DEPARTMENT OF COMMUNITY SERVICES

Disability Support Program

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DEPARTMENT OF COMMUNITY SERVICES

Disability Support Program

Program Policy

Effective: June 2012

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1.0 POLICY STATEMENT

1.1 The Disability Support Program (DSP) provides for assistance to persons in need under the mandate of the *Social Assistance Act*. It provides support to children, youth, and adults with disabilities through residential and at-home support programs. DSP Support Options range from supporting families who care for a family member with a disability in their own home, to supporting people with disabilities in a 24-hour residential support option.

1.2 The DSP promotes a participant's independence, self-reliance, security, and social inclusion. The goal of the DSP is to support participants at various stages of their development and independence through a range of programs.

1.3 This policy applies to all DSP Programs with the exception of the Direct Family Support for Children (DFSC) Program, and Adult Service Centres / Community-based Day Programs.

2.0 POLICY OBJECTIVE

The objective of the DSP Policy is to ensure the consistent application of the initial and ongoing program eligibility process.

3.0 DEFINITIONS

For DSP policy and program definitions refer to the DSP Glossary of Terms.

4.0 GENERAL ELIGIBILITY REQUIREMENTS

4.1 Disability Requirement

4.1.1 To be eligible for DSP a person with a disability must meet the DSP eligibility criteria, and have a diagnosis that confirms one or more of the following disabilities:

1. **Intellectual Disability**: a disorder that includes an intellectual deficit which creates difficulties in functioning in two or more activities of daily living and/or instrumental activities of daily living within the range considered typical for a person of the same age and gender, which occurs prior to the age of 18 years. Each of these criteria must be present:

    a) Deficits in mental abilities such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning and learning from experience. An intelligence quotient (IQ) below the population mean, which is typically an IQ score of approximately 70. There are four levels of intellectual disability:

        1. Mild: IQ of 50 to 70;

2. Moderate: IQ of 39 to 55;

3. Severe: IQ of 20 to 40; and

4. Profound: IQ of 20 to 25.

This includes persons with a **Developmental Disability**, which is a disorder characterized by substantial impairment in several key areas of development, for example: social interaction, communication, behavioural presentation.

A learning disability is not the same as an Intellectual or Developmental Disability, as average or above average intellectual functioning is required for a learning disability; and

b) Impairments in functioning within two or more aspects of activities of daily living or instrumental activities of daily living; for example, communication, social participation, functioning at school or at work, or personal independence at home or in community settings; and

c) Onset before the age of 18 years; or

2. **Long Term Mental Illness**: a diagnosis of chronic and persistent mental illness which affects a person's thinking, feeling or behaviour and creates significant difficulties in functioning in two or more aspects of activities of daily living or instrumental activities of daily living within the range considered typical for someone of the same age or gender.

3. **Physical Disability**: a long-term, chronic and persistent physical limitation that creates significant difficulties in functioning in two or more aspects of activities of daily living or instrumental activities of daily living within the range considered typical for someone of the same age or gender. The physical disability substantially limits functional independence and results in the person requiring ongoing support and skill development.

4.1.2 Persons with an **Acquired Brain Injury,** which results in damage to a person's brain that occurs from events after birth rather than as part of a genetic or congenital disorder, may be included in one of the above three categories depending on their functional assessment.

4.2 Age and Residency Requirements

A person with a disability (see **section 4.1** of this Policy) may apply for admission to the DSP if the applicant:

a) is 19 years of age or over;

b) is lawfully entitled to be in or to remain in Canada;

c) makes their home in and is a resident of Nova Scotia; and

d) has a valid Nova Scotia Health Card.

4.3 Age Criteria Exceptions

4.3.1 A person with a disability between the ages of 16 and 19 may be considered for placement in a residential support option or an Alternative Family Support home, if:

a) they meet all other DSP eligibility requirements;

b) their assessed needs can be safely and consistently met by the DSP;

c) no alternative support program exists in Nova Scotia;

d) the placement is an appropriate option that can best meet the needs of the applicant;

e) the Director of DSP approves the placement.

4.3.2 Participants in the DSP may continue to receive services and supports as they age as long as they continue to be eligible and until their assessed support needs can no longer be safely met by the DSP.

4.4 Waiver for Applicants without a Valid Health Card or Residing in Another Province

A person with a disability who does not meet the requirements outlined in **section 4.2 (c) or (d**) of this Policy may apply by way of a written letter to the Minister of Community Services to have one or both of these requirements waived, under the following circumstances:

a) the person is residing in Nova Scotia and has made Nova Scotia their permanent home but does not yet have a valid Nova Scotia Health Card; or

b) the person is a resident of another province who wishes to move to Nova Scotia to be close to family supports and, for reasons related to their care and support, it is not feasible to establish Nova Scotia residency prior to their admission to the DSP.

4.5 Costs for Applicants with Waiver

Applicants who are granted a waiver under **section 4.4** of this Policy shall be responsible for:

a) ensuring adequate financial coverage for all of their physician, hospital, and prescription drug expenses, until they are covered by Nova Scotia Health Insurance and Nova Scotia Pharmacare; and

b) covering any and all transportation costs related to their relocating to Nova Scotia.

4.6 Community Treatment Orders/Certificates of Leave

A person with a disability who is the subject of a Community Treatment Order or a Certificate of Leave may apply for and be assessed to receive supports from the DSP provided they meet all other DSP eligibility criteria and that the terms and arrangements of their hospital readmission, if it becomes necessary, are secured prior to their hospital discharge.

4.7 Additional Eligibility Requirements

4.7.1 A person with a disability must agree to the following, prior to consideration of their eligibility for DSP services or supports:

a) provide documentation of an eligible diagnosis from a physician, psychologist, or nurse practitioner and collateral information on their activities of daily living (see **section 6.1.6** of this Policy)

b) consent to participation in an assessment for DSP services which will include the collection and sharing of their information for the purpose of determining their eligibility;

c) undergo a functional assessment of their support level requirements

d) complete a program application; and

e) undergo a financial assessment (see the DSP **Financial Eligibility Policy**).

4.7.2 A person with a disability may apply at a Department of Community Services Office nearest to their home.

4.8 Collaborative Partnership between Department of Community Services (DCS) and Department of Health and Wellness (DHW)

There are circumstances when services from both DCS and the Department of Health and Wellness are beneficial to a participant. In these circumstances the Care Coordinator shall:

- assist the participant to identify the availability of supportive programs and services through the DHW (e.g. Home Care, Self - Managed Care, Caregiver Benefit, etc.);

- ensure DCS provides no duplication of funding for services or supports.

4.8.1 Complex Case

An applicant/participant with long-term or chronic mental health issues, behavioral challenges, intellectual or developmental disabilities, and/or a physical health condition who has significant support needs which require collaboration of inter-departmental and other resources to address. To be considered a complex case 4 of the 6 characteristics must exist:

1. Applicant/participant is ineligible for existing programs or services based on support needs exceeding the criteria for the Department of Health & Wellness, the Disability Support Program, the IWK Health Centre, as well as the Nova Scotia Health Authority;
2. Current service option is not adequately addressing the needs of the individual from the view of courts or service providers;
3. Case requires resources that exceed service guidelines to participate in the community;
4. Based on assessment, the applicant/participant displays a high risk to themselves or others due to insufficient resources (related to their safety and well-being);
5. There is a need for two or more service agencies to be significantly involved with the individual – in such cases there would be inter-agency crossover and/or multiple high needs; and
6. Displays socio-economic instability.

5.0 DSP SUPPORT OPTIONS

DSP offers community based support and residential support through:

1) a Community Based Option (unlicensed);

2) a Community Home (licensed);

3) Residential Care Facility; and

4) Adult Residential/Regional Rehabilitation Centre (licensed).

Note: as required by the Interim Consent Order issued by the Human Rights Board of Inquiry on 28 June 2023, as of 29 June 2023, the Department of Community Services will not approve the development of new residential support options that exceed 4 placement beds for DSP participants. This includes, but is not limited to, the development of new Adult Residential Centres, Regional Rehabilitation Centres, Residential Care Facilities, Group Homes, and Developmental Residences.

5.1 Community Based Options (Unlicensed)

5.1.1 Flex Individualized Funding Program (Flex)

Flex provides individualized funding to participants living at home with their families or who live independently with support from their families or personal support networks. That funding is used to:

a) purchase supports specific to a participant's disability-related needs and goals;

b) promote the participant's independence, self-reliance, and social inclusion; and

c) offer an alternative to, prevent or delay a participant's placement in a DSP funded residential support option.

5.1.2 Independent Living Support (ILS) Program

The Independent Living Support (ILS) Program is a community-based option for eligible DSP participants requiring some support to live on their own. The program provides funding for participants to receive hours of support from an approved service provider, based on their circumstances and assessed needs.

5.1.3 Alternative Family Support (AFS) Program

The Alternative Family Support Program provides an approved, private family home, where support is provided for up to two persons who are not related to the AFS provider. Participants may receive varying levels of support with activities of daily living, and routine home and community activities.

5.2 Community Home (Licensed)

A Community Home provides support through:

5.2.1 Group Home (GH)

A Group Home provides participants with residential living support, learning and assistance with their activities of daily living, routine home and community activities. A Group Home focuses on enhancing a participant's skill development.

5.2.2 Developmental Residence (DR)

A Developmental Residence provides 24-hour residential support and supervision for four or more persons with intellectual disabilities who need moderate support with activities of daily living and high support with routine home and community activities. Developmental Residences provide program supports which emphasize the development of participant's interpersonal, self-care, domestic and community oriented skills. There are three categories of Developmental Residences:

1. DRI – for participants with a moderate to severe intellectual disability who require supervision or support to perform most of their activities of daily living and who do not present with persistent behavioral challenges.

2. DRII – for participants with a severe intellectual disability who have challenges performing most of their activities of daily living and may have a chronic health problem or a physical disability, and who rarely present with persistent behavioral challenges toward others but may present with persistent behavioral issues towards themselves (i.e. hitting oneself, self-stimulating behavior, etc.).

3. DRIII – for participants with intellectual disabilities who present with persistent behavioral challenges towards others and themselves that impact most of their activities of daily living or instrumental activities of daily living.

5.2.3 Small Option Home (SOH)

A Small Option Home provides residential home support for three to four participants with varying types of disability.

5.3 Residential Care Facility (RCF)

A Residential Care Facility provides participants with residential living support, minimal support with their activities of daily living, routine home and community activities. Participants are provided with limited direct support/supervision and generally do not have major medical or behavioral support needs.

5.4 Adult Residential/Rehabilitation Centre (ARC/RRC)

5.4.1 Adult Residential Centre (ARC)

An Adult Residential Centre provides support to participants who need high levels of supervision and support in their activities of daily living, routine home and community activities. An ARC provides structured supports and services to enhance the development of a participant's interpersonal, community oriented and activities of daily living skills to support their transition to a community-based option. Staffing is provided 24 hours/7 days a week.

5.4.2 Regional Rehabilitation Centre (RRC)

A Regional Rehabilitation Centre provides support to participants who need a range of support in activities of daily living, routine home community activities, and need high levels of support with severe/multiple behavior challenges. A RRC provides both rehabilitation and developmental programs to participants who require an intensive level of support and supervision related to complex behavioral challenges and skill development needs to support their transition to a community-based option. Staffing is provided 24 hours/7 days a week.

5.4.3 ARC and RRC Eligibility Criteria

To request an ARC or RRC support option, an applicant must meet the one of the following criteria:

- An adult in need of protection under sections 7, 9 or 10 of the Adult Protection Act requiring immediate support.
- A participant in hospital who has been discharged from their support option.
- An applicant referred from a hospital requiring immediate support.
- An applicant or participant evaluated by a DSP Care Coordinator as high risk, requiring urgent support. The DSP Director must confirm all available community support options have been explored and approve the request for ARC or RRC support.

Applicants who meet the above criteria may request ARC or RRC support using the DSP Service Request (section 7.0).

5.5 Community Transition Program

The Community Transition Program is an integrated care approach designed to address the needs of individuals experiencing mental and physical health issues and behavioural challenges that are impacting their ability to live successfully in

the community. The program is a transitional residential support option. To be considered for the Community Transition Program the following criteria apply:

- Has a chronic mental illness or intellectual/developmental disability, and in addition may have a chronic physical/medical condition, or serious behavioural challenges, which at times pose a high risk to self and others;
- Requires the expertise of an on-site inter-professional team to assess and address clinical and rehabilitation/life skills needs;
- Is medically stable, whereby the acute phase of the illness is over, major diagnostic testing is completed, medical needs are not requiring intensive daily intervention by a physician and nursing needs can be adequately addressed in the community with available resources; and
- Requires a 24/7 level of support in a highly-structured environment.

Individuals who meet the above criteria are referred to the program through the Department of Community Services Disability Support Program and/or the Nova Scotia Health Authority. An admission committee reviews the referrals and make recommendations.

6.0 ELIGIBILITY DETERMINATION PROCESS

6.1 Intake

6.1.1 Intake is the initial step in determining an applicant's eligibility for the Disability Support Program (DSP).

6.1.2 Intake includes:

- completion of an intake application
- registration and recording of personal information
- determining the supports and services being requested
- provision of detailed information regarding DSP supports and services
- advising of DSP's medical, functional, financial and consent requirements
- gathering required information
- referral to requested support program(s)

6.1.3 An intake application may be accepted from the applicant or, with the applicant's permission, any person acting on their behalf.

6.1.4 An applicant identified as an adult in need of protection, as defined by the *Adult Protection Act* or identified by the referee, will be immediately directed to the appropriate DSP regional contact.

6.1.5 To complete the intake process, an applicant is required to meet the age and residency requirements as per **section 4.2** of the program policy and submit the requested medical documentation that supports the confirmation of a disability.

6.1.6 When applying to the DSP, an applicant must provide documentation of an eligible diagnosis from a physician, psychologist or nurse practitioner and collateral information on their activities of daily living.

6.1.7 Applicants are responsible for any costs and fees associated with obtaining necessary medical documentation.

6.1.8 At completion of intake, an applicant may choose to continue with a referral to DSP and/or be referred to other programs that have been identified.

6.2 Evaluation of Referral Information

6.2.1 Evaluation of referral information is the process of confirming an applicant's eligibility for a full DSP assessment.

6.2.2 The evaluation of referral information includes

- assignment of a referral to a Care Coordinator
- review of the intake application and submitted documents
- contact with the applicant and/or referral sources, as required, for detailed discussion of DSP options as related to the applicant's stated medical, functional, and financial needs
- confirmation of consent **(section 6.4)**
- discussion of the Service Request List
- determination of eligibility for full DSP assessment

6.2.3 If a Care Coordinator believes an individual is an adult in need of protection as defined by the *Adult Protection Act*, the Care Coordinator must report the information to Adult Protection Services.

6.2.4 If an applicant does not meet the general eligibility requirements as outlined in section 4.0 of the program policy, the applicant will be advised of their ineligibility and the functional and financial assessments will not proceed.

6.3 Program Application and Consent

6.3.1 An applicant must complete a Program Application and sign a DSP Program Consent to allow the Disability Support Program to obtain and share their information for the purpose of determining their initial and ongoing eligibility, and for the provision of services and supports.

6.3.2 An applicant will undergo a functional assessment conducted by a Care Coordinator who will use an Individual Assessment and Support Plan (IASP). A recommendation regarding the applicant's eligibility and their assessed level of support will be made by the Care Coordinator to the Casework Supervisor.

6.3.3 An applicant's eligibility for financial assistance will be determined by the Care Coordinator through a financial assessment, in accordance with the **Financial**

Eligibility Policy. An applicant's individual circumstances are considered in the assessment and, therefore, the provision of assistance is determined on a case by case basis using Calculation of Financial Eligibility. An applicant who is eligible for DSP based on their functional assessment, but who is ineligible based on their financial assessment may access a DSP support option as a private payer.

6.3.4 If an applicant does not meet the eligibility requirements as per **section 4.0** or **section 9.0** of the program policy, they will be advised, in writing, of their ineligibility.

6.3.5 An applicant/participant or person acting on their behalf has the right to appeal any decision related to their DSP eligibility as per **Section 4.0 of Disability Support Program Appeal Policy.**

6.4 Capacity to Consent

6.4.1 An applicant/participant is required to provide consent for the DSP eligibility processes to continue. It will be assumed that an applicant/participant has the capacity to make decisions unless it is established, they do not.

6.4.2 For their consent to be valid an applicant/participant must be provided with all the information relevant to making the decision. The Care Coordinator must take all practical and appropriate steps to support an applicant/ participant to make their own decisions and provide their own consent.

6.4.3 When it appears that an applicant/participant may lack the capacity to make a decision about their personal care, living arrangements, or health needs, a Care Coordinator will complete the Capacity to Consent Evaluation.

6.4.4 If, after a consent evaluation has been conducted, an applicant/participant's capacity to make a decision remains in question, the Care Coordinator will ask the applicant/participant to have an assessment of capacity conducted by a physician.

6.4.5 If it is determined that an applicant/participant is not capable of making a decision regarding the initial and ongoing eligibility processes, consent must be obtained from a substitute decision maker before proceeding further. The Care Coordinator must ask the applicant/participant

a) if they have a guardian/representative appointed by the Court for purposes of personal care, including health care decisions

b) if they have a personal directive, power of attorney or other type of legal decision-making directive

c) to provide a copy of the guardianship/representation order, the personal directive or power of attorney document to the Care Coordinator

6.4.6 An applicant/participant who is not the subject of a guardianship/representation order, has not made a personal directive and lacks capacity to make such decisions, may require a statutory decision maker, as defined under the *Personal Directives Act*, to make decisions regarding their personal care, including health

care, placement or home-care services (**see DSP Glossary of Terms for definitions).**

6.4.7 If an applicant/participant is not capable of consenting to decisions, and does not have a court appointed guardian/representative or a personal directive, the Care Coordinator must:

a) identify a statutory decision maker in accordance with the criteria and hierarchy identified in the *Personal Directives Act.*

b) ensure that the identified statutory decision maker reads and signs a Declaration of Statutory Decision Maker.

6.4.8 The Care Coordinator can proceed to complete the intake eligibility process with the consent of the applicant's identified statutory decision maker.

6.4.9 On a continuing basis, it is assumed that a participant has the capacity to make decisions. When a decision is required regarding a participant's personal care, living arrangements or health needs and it appears that the participant may lack the capacity to make that decision, a Care Coordinator will complete the Capacity to Consent Evaluation.

7.0 SERVICE REQUEST

7.0.1 A service request is a documented request for a DSP option that is not immediately available.

7.0.2 To submit a request for service, individuals must be eligible for DSP as per **section 4.0** of this policy, meet all eligibility requirements for the requested support option (e.g. Independent Living Support Policy), and consent to sharing their information for the delivery of services and supports.

7.0.3 Individuals must be able and ready to accept the requested support option within two years. Children supported through DFSC may be assessed at 17, if requesting an adult program at 19.

7.1 Service Request Management

7.1.1 DSP cannot provide case specific timelines or position numbering for requested services.

7.1.2 Several factors impact an individual's position for a requested service, such as an applicant's:

a) preferred support option;
b) preferred location;
c) diagnosis;
d) assessed level of support; and
e) accessibility requirements.

7.1.3 An individual's position for a requested service is subject to prioritization as per **section 8** of this policy.

7.1.4 Before submitting a service request, the Care Coordinator must provide the applicant with enough information on all DSP support options (**section 5**) to make an informed decision regarding their preferred support.

7.1.5 The Care Coordinator must provide the applicant written confirmation once the service request is submitted.

7.1.6 The Care Coordinator must advise the regional Alternative Family Support (AFS) Coordinator when an applicant has requested AFS. This gives AFS Coordinators the information necessary to find a successful match with an AFS family.

8.0 PRIORITIZATION OF SERVICE REQUESTS

An applicant's priority is determined by the Care Coordinator, based on individual circumstances, in accordance with the table below. Ranking is in descending order of priority.

Adult Protection	
AP	a) An adult in need of protection under **sections 7, 9 or 10** of the *Adult Protection Act* requiring immediate placement.
Priority 1 - High Priority	
1.1	An individual evaluated by a DSP Care Coordinator as high risk, requiring urgent placement, as approved by the Casework Supervisor.
1.2	An eligible individual discharged from East Coast Forensics; or a participant in a transition placement**.**
1.3	An adult applicant pending transfer from the permanent care and custody of the Minister, or from a child-caring facility provided under the *Children and Family Services Act*.
Priority 2 - Hospitalization	
2.1	A participant in hospital who has been discharged from their program support option because of their hospitalization.
2.2	An applicant referred from a hospital who meets DSP eligibility criteria.
Priority 3 - Change in Support Needs	

3.1	A participant whose reassessment indicates a significant increase in their support needs and whose support needs cannot be met in their current program support option.
3.2	A participant whose reassessment indicates a significant decrease in their support needs, a change in their level of support, or who needs a change in their program support option.
Priority 4 - Transfers	
4	A participant who requests a transfer to a preferred program support option or location, in accordance with their assessment and support plan.
Priority 5 - Applicants	
5	An applicant who meets the DSP eligibility criteria but is not receiving DSP support (pending status).
Priority 6 - Out of Province	
6	An applicant from out of province who meets the DSP criteria and has completed a waiver as per section 4.4 of this Policy.

8.1 Emergency Placements

8.1.1 Emergencies requiring placement within 24-48 hours may be managed outside of the service request list, with DSP Director approval.

8.1.2 The criteria for emergency situations must include one or more of the following: imminent risk of serious harm to the individual; imminent risk to the provider; homelessness; or death of sole caregiver.

8.2 Maintaining Service Request Information

8.2.1 The Care Coordinator must complete an annual evaluation of the applicant's circumstances and update the service request submission.

8.2.2 When an applicant evaluated as high risk (AP or Priority 1.1) has not received service within six months, the Care Coordinator must review the individual's circumstances, and update their service request submission.

8.2.3 The Care Coordinator must advise the applicant of any changes to their service request submission.

8.3 Maintaining Service Provider Information

8.3.1 DSP will maintain an accurate list of all DSP service providers and provide this information to applicants upon their request.

8.3.2 Service providers must inform DSP of any changes in the services they provide.

8.3.3 Service providers must consult with Care Coordinators prior to any participant movements, including discharges.

8.3.4 Service providers must inform the Department of any movements as soon as possible, but no later than within 24 hours of a participant's move.

8.4 Referrals to Service Providers

8.4.1 The following criteria will be considered when referring an individual to a service provider:

a) the type of support option available and applicant's preferences;
b) the applicant's priority;
c) the applicant's assessed level of support need;
d) the date the applicant was added to the service request list;
e) the service provider's expertise;
f) accessibility requirements; and
g) support needs of other participants in the home.

8.4.2 DSP will forward three applicants for consideration by the service provider. The applicants must be reviewed in order of priority.

8.4.3 DSP will provide the service providers with referral packages that will allow them to make informed decisions regarding their ability to meet the applicants needs.

8.4.4 The referral package must include, but is not limited to:

a) Service Provider – Applicant Review Form;
b) current Individual and Assessment Support Plan;
c) current medical information
d) previous primary placements;
e) Any other assessments relevant to an applicant's support needs.

8.5 Applicant Refusal of Service Offer

8.5.1 DSP is a voluntary program. An applicant, or a person acting on the applicant's behalf in relation to placement options, has the right to refuse any offer of DSP support (exception: **8.5.3** below).

8.5.2 When an applicant refuses an offered residential option, the Care Coordinator shall document the refusal, re-evaluate and update the applicant's service request information.

8.5.3 An adult in need of protection under the *Adult Protection Act*, must accept the first appropriate bed offered. The Adult Protection client may request a transfer to a preferred option once they have been placed. They would then be prioritized as a Priority 4.

8.6 Service Provider Refusal of Applicant Referral

8.6.1 A service provider may not refuse an applicant on the basis of ethnicity, religion, language, sexual orientation or gender expression.

8.6.2 The service provider must evaluate each applicant in order of priority. If the service provider is unable to support an applicant's referral, they must:

a) demonstrate that they do not have the resources to meet the applicant's support needs;
b) work with DSP in an attempt to resolve the refusal decision;
c) inform DSP in writing of their reason(s) for refusal; and
d) indicate if, and under what circumstances, the applicant may be considered at a future date.

