information you'll receive from the agency to track your request. In case there is an issue submitting your request to the agency you selected, you can use this number to help.

Contact information

Name
David MEDEIROS

Mailing address
215 Mountain St
Willimantic, CT 06226
United States

Phone number
8604633638

Company/organization
ABI Resources LLC

Email
aabiwr@live.com

Your request

Subject: Freedom of Information Act Request – CMS Medicaid ABI Waiver Program and Connecticut Community Care Referrals Subject: Freedom of Information Act Request Pertaining to Connecticut Mediciad ABI Waiver Program. Dear Freedom of Information Officer, I am writing to submit a Freedom of Information Act (FOIA) request pursuant to the Connecticut Freedom of Information Act, C.G.S. § 1-200 et seq. I am seeking information related to the Acquired Brain Injury (ABI) Waiver Program, specifically concerning Connecticut Community Care's referral practices and any potential financial incentives provided to consumers for participating in services offered by the Supported Living Group. Please provide the following information: All records, communications, and documents pertaining to Connecticut Community Care's referral practices under the Medicaid ABI Waiver Program from January 1, 2019, to the present date. Any contracts, agreements, or MOUs between Connecticut Community Care and the Supported Living Group related to the ABI Waiver Program, including details on financial arrangements and incentives. Documentation of any payments, incentives, or benefits provided to consumers by the Supported Living Group as a result of their participation in services under the ABI Waiver Program. Policies, guidelines, or internal memos detailing the criteria and process for Connecticut Community Care's referrals to the Supported Living Group under the ABI Waiver Program. Records of any complaints, investigations, or audits concerning Connecticut Community Care's referral practices or the Supported Living Group's incentive programs related to the ABI Waiver Program. Correspondence between the State of Connecticut and Connecticut Community Care or the Supported Living Group regarding the ABI Waiver Program, referrals, and consumer incentives. Any evaluations, reports, or studies conducted by or on behalf of the State of Connecticut concerning the effectiveness, integrity, and compliance of the ABI Waiver Program, particularly in relation to referrals and consumer incentives. If my request is denied in whole or in part, I ask that you justify all deletions by reference to specific exemptions of the Act. I kindly request accommodations due to my disability. To facilitate my accessibility and participation, I would greatly appreciate the use of electronic records.

Your support in this matter is highly valued. Thank you for your understanding and assistance. Sincerely, David Medeiros ABI Resources

Fees

Fee waiver
no

Request expedited processing

Expedited processing
no

FOIA.gov

CONTACT

Office of Information Policy (OIP)
U.S. Department of Justice
441 G St, NW, 6th Floor
Washington, DC 20530
E-mail: National.FOIAPortal@usdoj.gov

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office for Civil Rights

New England Region ● Government Center
JFK Federal Building, Room 1875 ● Boston, MA 02203
Voice - (800) 368-1019 ● TDD - (800) 537-7697
Fax - (617) 565-3809 ● http://www.hhs.gov/ocr

10/05/2023

VIA ELECTRONIC MAIL

David Medeiros

Email: davidmedeiros@live.com

OCR Transaction Number: 01-23-547732

Dear Mr. Medeiros:

Thank you for your correspondence to the U.S. Department of Health and Human Services ("HHS"), Office for Civil Rights ("OCR").

OCR enforces federal civil rights laws which prohibit discrimination in the delivery of health and human services based on race, color, national origin, disability, age, sex, religion, and the exercise of conscience, and also enforces the Health Insurance Portability and Accountability Act ("HIPAA") Privacy, Security and Breach Notification Rules.

Based upon our review of your complaint, we have determined that the concerns you raise are more appropriately addressed by the U.S. Department of Justice ("DOJ"). For additional information and to file a complaint with DOJ, please see the following link.

Submitting a Complaint (justice.gov)

OCR's determination as stated in this letter applies only to the allegations in this complaint that OCR reviewed. If you have any questions regarding this matter, please contact William Lawton, Investigator, at 617-565-1354, or by email at William.Lawton@hhs.gov.

Sincerely,

Susan M. Pezzullo Rhodes
Regional Manager

ABI Waiver Program

ABI Program Services – Cognitive Behavioral Services Description:

Individual interventions designed to increase an individual's cognitive and behavioral capabilities and to further the individual's adjustment to successful community engagement including:

- Comprehensive assessment of cognitive strengths and liabilities, quality of adjustment and behavioral functioning
- Development and implementation of cognitive and behavioral strategies
- Development of a structured cognitive/behavioral intervention plan
- Ongoing or periodic consultation with the waiver participant, support system and providers concerning cognitive and behavioral strategies and interventions specified in the cognitive/ behavioral intervention plan
- Ongoing or periodic assistance with training of the waiver participant, support system and providers concerning cognitive behavior strategies and interventions
- Periodic reassessment and revision as needed, of the cognitive/behavioral intervention plan.

This service is performed within the context of the individual's person-centered team, in concert with the case manager. Cognitive/behavioral programs may be provided in the individual's home or in the community in order to reinforce the training in a real-life situation.

The service will be delivered utilizing two procedure codes, one for in person face to face visits that include the participant, providers and/or supporters. A quarterly, in person meeting with the waiver participant is required for this service.

The second procedure code is for non-face-to-face service that includes development of the cognitive behavioral plan and phone or other types of interactions with participants, providers or supporters.

Provider Qualifications: Agency: CARF certification in Brain Injury, or JCAHO, or Accreditation for Behavioral Health Care; Employ individual who meet qualifications below.

Individual: Professional licensed as any of the following with at least three years of experience in cognitive/behavioral programming for people with a brain injury, delivered in community settings:

- Behavior Analysts
- Psychologists
- Neuropsychologists
- Occupational therapists
- Educational Psychologists
- Speech therapists
- Physical therapists

Training requirement (if not proven as part of educational record):

Attend the **ABI Basic Information Session** and pass the associated quiz with a grade of 80 or higher.

- Provider will have completed an approved training program(s) concerning acquired brain injury and person-centered planning, given by a state agency, the fiduciary, community providers, Brain Injury Alliance of CT, or an Independent Living Center prior to providing services to a ABI Waiver Program participant.

Federal Agency Comment Form

Small Business Administration – Office of the National Ombudsman

OMB Control #3245-0313

Exp. Date 09/30/2022

Case #: 2309280095

PURPOSE: Small business owners may use this form to submit comments on Federal enforcement/compliance actions that they consider excessive or unfair. The National Ombudsman will use the information when it contacts the applicable Federal agency for a review of the action. Completion of this form is voluntary; however, failure to submit the requested information could impact whether SBA's Office of the National Ombudsman is able to provide you with assistance

Instructions

1. Complete, sign and date this form. (Signature not required if completed at Office-National-Ombudsman)
2. Provide a brief written statement on the reverse side or a separate sheet of paper regarding the specific enforcement or compliance action taken against your organization by the federal agency
3. Submit copies of substantiating documentation such as correspondence citation or notice (Note: canbe submitted separately from this form by fax or mail. Make sure to reference your name orcompany's name with this information).
4. If your comments concern the IRS, you must also submit a completed IRS Tax Information Authorization Form 8821, available at IRS.gov/forms (Can be sent by fax or mail.)
5. Fax, e-mail or send this form and requested information to: (1) Fax: (202) 481-5719; (2) Email:Ombudsman@sba.gov; (3) Address: SBA, Office of National Ombudsman,409 Third Street,SW,Washington, DC 20024.Telephone:(202) 205-2417.

Please Print

Organization/Company Name: ABI RESOURCES LLC

Address: 39 Kings Highway STE C

City: Gales Ferry State: CT Zip : 06335-

Phone: 860-942-0365 FAX: E-Mail: aabiwr@live.com

Contact Name: Mr. DAVID MEDEIROS Title: Founder Owner

Please indicate your organization type: Small Business

List the federal agency with which you are having a problem

Federal Agency Name: Connecticut Department of Social Services and COU Community Options Unit

Agency Contact Person:

Agency Office/Division:

Did the federal agency listed above inform you of your right to contact the SBA Office of the National ombudsman? No

If not how did you learn about this Office 0

Confidentiality/Disclosure

The National Ombudsman is required to keep confidential the identity of any person or small business providing a comment about an agency's compliance or enforcement action unless that person or small business provides consent, or disclosure is determined to be unavoidable. Confidentiality is governed by the Small Business Regulatory Enforcement Fairness Act 15 U.S.C. 657(b)(2(B) and the Inspector General's Act, 5 U.S.C. App., § 7(b). You may make a selection below to authorize SBA to share your identity with the federal agency with which you are having a problem so that agency can investigate your specific problem and offer a response tailored to your situation. By requesting confidentiality, the federal agency may not have sufficient information to investigate your specific problem, possibly delaying or preventing any potential resolution of your situation

☑ I request that my identity be shared only with the federal agency(ies) with which I am having a problem.

