to report suspected or confirmed malicious software:
1.) Close out of all open applications and power down the workstation
2.) Notify the Security Officer

The Security Officer will provide periodic training and awareness to workforce members about guarding against, detecting, and reporting malicious software. Training workforce members on protection from malicious software shall include:

a. How to discover malicious software,
b. How to report malicious software,
c. How to discover malicious software fraud,
d. How not to download or receive malicious software including not opening or launching email attachments that may contain malicious software.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that access to Protected Health Information (PHI) will be managed to guard the integrity, confidentiality, and availability of electronic PHI (ePHI) data. According to the law, the Agency must preserve the integrity and the confidentiality of individually identifiable health information (IIHI) pertaining to each patient or client.

The Security Officer will develop, implement and periodically review a documented process for guarding against, detecting, and reporting malicious software that pose risks to ePHI. The Agency's malicious software prevention, detection, and reporting procedures shall include:

Process to examine electronic mail attachments and downloads before they can be used on ePHI systems:

1.) Install Anti-Malware software that scans emails as well as email attachments.
2.) Train workforce on identifying suspicious email.
3.) Scan all download attempts prior to download being finalized.
4.) Train all workforce members on the potential dangers of downloading certain types of files (.exe, .dmg, .zip).
5.) Limit download capability to only key workforce members.

It is the policy of the Agency to comply with Protection from Malicious Software as outlined below:
Plan for recovering from malicious software attacks:

1.) Restoring any lost data following the Disaster Recovery Plan
2.) Determine level of lost data due to attack
3.) Document data lost

Log-in Monitoring
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that access to Protected Health Information (PHI) will be managed to guard the integrity, confidentiality, and availability of electronic PHI (ePHI) data. According to the law, The Agency must preserve the integrity and the confidentiality of individually identifiable health information (IIHI) pertaining to each patient or client.

The purpose of this policy is to comply with the HIPAA Security Rule's requirements pertaining to Log-in Monitoring

It is the policy of the Agency to comply with Log-in Monitoring as outlined below:

The Security Officer will develop, implement and periodically review a documented login process for ePHI systems and reporting log-in discrepancies. The log-in process may include:

1. Ensuring help messages that could assist an unauthorized user are not provided during the log-in process
2. Limitations on the number of unsuccessful log-in attempts to 3 attempts
3. The system does not state which part of the log-in information is correct or incorrect if there is an error
4. Prior to successfully completing the log-in process, information system or application identifying information is not provided
5. Upon completion of a successful log-in, the date and time of the previous log-in by the workforce member are displayed
6. If the system doesn't automatically recognize the IP address that the user is logging in from it will require a second authorization code. The system will automatically text another code to the user's mobile phone.

The Security Officer will develop, implement and periodically review a documented process for monitoring log-in attempts to ePHI systems and reporting log-in discrepancies. The log-in process may include:

1. Record failed log-in attempts
2. After the specific pre-determined number of failed log-in attempts, a time period is documented before permitting further log-in attempts, or any further attempts are rejected until the Security Officer or designated workforce member or business associate has given authorization.

The Agency will provide training and awareness periodically and as needed to the Agency workforce members regarding procedures for monitoring log-in attempts and reporting discrepancies regarding their log-in attempts. The log-in monitoring training and awareness shall include the following topics:

- How to detect a log-in discrepancy
- How to report a log-in discrepancy
- How to successfully use the Agency's log-in process

Password Management

Management Guidelines

- Passwords, if they need to be written down, or stored on-line, must be stored in a secure place separate from the application or system that is being protected by the password
    - Password vaults are encouraged
    - Users should not use the "Remember Password" feature of applications unless your system or application has the means to encrypt the "remembered password"
    - If an account or password is suspected to have been compromised, report the incident to the Security Officer and change all passwords
    - Password cracking or guessing may be performed on a periodic, random basis. If a password is guessed or cracked, the user will be required to change it.
- Passwords shall not be displayed in clear text when inputting into ePHI systems

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that access to Protected Health Information (PHI) will be managed to guard the integrity, confidentiality, and availability of electronic PHI (ePHI) data. According to the law, the Agency must preserve the integrity and the confidentiality of individually identifiable health information (IIHI) pertaining to each patient or client.

The Security Officer shall develop, implement, and review a documented process for appropriately creating, changing, and safeguarding passwords used to verify users' identities and obtain access to ePHI. The password management procedure shall include:

- Require and force regular password changes
    - The change interval should not exceed 2 years.
    - Use of Password Vault with password history is strongly recommended to be used by all workforce members.
- Require and force the use of individual passwords to maintain accountability.
- Permit workforce members to select and change their own passwords
- Require unique passwords that meet the standards defined by the Agency

The purpose of this policy is to comply with the HIPAA Security Rule's requirements pertaining to Password Management.

Construction Guidelines

- Use a pass phrase which is typically composed of multiple words or acronyms
- Contains both upper- and lower- case characters (a-z; A-Z)
- Contains at least 1 numeric character (0-9) d. Is at least 8 characters long
- Is not a word in any language, slang, dialect, or jargon
- Is not based on personal information

The purpose of this policy is to comply with the HIPAA Security Rule's requirements pertaining to Password Management.