8.6.3 The service provider must provide DSP with written evaluation of all referrals reviewed for service.

8.6.4 DSP shall maintain all evaluations provided in accordance with this section in the applicant's file.

8.6.5 If there appears to be an unreasonable number of refusals by the service provider, DSP will consult with the service provider to discuss the number of refusals and may take necessary steps to address the concern, including action that could impact future placement and funding decisions.

8.7 Response Time Standards

The table below identifies the maximum expected timeline to complete each step. These timeframes do not apply to emergency placements.

Step	Action	Responsibility	Timeline
1	DSP is notified of vacancy details.	Service Provider	1 business day
2	Applicants (3) identified from Service Request list, confirm interest in service and forward referral packages to service provider.	DSP	5 business days
3	Referral packages are reviewed in order of priority and DSP is notified of the decision to pursue or refuse an applicant for placement.	Service Provider	5 business days
4	Transition period	Service Provider/ DSP/ Applicant	Individualized
5	Placement begins		
If the applicant does not accept the service offer, DSP shall select the next appropriate applicant and make a referral.			

8.8 Transition Assistance

8.8.1 Transition is the time utilized to familiarize a participant with a new service or placement. The transition period is measured in days. It begins when a service provider and applicant agree to pursue placement, and ends upon placement, or decision by either party not to pursue placement.

8.8.2 Transition plans must be developed jointly with the applicant, service provider, DSP staff, and SDM where applicable. Transition assistance may include, but is not limited to:

a) familiarization with the new residence (pre-visit, etc.);
b) familiarization with community and co-residents; and
c) ensuring required individual supports are in place.

8.8.3 Extra staffing may be provided to the service provider who is assisting with the applicant's transition as per section 7.6.2 Extraordinary Funding for Staffing of the **Basic and Special Needs Policy**.

8.9 Applicant Preferences

8.9.1 When an applicant indicates they will only accept a particular location or service provider, they may be offered similar placements as they become available. The Care Coordinator must review and update the applicant's preferences annually.

8.9.2 When a participant is placed in an option that is not their first choice, the applicant's name will remain on the service request list, at a lower priority, until they reach their preferred option.

8.9.3 DSP will complete quarterly reviews for all participants requesting a transfer, or experiencing a change in their support need, to explore opportunities for internal movement based on participants' preferences.

8.9.4 A DSP participant may, at any time, request to transfer to another support option that aligns with their Level of Support.

8.9.5 When a participant's desired support option is outside their assessed Level of Support, they may add their name to the Future Planning Registry.

8.10 Future Planning Registry

8.10.1 The future planning registry is a collection of information, separate from the service request list that is used to assist in planning for future DSP services.

8.10.2 An eligible individual who is not willing and ready to accept the requested service within two years may add their name to the future planning registry.

8.10.3 The future planning registry will only be used to provide insight into future demand. Individuals added to this registry will not be prioritized or offered a DSP support option.

8.10.4 The Care Coordinator must assist individuals and their families in determining their readiness for service.

8.10.5 When the individual is willing and able to accept the requested service, their name will be removed from the future planning registry and added to the service request list.

9.0 COLLABORATION

9.1 Collaboration with appropriate partner agencies will be initiated to identify support options if:

9.1.1 an applicant/participant's support needs cannot be safely met within one of the five levels of support provided by the DSP. Consultation with the Casework Supervisor and DSP Specialist is required.

9.1.2 an applicant/participant whose primary need for care and support is palliative.

9.1.3 an applicant has a diagnosed Substance Use Disorder impacting the provision of support. Consultation with the Casework Supervisor and DSP Specialist is required.

9.1.4 an applicant/participant is an involuntary patient in a psychiatric facility. Refer to Policy 4.6 Community Treatment Orders and Certificates of Leave.

10.0 REVIEW AND REASSESSMENT OF PARTICIPANT ELIGIBILITY

10.1 A participant's support needs and eligibility will be reviewed by the Care Coordinator when there are any changes to their circumstances or support needs as outlined in the **Level of Support Policy**, or in accordance with the DSP program they are in (see program policies AFS, ILS, Flex).

10.2 When there are no significant changes in a participant's level of support, the Care Coordinator shall complete a review every two years, unless otherwise specified. The existing DSP Consent Form must also be reviewed to ensure the information that has been provided is accurate and current. The participant must sign an updated consent form if there are changes.

10.3 When there are significant changes in a participant's support needs or resources that may result in a change in the participant's level of support requirements, a full

reassessment of the participant shall be completed. The Care Coordinator must update the participant's Individual Assessment and Support Plan and, if required, obtain updated medical information from a participant's physician, psychologist or nurse practitioner. If, upon reassessment, the participant's needs may be best met by a new level of support, the Care Coordinator must submit this documentation to the Casework Supervisor with their recommendation for approval.

10.4 Reviews or reassessments of a participant's financial eligibility and Special Needs will be conducted during the review and documented. When there are significant changes in a participant's financial circumstances (e.g. change in type of service or program provided, new income, or the requirement for a new ongoing Special

Need, etc.), the Care Coordinator will re-calculate the participant's eligibility amount.

10.5 Reviews and reassessments shall be completed with the participant and in consultation with the participant's family or support network and service providers, as appropriate.

10.6 The participant's electronic and paper records must be updated by the Care Coordinator after each review or reassessment to reflect their current circumstances.

11.0 TRANSFERS WITHIN DSP PROGRAMS

11.1 No Change in Level of Support

11.1.1 A participant may request a transfer to another DSP support option that meets their support needs.

11.1.2 Transfers require the approval of the Care Coordinator and Casework Supervisor.

11.1.3 When an alternative program support option is not immediately available, the participant's name shall be added to the DSP Service Request List, with their consent.

11.1.4 Care Coordinators shall ensure that participants, their families and service providers, as appropriate are informed throughout the transfer process.

11.2 Changes in Level of Support

11.2.1 The DSP shall facilitate the transfer of a participant to another DSP support option when:

a) the participant's support needs can no longer be safely met within the scope of services and staffing complement of their current program support option, and with the assistance of standard community resources; or

b) the participant's support needs change and they can benefit from a more independent level of support.

11.2.2 In order to facilitate the transfer of a participant from one level of program support option to a different level of program support option, the participant must have an updated assessment and level of support determination completed prior to transfer (see **section 10.0** of this Policy).

11.2.3 The participant's name shall be added to the DSP Service Request List when an alternative program support option is not immediately available, upon their request.

12.0 TEMPORARY AND EXTENDED ABSENCES

12.0.1 The DSP supports participants to maintain contact with their family and other

supportive relationships in their community.

12.0.2 The DSP is committed to ensuring the continuity of a participant's residential placement in a DSP support option during their temporary absences due either to hospitalization or visits with family and friends, to a maximum of thirty (30) consecutive days.

12.0.3 A participant's bedroom shall not be used for any purpose, and their personal effects shall not be disturbed by the service provider, throughout any of their occasional absences or hospitalizations of up to thirty (30) days.

12.1 Hospitalization/Rehabilitation/Occasional Absences

12.1.1 If a participant needs to be hospitalized or requires a residential rehabilitation program, the DSP will fund the residential per diem rate for thirty (30) consecutive days, when the:

a) the participant's prognosis indicates their return to the placement within thirty (30) days and the Care Coordinator has approved the request to hold their placement; and

a) the participant has experienced no change in their level of support needs.

12.1.2 A participant's residential support option shall be cancelled when it has been confirmed that:

a) the participant will require hospitalization for an extended period of time; or

b) a change in the participant's support needs necessitate their move to an alternative residential support option.

12.1.3 The Care Coordinator will ensure that the participant, their family (when appropriate), service providers and hospital staff are informed of any changes in the participant's support option.

12.1.4 If a participant who is receiving a Standard Household Rate is hospitalized, the participant is eligible to continue to receive the Standard Household Rate for 30 days.

With the approval of a Supervisor, a participant may continue to receive a Standard

Household Rate after 30 days to maintain their own residence in the community to which they expect to return upon discharge from hospital.

12.1.5 A participant in any DSP-funded support program who is hospitalized or in a rehabilitation program for longer than 30 days, and who does not receive approval for their current support option to continue to be maintained and funded, will be eligible to receive the following supports and services, with the approval of the Casework Supervisor:

a) Standard Household Rate - Essentials;

b) Comfort Allowance;

c) Special Needs (if applicable); and

d) Case Management Support.

12.1.6 If a participant is hospitalized for 30 days or more, their support needs must be reassessed by the Care Coordinator prior to re-admission to the DSP.

Case Management Support

12.2 Absences/Hospitalization Beyond Thirty (30) Days

12.2.1 A participant who has been absent from the Province for more than 30 consecutive days will have their financial support discontinued by the Care Coordinator (unless section 12.2.2 applies).

12.2.2 A participant's program support option may be maintained and funded by the DSP if they are absent for more than 30 consecutive days, with the approval of the Specialist.

12.2.3 When a participant's absence from a residential placement extends beyond 30 days, under exceptional circumstances and with the agreement of both participant and service provider, their bedroom may be used temporarily by another DSP participant with the approval of the Casework Supervisor and Specialist. The participant's personal effects must be stored in a safe, secure and easily accessible area.

13.0 DISCHARGE FROM DSP

13.1 When a participant no longer meets the eligibility criteria of the DSP, as determined through their reassessment, the participant will be notified of their ineligibility by the Care Coordinator, in writing.

13.2 A participant has the right to appeal any decision related to their completed application for or receipt of assistance under the Disability Support Program (**Section 4.0 – Right to a Decision Review and an Appeal Hearing, DSP Appeal Policy**).

13.3 A participant shall have an opportunity to provide any supplemental information that may affect their eligibility decision.

13.4 The Care Coordinator shall meet with a participant who is leaving the DSP to provide support with regard to a transition plan. This may include referrals to the Employment Support and Income Assistance Program, the Department of Health and Wellness, or other programs.

13.5 A participant who becomes financially ineligible for the DSP due to changes in their financial circumstances may choose to pay privately for their supports and remain in their DSP support option. (see section 5.11 of the DSP Financial Eligibility

Policy).

14.0 APPLICATION

This policy applies to all applicants/participants or any person acting on their behalf, and all DSP staff.

15.0 ACCOUNTABILITY

15.1 The Executive Director is responsible for the establishment and implementation of this policy and ensuring that the Program achieves the objectives for which it was created.

15.2 The Executive Director is responsible for ensuring that the Program is delivered within a fiscally sustainable manner.

15.3 Supervisors are responsible for complying with policy and exercising financial approval within their authority level.

15.4 Specialists are responsible for complying with policy and Service Delivery Managers are responsible for exercising financial approval within their authority level.

15.5 The Program Directors and Service Delivery Directors are responsible for ensuring compliance within their respective areas of responsibility, as well as making best efforts to ensure the necessary resources are available.

15.6 Casework Supervisors are responsible for preparing their employees to carry out their respective functions.

16.0 MONITORING

16.1 The Program Director is responsible for implementing appropriate mechanisms to ensure monitoring and compliance with this policy.

16.2 Specialists and Service Delivery Managers are responsible for regularly monitoring and reporting on compliance with this policy.

NOVA SCOTIA

DEPARTMENT OF COMMUNITY SERVICES

Disability Support Program

Level of Support Policy

Effective: May 2014

Updated: January 11, 2024

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1.0 POLICY STATEMENT

This policy applies to all Disability Support Programs (DSP) for adults. It does not apply to the Direct Family Support for Children (DFSC) Program.

2.0 POLICY OBJECTIVE

The Level of Support Policy provides the eligibility requirements and the assessment process for determining the level of support required by all applicants/participants in the DSP.

The Level of Support Policy promotes a participant's independence, self-reliance, security and social inclusion, consistent with the applicant/participant's assessed needs, wishes, and choice, within the parameters of available DSP resources as outlined in the applicable DSP policies.

3.0 DEFINITIONS

For DSP policy and program definitions, refer to **DSP Glossary of Terms**.

4.0 LEVEL OF SUPPORT OVERVIEW

4.1 An applicant/participant of the DSP must be assessed as requiring supports and services consistent with one of the five levels of support available in the Program. As the level of support increases from 1 to 5, the intensity, duration and frequency of support increases.

4.2 An applicant/participant's eligibility for a level of support is based on:

a) a diagnosis of an intellectual developmental disorder, long term mental illness, physical disability, or any combination thereof;

b) a functional assessment which captures an applicant/participant's ability to carry out activities of daily living (ADL) and instrumental activities of daily living (IADL);

c) the medical and behavioural support needs of the applicant/participant.

5.0 FUNCTIONAL ASSESSMENT, ELIGIBILITY AND DETERMINING LEVEL OF SUPPORT

5.1 Assessment

5.1.1 An applicant/participant must participate in a functional assessment conducted by the Care Coordinator. The assessment affords the opportunity for the applicant/participant to provide information which is unique and meaningful to them. This information assists the Care Coordinator in developing a holistic, high level perspective of the applicant/participant's strengths, resources, goals, wishes, support needs, and special need requirements (see **Basic and Special Policy**).

The information gathered through the assessment informs the determination of the applicant/participant's Program eligibility and level of support.

5.1.2 An applicant/participant must provide their consent to the DSP functional assessment and support planning process.

5.1.3 An applicant/participant must provide all supporting documentation required by the Care Coordinator to assess or re-assess their level of support. This includes documentation of an eligible diagnosis from a physician, psychologist, or nurse practitioner, and collateral information on their current activities of daily living. Updated medical information may be requested if there is a significant change in the applicant/participant's health status.

5.1.4 An applicant/participant who fails or refuses to participate in the functional assessment or reassessment or to provide the supporting documentation required by the Care Coordinator to assess and determine their level of support is ineligible for the DSP.

5.2 Determining Eligibility and Level of Support (See Program Policy **section 4.0**)

5.2.1 When determining an applicant/participant's eligibility and level of support, the Care Coordinator must:

a) review the applicant/participant's supporting documentation;

b) assess the information gathered on the functional assessment;

c) assess the applicant/participant's medical care and behavioural support needs. If the support required by the applicant/participant exceeds the resources outlined in the applicable DSP policies, the support plan may be augmented with standard community resources, where available (see **section 8.1.2**).

d) determine if the applicant/participant's assessed needs are consistent with one of the five levels of support;

e) review the outcome of the assessment and eligibility determination with the applicant/participant, their family and support network, including the service provider if applicable.

5.2.2 An applicant who is in receipt of Adult Protection Services, and who requires emergency admission to the DSP, may have the functional assessment completed by the Care Coordinator following their admission to a DSP support option.

5.3 Casework Supervisor Review and Approval

The Casework Supervisor shall review the applicant's completed assessment or review, and any other supporting documentation, to ensure they are in agreement with the Care Coordinator's determination of the level of support.

5.4 Advisement of Assessment or Reassessment Outcome to Applicant/ Participant or Service Provider

5.4.1 The Care Coordinator shall advise the applicant/participant in writing of the Department's eligibility decision, their level of support, and any other applicable information such as a program support option being offered or placement on the Service Request list.

5.4.2 The Care Coordinator shall advise the applicant/participant in writing of the Department's ineligibility decision.

5.4.3 If the participant has a service provider, the Care Coordinator shall provide the service provider with the participant's updated determination of level of support.

5.4.4 The applicant/participant will be advised in writing of their right to appeal the Department's decision. An applicant/participant has thirty (30) business days after the communication of a decision to request a decision review. To account for regular mail delivery standards, the thirty (30) business day timeline begins five (5) business days following the date of the Notice of Level of Support Determination Decision Ineligibility Letter (**Section 4.0 - Notification of Decision, DSP Appeal Policy).**

6.0 SUPPORT PLANNING

6.1 Individual Support Plan

All DSP participants require an Individual Support Plan (ISP). The participant's health, safety, assessed needs, goals, wishes and personal preferences are the key considerations in the development of their support plan. The Care Coordinator documents this information to determine goals and high level strategies on how they may be achieved. This approach assists in achieving outcomes that support the participant's independence, self-reliance, security and social inclusion.

6.2 Detailed Daily Support Plan

6.2.1 Upon admission to a DSP support option, the participant's service provider is expected to develop a more detailed person-directed plan that details the supports the participant requires on a daily basis. The participant may choose to have other members of their personal support network contribute to their support plan. The Care Coordinator works collaboratively with the service provider and provides input to the support planning process, approves associated special needs costs, and monitors the effectiveness of the plan.

6.2.2 This support plan will be reviewed annually by the service provider. The Care Coordinator is kept apprised of this annual review and any changes made throughout the year.

6.3 Participant Rights – Supported Decision Making

The autonomy of the applicant/participant is respected. This includes a participant's right to knowingly undertake risk to themselves, and to accept or refuse services. Care Coordinators and Service Providers have a responsibility to

educate a participant on the nature, benefits, risks and alternatives to the available support services. This includes discussing the likely consequences of accepting or refusing recommended services. Participants must also be given the opportunity to ask questions and be given answers in a timely and respectful manner.

6.4 Reassessment of a Participant's Level of Support

6.4.1 The Care Coordinator shall complete a review of a participant's support needs and their level of support at a minimum of every two years (biennially).

6.4.2 A reassessment of a participant's support needs and their level of support shall be conducted at least once during a six-year period or when:

a) the participant's support needs have changed or their support plan requires changes;

b) their level of support requires reassessment;

c) the participant wishes to update their assessment.

6.4.3 When a participant's support needs have remained stable and there are few, if any changes, the Care Coordinator may complete a review of their Individual Assessment and Support Plan.

6.4.4 When it has been identified that significant changes have occurred to a participant's support needs, those changes will be documented using the Individual Assessment and Support Plan.

6.4.5 Superseding **section 6.4.3**, the assessment will be completed:

a) when a participant has never had an assessment previously completed;

b) when an assessment is not present on the participant's file.

7.0 LEVELS OF SUPPORT

A level of support is the amount and type of support an applicant/participant requires to strengthen or maintain their individual abilities. An applicant/ participant's level of support is assessed in a manner intended to maximize the person's independence, self-reliance, security and social inclusion.

7.1 Level 1 Support: Minimal

An applicant/participant whose assessed needs are determined to be Level 1 requires minimal to intermittent support and/or supervision to enhance or maintain their skills in two or more areas of functioning, primarily in instrumental activities of daily living. Support may also be needed to enhance and maintain the participant's health and wellness.

At Level 1, an applicant/participant is independent in their personal care or has limited personal care needs. They may have a physical disability and may have stable but chronic health/medical conditions. An applicant/participant may require assistance with establishing daily life routines, and has the ability to identify and access support or help. At Level 1, individuals can access the community independently.

An applicant/participant may have been involved in, or is capable of becoming involved in employment, training or a day activity consistent with their interests, abilities and needs. The applicant/participant may require support to develop and maintain social networks.

An applicant/participant whose needs are assessed as Level 1 has strengths, resources and support needs consistent with the criteria described in **sections 7.1.1 through 7.1.6** below.

7.1.1 Level 1 – Activities of Daily Living (ADL)

An applicant/participant may demonstrate one or more of the following:

a) an ability to follow multi-step processes and convey their feelings, wants and needs effectively with minimal support;

b) an ability to identify appropriate activities and an ability to complete them once the activity has been established;

c) an ability to follow directions and established routines;

d) a requirement for minimal prompts or monitoring, or minor assistance with their personal care and general activities of daily living;

e) a requirement for minimal prompts for choosing, changing, and maintaining their clothing;

f) a requirement for support in understanding personal relationships and sexuality.

7.1.2 Level 1 - Instrumental Activities of Daily Living (IADL)

An applicant/participant requires intermittent supervision or support and assistance with their instrumental activities of daily living, such as basic food preparation, household and financial management, transportation and accessing the community.

7.1.3 Level 1 - Health Status

An applicant/participant may demonstrate one or more of the following:

a) a requirement for general support and monitoring regarding their mental and physical health and wellness;

b) a requirement for routine medical care and evaluation of their general health;

c) a requirement for medical care due to chronic or intermittent health concerns, or a requirement for health care teaching;

d) a requirement for increased support when they are actively ill or experiencing anxiety;

e) difficulty with sleeping, settling, or occasionally waking through the night, but no requirement for supervision;

f) a requirement for monitoring and support with making significant health care decisions;

g) a requirement for support to access professional services as identified in their functional assessment.

7.1.4 Level 1 - Medical Conditions

An applicant/participant may demonstrate one or more of the following:

a) issues relating to a mental or physical health diagnosis which is considered stable but may have a significant, but manageable, impact on their daily routines;

b) a requirement for assistance with locating/accessing community medical supports;

c) a requirement for monitoring by a health care specialist;

d) an ability to manage medication when effective supports are in place;

e) a requirement for minimal prompts/reminders or education (e.g. for special diets).

7.1.5 Level 1 - Behaviour

An applicant/participant may demonstrate one or more of the following:

a) a requirement for minimal or no behavioural support;

b) a requirement for minimal or situational/occasional support with social interaction (e.g. relationships, sexuality, interpersonal skills or challenges);

c) a need for education, teaching or informal support for issues relating to manageable behaviours.

7.1.6 Level 1 - Safety

The applicant/participant may demonstrate one or more of the following:

a) a requirement for minimal or no direct supervision;

b) no unmanageable safety risks;

c) an ability to access the community independently for extended periods of time;

d) a requirement to have contact name/numbers for emergencies;

e) an ability to use an emergency response system;

f) an ability to self-evacuate from their residence in the event of an emergency.

7.1.7 Level 1 - Program Support Options

An applicant/participant whose assessed needs are determined to be Level 1 may be supported within the following options:

a) Flex Individualized Funding
b) Alternative Family Support
c) Independent Living Support
d) Small Option Homes
e) Group Homes
f) Residential Care Facility

All approvals will ensure that the applicant/participant's support needs can be met within:

- the option being considered;
- the scope of services;
- funding and staffing complement; and
- in adherence to all applicable policies.

7.2 Level 2 Support: Moderate

An applicant/participant whose assessed needs are determined to be Level 2 requires intermittent support and/or supervision to maintain or enhance their skills in two or more areas of functioning, primarily in activities of daily living and instrumental activities of daily living. They may require supervision and minimal support for on-going medical or health related issues. They may require moderate support that provides structure to maintain or enhance their skills, and health and wellness.

An applicant/participant may be able to access the community independently for varying lengths of time. An applicant/participant may have been involved in, or is capable of becoming involved in, employment, training or day activities consistent with their interests, abilities and needs. The applicant/participant may require support to develop and maintain social networks.

An applicant/participant whose needs are assessed to be Level 2 has strengths, resources and support needs consistent with the criteria described in **sections 7.2.1 through 7.2.6** below.

7.2.1 Level 2 - Activities of Daily Living (ADL)

An applicant/participant may demonstrate one or more of the following:

a) a requirement for periodic and brief prompts in some aspects of their personal care, and may demonstrate a requirement for ongoing support or education;

b) a requirement for physical assistance in some situations if their primary diagnosis is a physical disability;

c) a requirement for supervision and support with a range of their activities of daily living to develop and maintain routines;

d) a requirement for periodic reminders and monitoring or verbal prompts regarding their personal hygiene and grooming activities;

e) an ability to communicate but may require some supports;

f) a requirement for skills/knowledge enhancement;

g) a requirement for support in understanding personal relationships, and sexuality.

7.2.2 Level 2 - Instrumental Activities of Daily Living (IADL)

An applicant/participant may demonstrate one or more of the following:

a) a requirement for support/formal teaching to maintain, develop or enhance their instrumental activities of daily living skills;

b) a requirement for skill development and teaching;

c) a requirement for a day support, which may be either structured or informal.

7.2.3 Level 2 - Health Status

An applicant/participant may demonstrate one or more of the following:

a) a requirement for routine health care or pre-scheduled medical appointments due to chronic or intermittent health problems, more than once per year;

b) a requirement for support to manage their health and wellness;

c) a requirement for support to ensure that their daily activities and routines are appropriately maintained, which may involve informal to formal teaching and skill enhancement;

d) varying levels of knowledge and insight into their health status;

e) wakefulness through the night that intermittently requires support to resettle.