☐ I request that my identity be kept confidential. (Results may be limited.)

Signature: David Medeiros Date: 9/28/2023

Your signature authorizes the SBA Ombudsman to proceed on your behalf.

Pursue all legal options you believe are in your company's best interest.
This process is not a substitute for legal action.

SBA FORM 1993 (9-19) Previous Editions Obsolete

PLEASE NOTE: The estimated burden for completing this form is 45 minutes. You are not required to respond to this information collection if a valid OMB approval number is not displayed. If you have any questions or comments concerning this estimate or other aspects of this information collection, please contact the U. S. Small Business Administration, Director, Records Management Division, 409 Third Street, SW, Washington, D.C ., 20416 and/or Office of Management and Budget, SBA Desk Officer, New Executive Office Building, Rm. 10202, Washington, D.C. 20503. PLEASE DO NOT SEND FORMS TO OMB, as this will delay action on your request for assistance.

Type or (print) your comments below:

Subject: Formal Complaint: Unfair Regulatory Enforcement and Discrimination Against ABI Resources LLC by Connecticut Department of Social Services & COU Community Options Unit

To the Office of the National Ombudsman,

Small Business Administration

Dear Ombudsman,

I am David Medeiros, owner of ABI Resources LLC, and I am submitting this complaint to bring to your attention the serious and ongoing discriminatory practices and unfair regulatory enforcement exerted by the Connecticut Department of Social Services and COU Community Options Unit on my business.

Discriminatory Practices & Business Obstruction:

My company has experienced systemic neglect, biased communication, and targeted discrimination leading to professional hindrance and obstruction of growth opportunities.

Unfair Referral Allocation & Alleged Kickback System:

There's an evident bias in referral allocation, potentially part of an alleged kickback system favoring one agency, leading to undue competition and resource strain on my business.

Targeted Suppression of Small Businesses:

The aforementioned entities seem to employ resources to suppress and eliminate smaller businesses, manipulating competitive dynamics and violating principles of fair business practices.

Inadequate Grievance Addressal:

My reports of such misconduct are met with inadequate investigation and resolution, signaling systemic neglect of genuine concerns and grievances.

I request immediate intervention and an in-depth investigation into these allegations to ensure fair regulatory practices and eliminate any anti-competitive and discriminatory conduct adversely impacting my business. Such actions, if proven true, violate the principles of business fairness and equity, necessitating prompt redressal to uphold justice and competitive integrity.

Thank you for your attention to this urgent matter. I am willing to provide any additional information, documents, or clarification needed to aid your investigation and eagerly await your response and resolution to reinstate fair business practices and justice.

Sincerely,

David Medeiros

Owner, ABI Resources LLC

FMS-Applications Department
P.O. Box 479, East Windsor, CT 06088-0479
Phone: (860) 627-9500 Fax: (860) 627-0230
Toll-Free: 877-722-8833
www.acrfi.org

Connecticut DSS Waiver Programs - DIRECTORY APPLICATION

The **Personal Care Assistance (PCA) Waiver Program** and the **CT Home Care Program for Elders (CHCPE)** provide personal care assistance to eligible individuals. The **Acquired Brain Injury (ABI) Waiver Program** provides 19 home and community-based services to eligible individuals with an acquired brain injury. In order to be included in the ABI Directory, providers must meet the Department of Social Services requirements for qualification. This application is for the consumer and the fiscal intermediary records and provides information for the **Provider Directory** for these programs. This application must be completed in full and will be available for review by any program participant.

APPLICANT INFORMATION: (Please print clearly)

1. **PROVIDER NAME**: _____
   FIRST MIDDLE LAST

   _____
   (PLEASE LIST MAIDEN OR FORMER NAMES)

2. **ADDRESS**: _____
   NO. STREET

   _____
   CITY STATE ZIP CODE

3. **MAILING ADDRESS**: _____
   (IF DIFFERENT)

4. **Former address, if less than 5 years at above**: _____

5. **TELEPHONE**: ____-____-____ 5. **FAX NUMBER**: ____-____-____

6. **CELL PHONE**: ____-____-____ 7. **E-MAIL ADDRESS**: _____

7. **SOCIAL SECURITY NUMBER**: ____-____-____ 8. **DATE OF BIRTH*:** ____/____/____
   *Required for Criminal Background Check

Please indicate your choice(s) below by checking the applicable boxes.

☐ **Yes, I wish to be included on the P.C.A. Provider Directory**

☐ **Yes, I wish to be included on the A.B.I. Provider Directory* -** *Some ABI Services require successful completion of the* ***Please complete supplement.*** *Allied Community Resources sponsored ABI Informational Session.*

☐ No, I do not wish to be included in any Provider Directory at this time.

☐ **I am under 18 years of age. Providers under 18 years of age cannot work for individuals on the CT Home Care Program for Elders or ABI.**

SERVICE AREA: PLEASE LIST ALL TOWNS IN WHICH YOU WOULD CONSIDER WORKING
- see Enclosure - CT Towns by Region

☐ **MY TOWN AND ALL SURROUNDING TOWNS**

OR SPECIFY TOWNS: _____

AVAILABILITY (to be listed on the Directory):

DAYS YOU ARE AVAILABLE TO WORK: _____

HOURS YOU ARE AVAILABLE TO WORK: _____

ARE YOU WILLING TO PROVIDE BACK UP ASSISTANCE WHEN CALLED (CHECK ONE): ☐**YES** ☐**NO**

LANGUAGES SPOKEN (CHECK THOSE THAT APPLY):

☐**ENGLISH** ☐**SPANISH** ☐**OTHER (LIST):** _____

PROVIDER QUALIFICATIONS/EXPERIENCE/EDUCATION:

PLEASE LIST ANY SPECIAL TRAINING, SKILLS, OR CERTIFICATIONS YOU HOLD THAT WOULD PERTAIN TO THE POSITION YOU ARE APPLYING FOR BELOW:

_____

_____

_____

_____

PERSONAL OR EMPLOYMENT REFERENCES:

1) Name, address, phone: _____

2) Name, address, phone: _____

3) Name, address, phone: _____

Have you ever been convicted of a felony involving forgery, robbery, larceny, fraud, cruelty to persons, sexual assault, assault, assault of an elderly, blind, developmentally disabled, pregnant or for abuse of the elderly, blind, physically or developmentally disabled person in the United States and/or its territories? ☐ **Yes** ☐ **No**

If you have been convicted of any of the above felonies, you may be restricted from being listed on the Provider Directory. *(Failure to disclose any criminal convictions that appear on the Criminal History Background check may prohibit you from being listed on the active Provider Directory or from employment under the DSS Waiver Programs.)*

Any provider whose name appears on the list of exclusions of the Office of Inspector General is prohibited from receiving paid services under the DSS Waiver Programs.

By signing and dating below, I understand that a Criminal History Background check will be performed as part of the application process, before my name may be added to the DSS Provider Directory and before I am allowed to be hired by a DSS Waiver Program participant. I attest that all of the information outlined on my application is a true and accurate depiction of my personal information and qualifications. I also authorize full release of information from my listed employers or references.

Provider Name: *(please print)* _____

Provider Signature: _____ Date Signed: _____

Source code:_____

Form Approved: OMB No. 0945-0002
Expiration Date: 11/30/2022

COMPLAINANT CONSENT FORM

The Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) has the authority to collect and receive material and information about you, including personnel and medical records, when they are relevant to its investigation of your complaint.

To investigate your complaint, OCR may need to reveal your identity or identifying information about you to persons at the entity or agency under investigation or to other persons, agencies, or entities. In some circumstances, OCR may refer your complaint to another government agency, as warranted.

The Privacy Act of 1974 protects certain federal records that contain personally identifiable information about you and, with your consent, allows OCR to use your name or other personal information, if necessary, to investigate your complaint.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

Additionally, OCR may disclose information, including medical records and other personal information, which it has gathered during the course of its investigation in order to comply with a request under the Freedom of Information Act (FOIA) and may refer your complaint to another appropriate agency.