The Agency shall provide its workforce members with training and awareness on appropriately creating, changing, and safeguarding passwords used to verify users' identities and to obtain access to ePHI systems. Password management training and awareness shall include:

- The Agency's password standards and guidelines
- The process for changing temporary passwords when assigned for a new log-in
- The importance of avoiding maintaining passwords in a paper record
- The importance of utilizing password vaults
- The significance of changing passwords and avoiding reusing passwords
- The significance of keeping passwords confidential
- The significance of using different passwords for personal and business accounts
- The importance of not including passwords in any automated log-in process
- The importance of changing passwords when there is an indication of password or information system compromise
- The importance of logging off prior to leaving a workstation

Response and Reporting

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that access to Protected Health Information (PHI) will be managed to guard the integrity, confidentiality, and availability of electronic PHI (ePHI) data. According to the law, The Agency must preserve the integrity and the confidentiality of individually identifiable health information (IIHI) pertaining to each patient or client.

The purpose of this policy is to comply with the HIPAA Security Rule's requirements pertaining to Response and Reporting of security incidents

It is the policy of the Agency to comply with Response and Reporting as outlined below:

The Agency shall have a process for identifying, documenting, and retaining a record of security incident. Records of a security incident will be maintained for a period of 6 years from the date the security incident occurred, was discovered, or was mitigated, whichever is the greater timeframe. the Agency will maintain a log of security incidents. The log shall include:

a. A description of the incident
b. The location of the incident
c. Workforce members involved in the incident
d. Workforce members who discovered the incident
e. Number of patients affected by the incident
f. Investigative Process and findings g. Remediation Plan

All workforce members are required to report suspicious activities to the Security Officer. The Security Officer shall thoroughly investigate all reported suspicious activities. The Agency will conduct an assessment of all discovered security incidents. Security Incidents that are determined to be a significant risk will require a complete risk analysis around the incident.

Reporting of security incidents to the Office of Civil Rights: https://ocrnotifications.hhs.gov/. The Agency shall adhere to its Breach Notification Policy when reporting security incidents. The Agency shall report all incidents affecting fewer than 500 individuals to the Office of Civil Rights annually. The Agency shall report all incidents affecting 500 or more individuals to the Office of Civil Rights within 60 days of the date of incident or date of discovery, whichever is less.

The Agency recognizes that there may be security incidents that require an incident response team. The Agency shall deploy an incident response team to oversee security incidents. The determination of whether or not to deploy an incident response team will be a direct result of the security assessment conducted around the incident itself. The security response team will consist of team members with appropriate administrative and technical expertise/authority. The incident response team may vary from incident to incident.

Conduct training and awareness for workforce members to include:
a. Documentation process for promptly reporting a security incident, and
b. Responding to security incidents in accordance to ACSDDB's policies and procedures.

No Agency workforce member will prohibit or otherwise attempt to hinder or prevent another workforce member from reporting a security incident. The workforce members shall cooperate fully with the Incident Response Team investigations. The workforce members are free to report known or perceived security incidents without fear of retaliation.

Risk Analysis
The purpose of this policy is to comply with the HIPAA Security Rule's requirements pertaining to the integrity, confidentiality, and availability of ePHI.

Identify the conditions under which ePHI is created, received, maintained, processed, or transmitted. This includes identifying the security controls being used to protect the ePHI.

Determine the likelihood, and the potential adverse impact resulting from a threat successfully exploiting a vulnerability. A business impact assessment prioritizes the impact levels associated with the compromise of information assets based on a qualitative or quantitative assessment of the sensitivity and criticality of those assets. An asset criticality assessment identifies and prioritizes the sensitive and critical organization information assets (e.g., hardware, software, systems, services, and related technology assets) that support critical missions.

Identify potential threat sources and compile a threat statement listing potential threat sources that are applicable to the operating environment. The listing of threat sources includes realistic and probable human and natural incidents that can have a negative impact on the ability to protect ePHI.

Assess the level of risk to the Information Technology (IT) systems. The determination of risk takes into account the information gathered and determinations made during the previous steps. The level of risk is determined by analyzing the values assigned to the likelihood of threat occurrence and the resulting impact of threat occurrence.

It is the policy of the Agency to conduct or review a Risk Analysis on an annual basis as outlined below. Develop a list of vulnerabilities (flaws or weaknesses) that could be exploited by threat sources. This list focuses on realistic technical and nontechnical areas where ePHI can be disclosed without proper authorization, improperly modified, or made unavailable when needed.