7.2.4 Level 2 - Medical Conditions

An applicant/participant may demonstrate one or more of the following:

a) issues relating to a mental or physical health diagnosis, which is generally stable, but requires intermittent support and monitoring. The diagnosis may have a significant, but manageable impact on their daily routines;

b) a requirement for support with medication management, which may include support to manage prescriptions and changes in medication routines, on-going monitoring, supervision, or assistance with the administration of medications;

c) a requirement for support and monitoring with their health issues and attending medical and specialist appointments;

d) a requirement for teaching, assistance and support with special diet requirements.

7.2.5 Level 2 – Behaviour

An applicant/participant may demonstrate one or more of the following:

a) a history of behaviours with no, or minimal risk to themselves, others, or their environment;

b) a level of behaviour which is manageable through informal interventions, but may require short-term moderate interventions;

c) a requirement for behavioural support which is intermittent or ongoing and which can be accessed from available standard community resources.

7.2.6 Level 2 - Safety

An applicant/participant may demonstrate one or more of the following:

a) a minimal safety risk to themselves, others, or their environment;

b) the ability to access the community independently for varying periods of time;

c) a requirement for occasional but brief periods of direct supervision;

d) a discomfort with being alone at home for periods of time, and a need to access overnight support/supervision;

e) a requirement for support, education or supervision to build their capacity to manage their behaviour, support decision making and enhance social skills;

f) a requirement for monitoring of their mental health during periods of active illness, for safety reasons; and

g) an ability to self-evacuate from their residence in the event of an emergency, with minimal support.

7.2.7 Level 2 - Program Support Options

An applicant/participant whose assessed needs are determined to be Level 2 may be supported within the options:

a) Flex Individualized Funding
b) Alternative Family Support
c) Independent Living Support
d) Small Option Homes
e) Group Homes

All approvals will ensure that the applicant/participant's support needs can be met within:

- the option being considered;
- the scope of services;
- funding and staffing complement; and
- in adherence to all applicable policies.

7.3 Level 3 Support: High

An applicant/participant whose assessed needs are determined to be Level 3 requires support that may range from minimal up to 24 hours per day. Supports may include supervision and skill enhancement with activities of daily living and instrumental activities of daily living.

An applicant/participant may require support that provides structure to maintain or enhance their skills, health and wellness. They may also require moderate, up to a high, level of support with their medical conditions.

An applicant/participant may have the ability to access the community independently for brief periods of time. An applicant/participant may have been involved in, or is capable of becoming involved in, employment, training or day activities consistent with their interests, abilities and needs. The applicant/ participant may require support to develop and maintain social networks.

An applicant/participant whose needs are assessed to be Level 3 has strengths, resources and support needs consistent with the criteria described in **sections 7.3.1 through 7.3.6** below.

7.3.1 Level 3 - Activities of Daily Living (ADL)

An applicant/participant may demonstrate one or more of the following:

a) a requirement for support with their activities of daily living, ranging from a

supportive presence to the provision of direct assistance;

b) a requirement for personal supports on an on-going basis;

c) moderately impaired communication skills that require support;

d) a requirement for support in understanding personal relationships and sexuality.

7.3.2 Level 3 - Instrumental Activities of Daily Living (IADL)

An applicant/participant may demonstrate one or more of the following:

a) a requirement for support and assistance with their instrumental activities of daily living, which can vary from minimal supervision up to high level of support/assistance in the areas of basic food preparation, household and financial management, transportation, and accessing the community;

b) a vulnerability in unusual or unfamiliar situations and a requirement for support in judgment/decision making;

c) a requirement for accompaniment when accessing the community;

d) a requirement for a day activity support.

7.3.3 Level 3 - Health Status

An applicant/participant may demonstrate one or more of the following:

a) a requirement for regular monitoring and intermittent consultation from health care practitioners;
b) a requirement for support with managing a mental or physical health diagnosis which is considered stable but may be chronic or cyclical in nature and have a significant, but manageable impact on their daily routines;

c) a requirement for on-going support to manage their daily routines or ongoing reassurance to supplement their insight into their health issues;

d) sleep disruptions which require intermittent support throughout the night.

7.3.4 Level 3 - Medical Conditions

An applicant/participant may demonstrate one or more of the following:

a) significant medical conditions that are stable with the required supports;

b) episodes of acute illness and/or seizure conditions that require clinical protocols;

c) a requirement for frequent medical testing and monitoring of their medical conditions;

d) a requirement for intermittent assessment and support services from health professionals such as occupational therapists, physiotherapists, nurses;

e) a requirement for monitoring or support to administer medication, but demonstrates no major issues or concerns with medication compliance.

7.3.5 Level 3 - Behaviour

An applicant/participant may demonstrate one or more of the following:

a) a requirement for moderate behavioural supports;

b) behaviours which are manageable, either through informal interventions or, when required, formal interventions/programs.

7.3.6 Level 3 - Safety

An applicant/participant may demonstrate one or more of the following:

a) an ability to access the community with support;

b) a requirement for supervision that is easily accessible, or a requirement for brief but frequent, direct supervision;

c) a requirement for informal interventions to manage safety, and may demonstrate a requirement for occasional formal interventions/programs for limited periods of time;

d) a requirement for structured support and supervised programs to reduce safety risks to themselves, others and their environment;
e) a requirement for overnight awake support;

f) a requirement for support to evacuate from their residence in the event of an emergency.

7.3.7 Level 3 - Program Support Options

An applicant/participant whose assessed needs are determined to be Level 3 may be supported within the following options:

a) Flex Individualized Funding
b) Alternative Family Support
c) Independent Living Support
d) Small Option Homes
e) Developmental Residences (I)
f) Adult Residential Centres

All approvals will ensure that the applicant/participant's support needs can be met within:

- the option being considered;
- the scope of services;
- funding and staffing complement; and
- in adherence to all applicable policies.

7.4 Level 4 Support: Enriched

An applicant/participant whose assessed needs are determined to be Level 4 requires high to enriched on-site 24 hour supervision and assistance with all of their activities of daily living and instrumental activities of daily living. They may require structured support to maintain or enhance their skills, health and wellness. They may have varying personal and health care needs, and their overall health status and medical conditions may require monitoring.

An applicant/participant may have behavioural challenges that can be supported within the scope of the programs and services provided by a program support option, or with the assistance of available standard community resources, as required.

An applicant/participant may have been involved in, or is capable of becoming involved in, employment, training or day activities consistent with their interests, abilities and needs. The applicant/participant may require support to develop and maintain social networks.

An applicant/participant whose needs are assessed as Level 4 has strengths, resources and support needs consistent with the criteria described in **sections 7.4.1 through 7.4.6** below.

7.4.1 Level 4 - Activities of Daily Living (ADL)

An applicant/participant may demonstrate one or more of the following:

a) a requirement for close supervision, and up to a high level of physical support with most of their activities of daily living and other aspects of their personal care;

b) a requirement for on-going support with self-help and personal care skills;

c) a requirement for physical assistance with all mobility and transfers (mechanical aids may also be required);

d) a requirement for support in understanding personal relationships and sexuality.

7.4.2 Level 4 - Instrumental Activities of Daily Living (IADL)

An applicant/participant may demonstrate one or more of the following:

a) a requirement for total support and accompaniment with all aspects of their

instrumental activities of daily living;

b) a requirement for basic skill development and daily support to promote their independence;

c) a requirement for active supervision or support to identify and pursue interests and structure their time;

d) a requirement for specific supports related to communication, such as interveners, communication boards or other assistive devices;

e) a requirement for a day activity support.

7.4.3 Level 4 - Health Status

An applicant/participant may demonstrate one or more of the following:

a) a requirement for regular monitoring and consultation from health care practitioners;

b) a requirement for support with health-related interventions to maintain optimal wellness or support relating to insight into their health issues;

c) a requirement for active awake support throughout the night on an ongoing basis.

7.4.4 Level 4 - Medical Conditions

An applicant/participant may demonstrate one or more of the following:

a) a requirement for frequent medical care, appointments, or close monitoring when ill with chronic conditions or episodes of acute illness that do not require hospitalization;

b) a requirement for support with the administration of medication and all aspects of medication management.

7.4.5 Level 4 – Behaviour

An applicant/participant may demonstrate one or more of the following:

a) a requirement for a high level of support to manage behaviours which may be directed towards themselves, others, or their environment and which require support programs and intermittent involvement of health care specialists and available standard community resources;

b) behavioural resistance and safety issues that are generally predictable and responsive to individualized skill and behavioural program approaches.

7.4.6 Level 4 - Safety

An applicant/participant may demonstrate one or more of the following:

a) personal safety issues including vulnerability to others;

b) a requirement for support program(s) to manage safety risks to themselves, others, or their environment;

c) a requirement for support to evacuate from their residence in the event of an emergency.

7.4.7 Level 4 - Program Support Options

An applicant/participant whose assessed needs are determined to be Level 4 may be supported within the following options:

a) Flex Individualized Funding

b) Alternative Family Support

c) Independent Living Support

d) Small Option Homes

e) Developmental Residences (II or III)

f) Adult Residential Centres

All approvals will ensure that the applicant/participant's support needs can be met within:

- the option being considered;
- the scope of services;
- funding and staffing complement; and
- in adherence to all applicable policies.

7.5 Level 5 Support: Intensive

An applicant/participant whose assessed needs are determined to be Level 5 requires support that may vary widely from minimal to intensive, and may require direct support with some or all their activities of daily living or instrumental activities of daily living.

An applicant/participant may require intensive levels of supervision, assessment, assistance, skill development, and behavioural interventions. They may be physically well or have chronic health conditions. They may require support that provides structure to maintain or enhance their skills, health and wellness.

An applicant/participant may demonstrate behaviour or safety issues that are frequent or are unpredictable in nature, and they may have involvement with other departments, agencies, programs or the justice system.

An applicant/participant may require access to multi-disciplinary teams and skilled staff members, along with specialized programs to manage safety and risks related to themselves, staff and other residents. They may require a significant level of supervision with community access.

An applicant/participant may have been involved in, or is capable of becoming involved in employment, training, or day activities, consistent with their interests and abilities, and their requirements for supervision with community access. The applicant/participant may require support to develop and maintain social networks.

An applicant/participant whose needs are assessed as Level 5 has strengths, resources and support needs consistent with the criteria described in **sections 7.5.1 through 7.5.6** below.

7.5.1 Level 5 - Activities of Daily Living (ADL)

An applicant/participant may demonstrate one or more of the following:

a) a requirement for minimal to maximum support for their activities of daily living;

b) a requirement for minimal to maximum support with personal care;

c) a requirement for support in understanding personal relationships and sexuality.

7.5.2 Level 5 - Instrumental Activities of Daily Living (IADL)

An applicant/participant may demonstrate one or more of the following:

a) a requirement for minimal to intensive support to perform their instrumental activities of daily living;

b) a requirement for direct support to engage in activities, follow directions or routines;

c) a requirement for support and programs to develop, enhance, or reinforce social skills and communication;

d) a requirement for active supervision or support to identify and pursue interests and structure their time;

e) a requirement for a day activity support.

7.5.3 Level 5 - Health Status

An applicant/participant may demonstrate one or more of the following:

a) a requirement for monitoring of their general health and wellness;

b) a requirement for skilled assessment and intervention from a range of health care practitioners, including medical and behavioral specialists and mental

health clinicians.

7.5.4 Level 5 - Medical Conditions

An applicant/participant may demonstrate one or more of the following:

a) varying needs, from physical wellness to chronic health conditions, requiring varying levels of supervision and support needs;

b) a requirement for frequent medical care, medical appointments and close monitoring when ill with an acute or chronic condition;

c) a requirement for monitoring by staff, and assessment as needed by a variety of health care practitioners;

d) a requirement for support with the administration of medication and with all aspects of medication management.

7.5.5 Level 5 – Behaviour

An applicant/participant may demonstrate one or more of the following:

a) challenging behaviours which are persistent, ongoing, and which complicate and interfere with their daily functioning or present a level of risk to themselves, others or their environment. These behaviours can be managed within the scope and resources of their appropriate program support option or with the assistance of available standard community resources, as required;

b) a requirement for frequent crisis stabilization;

c) a requirement for involvement with other governmental departments, the courts, agencies, or programs (e.g. DHW or Department of Justice);

d) a requirement for extensive formal behavioural procedures/protocols.

7.5.6 Level 5 - Safety

An applicant/participant may demonstrate one or more of the following:

a) a requirement for an intensive level of structured monitoring, assessment and therapeutic responses to their behaviors;

b) a requirement for support to evacuate from their residence in the event of an emergency.

7.5.7 Level 5 - Program Support Options

An applicant/participant whose assessed needs are determined to be Level 5 may be supported within the following options:

a) Flex Individualized Funding

b) Alternative Family Support

c) Independent Living Support

d) Small Option Homes

e) Developmental Residences (III)

f) Regional Rehabilitation Centres.

All approvals will ensure that the applicant/participant's support needs can be met within:

- the option being considered;
- the scope of services;
- funding and staffing complement; and
- in adherence to all applicable policies.

8.0 MEDICAL CARE AND BEHAVIOURAL SUPPORT REQUIREMENTS

8.1.0 When conducting an applicant/participant's functional assessment, the Care Coordinator may identify a need for medical or behavioural supports as a necessary part of the applicant/participant's support plan. The Care Coordinator will consider the following:

a) the stability of the applicant/participant's condition that requires additional medical or behavioural supports;

b) the applicant/participant's level of independence with their condition and support needs (e.g., medication administration);

c) the potential impact of the medical need or behaviour on co-residents;

d) the specific supports required and the availability of those supports;

e) that the provision of supports is within DSP policies;

f) the service provider's willingness and ability to support the applicant/ participant, within their existing per diem and staffing resources.

8.1.1 There may be some situations when the assessed supports required by the applicant/participant are not included in DSP policies, or are outside of the existing per diem or staffing levels of an identified support option. The Care Coordinator will attempt to secure further supports through available standard community resources that would typically be available to all residents of Nova Scotia.

8.1.2 To be eligible for the DSP, all supports required for the applicant/participants identified medical and behavioural needs must be approved and available.

8.2 Medical Care Parameters

If the applicant/participant has a medical diagnosis or chronic health condition

identified in their submitted medical documents, the following parameters apply:

a) the medical condition(s) must be stable for the applicant/participant to be assessed for a level of support. If an applicant/participant is hospitalized, their medical condition(s) must be stable prior to assessment;

b) an applicant/participant's stable chronic medical condition may have a component of continual deterioration, or short periods of acute illness, but the support needs required as a result of the medical condition must be available within the scope of services of the support option and within its approved per diem and staffing complement. The applicant/participant's support plan may include standard community resources that help support these types of conditions.

8.3 Acute Nursing Services

8.3.1 If an applicant/participant requires short term acute medical interventions, support shall be accessed through the Nova Scotia Health Authority (NSHA). Examples of interventions for which acute nursing services may be required include, but are not limited to:

a) intravenous (IV) therapy;

b) intramuscular (IM) injection of medications associated with acute illness;

c) specific treatments directly related to the applicant/participant's acute episodes, as appropriate.

8.3.2 If the applicant/participant cannot access short term acute nursing services through the NSHA, the Care Coordinator may consider covering these costs under the **Basic and Basic and Special Needs Policy Needs Policy**.

8.4 Chronic Medical Conditions

8.4.1 If an applicant/participant's chronic medical condition has a component of continual deterioration that requires ongoing or intermittent medical intervention, support may be accessed, where possible, through standard community resources.

8.4.2 If an applicant/participant requires a resource that cannot be provided within the approved per diem and staffing resources of their support option or through standard community resources, the Care Coordinator may consider if the resource can be covered under the **Basic and Special Needs Policy**.

8.4.3 Coverage of supports as a special need will only continue until such time as the required resource becomes available. A reassessment of the applicant/ participant's level of support may be required if the support need is long term or permanent.

8.5 Medication

When a participant undergoes significant changes to their medication schedule the

Care Coordinator may need to assess if changes to the participant's supports are required, the following may be considered:

a) consultation with the prescribing health professional to understand the nature of the medication and the anticipated psychological and physiological effects on the applicant/participant;

b) a requirement for additional medical monitoring or medical appointments;

c) the time frame for effectiveness;

d) a service provider's ability, within their existing resources or through the provision of standard community resources, to safely monitor and evaluate the effects of the medication on the applicant/participant.

8.6 End of Life Care

End of life care may be provided to participants who have been diagnosed with a life limiting medical condition as per the End of Life Care Policy.

8.7 Behavioural Support Parameters

To assess whether an applicant/participant's behavioural support needs can be safely met within the resources available through the DSP or with the assistance of available standard community resources, the following parameters shall be considered:

a) frequency, intensity and duration of an applicant/participant's behaviour(s) as they relate to:

- physical aggression;
- sexual aggression;
- harmful behaviour that is premeditated or predatory in nature and that has compromised, or has the potential to compromise, the safety of others;
- risk to themselves, others or their environment.

b) if an applicant/participant's required supports can be provided within the scope of services and approved per diem and staffing complement of a program support option, or with the assistance of standard community resources such as mental health outreach;

c) if a behavioural support plan can be:

- developed to respond to an applicant/participant's behavioural support needs;
- developed by a service provider, with an applicant/participant in

collaboration with standard community resources when the required expertise is not available within the service provider's resources; and

- reviewed frequently by the service provider, and subject to regular review by the Care Coordinator, to ensure that the behavioural supports being provided remain current and effective.

9.0 DISCRETIONARY CASE MANAGEMENT REGARDING A PROGRAM OPTION

9.1 There may be individually distinct circumstances in which a participant may be best supported in a program support option outside of their assessed level of support. This would be an exceptional situation and may be considered with the approval of the Casework Supervisor in consultation with the Care Coordinator. In this circumstance the parameters outlined in **sections 9.2 - 9.4** must also be in place.

9.2 All supports and services required by the participant must be available within the service provider's existing scope of services, and approved per diem and staffing complement of the program support option being considered.

9.3 All applicable DSP policies for the type of support option being considered must be followed.

10.0 ASSESSED SUPPORT NEEDS IDENTIFIED OUTSIDE OF DSP LEVELS OF SUPPORT

10.1 Collaborative option with appropriate partner agencies initiated (See Program Policy sections 9.0 or 4.8)

10.2 Referral to Alternative Programs Indicated

10.2.1 If the applicant is a senior with an age-related condition, they will be supported to apply for supports under the mandate of the Department of Seniors and Long- Term Care (SLTC).

10.3 When a participant has been referred to, and approved by, a service under the mandate of the SLTC the participant will be supported in their current DSP support option until such time as the SLTC support option becomes available.

11.0 APPEAL OF LEVEL OF SUPPORT DECISION

11.1 Right to Appeal

11.1.1 An applicant/participant has the right to appeal any decision related to their completed application for or receipt of assistance under the Disability Support Program. For information on how to file an appeal refer to the **DSP Appeal Policy**.

12.0 APPLICATION

This policy applies to all applicants/participants and any person acting on their behalf, and all DSP staff.

13.0 ACCOUNTABILITY

13.1 The Executive Director is responsible for the establishment and implementation of this policy and ensuring that the Program achieves the objectives for which it was created.

13.2 The Executive Director is responsible for ensuring that the Program is delivered within a fiscally sustainable manner.

13.3 Supervisors are responsible for complying with policy and exercising financial approval within their authority level.

13.4 Specialists are responsible for complying with policy and Service Delivery Managers are responsible for exercising financial approval within their authority level.

13.5 The Program Directors and Service Delivery Directors are responsible for ensuring compliance within their respective areas of responsibility, as well as making best efforts to ensure the necessary resources are available.

13.6 Casework Supervisors are responsible for preparing their employees to carry out their respective functions.

14.0 MONITORING

14.1 The Program Director is responsible for implementing appropriate mechanisms to ensure monitoring and compliance with this policy.

14.2 Specialists and Service Delivery Managers are responsible for regularly monitoring and reporting on compliance with this policy.

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DEPARTMENT OF COMMUNITY SERVICES

Disability Support Program

Financial Eligibility Policy

Effective: June 2012

Updated: March 18, 2024

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1.0 POLICY STATEMENT

1.1 This policy applies to all DSP Programs, with the exception of the Direct Family Support for Children (DFSC) Program and Adult Service Centres / Community-based Day Programs.

1.2 An applicant must be willing to participate in a financial assessment to determine their eligibility for the DSP.

1.3 An applicant/participant's income and applicable assets are assessed against financial eligibility criteria for participation in the DSP.

2.0 DEFINITIONS

For DSP policy and program definitions, refer to the DSP Glossary of Terms.

3.0 POLICY OBJECTIVE

3.1 The Financial Eligibility Policy provides the financial eligibility criteria, the eligibility assessment procedures, and the review and appeal procedures related to the determination of a person's financial eligibility for participation in the DSP.

3.2 The objective of the Financial Eligibility Policy is to ensure the consistent application of the initial and ongoing financial eligibility process.

4.0 ELIGIBILITY

4.1 A person in need may be eligible for financial assistance from the Department of Community Services based on their assessed needs, their eligibility amount calculation, and the availability of Departmental resources.

4.2 A Care Coordinator will conduct a financial assessment of the income and applicable assets available to an applicant/participant to meet the costs associated with the provision of DSP supports and will decide whether an applicant/participant is financially eligible for the DSP.

4.3 When an applicant is eligible for the DSP and Departmental resources or DSP support options are not available, the applicant's name shall be placed on the Service Request List, upon their request, as outlined in **section 7.0** of the DSP Policy.

5.0 FINANCIAL ASSESSMENT PROCESS

5.1 Mandatory Program Application

5.1.1 All applicants, including private paying persons as outlined in **section 5.10** of this Policy, must complete an application for the DSP.

5.1.2 An applicant who does not complete the program application is ineligible for the DSP.

5.1.3 An applicant must provide written consent for the Department to obtain their financial information from a third party, and to share their financial information with other agencies involved in their support, as necessary.

5.1.4 Applicants in receipt of Adult Protection Services, or a person with a disability who requires emergency admission to a DSP program, may complete the program application following their admission to a DSP support option.

5.2 Application Completion

5.2.1 If anyone other than an applicant makes the referral to the DSP, a Care Coordinator must ensure that the applicant is:

a) aware of the application; and

b) willing to participate in the eligibility assessment process.

5.2.2 An applicant/participant must provide all financial information required by the Care Coordinator to make a determination of their financial eligibility.

5.3 Financial Assessment

5.3.1 When completing an applicant/participant's financial assessment, the Care Coordinator shall:

a) review the applicant/participant's financial information;

b) assess the applicant/participant's income and applicable assets; and

c) consider the applicant/participant's support needs and all associated costs, including special needs (see DSP Basic and Special Needs Policy).

5.3.2 Only the assets outlined in section 5.4 of this Policy, shall be considered by the Care Coordinator in the financial assessment process.

5.4 Applicable Assets

5.4.1 The payment of money to an applicant/participant through a court order or through a liability award or settlement (except those listed in sections 5.5.7 and 5.5.8 of this Policy) for the cost of care, support and accommodations, is an applicable asset.

5.4.2 An applicant/participant who has received or will receive payment of money through a court order or through a liability award or settlement for future care, support and accommodations, is ineligible for assistance in the form of money until the money is expended on the full cost of their care, support and accommodations.

5.4.3 A participant whose cost of care, support, and accommodation is provided for by a court order, liability award or settlement shall be charged the per diem rate paid to a service provider for the full cost of providing their care, support and accommodations.

5.4.4 A participant's financial eligibility may be reassessed after the money they received for the cost of their care, support and accommodations is expended. At the time of reassessment, any remaining monies which were awarded for damages other than care, support and accommodation, such as wage loss or for pain and suffering, are considered part of the participant's income.

5.4.5 Notwithstanding sections 5.4.2, 5.4.3, 5.4.4 and 5.9.2, where an applicant/participant has received or will receive payment of money through a court order or through a liability award or settlement for the cost of care, support and accommodations, and where this payment of money is insufficient to indemnify the participant and cover the realized and anticipated cost of care, supports and accommodations; a plan will be developed that includes consultation with the Casework Supervisor, Specialist and DSP Director as well as the participant, their family, and their representative(s) to determine financial contributions and will recognize the proportion of past and future costs to be paid by the participant and by the Department.