Under FOIA, OCR may be required to release information regarding the investigation of your complaint; however, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

OCR will use any applicable protections in that law to safeguard information which could identify you, or other individuals, or that, if released, could constitute a clearly unwarranted invasion of personal privacy. OCR may be required to release some information regarding the investigation of your complaint under the Freedom of Information Act (FOIA), however, information concerning your complaint which could reveal your identity is protected from disclosure to third party requesters under FOIA.

Please read and review the documents entitled *Notice to Complainants and Other Individuals Asked to Supply Information to the Office for Civil Rights* and *Protecting Personal Information in Complaint Investigations* for further information regarding how OCR may obtain, use, and disclose your information while investigating your complaint.

In order to expedite the investigation of your complaint if it is accepted by OCR, please read, sign, and return one copy of this consent form to OCR with your complaint. Please make one copy for your records.

- As a complainant, I understand that in the course of the investigation of my complaint it may become necessary for OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.

- I am also aware of the obligations of OCR to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for OCR to disclose general information which it has gathered as part of its investigation of my complaint, excluding personally identifiable information.

- In addition, I understand that, as a complainant, I may be covered by the Department of Health and Human Services' (HHS) regulations which protect any individual from being intimidated, threatened, coerced, retaliated against, or discriminated against because he/she has made a complaint, testified, assisted, or participated in any manner in any mediation, investigation, hearing, proceeding, or other part of HHS's investigation, conciliation, or enforcement process.

After reading the above information, please check ONLY ONE of the following boxes:

☐ **CONSENT**: I have read, understand, and agree to the above and give permission to OCR to reveal my identity or identifying information about me in my case file to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of HHS' investigation, conciliation, or enforcement process.

☐ **CONSENT DENIED**: I have read and I understand the above and do not give permission to OCR to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my complaint and may result in closure of the investigation.

Signature:_____ Date: _____

**Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.*

Name (Please print): _____

Address: _____

Telephone Number: _____

Form Approved: OMB No. 0945-0002
Expiration Date: 11/30/2022

NOTICE TO COMPLAINANTS AND OTHER INDIVIDUALS ASKED TO SUPPLY INFORMATION TO THE OFFICE FOR CIVIL RIGHTS

Privacy Act

The Privacy Act of 1974 (5 U.S.C. §552a) requires OCR to notify individuals whom it asks to supply information that:

— OCR is authorized to solicit information under:
(i) Federal laws barring discrimination by recipients of Federal financial assistance on grounds of race, color, national origin, disability, age, sex, religion under programs and activities receiving Federal financial assistance from the U.S. Department of Health and Human Services (HHS), including, but not limited to, Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d *et seq.*), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794), the Age Discrimination Act of 1975 (42 U.S.C. §6101 *et seq.*), Title IX of the Education Amendments of 1972 (20 U.S.C. §1681 *et seq.*), Sections 794 and 855 of the Public Health Service Act (42 U.S.C. §§295m and 296g); and Section 1557 of the Affordable Care Act (42 U.S.C. §18116);
(ii) Federal laws protecting rights of conscience and religious freedom in health and human services programs, such as Sections 1303(b)(4) and 1553 of the Affordable Care Act (42 U.S.C. §§18113, 18023(b)(4)), the Church Amendments (42 U.S.C. § 300a-7), the Coats-Snowe Amendment (42 U.S.C §238n), the Religious Freedom Restoration Act (42 U.S.C. § 2000bb *et seq.*), and the Weldon Amendment (*e.g.*, Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2019, Pub. L. No. 115-245, Div. B., §507(d)), and applicable regulations;
(iii) Titles VI and XVI of the Public Health Service Act (42 U.S.C. §§291 *et seq.* and 300s *et seq.*) and 42 C.F.R. Part 124, Subpart G (Community Service obligations of Hill-Burton facilities);
(iv) 45 C.F.R. Part 85, as it implements Section 504 of the Rehabilitation Act in programs conducted by HHS; and
(v) Title II of the Americans with Disabilities Act (42 U.S.C. §12131 *et seq.*) and Department of Justice regulations at 28 C.F.R. Part 35, which give HHS "designated agency" authority to investigate and resolve disability discrimination complaints against certain public entities, defined as health and service agencies of state and local governments, regardless of whether they receive federal financial assistance.

HIPAA Standards for the Privacy of Individually Identifiable Health Information (The Privacy Rule), 45 C.F.R. Part 160 and Subparts A and E of Part 164, Health Insurance Reform: Security Standards (The Security Rule), 45 C.F.R. Part 160 and Subparts A and C of Part 164, Breach Notification for Unsecured Protected Health Information (The Breach Rule), 45 C.F.R. Part 160 and Subparts A and D of Part 164, and Administrative Simplification: Enforcement, 45 C.F.R. Part 160, Subparts C, D, and E, which contains provisions relating to compliance and investigations, the imposition of civil money penalties, and procedures for hearings related to violations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (42 U.S.C. §1320d-2).

OCR will request information for the purpose of determining and securing compliance with the Federal laws listed above. Disclosure of this requested information to OCR by individuals who are not recipients of federal financial assistance is voluntary; however, even individuals who voluntarily disclose information are subject to prosecution and penalties under 18 U.S.C. § 1001 for making false statements.

Additionally, although disclosure is voluntary for individuals who are not recipients of federal financial assistance, failure to provide OCR with requested information may preclude OCR from making a compliance determination or enforcing the laws above.

OCR has the authority to disclose personal information collected during an investigation without the individual's consent for the following routine uses:

(i) to make disclosures to OCR contractors who are required to maintain Privacy Act safeguards with respect to such records;
(ii) for disclosure to a congressional office from the record of an individual in response to an inquiry made at the request of the individual;
(iii) to make disclosures to the Department of Justice to permit effective defense of litigation; and
(iv) to make disclosures to the appropriate agency in the event that records maintained by OCR to carry out its functions indicate a violation or potential violation of law.

Under 5 U.S.C. §552a(k)(2) and the HHS Privacy Act regulations at 45 C.F.R. §5b.11 OCR complaint records have been exempted as investigatory material compiled for law enforcement purposes from certain Privacy Act access, amendment, correction and notification requirements.

Freedom of Information Act

A complainant, the recipient or any member of the public may request release of OCR records under the Freedom of Information Act (5 U.S.C. §552) (FOIA) and HHS regulations at 45 C.F.R. Part 5. Generally, most records will be available only to the complainant if they are not privileged. Most or all records from a complaint file will be withheld to protect privacy.

Fraud and False Statements

Federal law, at 18 U.S.C. §1001, authorizes prosecution and penalties of fine or imprisonment for conviction of "whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry."

Form Approved: OMB No. 0945-0002
Expiration Date: 11/30/2022

PROTECTING PERSONAL INFORMATION IN COMPLAINT INVESTIGATIONS

To investigate your complaint, the Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) will collect information from different sources. Depending on the type of complaint, we may need to get copies of your medical records, or other information that is personal to you. This Fact Sheet explains how OCR protects your personal information that is part of your case file.

HOW DOES OCR PROTECT MY PERSONAL INFORMATION?

OCR is required by law to protect your personal information. The Privacy Act of 1974 protects Federal records about an individual containing personally identifiable information, including, but not limited to, the individual's medical history, education, financial transactions, and criminal or employment history that contains an individual's name or other identifying information.

Under the Privacy Act, OCR will disclose your name or other personal information with a signed consent from you, and only when it is necessary to complete the investigation of your complaint or to enforce civil rights laws or when it is otherwise permitted by law.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

CAN I SEE MY OCR FILE?

Under the Freedom of Information Act (FOIA), you can request a copy of your case file once your case has been closed; however, OCR can withhold information from you in order to protect the identities of witnesses and other sources of information. Additionally, some records may be withheld to protect OCR's deliberative process privilege or any other legally protected privilege.

CAN OCR GIVE MY FILE TO ANY ONE ELSE?

If a complaint indicates a violation or a potential violation of law, OCR can refer the complaint to another appropriate agency without your permission.

If you file a complaint with OCR, and we decide we cannot help you, we may refer your complaint to another agency, such as the Department of Justice.

CAN ANYONE ELSE SEE THE INFORMATION IN MY FILE?

Public access to OCR's files and records is controlled by the Freedom of Information Act (FOIA). Under FOIA, OCR may be required to release general information about this case upon public request. In the event that OCR receives such a request, we will apply every legal protection to information that identifies individuals.

If OCR receives protected health information about you in connection with a HIPAA investigation or compliance review, we will only share this information with individuals outside of HHS if necessary for our compliance efforts or if we are required to do so by another law.