Recommend security controls that could mitigate the identified risks, as appropriate to the organization's operations. The goal of the recommended controls is to reduce the level of risk to the IT system and its data to an acceptable level. Security control recommendations provide input to the risk mitigation process, during which the recommended security controls are evaluated, prioritized and implemented.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that access to Protected Health Information (PHI) will be managed to guard the integrity, confidentiality, and availability of electronic PHI (ePHI) data. According to the law,

The Agency must preserve the integrity and the confidentiality of individually identifiable health information (IIHI) pertaining to each patient or client. The first step in assessing risk is to define the scope of the effort. To do this, it is necessary to identify where ePHI is created, received, maintained, processed, or transmitted. Ensure that the risk assessment scope takes into consideration the remote work force and telecommuters, and removable media and portable computing devices (e.g., laptops, removable media, and backup media). Determine if the implemented or planned security controls will minimize or eliminate risks to ePHI. A thorough understanding of the actual security controls in place for a covered entity will reduce the list of vulnerabilities, as well as the realistic probability, of a threat attacking (intentionally or unintentionally) ePHI.

Once the risk assessment has been completed (threat sources and vulnerabilities identified, risks assessed, and security controls recommended), the results of each step in the risk assessment should be documented.

Risk Management
Select the most appropriate security methods to mitigate or manage identified risks to critical information systems and ePHI. Such selections will be based on the nature of specific risks and the feasibility, effectiveness, and cost of specific safeguards.

It is the policy of the Agency to maintain a continuous risk management program to ensure that appropriate security measures are selected and implemented to protect the confidentiality, integrity, and availability of ePHI. Security measures will commensurate with the risks to the information systems that store, process,

transmit or receive ePHI, and will be designed to reduce the risks to ePHI to reasonable and manageable levels.

Selected security safeguards will be regularly evaluated and revised as necessary.

The purpose of this policy is to comply with the HIPAA Security Rule's requirements pertaining to the integrity, confidentiality, and availability of ePHI.

Using information from the risk analysis, risks will be ranked based on the potential impact to information systems containing ePHI and the probability of occurrence. When deciding what resources should be allocated to identify risks, the highest priority will be given to risks with unacceptable risk ratings.

For the risk management plan to be successful, key members of the Agency must be involved. Management will determine which risks uncovered by the risk analysis must be addressed immediately as well as create a timetable for risks that are determined to be a lower priority. The Agency Security Officer shall delegate tasks necessary to appropriate team members as well as monitor the completion of the delegated tasks. Steps taken to mitigate risks shall be documented in the Risk Management Plan.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that access to Protected Health Information (PHI) shall be managed to guard the integrity, confidentiality, and availability of electronic PHI (ePHI) data. According to the law, the Agency must preserve the integrity and the confidentiality of individually identifiable health information (IIHI) pertaining to each patient or client.

Selection, implementation, and operation of safeguards will be based on a formal, documented risk management process and will include the following.

- A formal risk analysis that documents and prioritizes risks to information assets that store, process, transmit, or receive ePHI. See the Risk Analysis Policy.
- Selection and implementation of reasonable, appropriate, and cost-effective security measures to manage or mitigate identified risks.
- Security awareness training for workforce member and security management training for HIPAA Security Officer.
- A regular patch management program to ensure that systems and software are protected from new software vulnerabilities.

The results of each of the above steps will be formally documented.

Sanctions

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that access to Protected Health Information (PHI) shall be managed to guard the integrity, confidentiality, and availability of electronic PHI (ePHI) data. According to the law, the Agency must preserve the integrity and the confidentiality of individually identifiable health information (IIHI) pertaining to each patient or client. The Sanction Policy of the rule requires formal, documented policies and procedures that address how a covered entity addresses the security violations of ePHI by its workforce to include misuse of workstation, breach of security, and disregard for the security environment.

It is the policy of the Agency to ensure that all HIPAA Security policies are followed. Appropriate sanctions will be taken against those who violate HIPAA security policies and/or procedures within the HIPAA Security Manual.

All staff and workforce members will be provided a copy of the HIPAA Security Manual and will sign a statement confirming receipt.

Each employee will be oriented on HIPAA security, its importance, and disciplinary actions for violations. The HIPAA Security Officer will monitor to ensure all policies are followed. Employees witnessing violations should report the violations to the HIPAA Security Officer. If there is a breach or a violation of these policies/procedures, the HIPAA Security Officer will address the situation. Employees violating any policy and/or procedure within the HIPAA Security Manual will face disciplinary action as defined.

Level 1 (Least Severe) Violation

- Accessing information that you not need to know to perform your job
- Sharing computer access codes (user name amp; password)
- Leaving your computer unattended while you are logged into a ePHI program
- Changing information without authorization
- Failing/refusing to cooperate with the Management, Supervisors, and/or the HIPAA Security Officer

Level 2 (Moderately Severe) Violation

- Second occurrence of any Level 1 offense (does not have to be the same offense)
- Unauthorized disclosure or use of PHI
- Using another person's computer access code
- Failing/refusing to comply with remediation resolution or recommendation

Level 3 (Most Severe) Violation

- Copying information without authorization
- Disclosing confidential or patient information with unauthorized persons
- Discussing confidential information with an unauthorized person (this includes all unauthorized online discussions and social networking posts)
- Failure to report security incidents as outlined.