5.5 Income

5.5.1 An applicant/participant shall apply all of their income, with the exception of the income sources outlined in section 5.5.7 of this Policy, towards the cost of supports provided to them by the DSP.

5.5.2 An applicant/participant must apply for any and all income for which they are eligible, including pension income, and will apply for the maximum level for which they are eligible. All eligible participants will be required to apply for Canada Pension Plan Benefits (Canada) at age 65, including the following:

a) Canada Pension Plan Retirement Benefits;

b) Old Age Security Pension; and

c) Guaranteed Income Supplement.

5.5.3 In the assessment of the applicant/participant's finances, the Care Coordinator shall include the following income sources as chargeable income:

a) 100% of unearned income;

a) Earned income from wages, net business income, tips, gratuities and commissions in the amount determined by the exemptions and chargeable rates set out in section 5.5.6 of this policy;

b) 100% of the applicant/participant's monthly training allowance, minus $300;

c) 100% of the sum set aside in trust by a court for the benefit of the applicant/participant at the request of an applicant/participant or with the consent of an applicant/participant; and

d) 100% of income earned from an estate or trust.

5.5.4 All income, other than earned income, is calculated at the gross amount. Participants who have income tax deductions being made from their income source must complete a Revenue Canada 'TD1' form. Completion of this form can ensure that the income tax will not be deducted or will be deducted at the minimal rate.

5.5.5 Every person to whom assistance is paid in trust for the benefit of an applicant/participant, pursuant to the *Social Assistance Act*, shall submit any information a Care Coordinator may require regarding the administration of the trust money.

5.5.6 An applicant/participant who is earning income from wages, tips, gratuities, commissions or net business income, shall retain the first $350 of the net earned income. For any income earned in excess of $350, earnings shall be applied to their DSP support costs in accordance with the table below:

Total Net Earned Income from Employment or Business	Exemption Rate	Chargeable Rate
On your first $350	100%	0%
Your next $150 ($350.01 - $500.00)	75%	25%
Your next $250 ($500.01 - $750.00)	50%	50%
Over $750	25%	75%

5.5.7 An applicant/participant's income assessment does not include payments from the following sources:

a) goods and services tax credit (GST) paid under the *Income Tax Act (Canada);*

b) Nova Scotia Affordable Living Tax Credit under the *Income Tax Act*;

c) income tax refunds;

d) Working Income Tax Benefit (WITB);

e) the provincial low-income fuel assistance program, and Federal Relief for Heating Expenses Program;

f) Registered Disability Savings Plan payments (RDSP) or any income from an RDSP;

g) Registered Education Savings Plan payments (RESP);

h) payments under the Department of Health and Wellness (DHW) Caregiver Benefit Program;

i) honorarium payments provided to persons serving on boards of agencies or commissions;

j) earned income of dependent children;

k) the Canada Child Benefit paid under the *Income Tax Act (Canada),* including the following:

   i. payments under the Nova Scotia Child Benefit Program under the Income Tax Act, and

   ii. the Child Disability Benefit;

l) payments made under the *Children and Family Services Act*:

   i. adoption subsidy payments

   ii. payments made to foster parents in support of a child in the care of an agency

   iii. Path program payments;

m) student loans, bursaries, scholarships, and stipends received for the purpose of assisting with the costs associated with attending an approved educational program;

n) child support and/or child maintenance;

o) the Canada Nova Scotia Targeted Housing Benefit (CNSTHB); and

p) the Canada Pension Plan Children's Benefits (Canada), including:

   i. the Disabled Contributor's Child's Benefit, and

   ii. the Surviving Child's Benefit.

5.5.8 In determining an applicant/participant's initial and ongoing eligibility, financial compensation received from the following sources will not be considered income:

a) the Memorandum of Understanding regarding Compensation for Survivors of Institutional Abuse;

b) payments under a victim's compensation program paid by a federal or provincial government;

c) payments to a victim of abuse by a church organization in compliance with a court order or under a victim's compensation program;

d) payments by a provincial or federal government, either monthly or in a lump sum, to victims or survivors of abuse to redress or compensate an injury or harm in respect to a government program or service;

e) payments made by the federal government as a support package to Canadian thalidomide survivors;

f) a payment, other than a payment for loss of income or loss of support, pursuant to:

i. a payment under the 1986 - 1990 Hepatitis C Settlement Agreement or the pre – 1986/Post – 1990 Hepatitis C Settlement Agreement; or

ii. the federal/provincial/territorial assistance program of HIV Secondarily Infected Persons;

g) payment as a Merchant Navy Veteran, or as a surviving spouse of a Merchant Navy Veteran, for post-war benefits;

h) the Memorial Grant payment to families in recognition of service and sacrifice of first responders and volunteers;

i) a payment pursuant to the Nova Scotia Home for Coloured Children Class Action Settlement;

j) the Federal Indian Day Schools Settlement (McLean),2019*;*

k) the Veterans Affairs Canada settlement agreement in *Raymond Michael Toth v. her Majesty the Queen, 2019;* and

l) the Sixties Scoop Settlement Agreement.

5.5.9 Any money generated from the compensation (e.g. interest income) shall be considered income for the applicant/participant in the month in which it is received.

5.6 Initial Eligibility Amount Calculations for Participants

5.6.1 Once an applicant has been determined to be eligible for the DSP (now a DSP participant), through completed functional and financial assessments, assistance will be provided to them based on their eligibility amount. For a participant to receive financial assistance, the cost of services and supports provided to them must exceed their income.

5.6.2 To determine the amount of financial assistance required by the participant to fund or assist with the costs of services and supports provided by the DSP, an initial eligibility amount must be determined.

5.6.3 The Care Coordinator will calculate the applicant's initial eligibility amount using the

a. document the applicant's total costs associated with any services and supports provided to the applicant by DSP;

b. document the applicant's income;

c. subtract the applicant's chargeable income from the total cost of services and supports provided to the applicant by DSP. This will result in an eligibility amount.

If the applicant's chargeable income exceeds the total cost of services and supports provided to the applicant by DSP, they are ineligible for financial assistance.

5.6.4 A participant's ongoing financial eligibility and special needs requirements are based on their current circumstances and are updated and documented at the time of the individual's re-assessment or as deemed appropriate by the Care Coordinator.

5.6.5 When there are significant changes in a participant's financial circumstances (e.g. change in type of service or program provided, new income, or the requirement for a new ongoing Special Need, etc.), the Care Coordinator will re-calculate the participant's eligibility amount.

5.7 Eligibility Amount Development for Eligible Participants

5.7.1 Living in a Residential Option

A participant living in a residential support option, whose basic and support requirements are covered by a per diem rate, can be eligible for:

- the approved per diem rate
- Comfort Allowance
- Special Needs

5.7.2 Living independently in own home or with family

A DSP participant who lives alone in their own home or with their family are eligible for basic needs and may be eligible for special needs as outlined in the **Independent Living Support Program Policy** or **Flex Individualized Funding Policy** and the **Basic and Special Needs Rates (Appendix A)**.

5.7.2.1 Living with Family

A participant living with their family is eligible for:

- Standard Household Rate for Boarders, (or when a participant is on a rental lease, Standard Household Rate for rent/own). See **Basic and Special Needs Rates (Appendix A)**.
- Comfort Allowance
- Special Needs

5.7.2.2 DSP Participant Living on their Own

A participant who boards, rents or owns their own home is eligible for:

- Standard Household Rate at the boarder or rent/own amount. See **Basic and Special Needs Rates (Appendix A)**.
- Comfort Allowance
- Special Needs

5.7.2.3 DSP Participant Sharing Accommodations

Any DSP participant who shares accommodations with one or more persons will have their own eligibility amount and be eligible for:

- Standard Household Rate - see **Basic and Special Needs Rates (Appendix A)**
- Comfort Allowance
- Special Needs (including the participant's share of the telephone and home or apartment fire/liability insurance)

The participant's income will be included in their eligibility amount calculation, as per **section 5.5** of the Financial Eligibility Policy.

5.7.2.4 DSP Participant Living with a Spouse who is also a DSP Participant

When the needs of a DSP participant and spouse have been assessed and it is found that they are both eligible for DSP support, they will each have their own case number, and their eligibility amounts will be developed individually. Each is eligible for:

- Standard Household Rate - see **Basic and Special Needs Rates (Appendix A)**
- Comfort Allowance
- Special Needs (including equal share of the telephone and home or apartment fire/liability insurance)

Both DSP participants will contribute their income, if any, to their individual eligibility amount calculation, as per **section 5.5** of the Financial Eligibility Policy.

5.7.2.5 DSP Participant Living with a Spouse who is not a DSP Participant

When a DSP participant is living with their spouse who is not a DSP participant the eligibility amount calculation will include:

- Standard Household Rate for a participant and spouse - see **Basic and Special Needs Rates (Appendix A)**
- Comfort Allowance for the participant only
- Special Needs for the participant only

The total family income will be included in the eligibility amount calculation when determining the eligibility amount.

If the participant and/or spouse are engaged in employment, they will each retain the first $350 of their net wages. For any wages in excess of $350, earnings will be applied to their DSP support costs in accordance with the table in **section 5.5.6**.

5.7.2.6 DSP Participant Living with Dependent child(ren)

When a DSP Participant is living with a dependent child(ren), the dependent child(ren) is included in the household composition when determining the Standard Household Rate up to the allowable maximum in **Basic and Special Needs Rates (Appendix A)**

When a dependent child is 18 years old, the DSP participant will be eligible for a Dependent Allowance of $380.

5.8 Eligibility Amount Options for Eligible Participants

5.8.1 Mid-Monthly Payments

Payments for participants living independently, without the support of a service provider, or who are in the Flex Individualized Funding program, will be issued by a Care Coordinator by cheque or electronic bank transfer (direct deposit) in the name of a recipient or their trustee.

If payments are provided through electronic bank transfer (direct deposit), a participant will be responsible for payment of any applicable bank charge and/or fees associated with overdrawn accounts or completion of applicable authorization forms.

Payments will normally be issued monthly, in advance of the next month. A participant can request to have their monthly payment amount be split into two payments, an initial and a mid-monthly payment, based on the following criteria:

1. The total monthly eligibility amount is a minimum of $100 (after any disbursement and overpayment recovery payment amounts)

1. The two payments are equal to a minimum of $50

2. The monthly payments are set up as direct deposit.

5.8.2 Electronic Funds Transfer (EFT) Payment Information by Email

Participants living independently, without the support of a service provider, or who are in the Flex Individualized Funding program, have the option of receiving Electronic Funds Transfer (EFT) payment information by email.

If a participant chooses EFT payment information by email, their Care Coordinator must ensure participant understands that they will receive EFT payment information by email for all payments from DCS that do not require additional reporting. An example of additional reporting is when a participant is required to submit an income statement.

The option for EFT by email is encouraged for all new participants as well as existing participants.

Note: EFT email option is available only if participant is on direct deposit.

- For new participants, the Care Coordinator will review the EFT email option as part of setting up direct deposit. The direct deposit form **(DCS-201)** is used to collect the participant's EFT email address.

- For existing participants who are on direct deposit or who receive payments by cheque, the Care Coordinator will review the EFT email option with the participant at time of review or at any time as part of on-going case management. For a participant already on direct deposit, the participant can complete **DCS-201 S** (a shortened version of DCS-201) to provide the EFT email address without providing the banking information again.

The Care Coordinator provides the corresponding form to the regional financial clerks to add the EFT email address to the banking details.

If a participant informs their Care Coordinator that they did not receive the EFT payment information by email, the Care Coordinator:

- Can print the participant payment information from ICM on Payment History page and send to the participant.

- Should confirm that the email on the ICM Banking Details is correct.

    - If the email address on the ICM Banking Details is correct, have the participant check their junk email folder and/or confirm email was not deleted in error. If not resolved, notify the regional financial clerk to contact Operational Accounting to inform Royal Bank of Canada (RBC) of an error in sending EFT email. RBC can re-send the EFT payment information email.

    - If the email address on the ICM Banking Details is incorrect and you determine that participant has changed the EFT email address, have them complete a **DCS-201 S** form to update the banking details.

- If the email address on the ICM Banking Details is incorrect and:
  - the participant has not changed EFT email address, the Care Coordinator must report a potential privacy breach. See below: Reporting a potential privacy breach.
  - the **DCS-201** form is correct, have the regional financial clerk update the banking details in ICM.
  - the **DCS-201** form is incorrect, have the participant complete a **DCS-201 S** to update the banking details.

To report a potential privacy breach, in relation to EFT payment information, send an email to CS_Privacy@novascotia.ca and include name of participant, incorrect and correct email address, and payment information from Payment History page.

5.9 Ongoing Eligibility for Financial Assistance

5.9.1 A participant continues to be eligible for ongoing financial assistance as long as they continue to:

a) have an eligibility amount as a result of their eligibility calculation

b) be eligible for DSP.

5.9.2 A participant's financial and program eligibility will be reviewed by the Care Coordinator during the participant's review.

5.9.3 A participant must inform the Care Coordinator when there is any change in their income or applicable assets.

5.9.4 Failure to disclose information required in **section 5.6.3** of this Policy shall result in a reassessment of the participant's financial eligibility and may result in a change in, or termination of, financial assistance to the participant.

5.9.5 A review of the participant's financial eligibility may be undertaken at any time when the Department receives information related to the participant's income or applicable assets which may affect the level of financial assistance provided to the participant.

5.9.6 A participant, or any other person to whom assistance is paid in trust for the benefit of a participant, may be the subject of legal action by the Department, if at any time the participant or another person:

a) willfully withholds information about a participant's income or applicable assets;

b) under-reports the amount of a participant's income or applicable assets; or

c) provides false or misleading information regarding the participant's income, which results in a participant obtaining a level of financial assistance to which the participant would not otherwise be eligible.

5.10 Ineligibility for Financial Assistance

5.10.1 An applicant/participant's failure to provide all required documents, or their refusal to participate in the financial assessment process, will result in their ineligibility for the DSP.

5.10.2 An applicant/participant who has received or will receive payment of money through a court order or through a liability award or settlement (except for those listed in **sections 5.5.7 and 5.5.8** of this Policy) for the cost of their care, support and accommodations, is ineligible for assistance in the form of money until the money is expended on the full cost of their care, support and accommodations. The applicant/participant will be considered a private payer and will be responsible for the full cost of their care, support and accommodations, whether in their own home or in a residential support option.

5.10.3 An applicant/participant will be ineligible for financial assistance if they are provided for, at 100%, under the mandate(s) of:

a) Veterans Affairs Canada;

b) Workers Compensation Board;

c) the Government of Canada; or

d) any other statute or program.

5.11 Private Pay

5.11.1 A private paying person is required by the Department of Community Services to complete an application for eligibility for admission into a DSP Program support option. The Department will not recognize arrangements negotiated between an individual applicant and service provider.

5.11.2 An applicant who is eligible for DSP based on their functional assessment, but who is ineligible based on their financial assessment may access a DSP support option as a private payer.

5.11.3 A participant who becomes financially ineligible for the DSP may choose to pay privately for their supports and remain in their program support option.

5.11.4 A private paying person may apply for financial assistance for their support costs from the Department of Community Services, based on a reduction in their income or applicable assets.

5.11.5 A private paying person who applies for financial assistance must undergo a support level assessment and financial assessment conducted by a Care Coordinator.

6.0 APPEAL PROCESS

6.1 Right to Appeal

6.1.1 An applicant/participant has the right to appeal any decision related to their completed application for or receipt of assistance under the Disability Support Program. For information on how to file an appeal refer to the **DSP Appeal Policy**.

7.0 APPLICATION

This policy applies to all applicant/participants and any person acting on their behalf, and all DSP staff.

DEPARTMENT OF COMMUNITY SERVICES

Disability Support Program

Basic and Special Needs Policy

Effective: June 2012

Updated: April 11, 2023

1.0 POLICY STATEMENT

1.1 A participant or person acting on their behalf may request basic and special needs in the form of items of special requirement or services as set out in this policy.

1.2 Once an applicant becomes eligible for the DSP, they are eligible for basic support needs, which include shelter, food and clothing.

1.3 The provision of basic and special needs is based on a person's disability and their related health and support needs. Special needs are assessed on an individual basis.

1.4 This policy applies to all DSP Programs, with the exception of the Direct Family Support for Children (DFSC) Program and Adult Service Centre / Community-based Day Programs.

2.0 DEFINITIONS

For all DSP policy and program definitions, refer to the Glossary of Terms.

3.0 POLICY OBJECTIVE

3.1 This policy outlines the items and services of basic and special needs which may be provided in the DSP.

3.2 The objective of the **Basic and Special Needs Policy** is to ensure the consistent application of the process of approval for the funding of basic and special needs across the province.

4.0 PROVISION OF SPECIAL NEEDS

4.1 Prior to making a special needs request, a participant must first access any coverage available through private or publicly funded programs and entities such as:

a) Nova Scotia Health Authority (NSHA):

b) Department of Health and Wellness (DHW);

c) Medical Services Insurance (MSI);

d) Pharmacare;

e) Private insurance.

4.2 After accessing these programs, a participant may apply for special needs funding to assist with covering the remaining costs (e.g. co-pay amount), up to the maximum rates as outlined in the **Appendices A to D**.

5.0 POLICY DIRECTIVES

5.1 Process for Requesting Special Needs Items or Services

5.1.1 A participant, or service provider acting on behalf of a participant, when requesting a special need item or service, must provide the Care Coordinator with the following information before the request is assessed for approval:

a) the reason for the request;

b) a description of the special needs item or service;

c) documentation supporting the special need request, if appropriate (for example, from a physician, nurse practitioner, dietician, dentist, social worker, psychiatrist, etc.) see **section 5.3.3 Recurring Special Needs**;

d) resources or alternatives that have been explored, if applicable;

e) the monthly and/or total cost of the special need item or service;

f) written confirmation of costs related to the special need item or service (e.g. written estimate or invoice);

g) if the cost for the special needs item exceeds five hundred dollars ($500), two estimates are required, except as in **section 5.1.6**.

5.1.2 The Care Coordinator will assess the request (see **Basic and Special Needs Rates (Appendix A)**, **Funding Source Guidelines (Appendix E**) and, where required, will obtain the necessary approvals in accordance with **section 6.0** of this Policy.

5.1.3 Prior approval for the special need item or service is required. In some circumstances, requests for special needs funding may be considered for approval after purchase and use, with the provision of all required documentation, including a receipt or invoice.

5.1.4 A participant must purchase the most economical special need item or service available that meets their individual health and support needs, within the approved **Basic and Special Needs Rates (Appendix A).** Where a special need item or service is not identified in **Appendix A**, DSP approval levels shall apply (see **section 6.1** of this Policy).

5.1.5 Where the **Basic and Special Needs Rates (Appendix A)** does not contain an approved rate for a particular special need item or service and the item or service exceeds five hundred dollars ($500.00), two (2) estimates must be submitted with the request, except in certain circumstances, in accordance with **section 5.1.6** of this Policy.

5.1.6 Exceptions to the submission of two (2) estimates applies when there is:

a) only one source available for the special need item or service; or

b) when costs related to obtaining a second quote are such that it is not reasonable or economical to obtain the second estimate; and/or

c) documented evidence of the reason for the exception.

5.2 Approving Special Needs

Funding of a Special Need item or service will be considered when:

a) the participant is financially eligible, or will be financially eligible when the Special Need is included in the eligibility amount calculation.

b) proof of the participant's need for the item or service and the possible impact of the decision to fund or not to fund the Special Need has been provided.

5.2.1 Prior to approving the special need request the Care Coordinator may require additional information and documentation from a health care practitioner or another professional who specializes in the area related to the special need.

5.2.2 Requests for special need items or services that are included in the per diem rate will not be granted.

5.3 Recurring Special Needs

There are two (2) types of recurring special needs:

a) short term, which are temporary but may be required by the participant for more than one (1) month and less than six (6) consecutive months; and

b) long term, which are ongoing and are required by the participant for six (6) consecutive months or more.

5.3.1 Short term special needs are reviewed at the expiry of the initial term for which they are approved, which will vary according to the participant's circumstances. Documentation to support the participant's need and confirmation of the costs of the recurring special need are required at the time of approval.

5.3.2 Long term special needs are reviewed at the time of the participant's review, unless there is a change in the participant's circumstances or a change to the cost of the special need item or service.

5.3.3 Documentation to support the participant's need and confirmation of the costs of the recurring special need are required at the time of first approval. Verification of the participant's ongoing need and the cost of the special need item or service is required at the time of review.

5.3.4 Documentation from a health care practitioner is required when there is a change in a participant's medical circumstances.

5.4 Excluded Items and Services

Unless otherwise specified in this policy, a special need does not include:

a) an item or service that is provided under provincial insured health services programs or is otherwise funded by the government;

b) structural modifications to the home or property;

c) costs associated with compliance with court orders, conditions, and programs that are not mandated by the DSP;

d) post-secondary courses and associated costs; and

e) purchase of vehicles or the associated costs of modifications/repairs.

5.5 Special Needs Not Identified in DSP Policy

When there is a request for an item of special need or service that is not identified in DSP Policy or **Basic and Special Needs Rates (Appendix A)** consultation with the Specialist is required. The Specialist will make a recommendation for approval, as per DSP approval levels.

The participant's distinctive need must be assessed when approving a special need item or service. Special needs may be approved in circumstances pertaining to the participant's health or safety, or when a breakdown in the participant's support plan would be the likely result of not issuing the special need.

6.0 APPROVAL LEVELS

6.1 Approval Levels for All Special Needs

DSP staff will refer to the Appendices A to D for rates and approval levels for all Special Needs. When there is no specific rate referenced approval levels should be as per the approval level guidelines below with the exception of dental requests. For dental procedures not listed in DSP Dental Rate Guidelines (Appendix B) please provide details via e-mail to 'DSP@gov.ns.ca' for further review and approval.

All ongoing items of Special Need will form part of an approved monthly eligibility amount. For new or intermittent requests, a special needs approval form is completed for items that require approval at the Casework Supervisor level or higher.

All escalations above Casework Supervisor are communicated by forwarding the email request and supporting documentation to the next appropriate level. All final decisions above Casework Supervisor are communicated by forwarding the email request and supporting documentation to the Care Coordinator, copying the Casework Supervisor, Service Delivery Manager and Specialist, as appropriate.

Specialists review all requests above the Casework Supervisor's threshold and forward the request to either the Service Delivery Manager, or the Director, depending on the amount of the request. If the Specialist disagrees with the Service Delivery Manager's recommendation on a request, they have the option

to forward the request directly to the Director.

Any recurring Special Need that is required by a participant must be approved as part of the overall monthly eligibility amount.

Special Needs Request	Recommendation	Final Approval
Up to and including $800		Care Coordinator
Up to and including $2200		Casework Supervisor
Over $2200	Specialist	
Between $2200 and up to $5000		Service Delivery Manager
Over $5000		Director

6.2 Casework Supervisor or Specialist Approval of Higher Amount for a Special Need Item or Service

Due to the distinctive needs of a participant, a higher amount for a special need item or service may be approved by a Casework Supervisor or Specialist, as per DSP approval levels as in exceptional circumstances. Documentation must support that the maximum amount allowed as prescribed in **Basic and Special Needs Rates (Appendix A)**, is insufficient to pay for the cost of the item or service.

7.0 BASIC AND SPECIAL NEEDS BY ITEM OR SERVICE

7.1 Clothing

7.1.1 Regular Clothing

Participants in residential programs, the Alternative Family Support (AFS), Independent Living Support (ILS) and Flex Independent programs are eligible for clothing allowance as outlined in the **Basic and Special Needs Rates (Appendix A)**

Amounts can be disbursed to the participant either monthly or twice yearly as per the participant's request. When disbursed in trust to the service provider, clothing allowance is to be held in trust by the service provider and any unspent funds are to be retained in the participant's trust account. Trust funds are to be managed in accordance with Section 9.0.