DOES IT COST ANYTHING FOR ME (OR SOMEONE ELSE) TO OBTAIN A COPY OF MY FILE?

In most cases, the first two hours spent searching for document(s) you request under the Freedom of Information Act and the first 100 pages are free. Additional search time or copying time may result in a cost for which you will be responsible. If you wish to limit the search time and number of pages to a maximum of two hours and 100 pages; please specify this in your request. You may also set a specific cost limit, for example, cost not to exceed $100.00. For details, see HHS's FOIA page.

If you have any questions about this complaint and consent package, please contact OCR at www.hhs.gov/ocr/office/about/contactus/index.html.

OR

Contact the Customer Response Center at (800) 368-1019 (see contact information on page 2 of the Complaint Form).

ABI II Waiver Program

ABI II Program Service – Consultation Services Description:

Services provided to assist a team and individuals to address service-implementation issues that have presented a barrier to resolution. This service aids in the development of individual interventions designed to decrease an individual's severe maladaptive behaviors, which jeopardize the individual's ability to remain integrated in the community. Services may be provided in a team meeting at the individual's home or community location.

This service is only available to individuals on ABI II Wavier. This service may not be provided by the individual's conservator, power of attorney, or a family member of such conservator or power of attorney, or an agency provider owned by the individual's conservator or power of attorney.

Agency/Self-employed Individual Requirements:

Employ Professionals Licensed by the CT Department of Public Health who meet all applicable training, state licensure or certification requirements:

- Licensed Psychologist
- Clinical Social Worker
- Speech Pathologist
- Speech Therapist
- Occupational Therapist
- Physical Therapist
- Registered Nurse
- Dietician/Nutritionist
- Qualified Neuropsychologist
- Certified Rehabilitation Counselor
- Certified Substance Abuse Specialist

A.B.I. Resources LLC
39 Kings Highway, Suite C
Gales Ferry CT, 06335
Phone: (860) 942-0365
Fax: (860) 465-9591
https://www.CTbrainINJURY.com

A.B.I. RESOURCES

CT DSS FOIA request 11/07/2022.

Medicaid Programs.

To the Connecticut Department of Social Services, DSS Legal, and FOIA request departments. In reference to Medicaid funding of ABI Waiver programs I and II, and MFP, Money Follows the Person program.

Medicaid FOIA request: Current Medicaid funding service information pertaining to November 7, 2022.

1. What is the total number of Medicaid ABI Waiver programs I and II, and MFP Money follows the Person program consumers mutually served by The Supported Living Group Inc and Connecticut Community Care Inc?

2. What is the total number of Medicaid ABI Waiver programs I and II, and MFP Money follows the Person program consumers mutually served by The Supported Living Group Inc and SWCAA Southwestern Connecticut Area on Ageing?

3. What is the total number of Medicaid ABI Waiver programs I and II, and MFP Money follows the Person program consumers mutually served by The Supported Living Group Inc and WCAAA Western Connecticut Area on Aging?

4. What is the total number of Medicaid ABI Waiver programs I and II, and MFP Money follows the Person program consumers mutually served by The Supported Living Group Inc and Area on Aging South Central Connecticut?

Best regards,
David Medeiros
David Medeiros CBIS
Brain Injury Survivor and
Founder of
ABI Resources, LLC

A.B.I. RESOURCES HEALTHCARE PROFESSIONAL
7613

ABI RESOURCES LLC
39 KINGS HIGHWAY SUITE C
GALES FERRY, CT. 06335
860 942-0365
WWW.CTBRAININJURY.COM

United States Department of Justice
Civil Rights Division
civilrights.justice.gov

Thank you for submitting a report to the Civil Rights Division.

Report successfully submitted

Please save your record number for tracking.

Your record number is: **327016-TNM**

What to expect

1 We review your report

Our specialists in the Civil Rights Division carefully read every report to identify civil rights violations, spot trends, and determine if we have authority to help with your report.

2 Our specialists determine the next step

We may decide to:
Open an investigation or take some other action within the legal authority of the Justice Department.
Collect more information before we can look into your report.
Recommend another government agency that can properly look into your report. If so, we'll let you know.

In some cases, we may determine that we don't have legal authority to handle your report and will recommend that you seek help from a private lawyer or local legal aid organization.

3 When possible, we will follow up with you

We do our best to let you know about the outcome of our review. However, we may not always be able to provide you with updates because:
We're actively working on an investigation or case related to your report.
We're receiving and actively reviewing many requests at the same time.

If we are able to respond, we will contact you using the contact information you provided in this report. Depending on the type of report, response times can vary. If you need to reach us about your report, please refer to your report number when contacting us. This is how we keep track of your submission.

What you can do next

1 Contact local legal aid organizations or a lawyer if you haven't already

Legal aid offices or members of lawyer associations in your state may be able to help you with your issue.
American Bar Association, visit www.americanbar.org/groups/legal_services/flh-home or call (800) 285-2221
Legal Services Corporation (or Legal Aid Offices), to help you find a legal aid lawyer in your area visit www.lsc.gov/find-legal-aid

2 Get help immediately if you are in danger

If you reported an incident where you or someone else has experienced or is still experiencing physical harm or violence, or are in immediate danger, please call 911 and contact the police.

Your submission

Contact

Contact information

Your name

David Medeiros

Email address

aabiwr@live.com

Phone number

8604633638

Address

215 Mountain St
-
Willimantic, Connecticut 06226

Are you now or have ever been an active duty service member?

No

Primary concern

What is your primary reason for contacting the Civil Rights Division?

Discriminated against in a commercial location or public place

Location

Please choose the type of location that best describes where the incident happened

Public space

Where did this happen?

Organization name
Connecicut: State of.

Address
165 Capitol Avenue Suite 1000
-
Hartford, Connecticut

Personal characteristics

Do you believe any of these personal characteristics influenced why you were treated this way?

Disability (including temporary or recovered and including HIV and drug addiction)

Date

When did this happen?

8/3/2023

Personal description

In your own words, describe what happened

U.S. Department of Justice
950 Pennsylvania Avenue, NW
Washington, D.C. 20530-0001
Subject: Formal Complaint Regarding Restricted Choice of Cognitive Behavioral Therapists (CBTs) within ABI Waiver and MFP Programs in Connecticut
Dear Sir/Madam,
I am writing to bring to your attention a matter of grave concern involving potential violations of the rights of disabled individuals within Connecticut's Acquired Brain Injury (ABI) Waiver and Money Follows the Person (MFP) programs.
It has been observed that participants in these programs are being directed towards preselected Cognitive Behavioral Therapists (CBTs) and prescribed therapy sessions without being provided with the full list of available therapists or being informed of their right to select other providers. This alarming practice not only undermines the principles of choice and autonomy but may also be in direct contravention of federal laws, including the Americans with Disabilities Act (ADA).
The specific issues I wish to highlight are:

Lack of Transparency and Choice: Individuals must be provided with a complete list of qualified CBTs, and the freedom to choose the therapist that best aligns with their needs and preferences. The current practice denies them this essential right to make informed decisions about their care.
Violation of Informed Consent: Coercing participants into preselected therapy options without clear disclosure of all available options compromises the integrity of informed consent, a cornerstone of medical ethics and legal compliance.
Potential Impact on Quality of Care: This restricted choice may result in a mismatch between the therapy provided and the unique needs of the individual, affecting overall effectiveness and quality of care.
Given the Department of Justice's critical role in upholding federal laws and protecting the rights of American citizens, I request your immediate intervention to investigate this matter within the ABI Waiver and MFP programs in Connecticut.
I urge you to take appropriate measures to ensure transparency, choice, and the right to informed consent for participants in these programs. The implementation of clear guidelines, education, and enforcement must be prioritized to rectify this troubling situation.
I look forward to your prompt response and trust that you will act with the urgency and dedication that this serious matter demands. The rights, dignity, and well-being of individuals within the ABI Waiver and MFP programs must be preserved, and I believe that the Department of Justice is uniquely positioned to ensure that these principles are upheld.
Thank you for your immediate attention to this matter.
Sincerely,
David Medeiros
ABI Resources

United States Department of Justice
Civil Rights Division
civilrights.justice.gov

Thank you for submitting a report to the Civil Rights Division.

Report successfully submitted

Your record number is: **275528-PKR**

What to expect

1 We review your report

Our specialists in the Civil Rights Division carefully read every report to identify civil rights violations, spot trends, and determine if we have authority to help with your report.