Sanctions

Sanctions:

In the event that a member of the the Agency workforce violates the HIPAA Security and Privacy policies/procedures, the following recommended disciplinary actions will apply:

Level 1 (Least Severe) Sanction

- Verbal or written counseling
- Retraining on privacy/security awareness
- Retraining on The Agency's privacy and security policies and/or civil and criminal prosecution
- Retraining on the proper use of internal/required forms.

Level 2 (Moderately Severe) Sanction

- Final written counseling
- Retraining on HIPAA awareness
- Retraining on The Agency's privacy and security policies and civil and criminal prosecution
- Retraining on the proper use of internal/required forms.

Level 3 (Most Severe) Sanction

- Termination of employment Civil penalties as provided under HIPAA or other applicable Federal/State/Local law.

Exceptions:

Depending on the severity of the violation, any single act may result in disciplinary action up to and including termination of employment with the Agency as well as civil penalties as applicable by Federal/State/Local Law.

Disclaimer

The recommended disciplinary actions are identified in order to provide guidance in policy enforcement and are not meant to all-inclusive. If formal discipline is deemed necessary, Management and/or HIPAA Security

Officer shall consult prior to taking action. When appropriate, progressive disciplinary action steps shall be followed allowing the employee to correct the behavior which caused the disciplinary action.

Information System Activity Review
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that access to Protected Health Information (PHI) shall be managed to guard the integrity, confidentiality, and availability of electronic PHI (ePHI) data. According to the law The Agency must preserve the integrity and the confidentiality of individually identifiable health information (IIHI) pertaining to each patient or client.

The purpose of this policy is to comply with the HIPAA Security Rule's requirements pertaining to the integrity, confidentiality, and availability of ePHI.

It is the policy of the Agency to ensure that all HIPAA Security policies are followed. The Agency will make reasonable efforts to regularly review records of activity on information systems containing ePHI. Appropriate hardware, software, or procedural auditing mechanisms should be implemented on the Agency's information systems that contain or use ePHI. The level and type of auditing mechanisms that must be implemented on the Agency's risk analysis process. Records of activity created by auditing mechanisms should be reviewed regularly.

The Agency shall make reasonable efforts to regularly review records of activity on information systems containing ePHI. Records of activity may include but are not limited to

- Audit Logs
- Access Reports
- Security Incident Tracking Reports
  Appropriate hardware, software, or procedural auditing mechanisms should be implemented on ACSDDB information systems that contain or use ePHI. At a minimum, such mechanisms should provide the following information:
- Date and time of activity
- Origin of activity
- Identification of user performing activity
- Description of attempted or completed activity
  The level and type of auditing mechanisms that must be implemented on ACSDDB information systems that contain or use ePHI must be determined by ACSDDB's risk analysis process. Auditable events can include but are not limited to:
- Access of sensitive data
- Use of audit software programs or utilities
- Use of privileged account
- Information system start-up or start
- Failed authentication attempts
- Security incidents
  Records of activity created by audit mechanisms implemented on ACSDDB information systems should be reviewed regularly. The frequency of such review must be determined by ACSDDB's risk analysis. At a minimum, the risk analysis should consider the following factors:
- The importance of the applications operating on the information system
- The value or sensitivity of the data on the information system
- The extent to which the information system is connected to other information systems
  Such review should be via a formal documented process. At a minimum, the process should include:
- Definition of which workforce members will review records of activity
- Definition of what activity is significant
- Definition of which activity records need to be archived and for what period of time

- Procedures defining how significant activity will be identified and reported
- Procedures for preserving records of significant activity
  Whenever possible, the Agency's workforce members should not monitor or review activity related to their own user account.

Assess whether each implementation specification is a reasonable and appropriate safeguard in its environment, when analyzed with reference to the likely contribution to protecting the entity's electronic health information.

Implement the implementation specification if reasonable and appropriate.

If implementing the implementation specification is not reasonable or appropriate

- Document why it would not be reasonable and appropriate to implement the implementation specification.
- Implement an equivalent alternative measure if reasonable and appropriate
  Implementation of this specification is accomplished through:
- The Security Officer will develop and implement an internal audit procedure that will provide regular review of records of information system activity.
- The process implemented to provide review will be designed to promote a continuing review of information system activity that will assist in the identification of potential and/or actual security breaches so that immediate corrective action may be taken.
  The internal audit procedure reviewing information system activity will be performed by the Security Officer.
  The internal audit procedure will include:
- Identification of electronic data sites
- Identification of information to be collected from the data sites that will assist in identification of actual and/or potential security issues
- Assimilation of information from the data collection sites into a report format that will be useful for reviewing electronic information system activity and assist in identification of security issues
- As deemed necessary, review designated records or reports of information system activity
  The Security Officer will develop, implement, and monitor all necessary information system review reports.
- The Security Officer will identify what information or reports are needed by the information system to adequately audit internal electronic security process
- The Security Officer will develop all reports necessary to adequately monitor the electronic security processes
- The Security Officer will, as deemed necessary, review the electronic system activity reports
- The Security Officer, based on review of information system activity reports, will develop parameters for normal or average; activity levels. Normal based on access at a specific site, frequency of access of other relevant criteria
  Based on development of "normal" information system levels, the Security Officer will be responsible for investigating identified abnormalities or unusual information system activities. Investigation may include:
- Interview of workforce member(s)
- Review of information system activity and/or
- Any other additional information gathering that may be necessary
  The Security Officer will be responsible for any necessary response to the identified security abnormality. The response may include:
- Correction of any information system security problem
- Workforce member education of sanction.