7.1.2 Special Clothing

A participant in any DSP, including the Independent Living Support (ILS) Program, Alternative Family Support (AFS), and the Flex Program, may request assistance for special clothing, including the cost of tailoring and repairs when:

a) the participant requires special clothing (e.g., resulting from a mastectomy, atypical size requirements, customized clothing to prevent disrobing, footwear

to address orthopedic or mobility needs, or to accommodate an orthotic insert);

b) the participant destroys their clothing as a direct result of their disability;

c) the participant requires training or employment related clothing (e.g. uniforms or specialized clothing required for the program); or when

d) emergency situations arise or there are exceptional circumstances such as a participant's significant weight loss or weight gain.

7.2 Funeral and Burial

7.2.1 When a participant dies, and neither the participant nor their family are able to pay for the participant's funeral and burial, the Department may pay for funeral expenses and the cost of the burial in accordance with the funeral rate schedule (**Basic and Special Needs Rates (Appendix A)**).

7.2.2 Where a participant is eligible to receive Canada Pension Plan (CPP) Death Benefits, and the Department of Community Services has paid for the participant's funeral expenses, the Care Coordinator will ensure that the application for these benefits is completed and the required documents are forwarded to CPP. The CPP death benefit must be provided to the Department and applied to the costs of the participant's funeral and burial as paid for by the Department.

7.3 Health Care Services

7.3.1 Ambulance

See Transportation, **section 7.7** of this Policy.

7.3.2 Dental

Dental services required by the participant may be approved as a special need. A participant must access any available private dental plans or other dental program services provided by the Department of Health and Wellness (DHW) before requesting dental services coverage from the DSP.

Payments for dental services will be based on the amounts listed in the most current Nova Scotia Dental Fee Guide approved by the Director (**DSP Dental Rate Guidelines - Appendix B**).

7.3.3 Dentures

Dentures required by a participant may be approved as a Special Need in accordance with **DSP Dental Rate Guidelines** **(Appendix B)**.

7.3.4 Foot Care and Podiatry

Foot care and podiatry required by a participant may be approved as a special need when:

a) the treatment has been prescribed by a health care practitioner;

b) it is medically necessary, and no other options are available; and

c) the most economical alternatives have been explored (e.g. foot clinics).

7.3.5 Guide Dog Allowance

A participant may be eligible for a monthly allowance for a guide dog, and an annual allowance for routine veterinary costs, when all other available resources have been exhausted, if the dog is:

a) provided to the participant through the support of a certified guide dog organization or school, with documentation outlining the provision of supports; and

b) required by the participant due to their disability.

The monthly guide dog allowance is for food and routine care costs such as, but not limited to: grooming, teeth cleaning, toenail clipping, leashes, and incidentals. Routine veterinary costs include checkups, vaccinations, and flea and heartworm treatments (**Basic and Special Needs Rates - Appendix A**).

Expenses for non-routine care for a guide dog are not funded. Non-routine expenses include, but are not limited to: surgical procedures, treatment for fractures and infections, special diets, euthanasia, and travel, room and board to acquire a dog.

Participants who maintain their retired guide dog are not eligible to receive this allowance.

7.3.6 Hearing Aids and Hearing Aid Batteries

A hearing aid required by a participant may be approved as a special need when:

a) it has been prescribed by an audiologist; and

b) supervisory approval has been obtained for the most economical hearing aid option.

Hearing aid batteries may be approved as a recurring special need.

7.3.7 Maternal Nutritional Allowance

A participant who becomes pregnant may have a maternal nutritional allowance included in their monthly eligibility amount, from the date the Care Coordinator is notified of the pregnancy or the birth of the child, up to and including twelve (12) full months after the birth of the child.

7.3.8 Meal Programs

When a participant is receiving service from an approved community based meal program as a part of their support plan, the fee may be included as a recurring special need in addition to a basic food allowance.

7.3.9 Medical Equipment

Requests for wheelchairs and repairs for DSP participants under 65 years of age are referred directly to Easter Seals Nova Scotia for assessment and eligibility for funding.

The purchase of wheelchairs, inserts, and repairs for DSP participants age 65 and over and the purchase, rental and repair of other types of medical equipment for all DSP participants, such as prosthetics, CPAP machines, walkers, and crutches may be approved as a special need when:

a) the participant's need for the requested item or service has been verified through documentation provided by a physician or health care practitioner; and

b) it is confirmed to be the most economical option available for purchase.

Prior to determining the participant's eligibility for the special need, the Care Coordinator may refer to a second physician or health care practitioner to provide advice in respect of the appropriateness, necessity and effectiveness of the requested item.

Requests for inspections of mechanical lifts may be approved annually, or as needed.

7.3.10 Medical File Transfer Fee

The cost of transferring a participant's medical file from one physician to another may be approved as a special need by the Care Coordinator when it is assessed as being required for such reasons as physician retirement.

7.3.11 Medical Insurance (Private)

The cost of a participant's private medical insurance may be included in their monthly eligibility amount as a recurring Special Need when an assessment has identified that the continuation of this coverage contributes to a cost-effective support plan. The participant must actively use the plan and no other dependants are to be covered unless DSP assistance is provided as a family unit.

7.3.12 Medical Report Provision Fee

When a medical report is requested by a Care Coordinator for the purpose of assessing an existing DSP participant's medical condition(s) or is required to determine capacity to consent pursuant to the *Personal Directives Act* (see, **Capacity to Consent**, **section 6.3** of the DSP Policy), the cost of a physician's fee to complete a medical report may be approved as a special need.

7.3.13 Medical Supplies

Medical supplies are considered special needs only when they are not included in the per diem rate funding for the participant. The purchase of medical supplies, such as, but not limited to, incontinent supplies, colostomy supplies, and dressings may be considered a special need when:

a) the participant's need for the requested item has been verified through documentation provided by a physician or health care practitioner; and

b) it is confirmed that it is the most economical option available for purchase.

Prior to determining the participant's eligibility for a special need, the Care Coordinator may refer to a second physician or health care practitioner to provide advice in respect of the need, necessity and effectiveness of the requested item.

7.3.14 Nursing Care

For a participant whose medical condition cannot be safely managed in the Community Home where they live due to an inability to immediately access standard community resources or an alternate support option, the Care Coordinator shall seek Casework Supervisor approval to cover the costs of nursing care for the participant as a special need only until such time as the required community resources or an alternate support option becomes available. The Care Coordinator shall ensure referrals are made to the Nova Scotia Health Authority for standard community resources.

7.3.15 Optical Care

Costs associated with a participant's routine eye exams and the purchase of corrective eye wear prescribed by an optometrist or physician will be covered to a maximum of once every two (2) years, subject to the maximum rates, unless there is a medically substantiated reason for new eye wear provided by the optometrist or physician.

Based on the distinctive need of a participant, special lenses may be covered at additional cost, when prescribed by an optometrist or physician.

7.3.16 Orthotics

The purchase of customized orthotic shoes and orthotic modifications and inserts may be covered when:

a) documentation is provided by a physician or health care practitioner confirming that the participant requires the item; and

b) it is confirmed that it is the most economical option available for purchase.

7.3.17 Over-the-Counter (Non-Prescription) Medication

Over-the-counter (non-prescription) medications may be covered as a special need when the need is substantiated in writing and is authorized by a physician, nurse practitioner, pharmacist or dietician.

Prior approval by the Care Coordinator is required for over-the-counter (non-prescription) medication. Exceptions to prior approval may be considered in emergency situations.

7.3.18 Prescription Medication

Funding for prescription drugs is based on the Department of Health and Wellness (DHW) Nova Scotia Formulary list. This list provides access to approved drugs, biological and related preparations, diabetes and ostomy supplies.

Prescription drug coverage is administered through the Pharmacare Program and is available to eligible participants (Pharmacare NS Formulary).

Participants with access to another drug plan, from a public or private entity, will be required to use that plan and will not be eligible for the Pharmacare Program. A participant with a private health care plan may be eligible for the cost of the co-payment amounts. Receipts or invoices verifying the co-payment from the pharmacy or private health plan organization must be provided.

If a participant is prescribed or is requesting a drug that is not a benefit on the Nova Scotia Formulary, the participant should have their physician request approval through the "Exception Drug" status process offered through the Pharmacare Program (Exemption Status Drugs).

7.3.19 Special Diets

Special diet allowances may be approved as a special need where special diets are not included within the participant's per diem rate. See **Special Diet Rate Guidelines (Appendix C)** and **Funding Source Guidelines (Appendix E)** for a full list of special diet rates.

A participant's request for a special diet allowance shall be assessed by the Care Coordinator as outlined in **section 5.1.1** of this Policy.

If a participant has more than one special diet recommended, the approved monthly amount for individual diet allowances may be added together, up to the combined maximum amount allowable per month.

A participant's continuing eligibility for a special diet allowance must be reviewed at least once per year, with the exception of participants with paraplegia or quadriplegia or any participants with chronic conditions (e.g. diabetes, colitis). These participants require initial confirmation from a registered dietician or physician to support the need for a diet allowance. There is no need to provide annual documentation from a health care practitioner for special diets unless there is a change in the participant's dietary needs.

7.4 Medical Rehabilitation Services

A participant may require medical rehabilitation services for their health and safety or for the success of their support plan.

Medical rehabilitation services include:

- counseling;
- occupational/physical/speech therapy; and
- massage therapy.

When these supports are not accessible through standard community resources or privately insured services they can be requested as a special need, until standard community resources are available.

These services are intended to be short-term interventions (up to six (6) consecutive months). Documentation of the counseling/therapy request and approval by the Casework Supervisor are required.

Exceptions may be considered when the participant requires medical services beyond six (6) months, but not exceeding twelve (12) months, if the participant can document that an inability to access the required services will increase the likelihood that a more costly intervention will be required (i.e. extraordinary staffing, or a more costly DSP support option).

Documentation for extensions beyond six (6) months must include:

a) an DSP counseling/therapy request

b) a written report and requirement for extension/renewal from the therapist, and

c) approval by the Casework Supervisor in accordance with DSP approval levels.

Requests to extend these services beyond a twelve (12) month period requires a reassessment of the participant's support plan.

Exceptions to the requirement for accessing standard community resources may be considered when it is more cost effective to have the requested service provided in the participant's support option, due to transportation and staffing costs.

7.4.1 Counseling

When it is a part of a participant's IASP or is necessary for the health and safety of the participant, counseling activities such as, but not limited to, behavioural, anger management, self-esteem or sexuality programs, and individual counseling may be approved as a special need.

Completed documentation outlining the rationale and anticipated outcome(s) of all requested counseling is required. Supervisory approval is required.

Counseling requests shall be approved only for services provided by licensed practitioners and practitioners with private practice certification (e.g. Nova Scotia Association of Social Workers, Canadian Psychology Association).

7.4.2 Occupational Therapy, Physiotherapy and Speech Therapy

The cost of occupational therapy, physiotherapy or speech therapy services may be approved as a special need for a participant only when:

a) they are not available through insured services; and

b) the lack of availability creates a significant impact on the health and safety of

the participant.

These interventions may only be considered until such time as standard community resources become available.

The request for therapy must be accompanied by written documentation from a qualified health care practitioner.

7.4.3 Massage Therapy

A participant with significant physical disabilities/spasms may have the cost of massage therapy services approved as a special need when it is recommended in written documentation as a course of treatment by a qualified health care practitioner.

7.5 Emergency Response Devices

A participant's monthly eligibility amount may include the cost of a personal alert emergency response system (i.e. LifeLine, Project Lifesaver) as a recurring Special Need when it has been identified and included in their IASP. The approved cost will include start-up fees and monthly maintenance (e.g. batteries).

7.6 Support Services

7.6.1 Child Care

A participant who lives in their own home and cares for their own children may have the cost of child care approved as a special need when they are:

a) unable to provide care for their own children due to medical reasons; or

b) participating in employment or training programs.

7.6.2 Extraordinary Funding for Staffing

Service providers will accommodate short-term increases in staffing needs within their approved budgets.

Short-term extraordinary funding for staffing may be requested as a Special Need where the service provider demonstrates that the staffing costs cannot be absorbed within the approved per diem.

The service provider shall provide all requested documentation supporting the need for extra staffing. The Care Coordinator must review the documentation and make a recommendation. Approval of the Casework Supervisor is required.

When the need for extra staffing is expected to extend beyond a three (3) month period, a reassessment of the participant shall be conducted to determine whether they are living in the program support option that best meets their needs.

If the participant's reassessment determines that their needs can be best met by a program support option that is not currently available, the participant's name shall be added to the DSP Service Request List with their consent (see **DSP Program Policy, section 7.0**).

In the interim, while the participant is waiting for a new DSP support option, a request for funding for extra staffing may be made by the Care Coordinator and Casework Supervisor. DSP approval levels shall apply.

7.6.3 Homeless Shelter/Residential Recovery Program/Youth Facility

A participant may request approval for the costs of:

- A homeless shelter;
- A youth facility in emergency and transitional situations (if the shelter or facility is funded through per diems); or,
- A residential recovery program for drug and alcohol addiction considered as a Special Need when it is a part of their IASP (and when the program is funded through per diems);

Special Needs requests for a homeless shelter, youth facility or residential recovery program require the approval of the Casework Supervisor.

If a participant who is receiving a Standard Household Rate begins living or staying at a homeless shelter, residential recovery program or, youth facility, the participant is eligible to continue to receive the Standard Household Rate for 30 days.

With the approval of the Casework Supervisor, a participant may continue to receive a Standard Household Rate after 30 days to maintain their own residence in the community to which they expect to return.

A participant in any DSP-funded support program who is in a homeless shelter, residential recovery program or, youth facility for longer than 30 days, and who does not receive approval for their current support option to continue to be maintained and funded, will be eligible to receive the following supports and services, with the approval of the Casework Supervisor:

a. Standard Household Rate - Essentials;

b. Comfort Allowance;

c. Special Needs (if applicable); and

d. Case Management Support.

7.6.4 Interpreter Services and Intervener Services

Interpreter and/or Intervener services may be approved as a special need for participants who are deaf, blind or deaf-blind, when those services are not available without cost through a non-profit agency or family and community resources.

7.6.5 Personal Care

A participant may be eligible for funding for assistance with personal care tasks as a special need if it is not provided through the Nova Scotia Health Authority or any other insured services. This assistance is not available if it is covered by a per diem rate or approved hours of support.

7.6.6 Respite

As outlined in the **Flex Individualized Funding Policy** and **Alternative Family Support Policy**, costs associated with providing at home respite relief to the parent, family, caregiver, or guardian of a participant, for a specific period of time, shall be funded as a special need based on the assessed needs of the participant.

7.6.7 Respite in Licensed Homes

Costs associated with providing respite care in a licensed home in the DSP may be approved as a special need to a participant who meets the DSP criteria.

7.7 Transportation

A participant may be approved for a transportation allowance when it is required for medical reasons or for them to engage in a day program, employment, training, upgrading, volunteer activities, job searches, or other social inclusion activities as part of their IASP.

A participant will receive the actual cost of transportation up to the maximum allowable amount per month as per the **Basic and Special Needs Rates (Appendix A)**for the most economical and efficient means of transportation that can meet their needs.

A participant who is unable to use public transit due to their disability or mental health status, in areas served by public transit, may request the use of taxis for transportation as a special need as per the **Basic and Special Needs Rates (Appendix A)**

The Casework Supervisor must approve any costs which exceed the standard monthly maximum rate for travel.

7.7.1 Medical Transportation Outside of the Local Community

The cost of a participant's medical transportation outside their community to attend required medical appointments and procedures shall be approved as a special need when the service or procedure is not available in the local community, or in emergency situations when recommended and documented by a physician or health care practitioner.

Out-of-community travel shall not be approved in order for the participant to obtain quicker access to routine procedures which can be addressed through standard community resources.

Food, shelter and staffing costs associated with medical travel outside the local community may be considered for approval when necessary.

The most economical and efficient means of transportation that can meet the participant's needs shall be considered for approval. The approval of transportation costs shall be made in accordance with DSP approval levels.

7.7.2 Ambulance

A participant may be eligible to access ambulance services as a special need when it is for emergency use or for a necessary transfer. Prior approval by the Care Coordinator is required in non-emergency situations.

7.7.3 Out-of-Province Travel and Accommodation

Where a medical specialist has referred a participant for out-of-province treatment that is not available in Nova Scotia, the participant shall be referred to the Out-of-Province Travel and Accommodation Assistance program offered by the Department of Health and Wellness.

7.8 Day Activities, Education and Employment

7.8.1 Day Activities

A participant of the Independent Living Support (ILS) Program who wishes to pursue day activities to enhance their independence, self-reliance and social inclusion may apply for funding to access low cost leisure, lifestyle or social programs. The participant may be eligible if they do not attend a day program and are not employed (a participant with Project 50 is eligible), but would benefit from additional socialization and structure that these activities could provide.

7.8.2 Education Programs

The DSP shall refer participant's requests for skill building courses to existing training and employment programs wherever possible. A participant may be approved for a skills training course such as a General Educational Development (GED), as part of their IASP. Funding for post-secondary courses is not provided by the DSP.

A participant who wishes to attend a post-secondary education program should be referred to Student Assistance, Department of Labour and Advanced Education.

7.8.3 Books, Supplies, and Deposits

The cost of books, supplies and deposits (such as seat confirmations) required for a participant to participate in an approved educational program which is not eligible for student loan assistance, (such as, but not limited to, academic upgrading, high school, short term course) may be eligible as a special need.

7.8.4 Employability Related Expenses

A participant may be approved for special needs funding to cover employability expenses that are directly related to and necessary to facilitate their paid

employment or participation in an employment plan when a participant is:

a) employed on a full-time or part-time basis; or

b) participating in employment as part of their IASP, with Casework Supervisor approval.

Fees that are directly related to a return to employment, such as but not limited to driver's licenses, criminal record check/pardon applications, drivers abstract, and medicals, may be considered as a special need.

7.8.5 Project 50 (Voluntary Work Experience)

A participant may be approved for a Project 50 where involvement in a meaningful community work experience is an identified need in their IASP. An agreement must be completed by the participant, sponsor and Care Coordinator.

The sponsor of a Project 50 should be a non-profit or charitable organization and the work should occur in a location other than the participant's current residence. Exceptions may be considered when the participant has no other feasible work placement and the work placement provides the participant with a meaningful and beneficial experience. These exceptions require the approval of the Casework Supervisor.

Project 50 work experience and allowance will only be approved when:

a) a participant does not attend a day program on a full-time basis, and does not have part-time or full-time paid employment;

b) a Project 50 monthly review form is completed by the participant and the work supervisor and submitted to the Care Coordinator monthly for payment; and

c) the program is reviewed as part of the participant's support plan or as part of their individual review/reassessment.

A Care Coordinator my approve a participant's transportation expenses to and from their work placement if the participant is not already receiving a travel allowance.

8.0 LIVING ALLOWANCES – Independent Living

8.1 Standard Household Rate

A participant who rents, boards or owns their own home may be approved for the Standard Household Rate as outlined in the **Basic and Special Needs Rates (Appendix A)**.

8.2 Standard Household Rate - Essentials

A participant who is not eligible for a board or rent/own Standard Household Rate, a residential support option, or an Alternative Family Support option, may

be deemed eligible for a Standard Household Rate – Essentials by the Care Coordinator. Such circumstances include, but are not limited to, when a participant is:

- Receiving homelessness supports (Policy 7.6.3), or
- Hospitalized or in a residential rehabilitation program (Policy 12.1.1).

The Standard Household Rate - Essentials is outlined in the **Basic and Special Needs Rates (Appendix A)**

8.3 Standard Household Rate when Expecting a Child

A participant or dependent child expecting a child(ren) within three (3) months is eligible for the Standard Household Rate for a household composition that includes the addition of the child(ren).

8.4 Emergency Food Orders

Emergency food orders may be approved as a special need by a Care Coordinator, with prior approval from a Casework Supervisor.

8.5 Excess Shelter

While the Standard Household Rate is intended to cover shelter costs, excess shelter of a flat amount of $200 may be approved as a Special Need when a more economical option is not available to meet the participant's needs, and when one or more of the following criteria applies:

a. a participant requires barrier-free access (i.e. housing that has been adapted for individuals with mobility disabilities or visual impairments); or

b. the cost of relocating the participant exceeds the total annual rental increase; or

c. a participant's IASP has identified elements related to their shelter that promote independence and result in lowered long-term DSP support costs (e.g. reducing transportation expenses, extra staffing, security of the location, etc.); or

d. a participant cannot secure housing in a safe location where they can safely access the community; or in a location which allows them to pursue the goals identified in their support plan;

Actual shelter expenses must exceed the amounts listed in the following table for the participant to be eligible;

Household Size	Amount
1	$535
2	$570
3 or more	$620

Where two or more DSP participants share accommodations, the actual shelter expenses must exceed the combined amount (listed in the table above) for each DSP participant before an excess shelter amount of $200 can be considered.

A request for excess shelter of $200 requires the approval of the Casework Supervisor. See **Basic and Special Needs Rates (Appendix A)**.

8.6 Extermination Services

Extermination services may be approved as a special need when it has been determined that there is a need for the service and written confirmation has been received that a participant's landlord is not responsible for the cost of this service.

8.7 Fire and Liability Insurance for Homeowners or Tenants

A participant who owns and occupies their own home or is a tenant in an apartment may be approved for assistance with the cost of obtaining fire, liability and content insurance. A participant shall provide proof of insurance upon request.

8.8 Household Start Up and Replacement Costs

When a participant has insufficient furniture or household items to contribute to the establishment of an apartment or home, funding may be provided to assist with the set-up of their apartment.

Replacement of household items and furniture may also be considered. The Care Coordinator, in consultation with the Casework Supervisor, may approve funding to replace, or help with replacement, of furnishings or household items when the existing item owned by the participant is no longer serviceable. See **Independent Living Furniture, Set-Up, and Replacement Rate Guidelines (Appendix D)**.

8.9 Homemaker Services

A participant may access homemaker services or household cleaning services as a special need, as part of their IASP. This assistance is not available if it is provided by the Nova Scotia Health Authority, a standard community resource, or is provided through the participant's approved hours of support.

8.10 House Repairs

All requests for house repairs will be referred to the Department of Community Services Housing Services for assessment prior to determining their approval as a special need. Approval is dependent on the availability of Departmental resources, and if it is cost-effective to complete the repairs instead of the participant moving. Final approval is subject to DSP approval levels (see **section 6.0**).

If assistance from Housing Services is not available, house repairs may be considered as a special need for a participant who owns and occupies their own home. Assistance will only be provided when repairs are essential to the health and safety of the participant, and where alternative funding is not available.

Participants must provide documentation of health or safety hazard(s) to the Care Coordinator. Final approval is subject to DSP approval levels.

8.11 Moving Allowances

When the participant is relocating to a new living arrangement as per their IASP, moving costs related to transporting their belongings may be approved as a special need.

8.12 Security/Damage Deposits

A participant may be approved for the cost of a security/damage deposit, for up to one-half of the approved monthly rent, as a special need.

The participant must confirm their rental arrangements by providing written documentation (i.e. a copy of the lease agreement) or an official receipt for the deposit payment.

8.13 Shelter-Related Arrears

In some circumstances and with approval from a Casework Supervisor, a participant who lives in their own home may be eligible for a special need payment for:

a) mortgage/rental arrears;

b) property tax arrears; and

c) utility arrears.

8.14 Telephone

Basic telephone service costs may be approved as a recurring special need for a participant. Long distance telephone costs will not be approved.

The cost of specialized telephone services and equipment, such as but not limited to call display, call block and voice mail, may be approved as a special need when it is part of an IASP.

8.15 Utility Connection Fees

A participant may be approved for the actual costs related to the connection of utilities, such as electricity and telephone, when the costs are incurred as a part of their IASP.

8.16 Comfort Allowance

Participants receive a monthly comfort allowance as a special need to purchase items for their personal comfort and enjoyment.

Upon the participant's death, any remaining balance in service provider managed accounts will be returned to the Department.

9.0 Trust Funds

Service providers will offer participants the option for their personal monies to be held in a trust fund bank account and will record all transactions and balances in ledgers. The service provider will have a written policy that defines staff roles and responsibilities and includes, at a minimum:

a) the service provider will deposit funds in a trust bank account
b) the service provider will maintain a ledger for each participant that details all transactions in and out of the trust account
c) the bank account will be reconciled to participant ledgers on a monthly basis
d) transaction details should be supported by documentation such as invoices and receipts, and records of cash distributions to participants.