2 Our specialists determine the next step

We may decide to:
Open an investigation or take some other action within the legal authority of the Justice Department.
Collect more information before we can look into your report.
Recommend another government agency that can properly look into your report. If so, we'll let you know.

In some cases, we may determine that we don't have legal authority to handle your report and will recommend that you seek help from a private lawyer or local legal aid organization.

3 When possible, we will follow up with you

We do our best to let you know about the outcome of our review. However, we may not always be able to provide you with updates because:
We're actively working on an investigation or case related to your report.
We're receiving and actively reviewing many requests at the same time.

If we are able to respond, we will contact you using the contact information you provided in this report. Depending on the type of report, response times can vary. If you need to reach us about your report, please refer to your report number when contacting us. This is how we keep track of your submission.

What you can do next

1 Contact local legal aid organizations or a lawyer if you haven't already

Legal aid offices or members of lawyer associations in your state may be able to help you with your issue.
American Bar Association, visit www.americanbar.org/groups/legal_services/flh-home or call (800) 285-2221
Legal Services Corporation (or Legal Aid Offices), to help you find a legal aid lawyer in your area visit www.lsc.gov/find-legal-aid or call (202) 295-1500

2 Get help immediately if you are in danger

If you reported an incident where you or someone else has experienced or is still experiencing physical harm or violence, or are in immediate danger, please call 911 and contact the police.

Your submission

Contact

Contact information

Your name

David Medeiros

Email address

AABIWR@LIVE.COM

Phone number

8604633638

Address

39 Kings Highway STE C
-
Gales Ferry, Connecticut 06335

Are you now or have ever been an active duty service member?

No

Primary concern

What is your primary reason for contacting the Civil Rights Division?

Something else happened

Location

Where did this happen?

Organization name

Connecticut Community Care Inc.

Address

43 Enterprise Drive
-
Bristol, Connecticut

Personal characteristics

Do you believe any of these personal characteristics influenced why you were treated this way?

Disability (including temporary or recovered and including HIV and drug addiction)

Date

When did this happen?

4/4/2023

Personal description

In your own words, describe what happened

Dear United States Department of Justice Civil Rights Division,
I am writing to bring to your attention a pressing issue affecting individuals and families living with brain injuries in Connecticut who rely on federally funded programs. Specifically, there are concerns that covert referral practices by Connecticut contracted care management agencies may be restricting full access to available services for disabled Medicaid consumers enrolled in programs such as the MFP Money Follows the Person Program and the ABI Waiver Program.
As an organization committed to promoting equal and full access to care for people with disabilities, we respectfully request your advocacy support in investigating this matter and ensuring that appropriate actions are taken to ensure that individuals with disabilities receive the necessary resources and services they are entitled to. The negative impact of limited access to care for brain injury survivors cannot be overstated, as it can lead to delayed recovery, increased health risks, reduced quality of life, financial burden, and mental health consequences.
We believe that the United States Department of Justice Civil Rights Division is uniquely positioned to address this issue in a fair and unbiased manner. Your advocacy expertise and commitment to protecting the rights of individuals with disabilities can make a significant difference in ensuring that they have full access to all available resources and services.
Thank you for your unwavering dedication to promoting equality and access to necessary resources and services for individuals with disabilities.
Provided is a link with more details for your reference.
https://www.ctbraininjury.com/blog-ABI-RESOURCES/categories/medicaid-federal-programs-state-programs
Sincerely,

David Medeiros 860 463-3638
ABI Resources

Employer Manual Appendix

For Self-Directed Services under the

Acquired Brain Injury Medicaid Waiver Program

Information provided to the Participant / Employer by the Financial Management Services Agent

ALLIED COMMUNITY Resources

Revised December 2015

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Section A Program & General Information

A-1 Program Information

(as taken from the ABI Waiver Provider Manual, 12/07)

The Department of Social Services implemented the Acquired Brain Injury (ABI) Program on January 1, 1999. The program is funded under a Medicaid Home and Community-Based Services waiver, approved by the Federal Centers for Medicare and Medicaid Services (CMS).

The services available under the ABI waiver program are intended to help Medicaid-eligible persons with acquired brain injury to live in the community rather than institutions. These services are non-medical in nature.

Providers of ABI services must meet the qualification standards established by the Department of Social Services for the performance of these activities. Family members who are authorized to perform personal care assistance under the ABI Waiver must also meet the Department's qualification standards which are:

- Personal Care Assistance is the only service that can be performed by family members; however, these services cannot be performed by the participant's spouse or his / her parent if the participant is under the age of 21. The State of Connecticut has final authority in determining provider approval.

The Department of Social Services also states that neither a Conservator, nor a member of the Conservator's family may be paid as a provider of services under the ABI program. The definition of a family member, per the ABI Waiver Manual is: "An individual who is related to the waiver participant by either blood, adoption, or by marriage".

The Department of Social Services has established rates and provider qualifications for each of the covered home and community-based services allowed on the program. This does not mean that you have been approved for each of these services. Each individual participant's plan of care is different and is based solely on their needs assessed in determining their eligibility and participation on the program.

Enclosed in your enrollment binder, you will find the DSS Employer Manual for your reference. As the Employer, it is important that you understand your minimum responsibilities when hiring Providers for the support services included in the approved plan of care.

A-2 Pre-Approval Information

In order to apply to become a provider under the ABI program, all individuals who wish to provide services must complete, for review and approval, the DSS Directory Packet and ABI Supplement Application specific to the service(s) they wish to provide. These documents should be completed by your prospective employee independently and completely. Once the application has been completed, it should then be forwarded to Allied Community Resources for review.

Upon review of the application, Allied will notify the applicant as to whether or not their application is approved or if more information is needed. This notification is provided in a written format and specifically states the information lacking on the application.

If the individual's application has been approved, the applicant will receive a welcome packet including a letter stating the effective date and services they have been approved for. This approval is for purposes of listing the individual on the provider directory maintained by Allied Community Resources as well as for assuring the provider's status, potential hiring, and subsequent listing on your approved plan.

Please note that submission or approval of an application does not mean that an individual is authorized to provide services to you. This is just one of the steps a potential employee must take before they can begin providing services and receiving payment through the program based upon your approved plan of care.

You must be certain that the individual you wish to hire is an approved provider under the ABI Medicaid Waiver Program. To confirm that an individual is an approved provider, please contact our Outreach & Training Department at 860-627-9500, extensions 128 or 114.

A-3 Informational Session & Advanced Forum Information

It is a requirement under the Acquired Brain Injury Medicaid Waiver Program (ABI) that any individual providing the following services must attend and successfully complete a Basic Informational Session on Acquired Brain Injury administered by Allied Community Resources. These services are:

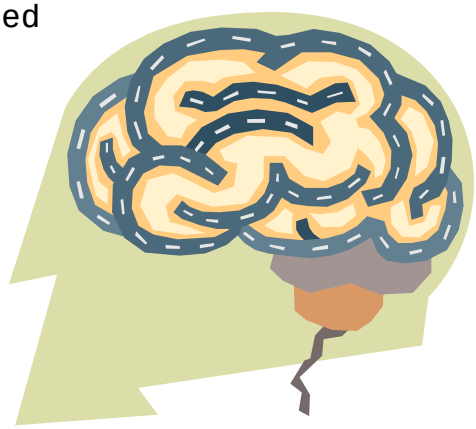
- Personal Care Assistance (PCA)
- Companion Services (COMP)
- Respite Services
- Independent Living Skills Training (ILST)
- Case Management Services

The session is not certification or formal training in the area of Brain Injury but rather information pertaining to the various aspects of Brain Injury for a better understanding of the deficits faced by those individuals who have acquired brain injury. **Successful completion of the session is required for qualification as an approved provider through the State of Connecticut's Acquired Brain Injury Medicaid Waiver Program.**

Basic Informational Sessions are held each month and are presented in either a Live Speaker format or Video format. Allied Community Resources administers these sessions and maintains the schedule. Information pertaining to the sessions may be found on our website at www.acrfi.org. For more information or to register to attend please contact our Outreach and Training Department at extension 128 or 114.

Please note that all individuals attending the Basic Informational Session must present acceptable identification in order to gain access to the session. Failure to present acceptable identification will result in non-admittance to the session and the individual will be required to attend on another date. Acceptable forms of ID are Driver's License, CT Non-Driver's Identification Card, U.S. Passport, U.S. Naturalization Certificate, U.S. Armed Forces Identification Card, U.S. Immigration Care-Resident Alien (Green Card), and State of Connecticut Department of Social Services Recipient Card.