The Security Officer will be responsible for collecting, documenting, and maintaining information system activity reports and related activities, including investigation and mitigation.
Documentation of information system activity review, investigation, and/or resolution will be maintained by the Security Officer for a minimum of six years from the date information was created.

Integrity Controls
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that access to Protected Health Information (PHI) shall be managed to guard the integrity, confidentiality, and availability of electronic PHI (ePHI) data. According to the law, the Agency must preserve the integrity and the confidentiality of individually identifiable health information (IIHI) pertaining to each patient or client.

The purpose of this policy is to comply with HIPAA's Security Rule requirements pertaining to the integirty of PHI being transmitted electronically.

It is the policy of the Agency to comply with Integrity Controls as outlined below.

Electronic transmissions will be through secure protocols: Email is permitted if and only if the email is properly encrypted as outlined in the Agency's Transmission Security Standard's Encryption Policy. Facsimile is permitted if and only if a cover sheet is used with the Agency's privacy statement and contact information clearly visible. Electronic Medical Record Messaging is permitted through the Agency 's certified EMR system. Other methodologies for transmitting PHI electronically must be reviewed and approved in writing by the Security Officer.

All receiving entities will be authenticated before transmission. Any transmissions should include only the minimum amount of PHI.

Encryption
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that access to Protected Health Information (PHI) shall be managed to guard the integrity, confidentiality, and availability of electronic PHI (ePHI) data. According to the law, the Agency must preserve the integrity and the confidentiality of individually identifiable health information (IIHI) pertaining to each patient or client.

The purpose of this document is to define and implement an encryption policy related to creating algorithms and keys that meet or exceed industry standards for data security. Additionally, this policy provides direction to ensure that Federal regulations are followed, and legal authority is granted for the dissemination and use of encryption technologies inside of the United States.

It is the policy of the Agency to comply with Encryption as outlined below.

All encryption mechanisms for electronic transmission are to support a minimum of 128-bit encryption, with 256 or higher being preferred.

Encryption for the purposes of transmission shall adhere to the Encryption and Decryption policy of the Access Controls Standard.

Transmission Security Procedures
The Transmission Security Standard of the Security Rule requires that covered entities implement policies and procedures to ensure the confidentiality, integrity, and availability of data and resources. The purpose of this standard is to ensure electronic Protected Health Information being transmitted is being protected.

In order to comply with the technical security measures of this standard, the Agency must specify methods used to transmit ePHI: email, Internet, Peer-to-Peer, VPN, RDP, and any other mechanism used to transmit ePHI. Appropriate means must be taken to protect the confidentiality, integrity and availability of the ePHI being transmitted. In accordance, it is strictly against the Agency's policies and procedures to allow transmission of ePHI through unsecure networks such as SMS texting, unapproved applications (mobile or standard), unsecured personal devices, and any other unapproved mechanism.

The Agency strives to protect the confidentiality, integrity and availability of ePHI by taking reasonable and appropriate steps to establish and implement documented transmission security controls.

Use of E-mail to transmit PHI can be used if the following conditions are met:
I. The PHI data must be in a password protected document.
ii. The sender can authenticate the receiver.
iii. The receiver has given permission to have their PHI sent via E-mail.
iv. The receiver has been made aware of the risks involved through "ePHI Disclosure" statement is included in the signature of every email containing ePHI: "The information contained in this email is confidential and may contain privileged patient information protected under federal and/or state law and is intended only for the use of the individual or entity to which it is addressed. If you are not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received the communication in error, please notify the sender as listed and destroy this message."

RDP: Internal
Adair County SB40 does not use RDP protocol to access laptops remotely.
VPN
Cisco Meraki MX64 is the firewall device that provides client VPN access to Adair County SB40 network.

- The client VPN service uses the L2TP tunneling protocol.
- Meraki Client VPN uses both pre-shared key-based authentication and user authentication.
- To request user access, staff will submit a helpdesk ticket to help@teamhuber.com, Huber will create a User ID and password using Meraki Cloud authentication, 8 characters minimum, upper- and lower- case with special character. Huber will contact user and install, setup and test VPN.
- Meraki VPN can only be installed on Adair owned laptops, no personal or home devices allowed on VPN.
- VPN Install how to is located here:
- https://documentation.meraki.com/MX-Z/Client_VPN/Client_VPN_OS_Configuration#Windows_10
- Once VPN established, client has access to all ip's in the production network
- VPN will timeout after 2 hours if no activity is found
- Client access is audited regularly to determine if still in use
- When user leaves, User ID is removed from Meraki Portal as documented in off boarding process.