All books and records will be made available to DCS upon request.

Upon discharge from one service provider to another service provider within Nova Scotia, the balance of the trust account is to be transferred to the service provider receiving the client.

10.0 Application

This policy applies to applicants/participants and any person acting on their behalf, and all DSP staff.

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DEPARTMENT OF COMMUNITY SERVICES
Disability Support Program

Appeal Policy

Effective: January 2020

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1.0 POLICY STATEMENT

1.1 An applicant/participant or person acting on their behalf has the right to appeal any decision related to their competed application for or receipt of assistance to the Disability Support Program, as set out in this policy.

1.2 This policy applies to all DSP Programs, with the exception of the Direct and Enhanced Family Support for Children (DFSC/EFSC) Program and Adult Service Centre/Community-based Day Programs.

2.0 DEFINITIONS

For all DSP policy and program definitions, refer to the Glossary of Terms.

3.0 POLICY OBJECTIVE

3.1 This policy outlines applicant/participant rights to appeal any decision regarding services which may be provided in the DSP.

3.2 The objective of the **DSP Appeal Policy** is to ensure the applicants/participants understand their rights and the appeal process when deciding to request an appeal of a decision regarding their DSP supports.

4.0 RIGHT TO A DECISION REVIEW AND AN APPEAL HEARING

4.1 An applicant/participant has the right to appeal any decision related to their completed application for or receipt of assistance under the Disability Support Program.

4.2 An applicant/participant will be notified in writing of any decision that affects their application for assistance or ongoing assistance and of their right to appeal that decision.

4.3 All requests for a decision review and/or appeal hearing will be addressed in accordance with the appeal process set out in the *Employment Support and Income Assistance Act* and the *Assistance Appeal Regulations*.

4.4 “When You Disagree: A Guide to Addressing Decisions that Affect You” outlines the steps of the appeal process. This Guide has been designed to help applicants/participants understand the appeal process and includes a form that can be used to submit a written request for a decision review or appeal board hearing. A Department employee may assist an applicant/participant in completing the form.

4.5 As part of the decision review and/or appeal hearing process, an applicant/participant will have the opportunity to discuss the decision with their care coordinator and provide any supplemental information that may affect the original decision.

5.0 RIGHT TO REPRESENTATION

5.1 An appellant has the right to be assisted by a representative throughout the appeal process. A representative can sign a request for a decision review and/or appeal board hearing on behalf of an appellant.

5.2 If a representative is acting on behalf of an appellant, the appellant must provide the Department with written consent to allow the representative to discuss the appeal on the appellant's behalf.

6.0 NOTIFICATION OF DECISION

6.1 The Care Coordinator will send an applicant/participant written notice of any decision relating to their application for or receipt of assistance.

6.2 The applicant/participant may ask the Care Coordinator for clarification on the decision including the reasons for the decision.

6.3 The Care Coordinator will discuss the decision with the applicant/participant; providing a summary of the facts and an explanation of the reasons for the decision based on the legislation, regulations and policy.

6.4 The applicant/participant will have the opportunity to provide any new information that could affect the original decision. If new information is provided, the Care Coordinator will make a new decision based on the information provided.

6.5 An applicant/participant has thirty (30) days after the communication of a decision to request a decision review. To account for regular mail delivery standards, the thirty (30) business day timeline will begin five (5) business days following the date of the decision letter.

6.6 If an applicant/participant decides to appeal a decision, they must first request a decision review (see **section 7.0**). If the applicant/participant disagrees with the outcome of the decision review, they can request an appeal board hearing (see **section 8.0**).

7.0 DECISION REVIEW

7.1 An applicant/participant must submit their request for a decision review in writing to any DCS office within thirty (30) days after the communication of a decision (per **section 6.5: Notification of Decision**).

7.2 The written request for a decision review must include the following:

a) the decision being reviewed;

b) the reason for the request; and

c) the date, address, contact information and signature of the applicant/participant (or representative).

7.3 Decision Review Services will complete the decision review ten (10) business days following receipt of written request from the appellant.

7.4 Decision Review Services will examine all written material submitted by the appellant and the Department to ensure that the decision being reviewed is consistent with the Act, Regulations and Policy, and that the appellant's request is given a fair and timely review. Decision Review Services may contact the appellant for additional information.

7.5 Upon review of all submitted materials Decision Review Services will:
a) uphold, vary or reverse the original decision; and
b) provide the appellant in writing, with the reasons for the decision.

8.0 REQUEST FOR AN APPEAL HEARING

8.1 If an appellant disagrees with the outcome of the decision review, they can request an appeal hearing. The appellant must advise the Department in writing, within ten (10) business days of receiving the decision review, if they want to proceed to an appeal hearing before an Appeal Board.

8.2 If an appellant has not requested an appeal hearing within ten (10) business days of receipt of the decision review, Decision Review Services will record that no response has been received and may close the file.

8.3 When an appellant provides written notice that they want to proceed to an appeal hearing, staff from the local DCS office will notify the Appeal Unit. The process is governed by the *Employment Support and Income Assistance Act* and the *Assistance Appeals Regulations.*

8.4 The Appeal Unit will coordinate the appeal hearing process and send notification of the date, time and place of the hearing by registered mail to the appellant ten (10) days prior to the date of the appeal hearing.

8.5 If an appellant wants to have a hearing but cannot attend, they can request that the appeal hearing be rescheduled or indicate that they would like the option of an appeal hearing using the telephone.

8.6 If an appellant is not able to attend the appeal hearing in person, they may send a representative. That representative will provide the Appeal Board with written proof that the appellant authorizes them to represent the appellant at the appeal hearing.

8.7 An appellant will be notified that if they do not attend the appeal hearing or send a representative, the appeal will be heard in their absence unless they have contacted the Appeal Unit before the scheduled hearing date to request an alternative date.

9.0 PROCEDURES FOR APPEAL BOARD HEARINGS

9.1 The Appeal Board will conduct an appeal hearing and render a decision within forty-five (45) business days following the date of the Department's receipt of the appellant's request for an appeal hearing.

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9.2 Before the hearing, Department staff will ask the appellant for: copies of any documents that they plan to submit to the Appeal Board, the name(s) of who will be attending the hearing with them, and if they have a representative.

9.3 Department staff will provide the Appeal Unit with information on who will represent the Department at the Appeal Board hearing.

9.4 The Assistance Appeal Board will hear the appeal and has up to seven (7) days after the conclusion of the hearing to communicate its decision to the appellant.

9.5 The Appeal Board hearing decision will be made in writing and will indicate if the appeal was granted, varied or denied. If an appellant is dissatisfied with a decision of the Appeal Board, the next level of appeal is to the Supreme Court of Nova Scotia by way of judicial review.

10.0 INTERPRETING DATES

10.1 Dates will be calculated according to the *Interpretation Act* and this means that Saturdays, Sundays and holidays are not included in the timeline calculations set out in the paragraphs above.

10.2 The date a decision is communicated or an application for a decision review is received is not counted as the timeline start date. The timeline begins on the next day that is not a Saturday, Sunday or a holiday.

11.0 APPLICATION

11.1 This policy applies to all applicants/participants and any person acting on their behalf, and all DCS staff.

12.0 ACCOUNTABILITY

12.1 The Executive Director, DSP is responsible for the establishment and implementation of this policy and ensuring that the Program achieves the objectives for which it was created.

12.2 The Executive Director, DSP is responsible for ensuring that the Program is delivered within a fiscally sustainable manner.

12.3 Supervisors are responsible for complying with policy and Specialists are responsible for exercising financial approval within their authority level.

12.4 The Program Directors and Service Delivery Directors are responsible for ensuring compliance within their respective areas of responsibility, as well as making best efforts to ensure the necessary resources are available.

12.5 Casework Supervisors are responsible for preparing their employees to carry out their respective functions.

12.6 The Decision Review Services Supervisor is responsible for ensuring that decision reviews are completed in compliance with procedures.

12.7 The Decision Review Services Reviewer is responsible for completing the decision review according to procedures.

DEPARTMENT OF COMMUNITY SERVICES

Disability Support Program

Glossary of Terms

October 2014

Acquired Brain Injury
Damage to a person's brain that occurs from events after birth rather than as part of a genetic or congenital disorder. As the brain controls every part of human life: physical, intellectual, behavioral, social and emotional, every person with an acquired brain injury will require support specific to their needs. When the brain is damaged, parts of a person's life may be adversely affected resulting in the person requiring supports that may be emotional, social, educational or vocational in nature.

Activities of Daily Living
A person's basic, routine personal care activities that are essential to their self-care. This includes activities such as bathing and dressing, toileting and grooming, and eating.

Acute Care
Short-term medical treatment, usually in a hospital, for patients experiencing an acute illness or injury, or recovering from surgery.

Adult Protection
A program which provides access to services for vulnerable adults (16 years and older) who are victims of abuse and/or neglect. The program is administered under the mandate of the Department of Health and Wellness, pursuant to the *Adult Protection Act*.

Aging in Place
A participant growing older in the place they call home, until their care and support needs, being provided for by their DSP support option, family or support network, reaches a point where they would be better served in another program or service.

Appeal Board
Appeal Board means the Assistance Appeal Board established by the Minister pursuant to section 12 of the Employment Support and Income Assistance (ESIA) Act. The Board is governed by legislation and regulations. The quorum of an appeal board is one (1) member. Appeal board members are not employed by the Department of Community Services.

Appeal Hearing
A hearing held by the Appeal Board where the Board determines the facts and on the basis of those facts, if the decision that was made is in compliance with the Act and regulations.

Appeal Unit
Appeal Unit means the Department of Community Services unit responsible for coordinating the appeal hearing process.

Appellant
An applicant/participant who has filed an appeal, or who has had an appeal filed on their behalf, under the Social Assistance Act or the Employment Support and Assistance Act, such as the ESIA program.

Applicable Asset
Money received by an applicant/participant through a court order or through a liability award or settlement, for the cost of their care, support and accommodations.

Applicant
A person with a disability, who applies for financial assistance and supports from the DSP. When it has been determined that an applicant lacks the capacity to make their own decisions, they must have a person acting on their behalf who is legally authorized to make decisions on their behalf (substitute decision maker).

Assessment
See Functional Assessment/Level of Support Assessment

Assessed Needs
An applicant/participant's need for supports as identified through a functional assessment.

Assistance
The provision of money, goods, services and support options to a DSP participant.

Basic Needs
Items of basic requirement: food, clothing, shelter, fuel, utilities, household supplies and personal requirements.

Behaviour
The manner in which an individual responds or reacts to a specific set of conditions or circumstances.

Behavioural Support
A component of care provided to persons with disabilities who have challenging behavioural issues, and skill development needs. A participant's behavioural support programs results from a thorough assessment, and is one part of their complete support plan.

Business Day means between the hours of 8:30 a.m. to 4:30 p.m. Monday through Friday, except when a public holiday, as defined in the Labour Standards Code and the regulations made thereunder, and Nova Scotia Provincial Government holidays.

Capacity
In relation to "informed consent", capacity is the ability to understand information relevant to making a decision and the ability to appreciate the reasonably foreseeable consequences of a decision (or lack of a decision). See **Informed Consent.**

Care Coordinator
A Department of Community Services employee responsible for financial and functional assessments, case planning and case management.

Case Management
A participant focused process that includes assessment, case planning, care coordination, and monitoring and evaluation of the DSP participant's case plan. It is a continuous and collaborative process where the participant and their family/personal support, as appropriate, works in tandem with the service provider to meet the participant's identified goals and outcomes. Case management addresses the well-being of the DSP participant, while promoting quality of care and support, as well as ensuring and managing cost effective outcomes.

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Casework Supervisor
A Department of Community Services employee responsible for overseeing the work and decisions made by Care Coordinators, and other assigned duties.

Certificate of Leave
A certificate issued by a psychiatrist, in the form prescribed by the Involuntary Psychiatric Treatment Regulations, which allows an involuntary patient to live outside the psychiatric facility for a leave of up to six months, subject to specific written conditions contained in the certificate.

A certificate of leave is not issued without the consent of the involuntary patient's substitute decision-maker. A patient for whom a certificate of leave is issued must attend appointments with the psychiatrist, or with any other health professional referred to in the certificate, at the times and places scheduled, and must comply with the medical treatment described in the certificate.

Chronic Care
Long-term medical care, usually lasting more than 90 days, usually for individuals with chronic physical or mental impairment.

Collaborative Approach
An approach based on a consensus building philosophy which respects and highlights the abilities and contributions of each participant in order to accomplish a specific goal.

Comfort Allowance (formerly Personal Use Allowance)
A monthly allowance issued to participants in DSP Programs which they can use to purchase items for their own personal enjoyment and comfort. The amount of this allowance is established by the Department of Community Services.

Community Treatment Orders
An order made by a psychiatrist, in the form prescribed by the Involuntary Psychiatric Treatment Regulations, that allows a person who has been detained in a psychiatric facility, or who has been the subject of a community treatment order, to reside in the community and be provided with treatment and supports, subject to specific conditions.

A community treatment order is not issued without the consent of the involuntary patient's substitute decision maker. A patient for whom a community treatment order is issued must attend appointments with the psychiatrist, or with any other health professional referred to in the order, at the times and places scheduled, and must comply with the medical treatment described in the order.

Complex Case
An applicant/participant who has significant support needs which require collaboration of inter-departmental and other resources to address, and which, it is determined through assessment, cannot be met by one of the levels of support provided in a residential or community based program under the mandate of the Department of Community Services, or by continuing care facilities under the mandate of the Department of Health and Wellness or the Nova Scotia Health Authority.

Day Program
Structured community-based programs for adults with disabilities, which provide pre-vocational/vocational programs or training, supported employment, and employment opportunities for persons with disabilities. Some day programs may also offer recreational and leisure activities.

Decision Review
An objective review of a decision that provides an opportunity for the original decision to be upheld, varied or overturned. The person conducting the Decision Review is independent of the original decision. They will ensure that the decision being appealed is consistent with the Act, Regulations and Policy, and that the appellant's request is given a fair and timely review.

Decision Review Services
Decision Review Services means the Department unit responsible for coordinating the decision review process.

Department
The Department of Community Services (DCS) is one of the Departments of the Government of Nova Scotia. DCS delivers a wide range of social services to Nova Scotians in need, including the Disability Support Program (DSP). The Department works with other levels of government and many community-based and non-profit organizations to provide a network of social services.

Department of Health and Wellness (DHW) / Nova Scotia Health Authority (NSHA)
Services and programs provided by the Nova Scotia Health Authority and the IWK Health Centre which fall under the jurisdiction of the Nova Scotia Department of Health and Wellness and the Nova Scotia Health Authority.

Dependent Child
"dependent child" means a person residing in Nova Scotia who is dependent for support upon an applicant or a recipient and is:

a. 18 years and under, or

b. 19 or 20 years of age and is attending an educational program;

Detailed Support Plan
Working with the participant, a service provider will facilitate the development of a detailed plan to address the participant's daily/weekly support needs, in accordance with their expressed preferences and goals. This plan also offers the opportunity to set and/or review current and future life goals and is required as a part of the ongoing individual support planning process. Service providers may use different terms to describe these detailed support plans such as, but not limited to, Individual Lifestyle Plans, Individual Program Plans, or Person Directed Plans. Also see IASP and **section 6** of the **Level of Support Policy**.

Director
A provincial Director of the Disability Support Program.

Disability
A persistent restriction or impairment that results in a reduced ability to perform an activity within the range considered typical for someone of the same age or gender. It describes a functional limitation and is ongoing in nature. For DSP eligibility an applicant must be assessed with an:

- Intellectual Developmental Disability
- Long Term Mental Illness
- Physical Disability

Easter Seals Nova Scotia
Easter Seals Nova Scotia is a not-for-profit organization and registered charity that advocates for a barrier-free Nova Scotia and provides services promoting mobility, inclusion, and independence for Nova Scotians with disabilities. Easter Seals provides funding for the purchase and repair of wheelchairs for DSP participants when recommended by a health care practitioner.

Earned Income
Income generated from employment activities including net wages from an employer, tips, gratuities, commissions and net business income

Eligibility
The determination of whether an applicant/participant meets the DSP criteria to receive DSP assistance.

Eligibility Amount
A monthly amount that is determined when the total cost of services and supports for which, an applicant /participant is eligible pursuant to legislation and Departmental Policy, exceeds their total chargeable income.

Extraordinary Funding for Staffing
Exceptional funding for short-term staffing that may be necessary in addition to the staffing complement approved for a DSP support option. The process for applying for this short-term funding is detailed in the Basic and Special Needs Policy.

Emergency Setting
A temporary DSP support option, which is established in response to a crisis requiring the immediate placement of a participant. When a vacancy in a permanent residential support option becomes available, emergency support and funding are no longer required or available.

Financial Assessment
A process of collecting information using a consistent methodology in order to determine an applicant/participant's financial eligibility for supports and services from the DSP.

Functional Assessment/Level of Support Assessment
The determination of an applicant/participant's support needs in the area of activities of daily living and instrumental activities of daily living, as well as their level of physical, social, leisure/recreational and/or vocational functioning, as assessed by a Care Coordinator. This process is completed using the Individual Assessment and Support Plan (IASP).

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Goods and Services Tax/Harmonized Sales Tax (GST/HST) Credit
The GST/HST credit is a tax-free quarterly payment that helps individuals and families with low and modest incomes offset all or part of the GST or HST that they pay.

Guardian/Guardianship
See **Substitute Decision Maker**.

Health Care
Any examination, procedure, service or treatment that is done for a therapeutic, preventative, palliative, diagnostic or other health related purpose, and includes a course of health care or a care plan.

Health Care Practitioner
Includes health care providers such as physicians (including general practitioners and medical specialists), nurse practitioners, dentists, pharmacists, dietitians, psychologists, registered nurses, physiotherapists, occupational therapists, audiologists, speech pathologists, optometrists, and social workers.

Home for Special Care
A residential support option licensed pursuant to the *Homes for Special Care Act*.

Independent/Independence
The degree to which applicants/participants are able to manage, on their own, their activities of daily living, as well as instrumental activities of daily living.

Individual Assessment and Support Plan (IASP)
The IASP is a written document that details the supports, activities, and resources the participant requires to achieve their desired outcomes as identified through a person-focused process of information gathering and planning.

The participant is central in the planning process and their needs, goals and personal preferences, as well as their health and safety, are the key considerations in the development of all IASP's. Members of the participant's support network may also contribute to the IASP.

The Care Coordinator is responsible for the person's initial assessment and the development of a high level support plan. The residential service provider is responsible for developing the Detailed Support Plan, including goal setting, implementation, daily management and reporting. The Care Coordinator works collaboratively with the service provider and provides input to the support planning process, approves associated special needs costs, and monitors the effectiveness of the IASP.

Informal Support/Intervention
An ongoing intervention or regular support provided to a participant by a service provider on a day-to-day basis.

Informed Consent
A process related to educating persons about the nature, benefits, risks and alternatives which pertain to personal care and health care decisions. A person's decision to consent to, or refuse, services or treatment must be informed.

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Instrumental Activities of Daily Living (IADL)
Functions of daily living which include budgeting and money management, medication management, maintaining a household, preparing meals, laundry and housekeeping, telephone use, making and keeping appointments, using transportation, accessing the community, finding and maintaining employment, and participating in leisure and recreational activities.

Intellectual Developmental Disability
A disorder that includes an intellectual deficit which creates difficulties in functioning in two or more activities of daily living and/or instrumental activities of daily living within the range considered typical for a person of the same age and gender, which occurs prior to the age of 18 years.

Level of Support
The amount and type of support an applicant/participant requires to promote their independence, self-reliance, security and social inclusion. Support is consistent with the applicant/participant's assessed needs, wishes, and choice, within the parameters of available DSP resources as outlined in the applicable approved DSP policies.

Long-Term Mental Illness
A diagnosis of chronic and persistent mental illness which affects a person's thinking, feeling or behaviour and creates significant difficulties in functioning in two or more aspects of activities of daily living or instrumental activities of daily living within the range considered typical for someone of the same age or gender.

Medical Equipment
Includes prosthetic appliances and other types of equipment (i.e. walkers, crutches) recommended by a health care practitioner.

Medical Services Insurance (MSI)
Medical Services Insurance (MSI) is available to eligible residents of Nova Scotia and provides coverage for medically required hospital, medical, dental and optometric services, with some restrictions. The Medical Services Insurance Programs are administered by Medavie Blue Cross on behalf of the Nova Scotia Government. The Department of Health and Wellness provides policy direction for the programs. The Hospital Insurance Program is administered directly by the Department of Health and Wellness. The cost of providing these services to Nova Scotians is met through the general revenues of the province.

Minister of Community Services
The elected politician charged with making and implementing decisions on policies and legislation within the Department of Community Services.

Natural Support Network
The relationships that naturally exist between an individual and their family, friends, co-workers and community. They are relationships upon which an individual can typically rely on for support. These relationships develop through a variety of experiences and evolve and change over the years.

Net Business Income
Any profit earned from self-employment, including profit earned from a registered or non-registered business.

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Nova Scotia (NS) Formulary
A document which lists drugs and supplies that are benefits under the Nova Scotia Senior's Pharmacare Program, Family Pharmacare Program, Diabetes Assistance Program, Community Services Pharmacare Programs and Drug Assistance for Cancer Patients.

Palliative
Active and compassionate care provided to an individual who is terminally ill.

Participant
A person with a disability who has undergone financial and functional assessments, is determined eligible for the DSP, and receives supports and services offered through the DSP.

When it has been determined that a participant lacks the capacity to make their own decisions, they must have a person acting on their behalf who is legally authorized to make decisions on their behalf (substitute decision maker).

Per Diem
Daily rate of funding provided to residential service providers for the purpose of providing supports to DSP participants.

Person Authorized to act on their Behalf
Any person authorized by the applicant/participant, or by law, to act on their behalf and includes:

- a guardian; and
- a person with a power of attorney, court order, personal directive.

Person in Need
A person who requires financial assistance to provide for them in a home for special care or a community based option.

Personal Care
Activities such as eating, bathing and dressing, toileting and grooming with which DSP participants may require support.

Personal Development
Includes activities that improve awareness and identity, develop talents and potential, facilitate employability, enhance quality of life and contribute to the realization of dreams and aspirations.

Personal Directives Act (PDA)
The PDA is a law that allows Nova Scotians to create a personal directive in which they can express their wishes and values relating to personal care decisions, and name a delegate to make decisions for them if they should become incapable of making personal care decisions in the future. The PDA also provides a hierarchy of statutory decision makers for decisions relating to health care, placement in a continuing care home, or home care services for individuals who are incapacitated and have not named someone to make those types of decisions for them in a personal directive.

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Personal Use Allowance
See Comfort Allowance

Personal Support Network
A network made up of individuals such as doctor(s), therapist(s), members of the community, family and friends that are involved in and/or support the individual with different parts of their life.

Physical Disability
A long-term, chronic and persistent physical limitation that creates significant difficulties in functioning in two or more aspects of activities of daily living or instrumental activities of daily living within the range considered typical for someone of the same age or gender. The physical disability substantially limits functional independence and results in the person requiring ongoing support and skill development.

Preference Details
The community, program option, or service provider the DSP applicant or participant prefers, within their assessed level of support need.

Project 50
A program in which a participant volunteers for up to twenty-five (25) hours a month and receives an allowance of up to $50 a month.

Reassessment
Reassessment confirms a participant's unmet needs and level of support or care requirements. Reassessments are performed in response to changes in a participant's circumstances and may identify changes in their support needs and program resource requirements.

Registered Disability Savings Plan (RDSP)
A tax-deferred savings tool that assists in planning for the long-term financial security for people with disabilities. The beneficiary named under an RDSP must be eligible to receive the disability tax credit.

Registered Education Savings Plan (RESP)
A savings tool that assists in planning for payments for a child's post-secondary education.

Representative
Any person, counsel or agent who assists and/or represents an appellant during the appeal process.