In addition to the Basic Informational Session, Allied also administers Advanced Forums on a quarterly basis. Advanced Forums are held following the Basic Informational Session and cover topics such as “Memory Impairment”, “Boundaries”, and other topics relevant to providing care and support to an individual with Acquired Brain Injury.



These Forums are not mandatory however they provide a great deal of information and knowledge for those who work with the brain injured population. Information pertaining to the Forums may be found on our website at www.acrfi.org or by contacting our Outreach and Training Department at extension 128 or 114. Please contact the Outreach and Training Department to register to attend the Forums as well.

Individuals interested in attending the Advanced Forums must have attended and successfully completed the Basic Informational Session.

A copy of the current year’s Basic Informational Sessions and locations are included in your enrollment binder.

The following steps must be taken prior to a potential employee receiving an authorization date to begin working for you. **Failure to follow these steps may result in you, the Employer, being responsible for wages incurred for any employee prior to their authorization date.**

1. You must be certain that the individual you wish to hire is an approved provider under the ABI Medicaid Waiver Program. If the individual is not an approved provider, they should immediately contact the Outreach & Training Department at 860-627-9500, Extensions 128 or 114 to receive an application and register for the required Acquired Brain Injury Basic Informational Session.

2. Individuals must complete all of the required application paperwork and submit to Allied Community Resources for review and subsequent approval.

3. ABI Basic Informational Sessions are held on a monthly basis. Basic Informational Sessions are presented in a live format as well as a video format. Please contact the Outreach and Training Department for information concerning the ABI Basic Informational Session registration, and further information. Information pertaining to sessions may also be found on Allied's website at **www.acrfi.org**.

4. Individuals attending the ABI Basic Informational Session must successfully pass a brief quiz at the conclusion of the session in order for their session to be considered as complete and valid.

5. Upon confirming the individual is an approved provider, you must contact your assigned Access Agency Care Manger to have this individual named to a care plan. **For Companion, Homemaker, Chore, Respite, and PCA services, the Participant or court appointed Conservator or Power of Attorney may add an individual to a care plan directly with Allied.** All other services must be done by the assigned Access Agency Care Manger.

6. All plan additions must be in writing and must include the Participant name, the potential employee name, the service and a ***requested*** start date. Note that the requested start date is not the authorization date and does not allow an individual the option to begin providing services.

7. After the approved provider has been officially named to the care plan, Allied will send a letter to the potential employee with additional information and paperwork necessary to complete the hiring process.

8. Allied will also send a letter to the Participant / Employer or their legal representative informing them of the individual's addition to the service plan and the additional requirements necessary to obtain an authorization date.

Although Personal Care Assistants, Companions, Homemakers, Chore, and Respite care providers are not licensed, they must meet certain requirements in order to be considered for employment by you, the Employer (as taken from The Personal Care Assistance Waiver Desk Guide, 7/10).

1. At least 18 years of age.

2. Able to understand and carry out directions given by the Participant / Employer.

3. Able to physically perform the duties outlined in the care plan.

4. Willing to receive training in the duties to be performed.

5. Able to handle emergencies.

6. Able to maintain an effective working relationship with the Participant / Employer, and operate any special equipment needed to help with the activities of daily living (ADL's).

7. Complete the New Hire packet and clear a criminal background check. If the outcome of the check indicates a criminal history, it is possible the PCA may still be hired by the Participant / Employer who has that option, and may have to sign an Acknowledgement of Risk to do so. The Department of Social Services may deny coverage of services performed by a PCA who does not meet the departments' qualifications as set forth in the Program Regulations, has a negative Office of the Inspector General Check (OIG), or has a criminal background deemed inappropriate by the Department.

B-1 Adding Providers to your Plan

Providers who have completed the application process and have gained approval to provide services to individuals under the ABI Medicaid Waiver program may be added to the DSS service plan in one of two ways:

1. The Participant/Employer, or their designated legal representative such as a Power of Attorney or Conservator, may add providers of Personal Care Assistance, Companion, Homemaker, Chore, and Respite Services by submitting a written request in writing. **These are the only services that the Participant / Employer or their legal representative may add service providers for.** Authorization is made when the Employer and Employee complete the ABI Employment Packet and submit the document to Allied for processing.

2. The Participant / Employer, or their designated Legal Representative such as a Power of Attorney or Conservator, is required to request provider additions for Independent Living Skills Training, Respite Services, and Case Management Services by contacting their Access Agencies assigned Care Manger. The Care Manager will then send written notification to Allied stating the following:

    - The Participant / Employer's complete name
    - The potential employee's complete name
    - The service(s) the potential employee will be providing

Note that adding the provider to the plan does not provide the potential employee with the authorization to work. All employees must complete the new hire packet and undergo a Criminal History Background Check as outlined in the Employer Manual, Chapter 5.

B-2 **Who fills out my Employee's Paperwork?**

Employee paperwork is completed by both the Employer and the Employee. The employee is required to complete the majority of the Employment Paperwork with the Employer providing their signature in several areas in the packet. A mutually agreed upon time should be scheduled between the Employer and Employee to complete the necessary paperwork.

Every new employee hired by the Participant must complete the **ABI Employment Packet**. Failure to complete and submit this packet to Allied for review and completion, as well as reporting of the Criminal Background Check will result in non-payment of funds to any individual who has worked prior to the completion of this process. **You, as the employer, will be responsible for the payment of wages to any employee who works prior to the completion of the required paperwork and the conducting of their Criminal Background Check.**

Section C Wage Information

C-1 Wage Calculation

The maximum wage you may offer your Employee is based on several factors:

1. The Medicaid reimbursement rate (this amount is set by the Department of Social Services).

2. The employer's Unemployment Tax Rate (also known as a SUI rate). This amount is set by the State of Connecticut Department of Labor.

Using the Medicaid reimbursement rate, the required Employer taxes are deducted. Employer taxes must be withheld. Employer taxes include:

1. FUTA – Federal Unemployment Tax

2. SUTA – State Unemployment Tax

3. Social Security

4. Medicare

The Medicaid reimbursement rate is calculated into a wage based upon the deduction of your employer taxes listed above as well as your current SUI rate with the State of Connecticut Department of Labor.

It is important to note that the individual employee's deductions based upon the information provided on the employee's W4 and CT-W4 will determine the net amount of the employee's paycheck. Allied Community Resources has no input, involvement, or role in determining the wage you may offer to your employee(s).

Employers are encouraged to openly discuss the wage they are offering to their employee before they begin working and to inform employees of notices concerning changes to their wage. Employers however should not give advice or direction regarding exemptions, withholding or other information concerning the employee's taxes.

Allied is not permitted to discuss wage information with your employee(s) and will refer these types of questions back to you as the employer.

It is also important to state to employees that the program does not provide for the payment of overtime wages, employee health insurance, paid time off such as vacations, personal days, or sick

time, reimbursement for gas or transportation expenses, and any other type of benefits such as retirement plans or pensions.

Be sure that the employee is clear about the wage they are going to receive, that the hourly wage is before their deductions, and when they will first receive a paycheck. It is important that the employee understand that you are their Employer and that this information come directly from you.

C-2 Employer Unemployment Rate (SUI Rate)

It is important to note that the information below only applies to ILST and Companion Services.

Annually, the Department of Labor evaluates the employer SUI rate.

The SUI Rate assigned to your plan at this time is: _____%.

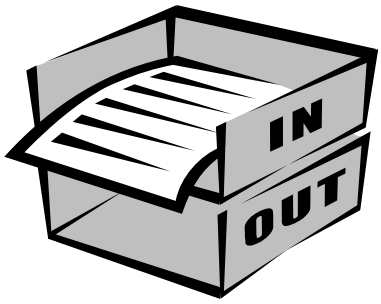
In some instances, this rate may be lowered which in turn will increase the hourly wage you are able to pay your employee. Allied will automatically adjust your employee(s) wage to this increased amount. In most cases however the rate will either stay the same or increase.

If your rate INCREASES, this will reduce the hourly wage you are able to pay your employee(s). If your rate increases, Allied will make adjustments automatically to reflect the new hourly rate allowed for your employee(s). Your history as an employer with regard to hiring / firing of employees and claims for unemployment have a direct impact on the SUI rate assigned to you by the Department of Labor.