Authorization and Supervision
It is the policy of the Agency to comply with the HIPAA Security Rule and regulations in regards to Authorization and Supervision as outlined below:

The purpose of this policy is to comply with the HIPAA Security Rule's requirements pertaining to authorization and/or supervision of workforce members to work with ePHI or in locations where it might be located.
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that access to Protected Health Information (PHI) will be managed to guard the integrity, confidentiality, and availability of electronic PHI (ePHI) data. According to the law, the Agency must preserve the integrity and the confidentiality of individually identifiable health information (IIHI) pertaining to each patient or client.

As part of the Risk Analysis: determine which workforce members have need for access to ePHI as part of their job responsibilities, describe such needs, corresponding authorization and supervision responsibilities in job descriptions, and be sure workforce members understand these needs

Procedures must be in place for logging and tracking authorized workforce members' access to systems containing ePHI. The Agency has implemented audit controls for all systems containing ePHI including Electronic Medical Records, Billing Systems, Workstations, Servers, and any other related equipment. Procedures must be in place for granting different levels of access to ePHI. The Agency has the ability to grant role-based access to systems. The Agency has implemented role-based access to systems containing ePHI. Minimum Necessary Access has been addressed and is noted in the Minimum Necessary Access policy of the Privacy Rule and/or on the Agency's job descriptions which are given to workforce members.

Workforce Clearance Procedures
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that access to Protected Health Information (PHI) will be managed to guard the integrity, confidentiality, and availability of electronic PHI (ePHI) data. According to the law, the Agency must preserve the integrity and the confidentiality of individually identifiable health information (IIHI) pertaining to each patient or client.

The purpose of this policy is to comply with the HIPAA Security Rule's requirements pertaining to workforce clearance procedures for workforce members who work with ePHI or in locations where it might be located, accessed, or transmitted.

It is the policy of the Agency to comply with Workforce Clearance Procedures as outlined below:
All The Agency's workforce members with access to confidential information and/or PHI must sign a confidentiality agreement. Confidentiality agreements will be updated on an annual basis and will be included in the annual review process.

Clearance will be an outcome of the risk analysis and elaboration of authorization in job descriptions. As part of the risk analysis, the Agency shall consider criteria for a background check for each workforce member candidate.

When defining an organizational position, the HIPAA Security Officer must identify and define both the security responsibilities and the level of supervision required for the position.

The background of all the Agency workforce candidates will be adequately reviewed during the hiring process. Verification checks must be made as appropriate, may include but not limited to:

i. Character references
ii. Verification of academic achievements
iii. Professional license verification
iv. Credit Checks – for positions with fiscal responsibility including management, billing
v. Criminal Background Checks.

Termination Procedures
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that access to Protected Health Information (PHI) will be managed to guard the integrity, confidentiality, and availability of electronic PHI (ePHI) data. According to the law, the Agency must preserve the integrity and the confidentiality of individually identifiable health information (IIHI) pertaining to each patient or client.

The purpose of this policy is to comply with the HIPAA Security Rule's requirements pertaining to workforce termination procedures for workforce members who work with ePHI or in locations where it might be located.

ASSUMPTIONS: This Terminal Procedure is based on the following assumptions:

- In any organization, people are the greatest asset in maintaining an effective level of security
- Conversely, people are the greatest threat to data security and confidentiality
- A terminated employee may pose a threat to data security and confidentiality, particularly if dissatisfied with his or her employment or termination

When an Agency employee will be ending their relationship with the Agency, the HIPAA Security Officer will plan the termination of access to ePHI for the departing workforce member and document the following:

1. Date and time of notice of workforce member departure received
2. Date of planned workforce departure
3. Description of access to be terminated
4. Date, time, and description of actions taken

When the Agency employee will be ending their relationship with the Agency, all privileges and access to ePHI systems, including both internal and remote information system privileges will be disabled or removed by the time of departure. Information system privileges include but are not limited to: workstations, server access, data access, network access, email accounts, and inclusion on the group email lists. Physical access to areas where ePHI is located will be terminated as appropriate. The Agency will deactivate or change physical security access codes used to protect PHI.

A workforce member who ends employment with the Agency will not retain, give away, or remove from the Agency's premises any information that could compromise the PHI of any client, past or present. At the time of his or her departure, a workforce member will provide information that could access ePHI in his or her possession to his or her supervisor. The Agency reserves the right to pursue any and all remedies against workforce members who violate this provision.

The Agency will track and log the return of equipment and property or having the ability to access ePHI with the workforce member’s name, date, and time equipment and property were returned. The equipment and property that may contain, allow or enable the workforce member to access ePHI may include; but is not limited to: portable computers, building/office keys, portable media, smart phones, and pagers.