Residential Support Option
Homes licensed under the *Homes for Special Care Act*, including Community Homes, Adult Residential Centres and Regional Rehabilitation Centres.

Respite
Respite provides the primary caregiver breaks from continuous caregiving responsibilities.

Review
A second or subsequent assessment of an applicant/participant and their circumstances, completed to establish ongoing DSP eligibility, performed in accordance with individual DSP program policies.

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Semi-Independent
A semi-independent participant is an individual who requires a minimal level of support and skill development in preparation for independence and/or enhancement of their independence.

Service Provider
An organization or person that is contracted to provide support services to participants in the Department of Community Services DSP.

Service Agreement
An agreement between the Department of Community Services and a service provider that outlines the responsibilities, expectations, and financial arrangements for supports for participants in the DSP.

Specialist
A Department of Community Services DSP employee, responsible for the regional delivery of DSP Programs.

Short-Term
A period of time that does not exceed six (6) consecutive months.

Social Assistance Act
The Act (section 19) allows any person who applies for or receives assistance under the Disability Support Program to appeal any decision related to that person's application or assistance received, to an appeal board. Section 12(2) of the ESIA Act authorizes the Appeal Board to hear appeals pursuant to the Social Assistance Act.

Special Needs
Items and services of special requirement that are set out in the DSP Policy and are not basic needs (as defined) and are not covered by the per diem of the program.

Spouse
A partner in a marriage or a common-law relationship (twelve (12) or more continuous months).

Supervision
The presence of support staff members for the purposes of ensuring the safety and well-being of participants.

Stable Medical Condition
An individual's medical condition, which is not meant to be a diagnosis, but a general guide to the individual's status as determined by several factors. An individual with a stable medical condition may have health conditions that can be managed and stabilized with monitoring or minimal intervention, and may require short term specialized/skilled nursing for acute episodes only.

Standard Community Resources
Resources provided by the Department of Health and Wellness Continuing Care Program or the Nova Scotia Health Authority such as mental health outreach services or home care nursing services. These resources are typically available to all residents of Nova Scotia.

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Substitute Decision Maker (SDM)
There are three categories of substitute decision makers for a person determined to be incapable of making their own decisions in Nova Scotia: (1) a delegate (identified in a personal directive or power of attorney document created by the person prior to their incapacity) pursuant to the *Personal Directives Act (PDA)* and *Powers of Attorney Act;* (2) a court appointed Guardian (or the Office of the Public Trustee) and (3) a statutory substitute decision maker. Each category has a defined realm of authority.

(1) Delegate – Power of Attorney and/or Personal Directive
A person of 19 years or older who is of sound mind may make a power of attorney and a personal directive to allow someone other than them to make certain decisions for them. That person is their delegate, who will have the authority to make those decisions. Usually a power of attorney document relates to the property (land and personal) and a personal directive relates to personal care* decisions. However, both types of decisions may be included in one document. It is important to read the power of attorney document and personal directive document to see what decision making powers have been given to the delegate.

*As defined in the *Personal Directives Act*, personal care includes, but is not limited to: health care, nutrition, hydration, shelter, residence, clothing, hygiene, safety, comfort, recreation, social activities, support services and any other personal matter that is prescribed in the Personal Directives Regulations. Health care is defined in those Regulations to mean any examination, procedure, service or treatment that is done for a therapeutic, preventative, palliative, diagnostic or other health-related purpose, and includes a course of health care or a care plan.

(2) Guardian
A person appointed by the Nova Scotia Supreme Court as a guardian for someone else, and in some cases the Public Trustee by virtue of the *Public Trustee Act*, without the need for a court appointment. The court order permits the guardian to make decisions consistent with the authority granted by the court (e.g. decisions about property and about personal needs). The Public Trustee may be a court appointed guardian too, and has the power to become guardian in certain situations for children and adults, pursuant to the *Public Trustee Act* and other statutes.

(3) Statutory Substitute Decision Maker
Pursuant to the *Personal Directives Act*, decisions relating to personal care, accepting an offer of placement in a continuing care home or home-care services * will be made by the nearest relative who:

- is 19 years of age or older (or is a minor spouse); and
- has capacity; and
- has had contact with the person within the preceding 12 months; and
- is willing to act; and
- features first on the following list:
  a) the spouse;
  b) an adult child of the patient;
  c) a parent;
  d) a person who stands in *loco parentis*;
  e) an adult brother or sister of the patient;
  f) a grandparent of the patient;
  g) an adult grandchild of the patient;
  h) an adult aunt or uncle of the patient;

i) an adult niece or nephew of the patient;
j) any other adult next-of-kin;
k) the Public Trustee.

The Public Trustee's office will take referrals related to health care decisions for persons who are not capable of making their own decisions and do not have anyone else who is available and willing to act as their statutory substitute decision maker.

The *Hospitals Act* and the *Involuntary Psychiatric Treatment Act* contain a similar list of substitute decision makers for persons needing treatment that cannot consent to it themselves due to a lack of capacity.

*As defined in the *Personal Directives Act*, 'home-care services' includes health- care services and support services provided to a person in their own home or while resident in a continuing-care home where the need for services is assessed. The assessment must be done by a person licensed or registered under provincial statute to provide health care, or a person who is authorized by the Ministers of Health and Wellness or Community Services to perform need assessments.

Standard Household Rate
A monthly amount of financial assistance for basic needs and personal requirements, including food and shelter costs (including rent and utilities).

The Standard Household Rate may be provided to a participant who is renting, boarding or owns their own home.

Standard Household Rate - Essentials
An allowance provided to DSP participants who are in hospital, residential rehabilitation programs, youth facilities or homeless shelters, are not receiving the rent, own or board Standard Household Rate, and who do not have funded residential support placements.

Unearned Income
Includes income maintenance payments such as Old Age Security, Guaranteed Income Supplement, Canada Pension, Workers' Compensation, War Veteran's Allowance, Employment Insurance, income from alimony and maintenance payments, and any other non-exempt income not directly resulting from employment.

Urgency for Placement
An individual's need for placement based on the assessed level of risk of the applicant, caregiver, and others in the home.

Waitlist for DSP Program
The Service Request list includes both participants of the DSP program and applicants to the DSP program. The DSP waitlist refers to any individual that has been assessed as eligible for the DSP program but is not receiving DSP support, including individuals in the following circumstances:

a) ESIA recipients;
b) Living home alone or with family;
c) Foster care;
d) Incarceration;
e) Hospital;

f) Nursing home;
g) Shelter.

Working Income Tax Benefit (WITB)
A refundable tax credit for low-income individuals and families who have earned income from employment or business. The WITB consists of a basic amount and a disability supplement.

APPENDIX A - Basic and Special Needs Rates

When a Special Need item or service does not have a specified rate the following approval levels as outlined in **section 6.0** of the **Basic and Special Needs Policy** will apply:

Special Needs Request	Recommendation	Final Approval
Up to and including $800		Care Coordinator
Up to and including $2200		Casework Supervisor
Over $2200	Specialist	
Between $2200 and up to $5000		Service Delivery Manager
Over $5000		Director

When a Special Need item or service is not listed in the table of rates, consultation shall be made with the DSP Specialist for consideration. If the decision is to fund the Special Need, the above approval levels shall also apply.

Any recurring Special Needs that are required for a period of more than one (1) month consecutively shall require approval on the basis of the full, cumulative amount of the request.

Basic and Special Needs Rates

<table>
<tr><th>ITEM / SERVICE
Policy # = blue</th><th>RATE & APPROVAL LEVEL</th></tr>
<tr><td colspan="2">Basic Requirements: For participants living in residential settings whose basic requirements (food, shelter and clothing) are not covered by an approved per diem.</td></tr>
<tr><td>Standard Household Rate (8.1) (8.2)</td><td>
<table>
<tr><th colspan="3">Household Composition</th><th colspan="3">Standard Household Rate (Monthly)</th></tr>
<tr><th>Participant</th><th>Spouse*</th><th>Dependent(s)</th><th>Rent/Own</th><th>Board</th><th>Essentials</th></tr>
<tr><td>1</td><td>-</td><td>-</td><td>$950</td><td>$608</td><td>$265</td></tr>
<tr><td>1</td><td>-</td><td>1</td><td>$962</td><td>$627</td><td>$265</td></tr>
<tr><td>1</td><td>-</td><td>2 (or more)</td><td>$1,013</td><td>$668</td><td>$265</td></tr>
<tr><td>1</td><td>1</td><td>-</td><td>$1,342</td><td>$1,008</td><td>$645</td></tr>
<tr><td>1</td><td>1</td><td>1 (or more)</td><td>$1,393</td><td>$1,049</td><td>$645</td></tr>
</table>
*if a spouse is also a DSP participant, the spouse will continue to have their own case and any dependents in the household will be included in only one participant's Standard Household Rate.
</td></tr>
<tr><td>Clothing – Regular (7.1.1)

When clothing funds are received in trust, service providers are required to maintain records of</td><td>$30 per month, approved by Care Coordinator, for participants in residential placements and the Alternative Family Support Program. Clothing allowance is billed monthly by the service provider on behalf of participants in residential programs. Clothing</td></tr>
</table>

distribution to participants and make them available to DCS upon request.	allowances will be paid directly to participants, or to service providers and held in trust. For the Independent Living Support Program and the Flex Independent Program, $12 per month is issued under Clothing Regular.
ITEM / SERVICE **Policy # = blue**	**RATE & APPROVAL LEVEL**
Special Needs	
Clothing	
Clothing – Special (7.1.2)	Actual cost of the most economical option, approved by Casework Supervisor (applies to participants in all DSPs).
Comfort Allowance	
Comfort Allowance (9.0)	$115 per month, approved by Care Coordinator.
Funeral and Burial	
Professional Services and Merchandise (7.2)	Up to a maximum total of $2700 + HST. Set rate, approved by Care Coordinator.
Items Eligible for Cash Disbursements: (7.2) • cemetery charges • burial permits, etc. • grave liner (wooden) • cemetery equipment & set up • radio notices • newspaper notices • clothing for the deceased • honorariums (clergy, music, etc.) • grave lot • mileage over 25 kms	Up to a maximum total of $1100 + HST. Set rate, approved by Care Coordinator. May be paid on a per kilometer basis at a rate of $0.60 per kilometer (60 cents/ km)
Any exceptions requested in addition to the approved funeral cost, such as but not limited to: oversized casket, special	Approved by Casework Supervisor.

embalming preparations, out of province transfer.	
Medical	
Ambulance (*also see Transportation*) (7.7.2)	Actual cost at the DHW rate, approved by Care Coordinator.
Dental (7.3.2 & 7.3.3)	Dental care approved in accordance with the approved DSP Dental Rate Guidelines. Set rates, approved by Care Coordinator. See **DSP Dental Rate Guidelines (Appendix B).**
Emergency Response Devices (7.5)	Actual cost of the most economical option, approved by Care Coordinator.
Attending Medical Appointments or Tests Outside of the Local Community (7.7.1) Food/Shelter (7.7.1) Transportation (7.7.1) Staffing (7.7.1)	Most economical option for all support costs including food, shelter and transportation. Costs in excess of $150 approved by Casework Supervisor.
Foot Care/Podiatry (7.3.4)	Actual cost, approved by Care Coordinator.
Guide Dog Allowance (7.3.5)	Maximum allowance of $90 per month, approved by Care Coordinator. Routine veterinary care actual cost to a maximum of $300 annually.
Hearing Aids/Hearing Aid Batteries (7.3.6)	Actual cost of the most economical option as per DSP approval levels.
Medical Report Provision Fee (7.3.12)	$25 up to actual cost for the provision of the medical information (applies to DSP participants only), approved by Care Coordinator.
Medical Equipment (7.3.9)	Assistance with purchase/rental of approved equipment at the actual cost of the most economical option, as per DSP approval levels. For wheelchair purchases and repairs, referrals should be made to Easter Seals Nova Scotia.
Medical File Transfer (7.3.10)	Electronic and/or paper file transfer, $25 up to actual cost, approved by Care Coordinator.
Medical Insurance (7.3.11)	Recurring need in monthly eligibility amount when it is part of a cost-effective support plan, approved by Care Coordinator.

APPENDIX A - Basic and Special Needs Rates

Health Care Services	
Medical Supplies (7.3.13)	Actual cost of the most economical option, up to $200 per month, approved by Care Coordinator. Amounts exceeding $200 per month approved by Casework Supervisor.
Nursing Care (7.3.14)	Most economical option for services not covered or available under Home Care Nova Scotia or other insured services. Casework Supervisor approval and as per DSP approval levels.
Optical Care/Glasses (7.3.15) Eye Exams (7.3.15)	Glasses and eye exams provided once every two (2) years. Most economical option to meet need - up to $500 every two (2) years, includes eye exams, approved by Care Coordinator.
Orthotics (7.3.16)	Customized orthotic shoes and orthotic modifications to regular shoes, as per DSP approval levels.
Over the Counter/Non-Prescription Medication (7.3.17)	Actual costs up to $200 per month (including blister-packing, when required), approved by Care Coordinator. Amounts exceeding $200 per month approved by Casework Supervisor.
Prescription Medication (7.3.18)	Prescription drug coverage is administered through the Pharmacare Program. Co-pays associated with private or senior health benefit plans may be eligible for coverage (including blister-packing, when required), approved by Care Coordinator.
Special Diets (7.3.19)	Refer to **Special Diet Rate Guidelines (Appendix C).** Care Coordinator may approve a maximum total of $150 per month, when more than one diet allowance is required/approved. Participants with paraplegia or quadriplegia or any participants with chronic conditions (e.g. diabetes, colitis) do not need to provide annual documentation from a health care practitioner for special diets unless there is a change in their dietary needs.
Maternal Nutritional Allowance (7.3.7)	$51 per month may be included in a participant's monthly eligibility amount from the date the Care Coordinator is notified of the pregnancy or birth of a child, up to and including twelve full months after the birth of the child. Approved by Care Coordinator.
Meal Programs (7.3.8)	As part of an individual support plan. Actual cost of approved meal program, approved by Casework Supervisor.

APPENDIX A - Basic and Special Needs Rates

Medical Care (Rehabilitation and Treatment Services)	
Counseling (7.4.1) Occupational Therapy, Physiotherapy and Speech Therapy (7.4.2)	Short-term interventions (up to six (6) months) where publicly funded or privately insured services are not accessible, approved by Casework Supervisor. Exceptions may be considered where medical services are required beyond six (6) months, as per DSP approval levels.
Massage Therapy (7.4.3)	Once a month or more, if recommended by a health care practitioner for a specific physical disability. Casework Supervisor approval required and as per DSP approval levels.
Shelter / Utility / Food * * For those who live in their own apartment/home and whose costs are not funded by an approved per diem.	
Emergency Food Orders (8.4)	$25 per participant, approved by Care Coordinator.
Utility connection fees (8.15)	Actual costs, approved by Care Coordinator.
Excess Shelter (8.5)	$200 per month, approved by Casework Supervisor.
Extermination Services (8.6)	Actual cost of the most economical option as per DSP approval levels.
Fire/Liability Insurance (8.7)	Actual cost calculated at 1/12 for each month, or full annual premium. Two quotes required, approved by Care Coordinator.
Household start up and replacement costs (8.8)	See **Independent Living, Furniture Set-up, and Replacement Rate Guidelines (Appendix D).** Up to $500 + HST, approved by Care Coordinator. $500 -1000 + HST, approved by Casework Supervisor.
Homemaker Services(8.9)	Most economical option when not available through Home Care Nova Scotia. Does not include costs normally funded by an approved per diem rate, units of service or hours of support. Approved by Casework Supervisor and as per DSP approval levels.
House Repairs (8.10)	As part of an approved individual support plan. As per DSP approval levels.
Security/Damage Deposits (8.12)	Maximum one half (1/2) of the approved rent, approved by Care Coordinator.

APPENDIX A - Basic and Special Needs Rates

Telephone* (8.14) *Applicable to Independent Living Programs	Telephone installation, equipment and services as part of an approved support plan, approved by Care Coordinator.
Shelter-Related Arrears (8.13) Mortgage/ Rental Arrears Property Tax Arrears Utility Arrears	Assessed individually. Approved by Casework Supervisor.
Moving Allowances – Within Region (8.11)	As part of an approved individual support plan. $200 approved by Care Coordinator.
Homeless Shelters and Recovery Programs	
Homeless Shelters (7.6.3)	Actual cost, approved by Casework Supervisor.
Residential Recovery Program (7.6.3)	Actual cost, approved by Casework Supervisor.
Youth Facility (7.6.3)	Actual cost, approved by Casework Supervisor.
Support Services	
Child Care (7.6.1)	As part of an approved individual support plan. Actual cost up to a maximum of $400 per month, approved by Care Coordinator.
Extra Staffing (Extraordinary Funding for Staffing) (7.6.2)	Short term requests. Approved by Casework Supervisor and as per DSP approval levels.
Interpreter Services (7.6.4)	Most economical option when these services cannot be accessed through a community organization. Approved by Care Coordinator.
Personal Care (7.6.5)	Most economical option for services not covered under Home Care Nova Scotia or other insured services. May not include costs normally covered by an approved per diem rate, units of service, or hours of support. Approved by Casework Supervisor and as per DSP approval levels.
Respite in Licensed Homes (7.6.7)	Applies to participants living with family(s). Sixty (60) days annually (per fiscal year) allowed per participant, approved by Care Coordinator.
Respite (In-Home) (7.6.6)	Applies to AFS program for AFS family respite. Up to thirty (30) days of annual respite funding, per resident, based on the AFS per diem.
Transportation	
Ambulance (7.7.2)	Actual cost at the current DHW rate. Approved by Care Coordinator.

APPENDIX A - Basic and Special Needs Rates

Regular Transportation (7.7)	Up to $150 per month based on the most efficient and economical means, approved by Care Coordinator. Requests beyond $150 per month, approved by Casework Supervisor.
Transportation for Medical Attention (Not an Ambulance) (7.7 & 7.7.1)	Max total of $150 per month based on the most efficient and economical options. For medical travel transportation requests which exceed the $150 per month maximum, approved by Casework Supervisor.
Vocation / Employment / Day Activity (Rehabilitation and Social Development)	
Day Activities (7.8.1) Adult Service Centres	As part of an approved individual support. Actual costs up to $40.00/month, approved by Care Coordinator and as per DSP approval levels.
Education Programs (7.8.2)	As part of an approved individual support plan, max total of $500 per course, approved by Care Coordinator.
Books/Supplies/Deposits (7.8.3)	As part of an approved individual support plan, max total of $700 per twelve (12) month period, includes seat confirmations, approved by Care Coordinator. Max total of $100 per twelve (12) month period for participants attending Senior High School.
Employability Related Expenses (7.8.4)	Max total of $500 per twelve month period, approved by Care Coordinator. See also Special Clothing, **section 7.1.2** for employment related clothing.
Project 50 (7.8.5)	The incentive allowed is prorated on a basis of $2 per hour service to a maximum of $50 per month, approved by Care Coordinator. Project 50 placement exceptions approved by Casework Supervisor.

Appendix B – DSP Dental Rate Guidelines

Disability Support Program (DSP) Dental Rate Guidelines – UPDATED JANUARY 2014

DSP policy allows for coverage of dental procedures up to 100% of the current fee guides for the Nova Scotia Dental Association and the Denturist Society of Nova Scotia.

The Denturist Society of Nova Scotia fee guide is effective January 1, 2014.

The Nova Scotia Dental Association fee guide is effective January 1, 2014.

The following is a list of dental procedures that are covered. If a dentist is claiming for a procedure that is not on the list, please provide details via e-mail to '**DSP@gov.ns.ca**' for further review.

DENTAL SERVICES FEE SCHEDULE

GP (General Practitioner) SP (Specialist) IC (Fee is an 'Individual Consideration')

Procedure Code	Description	Fee (GP) @ 100%	Fee (SP) @ 100%
	DIAGNOSTIC PROCEDURES		
01101 01102 01103	Complete Exam - primary dentition - mixed dentition - permanent dentition	 43.00 56.00 76.00	 81.00 116.00 158.00
01201	New Patient Exam	29.00	66.00
01202	Exam & Diagnosis	28.00	64.00
01204	Specific Exam	47.00	61.00
01205	Emergency Oral Exam	47.00	61.00
01501 01502	Examination and Diagnosis - periodontal - limited (previous patient)	 44.00 32.00	 169.00 110.00
01601	Surgical Consultation		103.00
02102	Radiographs – Complete Series	94.00	130.00
02111	Radiographs – Single Film	15.00	35.00
02112	Radiographs – Two Films	20.00	37.00
02113	Radiographs – Three Films	26.00	39.00
02114	Radiographs – Four Films	31.00	43.00
02115	Radiographs – Five Films	36.00	52.00
02116	Radiographs – Six Films	41.00	56.00
02117	Radiographs – Seven Films	47.00	64.00
02118	Radiographs – Eight Films	52.00	70.00
02131	Occlusal Radiograph - Single Film	28.00	37.00

Appendix B – DSP Dental Rate Guidelines

Procedure Code	Description	Fee (GP) @ 100%	Fee (SP) @ 100%
02132	Occlusal Radiograph – Two Films	37.00	48.00
02133	Occlusal Radiograph – Three Films	45.00	63.00
02134	Occlusal Radiograph – Four Films	54.00	77.00
02141	Bitewing X-Ray - Single	15.00	35.00
02142	Bitewing X-Ray – Two Films	20.00	37.00
02143	Bitewing X-Rays – Three Films	26.00	42.00
02144	Bitewing X-Ray – Four Films	31.00	48.00
02601	Panoramic Radiograph - Single Film	61.00	78.00
02801	Radiographs, CT scans, PET scans, MRI scans, interpretation - one unit	53.00 + materials	84.00 + materials
04403	Direct Fluorescence Visualization	28.00	64.00
	PREVENTIVE PROCEDURES		
11101	Polishing – one unit	27.00	43.00
11102	Polishing – two units	54.00	86.00
11107	Polishing – ½ unit	14.00	21.00
11111	Scaling - one unit	39.00	86.00
11112	Scaling - two units	78.00	172.00
11113	Scaling - three units	117.00	258.00
11114	Scaling - four units	156.00	344.00
11115	Scaling – five units	195.00	430.00
11116	Scaling – six units	234.00	516.00
11117	Scaling - half unit	20.00	43.00
11119	Scaling – each unit over six	39.00	86.00
12101	Fluoride Treatment – Topical	16.00	41.00
12102	Fluoride Treatment - Supervised	10.00	31.00
13601	Topical Application - one unit	31.00 + materials	68.00 + materials
14611	Maxillary appliance	258.00 + Lab	783.00 + Lab
14622	Appliances, Adjustment, Repair - two units	108.00 + Lab	201.00 + Lab
	RESTORATIVE PROCEDURES		
20111 20119	Caries/Trauma/Pain Control - first tooth - each additional tooth (same quadrant)	 89.00 89.00	 95.00 95.00
20121 20129	Caries/Trauma/Pain Control (plus retention band) - first tooth - each additional tooth (same quadrant)	 100.00 100.00	 111.00 111.00
	Smoothing of Fractured Surfaces		