It is important to note that Allied Community Resources has no input, involvement, or role in determining the wage you may offer to your employee(s). Employers are encouraged to openly discuss the wage they are offering to their employee before they begin working and to inform employees when notices of changes to their wage are provided by Allied to the employer. Employers however should not give advice or direction regarding exemptions, withholding or other information concerning the employee's taxes. Allied is not permitted to discuss wage information with your employee(s) and will refer these types of questions back to you as the Employer of Household Service providers.

For information pertaining to the wages authorized on your approved plan of care, please refer to the **Participant Information Form** found at the beginning of your enrollment binder.

D-1 Notification of Changes



Occasionally changes are made to the approved plan of care by the assigned Care Manager. Changes may happen when your needs have increased or decreased or when a service is added to or removed from your plan.

All changes are made by the Department of Social Services and forwarded to Allied for processing. Allied will process approved plan changes and notify the assigned Care Manager once the changes have been made. We will also notify any agency or private, self-employed providers listed on the plan should the changes affect them. Plan changes are communicated directly to the Participant or their designated legal representative by the Care Manager.

Please note that Allied cannot provide Participants, their designated legal representative, or providers with copies of approved plans on file in our office. If you have questions concerning the approved plan of care, you may contact the Intake Department and ask to speak with the Intake Liaison assigned to the ABI Program. We will do our very best to answer your questions. If you have questions which require answering from the assigned Care Manager, Allied will either refer you to that individual or assist you in gaining the answers to your questions.

Section E Timesheets & Payment of Wages Information

E-1 Employee Timesheets

For purposes of the program, timesheets are considered to be a legal document. Timesheets should not contain white out, cross outs, or overwriting and should be completed each day the employee works.

Who fills out my Employee's Timesheet?

Timesheets are to be completed by the employee. The employee should enter their start time when they arrive and their end time before they leave each day that they work. At the end of the week, the employee signs and dates their timesheet and forwards it to the employer for review. The employer will then verify the timesheet and sign and date the document. **Both** signatures and activities **must** be on the timesheet in order for it to be processed. Connecticut State Law (CT General Statutes Section 31-71i) requires payment of wages due within 8 days from the end of the pay period. According to this law, you as the employer are responsible to process payroll (or submit payroll information to your Fiscal Agent) in a timeframe that allows for payment within the 8 day window.

Please be sure that you have an adequate supply of timesheets on hand at all times. Timesheets may be obtained by calling Allied's Customer Service Department at 860-627-9500.

When do my Timesheets need to be in to Allied?

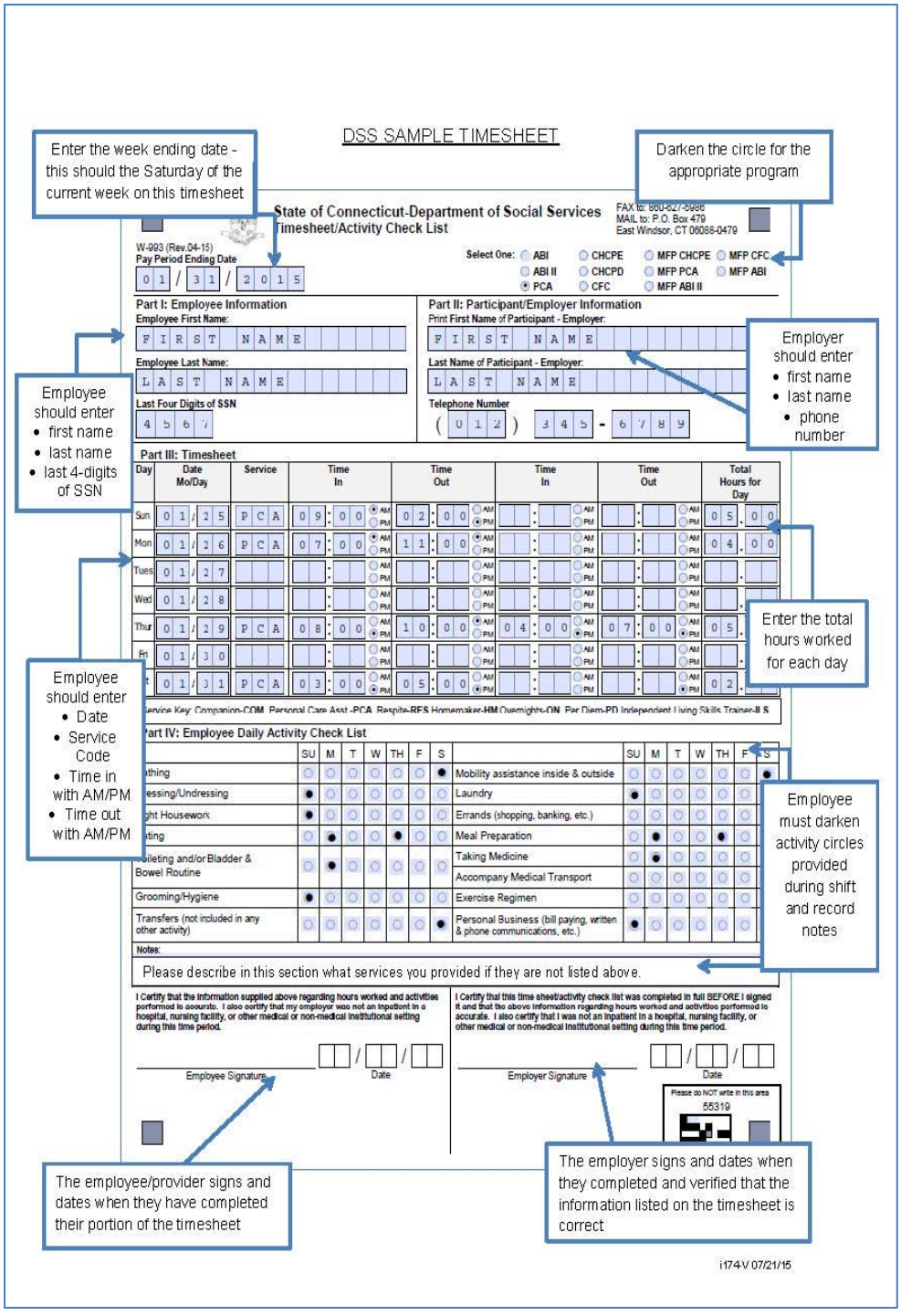
Timesheets should be submitted to Allied by Monday at 5pm. The pay week for the Acquired Brain Injury program is Sunday to Saturday at Midnight. Timesheets should be submitted to Allied Community Resources at the end of the two week cycle. It is our recommendation that timesheets be mailed or faxed on the last evening of the week. Fax is available 24 hours per day, 365 days per year. Please keep in mind that weekend faxing, as well as Monday faxing may be extremely heavy. **Please do not both fax and mail your timesheets.** If you are unsure of your pay cycle, please refer to the pay cycle schedule located in your enrollment binder or contact Allied's Customer Service Department and a printed schedule will be sent to you. You may also find this information on our website at www.acrfi.org.

When will my employee(s) received their paycheck?

Paychecks are issued every other week (bi-weekly). Paychecks are released on Fridays and therefore are mailed on Fridays. All paper checks will be mailed to the employee's home address. Timesheets received after the 5pm deadline on Monday may experience a delay in the receipt of checks.

E-2 Timesheet Sample

Below is a Sample copy of the required timesheet for the ABI program.



E-3 Responsibility for Payment of Wages

As the employer, you are responsible for the payment of wages. The Department of Social Services has issued a plan for your care. In doing so, they have determined the maximum number of hours you are eligible to received paid services for. They have also determined the maximum wage you are able to pay your employees. Allied processes your timesheets based upon the information submitted by the Department of Social Services (DSS).

For example,

> In the event that timesheets are submitted for 55 hours, Allied will contact the Employer to discuss the overage of the plan hours. The Employer will be asked which employee(s) should have their plan adjusted (deduction). The employee paychecks will then be processed based upon the direction the Employer gives Allied. This does not mean however that the employee does not need to be paid for the 5 hours of pay which were deducted from their check.

In the example above you as the employer are responsible for the decision made, notification of your decision to the affected employee, and for payment of wages, as well as any employer taxes and mandatory withholdings using your personal funds.

Failure to pay your employee for any hours over of your plan hours that the employee worked can have serious consequences. Your employee may file a Claim for Wages with the Department of Labor. If the Department of Labor rules in favor of the employee, you will be required to pay the employee the funds due to them as well as any fines, penalties, or fees determined by the Department of Labor in arriving to the decision. **Remember….it is a CRIMINAL offense to not pay your employee.**

It is EXTREMELY important that you know the plan hours, that you have a schedule for your employees to refer to and that you stay within the hours approved under the plan of care.