Voluntary Termination (Resignation) Steps are as follows:

1. Workforce member notifies HIPAA Security Officer of resignation
2. Supervisor will notify Payroll of termination
3. Supervisor will pull Employee Personnel File and schedule an exit interview
4. Payroll will issue final check including appropriate number of hours worked, vacation payoff, pro-rated PTO payoff.
5. Final paycheck will be issued with the next payroll
6. Termination of accesses will be scheduled for the final date of employment

a. Workforce member will sign an acknowledgement that access will be terminated and that any attempt of access after the Agency terminates access will be viewed as a criminal offense and will be prosecuted to the fullest extent of the law

7. The final date of employment, if appropriate, workforce member will be presented with separation package including legal notices regarding COBRA, 401(k), etc.

Involuntary Termination (Discharge or Layoff) Steps are as follows:

1. Supervisor compiles all documentation to support termination
2. Supervisor will total the workforce member’s last working day and total hours worked that pay period.

3. Supervisor will notify Payroll of the termination, pull the employee's personnel file and prepare for the termination.
4. Payroll will issue final check including vacation payoff and pro-rated PTO payoff.
5. The Security Officer will terminate all access to the Agency 's network, systems, and facilities no later than the date and prior to the time of the termination.
6. On the date of termination, if appropriate, the workforce member will be presented with separation package including legal notices regarding COBRA, 401(k), etc.

Workstation Security
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that access to Protected Health Information (PHI) shall be managed to guard the integrity, confidentiality, and availability of electronic PHI (ePHI) data. According to the law, the Agency must preserve the integrity and the confidentiality of individually identifiable health information (IHII) pertaining to each patient or client.

The Agency is committed to ensuring the security of its computerized clinical and business information systems and equipment. Its computer hardware and software as well as the information and data carried by the system are the sole property of The Agency.

It is the policy of the Agency to comply with the Workstation Security as outlined below:

The Agency will prevent unauthorized physical access to workstations that can access ePHI and ensure authorized workforce members have appropriate access.

The Agency workstations containing ePHI will be located in locations that minimize the risk of unauthorized access to them.

The Agency workforce members will take reasonable measures to prevent unauthorized access to ePHI visible on their workstation. Such measures include, but are not limited to: locating workstations and peripheral devices (printers, modem, scanners, etc) in secured areas that are not accessible by unauthorized persons; positioning monitors or shielding workstations so that data on the screen is not visible to unauthorized persons. Unauthorized Agency workforce members must not attempt to gain physical access to workstations without proper authorization from the HIPAA Security Officer.

The level of physical protection provided for the Agency workstations containing ePHI will be commensurate with that of identified risks. An assessment of the risks to the Agency workstations that can access ePHI will be conducted at least annually, as outlined in the Agency's Risk Management Policies. The risk assessment report will be securely maintained.

All portable workstation will be securely maintained when in the possession of the workforce member issued the device.

Workstation Use
The Workstation Use Standard of the Security Rule requires that all covered entities implement policies and procedures to ensure that specify the proper functions to be performed, the manner in which those functions are to be performed and the physical attributes of the surroundings of a specific workstation or class of workstations that can access ePHI.

The Agency is committed to ensuring the security of its computerized clinical and business information systems and equipment. Its computer hardware and software as well as the information and data carried by

the system are the sole property of the Agency. Any misuse of the Agency's workstations may result in sanctions as outlined in the Sanction Policy of the Agency.

The intent of The Agency's Workstation Use policy is to:

- Ensure that each workstation has the necessary access controls to restrict unauthorized users and programs from accessing ePHI or sensitive business information
- Ensure that software on each workstation on the network is compatible and will not lead to the degradation of the system
- Ensure that users are oriented and trained on workstation use and the maintenance of information integrity, privacy, and resource security
- Establish the security requirements for the appropriate use of mobile computing devices including: smart phones, laptops, notebooks, tablets, iPads and other Personal Digital Assistants or any other device that access ePHI or interface to the network.

User Responsibilities and the Agency Disclosure of Rights

Workforce members are responsible for maintaining the security of the Agency's computer resources under their control and for protecting the integrity and privacy of the data maintained on them by the appropriate use of lock down, password-controlled access, data encryption, virus protection, and routine backup as outlined elsewhere in the Agency's Security Policies and Procedures.

The Agency reserves the right to inspect all data and to monitor the use of all its computer systems, and as such, workstation users have no right of privacy with regard to information on or around workstations. The Agency's right of access to personally owned computed devices will be limited to the Agency's patient or business information and applications important to maintaining security over that information, including, but not limited to anti-virus software, operating systems, etc. the Agency reserves the right to remotely access, monitor, control, and configure workstations and any software residing on them. Non-compliance with this policy is subject to disciplinary action as defined in the Agency's Sanction Policy or as recommended upon management review.

The Agency protects ePHI by enforcing workstation use procedures on all workstations that access, store, or process ePHI. All workstations with fixed storage that support more than one user, process critical and/or sensitive information including modems, copiers, and scanners, must be equipped with security that protects hardware and/or restricts access to hardware.

All workstations must be equipped with updated software for detecting the presence of malware in accordance to the Agency's Malicious Software Policy. All computing devices must have the most current versions of anti-virus and anti-malware software enabled. Operating systems must have critical updates installed.