Appendix B – DSP Dental Rate Guidelines

Procedure Code	Description	Fee (GP) @ 100%	Fee (SP) @ 100%
20131	- first tooth	37.00	42.00
20139	- each additional tooth (same quadrant)	37.00	42.00
	Restorations, Amalgam Permanent Bicuspids & Anteriors		
21211	- one surface	94.00	93.00
21212	- two surfaces	123.00	122.00
21213	- three surfaces	151.00	149.00
21214	- four surfaces	179.00	182.00
21215	- five surfaces or maximum surfaces per tooth	212.00	213.00
	Restorations, Amalgam, Non-Bonded Permanent Molars		
21221	- one surface	109.00	109.00
21222	- two surfaces	137.00	146.00
21223	- three surfaces	165.00	169.00
21224	- four surfaces	194.00	212.00
21225	- five surfaces or maximum surfaces per tooth	246.00	279.00
	Restorations, Amalgam, Bonded Permanent Bicuspids & Anteriors		
21231	- one surface	109.00	112.00
21232	- two surfaces	137.00	135.00
21233	- three surfaces	165.00	163.00
21234	- four surfaces	194.00	198.00
21235	- five surfaces or maximum surfaces per tooth	227.00	238.00
	Restorations, Amalgam, Bonded Permanent Molars		
21241	- one surface	125.00	127.00
21242	- two surfaces	158.00	158.00
21243	- three surfaces	191.00	196.00
21244	- four surfaces	223.00	237.00
21245	- five surfaces	283.00	293.00
21301	Restorations, Amalgam Cores – Non-bonded in conjunction with Crown	147.00	146.00
21302	Amalgam Cores – Bonded in conjunction with Crown	162.00	160.00
	Retentive Pins per Restoration		
21401	- one pin	22.00	38.00
21402	- two pins	34.00	66.00
21403	- three pins	47.00	81.00
21404	- four pins	59.00	106.00
21405	- five pins or more	71.00	122.00
22311	Restorations Prefabricated Metal – Posterior	142.00	191.00
22312	Restorations Prefabricated Metal – Posterior Open Face		230.00

Appendix B – DSP Dental Rate Guidelines

Procedure Code	Description	Fee (GP) @ 100%	Fee (SP) @ 100%
	Restorations, Permanent Anteriors, Bonded		
23111	- one surface	111.00	118.00
23112	- two surfaces (Continuous)	140.00	144.00
23113	- three surfaces (Continuous)	170.00	211.00
23114	- four surfaces (Continuous)	200.00	277.00
23115	- five surfaces or maximum surfaces per tooth	263.00	359.00
	Restorations, Tooth Coloured, Permanent Bicuspids		
23311	- one surface	131.00	135.00
23312	- two surfaces	167.00	182.00
23313	- three surfaces	202.00	251.00
23314	- four surfaces	238.00	285.00
23315	- five surfaces or maximum surfaces per tooth	313.00	351.00
	Restorations, Tooth Coloured, Permanent Molars		
23321	- one surface	137.00	145.00
23322	- two surfaces	174.00	182.00
23323	- three surfaces	211.00	237.00
23324	- four surfaces	248.00	285.00
23325	- five surfaces	326.00	385.00
25731	Posts, Prefabricated Retentive - one post	145.00 + materials	190.00+ materials
25754	Posts with Non-Bonded Core for Crown Restorations + pins, where applicable	240.00 + materials	423.00 + materials
	ENDODONTICS		
32221	Pulpotomy Permanent Anterior and Premolars (excluding final restoration)	100.00	177.00
32222	Pulpotomy Permanent Molars	120.00	177.00
	Pulpectomy, Permanent Teeth, Retained Primary		
32311	- one canal	136.00	197.00
32312	- two canals	179.00	245.00
32313	- three canals	221.00	359.00
32314	- four canals or more	291.00	359.00
	Root Canals, Permanent Anteriors – One Canal		
33111	- one canal	403.00	592.00
33112	- difficult access	483.00	604.00
33113	- exceptional anatomy	483.00	638.00
	Root Canals, Permanent Anteriors – Two Canals		
33121	- two canals	572.00	727.00
33122	- difficult access	686.00	757.00
33123	- exceptional anatomy	686.00	788.00
	Root Canals, Apexification, Apexogenesis		
33601	- one canal	151.00	224.00

Appendix B – DSP Dental Rate Guidelines

Procedure Code	Description	Fee (GP) @ 100%	Fee (SP) @ 100%
33602	- two canals	200.00	321.00
	Periapical - Apicoectomy, Apical Currettage, Maxillary Anterior		
34111	- one root	227.00	465.00
34112	- two roots	325.00	601.00
	Periapical - Apicoectomy, Apical Currettage, Mandibular Anterior		
34141	- one root	226.00	484.00
34142	- two roots	324.00	591.00
	Endodontic procedures, Misc. Open & Drain		
39201	Anterior and Bicuspids	75.00	102.00
39202	Molars	75.00	102.00
39212	Opening through Artificial Crown (in addition to procedures) Molars	142.00	137.00
	PERIODONTICS		
41301	Desensitization - one unit	37.00	99.00
	Root Planning - Periodontal		
43421	- one unit	39.00	90.00
43422	- two units	78.00	180.00
43423	- three units	117.00	270.00
	PROSTHODONTICS - REMOVABLE		
	Complete Dentures, Standard		
51101	- Maxillary	741.00 +Lab	1495.00+Lab
51102	- Mandibular	894.00 +Lab	1719.00+Lab
	Dentures, Surgical, Std. (Immediate)		
51301	- Maxillary	889.00 +Lab	1645.00+Lab
51302	- Mandibular	971.00 +Lab	1989.00+Lab
	Partial Dentures, Acrylic Base (Immediate)		
52111	- Maxillary	530.00 +Lab	IC
52112	- Mandibular	530.00 +Lab	IC
	Partial Dentures Acrylic with Metal Wrought/Casts Clasps and/or Rests		
52301	- Maxillary	530.00 +Lab	771.00+Lab
52302	- Mandibular	530.00 +Lab	771.00+Lab
	DENTURES, PARTIAL, CAST WITH ACRYLIC BASE		
	Partial Dentures - Cast Frame / Connector		
53201	- Maxillary	894.00 + Lab	IC
53202	- Mandibular	894.00 + Lab	IC

Appendix B – DSP Dental Rate Guidelines

Procedure Code	Description	Fee (GP) @ 100%	Fee (SP) @ 100%
	DENTURES, ADJUSTMENTS		
54201	Denture adjustments, partial or complete denture, minor - one unit	73.00 + Lab	93.00 + Lab
	DENTURES, REPAIRS, RELINING AND REBASING		
	Repairs, Complete Denture - No Impression Required		
55101	- Maxillary	56.00 +Lab	87.00+Lab
55102	- Mandibular	56.00 +Lab	87.00+Lab
	Repairs, Complete Denture - Impression Required		
55201	- Maxillary	101.00 +Lab	174.00+Lab
55202	- Mandibular	101.00 +Lab	174.00+Lab
	Repairs, Partial Denture - No Impression Required		
55301	- Maxillary	56.00 +Lab	87.00+Lab
55302	- Mandibular	56.00 +Lab	87.00+Lab
	Repairs, Partial Denture - Impression Required		
55401	- Maxillary	139.00 +Lab	174.00+Lab
55402	- Mandibular	139.00 +Lab	174.00+Lab
55501	Dentures/Implant Retained Prosthesis, Prophylaxis and polishing - one unit	31.00 + Lab	94.00 + Lab
	Reline, Complete Denture		
56211	- Maxillary	243.00	304.00
56212	- Mandibular	243.00	304.00
	Reline, Partial Denture		
56221	- Maxillary	206.00	304.00
56222	- Mandibular	213.00	304.00
	Reline, Complete Denture (Processed)		
56231	- Maxillary	326.00 +Lab	526.00+Lab
56232	- Mandibular	335.00 +Lab	526.00+Lab
	Reline, Partial Denture (Processed)		
56241	- Maxillary	295.00 +Lab	349.00+Lab
56242	- Mandibular	326.00 +Lab	349.00+Lab
	Rebase, Complete Denture		
56311	- Maxillary	323.00 +Lab	523.00+Lab
56312	- Mandibular	375.00 +Lab	523.00+Lab

Appendix B – DSP Dental Rate Guidelines

Procedure Code	Description	Fee (GP) @ 100%	Fee (SP) @ 100%
	Rebase, Partial Denture		
56321	- Maxillary	296.00 +Lab	349.00+Lab
56322	- Mandibular	312.00 +Lab	349.00+Lab
	Complete Denture		
56511	- Maxillary	125.00	155.00
56512	- Mandibular	125.00	155.00
	Partial Denture		
56521	- Maxillary	125.00	155.00
56522	- Mandibular	125.00	155.00
	ORAL AND MAXILLOFACIAL SURGERY		
	Surgical Removal of Erupted teeth		
71101	- single tooth, uncomplicated	113.00	111.00
71109	- each additional tooth same quadrant/ appointment	76.00	73.00
71201	- single tooth, complicated requiring surgical flap	223.00	260.00
71209	- each additional tooth same quadrant/ appointment	149.00	260.00
	Removal, Impacted Teeth (Requires pre-approval)		
72111	- single tooth	223.00	260.00
72119	- each additional tooth, same quadrant	149.00	260.00
	Removal, Impacted Teeth involving Tissue and/or Bone (Requires pre-approval)		
72211	- single tooth	269.00	383.00
72219	- each additional tooth, same quadrant	179.00	383.00
72221	Removals, impaction requiring incision of overlying soft tissue, elevation of a flap, removal of bone and sectioning of the tooth for removal – single tooth	372.00	428.00
	Removal, Residual Roots, Erupted		
72311	- first tooth	88.00	107.00
72319	- each additional tooth, same quadrant	59.00	107.00
	Removal, Residual Roots, Soft Tissue Coverage		
72321	- first tooth	160.00	206.00
72329	- each additional tooth, same quadrant	107.00	206.00
	Removal, Residual Roots, Bone Tissue Coverage		
72331	- first tooth	327.00	317.00
72339	- each additional tooth, same quadrant	218.00	284.00
	Alveoloplasty, not in conjunction with Extractions (Requires pre-approval)		
73121	Per Sextant	198.00	221.00

Appendix B – DSP Dental Rate Guidelines

Procedure Code	Description	Fee (GP) @ 100%	Fee (SP) @ 100%
73211	Gingivoplasty and/or Stomatoplasty, Oral Surgery Per Sextant	84.00	225.00
	ADJUNCTIVE GENERAL SERVICES		
	Nitrous Oxide with Oral Sedation (Requires pre-approval)		
92431	One unit of time	IC	76.00
92432	Two units of time	IC	152.00

Appendix B – DSP Dental Rate Guidelines

DENTURIST SERVICES FEE SCHEDULE *

Procedure Code	Description	Fee @ 100%	Lab Fee @ 100% (where applicable)	Total
	DIAGNOSTIC PROCEDURES			
10010	General Oral Exam	108.00		108.00
10020	New Patient Exam. Limited Exam	70.00		70.00
10030	Previous Patient Exam, Limited Exam	70.00		70.00
	COMPLETE DENTURES			
31310	Complete Standard, Maxillary Denture	580.00	285.00	865.00
31320	Complete Standard, Mandibular Denture	667.00	$328.00	995.00
31330	Complete Standard, Maxillary & Mandibular Denture	1,247.00	614.00	1,861.00
	COMPLETE DENTURES – IMMEDIATE/SURGICAL			
31311	Complete Maxillary	620.00	305.00	925.00
31321	Complete Mandibular	731.00	360.00	1,091.00
	RELINE, LAB PROCESSED/FUNCTIONAL IMPRESSION			
32110	Maxillary	188.00	93.00	281.00
32120	Mandibular	208.00	103.00	311.00
32130	Maxillary & Mandibular, Combined	397.00	195.00	592.00
	CHAIRSIDE/TEMPORARY ACRYLIC			
32316	Complete Maxillary	137.00	68.00	205.00
32326	Complete Mandibular	149.00	74.00	223.00
32336	Complete Maxillary & Mandibular	287.00	141.00	428.00
	RELINE, CHAIRSIDE/PERMANENT SOFT LINING			
32318	Complete Maxillary	186.00	92.00	278.00
32328	Complete Mandibular	198.00	97.00	295.00
32338	Complete Maxillary & Mandibular	385.00	189.00	574.00
	DENTURE, REBASE, PROCESSED			
33117	Maxillary	226.00	111.00	337.00
33127	Mandibular	246.00	121.00	367.00
	DENTURE REPAIRS			
36110	Complete Maxillary Repair – No Impression	62.00	31.00	93 + materials

Appendix B – DSP Dental Rate Guidelines

Procedure Code	Description	Fee @ 100%	Lab Fee @ 100% (where applicable)	Total
36120	Complete Mandibular Repair – No Impression	62.00	31.00	93 + materials
36210	Complete Maxillary Repair - with Impression	90.00	45.00	135+ materials
36220	Complete Mandibular Repair - with impression	90.00	45.00	135+ materials
	TISSUE CONDITIONING, COMPLETE DENTURE			
37110	Maxillary	71.00		71.00
37120	Mandibular	71.00		71.00
	PARTIAL DENTURES ACRYLIC BASE – WITH CLASPS			
41610	Partial Maxillary	580.00	285.00	865.00
41620	Partial Mandibular	667.00	328.00	995.00
41630	Partial Maxillary & Mandibular	1,247.00	614.00	1,861.00
	PARTIAL DENTURES ACRYLIC BASE - IMMEDIATE WITH CLASPS			
41611	Partial Maxillary	608.00	299.00	907.00
41621	Partial Mandibular	717.00	353.00	1,070.00
	PARTIAL DENTRURES ACRYLIC BASE – IMMEDIATE WITHOUT CLASPS			
41613	Partial Maxillary	548.00	270.00	818.00
41623	Partial Mandibular	657.00	323.00	980.00
	PARTIAL DENTURES ACRYLIC BASE – WITHOUT CLASPS			
41612	Partial Maxillary	509.00	251.00	760.00
41622	Partial Mandibular	594.00	292.00	886.00
41632	Partial Maxillary & Mandibular	1,102.00	543.00	1,645.00
	RELINES, PROCESSED			
42116	Partial Maxillary	197.00	97.00	294.00
42126	Partial Mandibular	210.00	104.00	314.00
	RELINE, CHAIRSIDE/PERMANENT SOFT LINING			
42318	Partial Maxillary	193.00	95.00	288.00
42328	Partial Mandibular	208.00	103.00	311.00
42338	Partial Maxillary & Mandibular	401.00	198.00	599.00
	RELINE, CHAIRSIDE/TEMPORARY ACRYLIC			
42316	Partial Maxillary	143.00	71.00	214.00
42326	Partial Mandibular	161.00	80.00	241.00
42336	Partial Maxillary & Mandibular	305.00	150.00	455.00

Appendix B – DSP Dental Rate Guidelines

Procedure Code	Description	Fee @ 100%	Lab Fee @ 100% (where applicable)	Total
	REBASE, PROCESSED			
43116	Partial Maxillary	238.00	117.00	355.00
43126	Partial Mandibular	257.00	127.00	384.00
	REPAIRS			
46110	Partial Maxillary – No Impression	62.00	31.00	93.00 + materials
46120	Partial Mandibular – No Impression	62.00	31.00	93.00 + materials
46210	Partial Maxillary – with Impression	90.00	45.00	135.00 + materials
46220	Partial Mandibular – with Impression	90.00	45.00	135.00 + materials
	TISSUE CONDITIONING, PARTIAL DENTURE**			
47110	Partial Maxillary	71.00		71.00
47120	Partial Mandibular	71.00		71.00
	ADDITIONAL REPAIR MATERIAL			
71310	Repair Model		17.00	17.00
71311	Opposing Model	43.00	21.00	64.00
71313	Additional Tooth		29.00	29.00
71314	Multiple Fracture		34.00	34.00
71315	Addition - flange		39.00	39.00
	REINFORCEMENTS			
73008	Soft-lining – new denture		273.00	273.00

* Applicants may be eligible for assistance to cover the cost of dentures when recommended by a physician or a dentist. Dentures shall be obtained by the most economical means. If dentures are provided by a denturist, then the denturist must be licensed in the Province of Nova Scotia to do so.

**Tissue conditioning is limited to two services per arch in conjunction with new dentures, relines or rebases. If dentures have been done, tissue reconditioning can only be provided to the standard dentures.

Appendix C – Special Diet Rate Guidelines

Special Diet Rate Guidelines

(Combined maximum allowable amount of $150.00/month)

Conditions Requiring Special Diets	Criteria	Approved Monthly Amounts
Cardiovascular Disease	Low Sodium, Low Salt	$27.00
Celiac Disease	Gluten Free Diets	$30.00
Chronic Constipation / High Fiber Requirements	High Fiber or High Residue	$27.00
Crohn's Disease/ Ulcerative Colitis		$66.00
Chronic Fatigue/ Fibromyalgia	Combination of High Fiber/ Modified Fat	$54.00
Cystic Fibrosis		$133.00 plus cost for supplement or additional amount specified by nutritionist
Diabetes	1000 k calories and under	No additional funds
	1001-1200 k calories	No additional funds
	1201-1500 k calories	$5.00
	1501-1800 k calories	$18.00
	1801-2000 k calories	$26.00
	2001-2200 k calories	$34.00
	2201-2400 k calories	$42.00
	2401-2600 k calories	$51.00
	2601-2800 k calories	$60.00
	2801-3000 k calories	$68.00
	Above 3000 k calories	$8.00 for each additional 200 k calories
Dialysis		$27.00 plus supplement of Nepro or Supplena purchased at VGH up to $150.00 per month
Failure to Thrive	An individual assessment by a dietician is recommended	No amount specified, up to $150.00 per month
Food Allergy – Milk / Diary or Lactose Intolerance	Less than 2 years of age (see "Infant Formula"). Based on required referral letter from a dietician and funding is calculated individually.	Up to $150.00 per month with Supervisor approval
Food Allergy – Wheat	Based on required referral letter from a dietician and funding is calculated individually.	Up to $150.00 per month with Supervisor approval

Appendix C – Special Diet Rate Guidelines

Gastric / Ulcer or Bland Diets	Treatment is based on eliminating foods which cause distress.	No additional funds
High Calorie / High Protein Diets	Prescribed for illnesses such as, but not limited to, cancer or post-surgery where there has been significant weight loss.	$66.00
HIV / AIDS	High Protein / High Calorie Diet 3000 k calories	 $66.00
	3250 k calories	$88.00
	3500 k calories	$101.00
Hyperlipidemia	Low fat	$27.00
Infant Formulas ** **Allowance will be gradually reduced as the child begins eating solid foods**	** Soy Formula (includes Isomil and Prosobee)	$35.00
	** Lactose Free Formula	$28.00
	** Hypo-allergenic formula—Pregestimil (powder)	$144.00
	** Hypo-allergenic formula—Alimentum (ready to feed)	$144.00
	** Hypo-allergenic formula – Nutramigen	$121.00
Nutritional Supplements	Such as, but not limited to, Ensure, Boost, Essential, Advera, Pediasure and Jevity	Actual costs up to $150.00 per month
Paraplegic Diet		$36.50
Reducing Diets	For purposes of weight loss or prescribed following gastroplasty	No additional funds

Appendix D – Household Set-Up and Replacement Rate Guidelines for Living Independently

Household Set Up and Replacement Guidelines

Household Items & Furnishings	
Maximum of $1000.00 + HST (does not include set-up costs below). Care Coordinator approval up to $500.00, Casework Supervisor approval required over $500. The following is a list of suggested items and associated costs and are guidelines only. Participant's needs are to be considered on an individual basis.	
Suggested Furnishings:	
• Bed & Mattress	$200.00
• Couch & Chair	$150.00
• End Tables	$30.00
• Drapes or Blinds	$50.00
• Table & Chairs	$125.00
• Bureau/Storage	$60.00
Suggested Kitchen Items:	
Pots and pans, dishes, broom, kitchen utensils, waste basket, kettle, toaster, dish cloths and towels, etc.	$135.00
Suggested Bath & Bedding Items:	
• Towels & Face Cloths • Shower Curtain • Comforter • Sheets & Blankets & Pillows	$100.00
Appliances:	
• Refrigerator *	$200.00 (*replacement)
• Washer *	$200.00
• Stove *	$150.00
• Microwave	$75.00
• Vacuum Cleaner	$75.00
• Television	$75.00
Initial Set-up Costs	
The following is a list of suggested items and associated costs and are guidelines only. Participant's needs are to be considered on an individual basis.	
Basic Grocery/Household Supplies	Actual costs up to $75.00 approved by Care Coordinator
Suggested Emergency Items: First aid kit, flashlight, radio	Actual costs up to $75.00 approved by Care Coordinator
Utility Connection Charges: Telephone, power	Actual costs approved by Care Coordinator

APPENDIX E – FUNDING SOURCE GUIDELINES

Funding Source Guidelines
(Special Needs vs. Per Diem)

The following can be used as a guide; however, consultation with the Casework Supervisor may be required when a service provider advises that the item or services has not been included in their per diem.

PD = Per Diem **ES** = Easter Seals **SN** = Special Needs **Pharma** = Pharmacare

Item of Special Need/Service	RRC	ARC	GH RCF DR S/O	AFS	ILS	FLEX Living with Family	FLEX Ind
Clothing							
Regular	SN	SN	SN	SN	SN	Basics	SN
Special	SN	SN	SN	SN	SN	SN	SN
Comforts Allowance	SN	SN	SN	SN	SN	SN	SN
Funeral and Burial	SN	SN	SN	SN	SN	SN	SN
Medical							
Dental	SN	SN	SN	SN	SN	SN	SN
Emergency Response Devices	N/A	N/A	N/A	SN	SN	SN	SN
Foot Care / Podiatry	SN	SN	SN	SN	SN	SN	SN
Guide Dog Allowance	N/A	N/A	SN	SN	SN	SN	SN
Hearing Aid Hearing Aid Batteries	SN SN	SN SN	SN SN	SN SN	SN SN	SN SN	SN SN
Incontinent Supplies	PD	PD	SN	SN	SN	SN	SN
Medical Equipment	SN	SN	SN	SN	SN	SN	SN
Medical Insurance	SN	SN	SN	SN	SN	SN	SN
Medical Supplies	PD	PD	SN	SN	SN	SN	SN
Optical Care	SN	SN	SN	SN	SN	SN	SN
Orthotics	SN	SN	SN	SN	SN	SN	SN
Non-Prescription Meds	PD	SN	SN	SN	SN	SN	SN
Prescription Meds	PD	PD	Pharma	Pharma	Pharma	Pharma	Pharma
Special Diets	PD	PD	SN/PD	SN	SN	SN	SN
Wheelchair Repairs	ES	ES	ES	ES	ES	ES	ES
Medical Care (Rehabilitation and Treatment Services)	PD	PD	SN	SN	SN	SN	SN

APPENDIX E – FUNDING SOURCE GUIDELINES

Item of Special Need/Service	RRC	ARC	GH RCF DR S/O	AFS	ILS	Flex Living with Family	FLEX Ind
Support Services							
Extra Staffing	SN	SN	SN	SN	SN	SN	SN
Homemaker Services	N/A	N/A	N/A	SN	SN	SN	SN
Nursing Care	PD	PD	SN	SN	SN	SN	SN
Personal Care	PD	PD	SN	SN	SN	SN	SN
Residential Respite	N/A	N/A	N/A	SN	N/A	SN	N/A
Shelter / Utility / Food							
Electricity Hook-Up	N/A	N/A	N/A	N/A	SN	N/A	SN
Emergency Food	N/A	N/A	N/A	N/A	SN	N/A	SN
Excess Shelter	N/A	N/A	N/A	N/A	SN	N/A	SN
Extermination Services	N/A	N/A	N/A	N/A	SN	N/A	SN
Fire/ Liability Insurance	N/A	N/A	N/A	N/A	SN	N/A	SN
Food/ Shelter Expenses to Attend Non-Routine Specialist Appointments Outside the Community	SN	SN	SN	SN	SN	SN	SN
Furnishings	N/A	N/A	N/A	PD	SN	N/A	SN
House Repairs	N/A	N/A	N/A	N/A	SN	N/A	SN
Moving Expenses Within Region	SN	SN	SN	SN	SN	N/A	SN
Security / Damage Deposit	N/A	N/A	N/A	N/A	SN	N/A	SN
Shelter-Related Arrears	N/A	N/A	N/A	N/A	SN	N/A	SN
Telephone	N/A	N/A	N/A	N/A	SN	N/A	SN
Telephone Hook Up	N/A	N/A	N/A	N/A	SN	N/A	SN
Transportation							
Ambulance	SN	SN	SN	SN	SN	SN	SN
Regular Transportation	SN	SN	SN	SN	SN	SN	SN
Transportation for Medical Attention (not an Ambulance)	SN	SN	SN	SN	SN	SN	SN
Education / Employment /Day Programs							
Education / Employment / P50	SN	SN	SN	SN	SN	SN	SN
Transitional Day Programs	N/A	N/A	N/A	N/A	N/A	SN	SN