All workstations must be positioned or located in a manner that will minimize the exposure of any ePHI or business information from being displayed to any unauthorized individual. When appropriate, privacy screens should be deployed.

Users accessing the Agency network or information from remote locations, such as connections from home, should employ the appropriate safeguards. Do not access ePHI or sensitive business information in a location in which unauthorized viewing is likely, this includes family members. Do not access ePHI on a device in which the proper software for detecting the presence of malware is not deployed. Before utilizing a personal computing device to access ePHI or sensitive business information, the Agency must first approve. Ensure all Agency 's policies and procedures for workstation security are deployed when accessing ePHI or sensitive business information remotely. Access to the Agency's computer systems from remote locations must be

approved by the HIPAA Security Officer. All physical safeguards must be observed at the remote access including limiting unauthorized viewing of patient and/or sensitive business information. It is the responsibility of the remote user to ensure that remote access to the Agency's computer systems is not used by unauthorized individuals. Users with remote access from personally owned computing devices bear the responsibility of employing security protections such as anti-virus/malware software.

The Agency shall have sole discretion in determining which hardware, operating systems, and connectivity solutions will be supported. Users may not independently install connectivity hardware or software to the computing resources or devices of the Agency without the proper authorization from the Agency management and/or HIPAA Security Officer. All workforce members must comply with the Agency policies, state, federal, state, and local laws and regulations regarding the proper acquisition, use and copying of copyrighted software and commercial software licenses. Installation of personal software purchased or downloaded, including but not limited to, screensavers and animated GIFs is strictly prohibited on the Agency's Users are required to logoff of applications containing ePHI or sensitive business information as well as the workstation prior to leaving their workstation. All systems containing ePHI or sensitive business information shall have auto-logoff enabled. The delay is specified at 2-15 minutes. Exceptions must be approved in writing by the HIPAA Security Officer.

Users are not permitted to store ePHI or sensitive business information to portable media devices without the proper authorization from the Agency or the HIPAA Security Officer.

In the event a critical document or file is inadvertently deleted, contact the Agency immediately for help. Do not continue to use the workstation or save additional work as this could further compromise the availability and/or integrity of ePHI or sensitive business information.

All laptops and any other portable computer equipment must be secured when not in use. Proper security may be provided by locking the equipment in a cabinet, desk, office, etc. Where such alternatives are not feasible, keeping the device out of sight may be appropriate. Keeping information stored on a portable computing device secure and current is the responsibility of the person who has the device in his/her possession and control. Workforce members with portable computing devices which access, store or transmit ePHI or sensitive business information are responsible for breaches of security related to devices in their control.

Password Protection: All Agency workstations which access ePHI or sensitive business information are required to have enabled password protection. Any exceptions must be approved by HIPAA Security Officer in writing. In cases where password protection is not available, alternative security measures approved by HIPAA Security Officer must be deployed. Passwords must meet the Agency minimum security specifications of 8-12 digits, one capital letter, one lowercase letter, one number, and one special character. Passwords shall not be repeated within a twelve-month time frame ad may not be the same or similar to the username or previously used passwords.

All workstation users including, workforce members, physicians, vendors, volunteers, students, etc are required to have appropriate clearance including, but not limited to a background check and role-based necessity prior to being granted access to workstations.

Upon termination or change in of job position, users will have network access removed or modified.
All computing devices shall be tagged and tracked. Inventory of all workstations shall be maintained and up-to-date. The Agency will train all workforce members on this policy prior to granting access to a workstation. Periodic training on Workstation Use will be included in the Agency's privacy and security training programs.

Human Resources

Employee Handbook

It is the policy of ADAIR SB40 to maintain an Employee Handbook. The handbook will be available to all employees at all times through the Public Documents server. The Employee Handbook will be reviewed by the Executive Director and the HR Coordinator on an annual basis. Recommendations for additions, deletions or revisions to the Employee Handbook will be shared with the Board of Directors for their input during the annual fiscal planning process. Each employee will also be given an electronic copy of the handbook for their reference.

Employee's must sign the acknowledgement of receipt of the Employee Handbook upon hire and following any revisions to the handbook.

The Employee Handbook shall be included as Attachment A of the Adair SB40 Policies and Procedures Manual.

Job Descriptions

It is the policy of ADAIR SB40 that all permanent positions require a written Job Description. Each Job Description will include specific measurable goals to be traced by the Supervisor.

All Agency Job Descriptions shall be included as Attachment B of the Adair SB40 Policies and Procedure Manual.

Emergency & Disaster Plan Book

It is the policy of ADAIR SB40 to maintain an Emergency & Disaster Plan Book. The plan book will be available to all employees at all times through the Public Documents server. The Emergency & Disaster Plan Book will be reviewed by the Executive Director and the HR Coordinator on an annual basis. Additions, deletions and revisions will be made to the Emergency & Disaster Plan Book as needed. Each employee will also be given an electronic copy of the plan book for their reference.

The Emergency & Disaster Plan Books shall be included as Attachment C of the Adair SB40 Policies and Procedures Manual.