F-1 Employment Termination Form

Occasionally, problems arise resulting in the expected or unexpected termination of an employee. The termination may be voluntary on the employee's part or you may choose to terminate an employee for a specific reason. Some instances in which termination of an employee may be appropriate are:

- The employee is not performing the assigned work satisfactorily
- The employee has taken control out of your hands
- The employee is not neat and clean in personal appearance
- The employee does not come in to work on time or misses work frequently with or without advance notice
- The employee is not pleasant and respectful when working
- The employee is not following your direction when working for you

If the arrangement is not working, then inform the employee of your concerns. If changes do not occur, then you may wish to consider ending your relationship with this individual. Whenever possible, try to find a replacement provider. Be sure you have completed all of the necessary paperwork and processes before you have them start working. Another alternative is to have a back-up provider fill in.

Put an End to it!

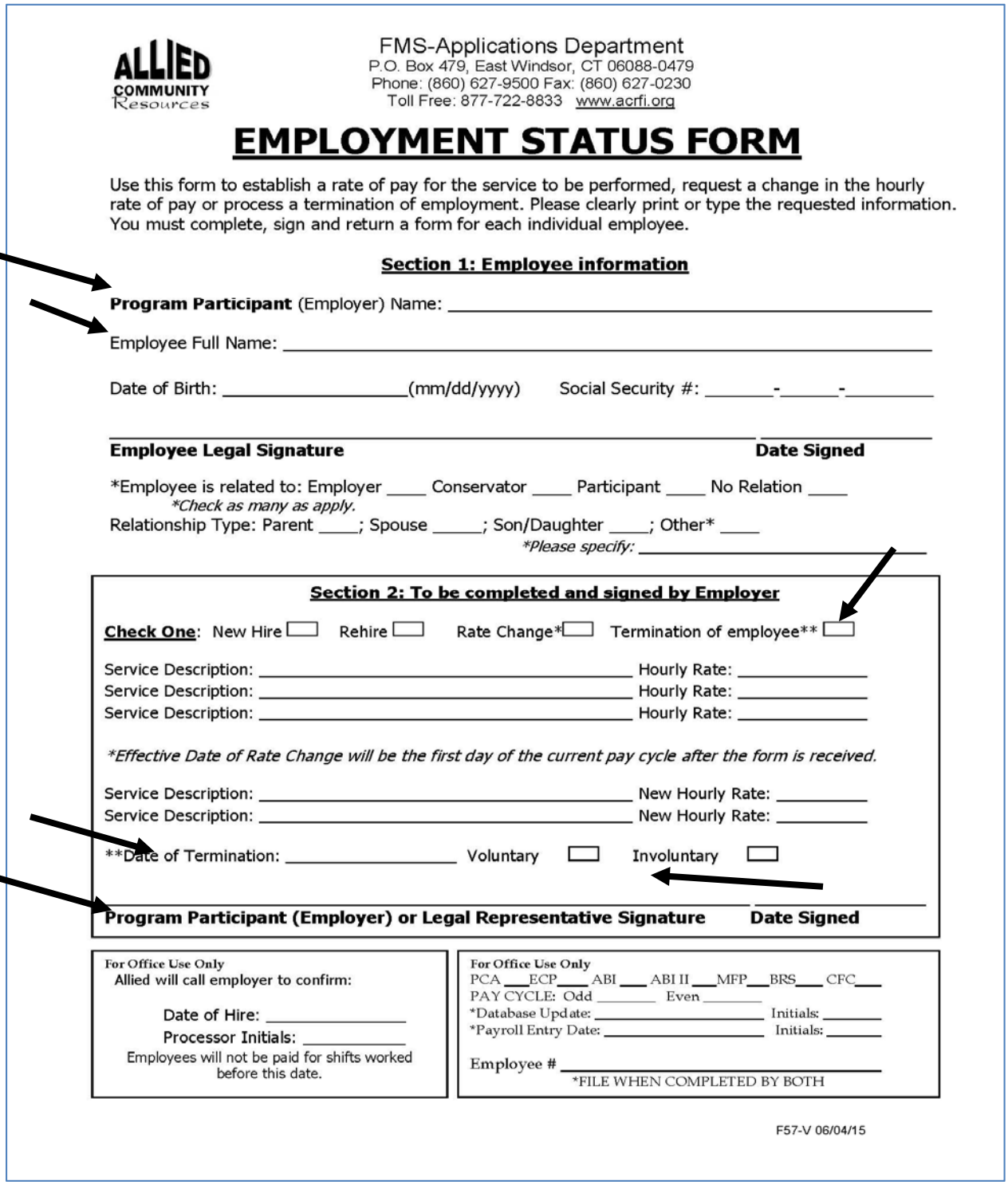
Regardless of the reason for their termination, whether they quit, deserted, or were fired you must inform your Care Manager. In addition, you must also complete the Employment Status Form to terminate your employee and forward this information to Allied for processing. By notifying your Care Manger and Allied immediately you help to reduce the possibility of fraudulent timesheets being submitted for payment.

In addition to completing the Employment Status Form, you must provide your employee with the State of Connecticut Department of Labor Separation packet found in your enrollment binder. For questions on completing the packet, you may contact Allied's Customer Service Department at 860-627-9500 or the Department of Labor directly at 860-263-6635.

The following page contains a sample of the Employment Status Form for Termination of an Employee.

F-2 Sample Employment Status Form for Termination

Fields indicated with an → must be completed by the Employer. The form should then be forwarded to Allied for processing.



ALLIED COMMUNITY Resources

FMS-Applications Department
P.O. Box 479, East Windsor, CT 06088-0479
Phone: (860) 627-9500 Fax: (860) 627-0230
Toll Free: 877-722-8833 www.acrfi.org

EMPLOYMENT STATUS FORM

Use this form to establish a rate of pay for the service to be performed, request a change in the hourly rate of pay or process a termination of employment. Please clearly print or type the requested information. You must complete, sign and return a form for each individual employee.

Section 1: Employee information

Program Participant (Employer) Name: _____

Employee Full Name: _____

Date of Birth: _____(mm/dd/yyyy) Social Security #: _____-_____-_____

_____ _____
Employee Legal Signature **Date Signed**

*Employee is related to: Employer ____ Conservator ____ Participant ____ No Relation ____
Check as many as apply.
Relationship Type: Parent ____; Spouse _____; Son/Daughter ____; Other* ____
*Please specify: _____

Section 2: To be completed and signed by Employer

Check One: New Hire ☐ Rehire ☐ Rate Change* ☐ Termination of employee** ☐

Service Description: _____ Hourly Rate: _____
Service Description: _____ Hourly Rate: _____
Service Description: _____ Hourly Rate: _____

Effective Date of Rate Change will be the first day of the current pay cycle after the form is received.

Service Description: _____ New Hourly Rate: _____
Service Description: _____ New Hourly Rate: _____

**Date of Termination: _____ Voluntary ☐ Involuntary ☐

_____ _____
Program Participant (Employer) or Legal Representative Signature **Date Signed**

For Office Use Only
Allied will call employer to confirm:
Date of Hire: _____
Processor Initials: _____
Employees will not be paid for shifts worked before this date.

For Office Use Only
PCA ___ECP___ ABI ___ ABI II ___MFP___BRS___ CFC___
PAY CYCLE: Odd _____ Even _____
*Database Update: _____ Initials: _____
*Payroll Entry Date: _____ Initials: _____
Employee # _____
*FILE WHEN COMPLETED BY BOTH

F57-V 06/04/15

We hope that you have found this Employer Manual Appendix to be informative and helpful as you begin your role as an Employer under the Acquired Brain Injury Medicaid Waiver Program. All of the forms used in this Appendix may be found on our website at:

www.acrfi.org

Or by contacting our Customer Service Department and requesting the document(s) be sent to you via mail or email.

Should you have any questions, please refer to the Allied staff Contact Page located in your enrollment binder.

We look forward to working with you; we are sure you will find that we strive to meet your needs while exceeding your expectations.

Sincerely,

The Management & Staff of Allied Community Resources

FMS-Provider Services
P.O. Box 479, East Windsor, CT 06088-0479
Phone: (860) 627-9500 Fax: (860) 627-0230

DSS PROVIDER INFORMATION MANUAL - Acknowledgement

Employee Printed Name: _____ **Date**: _____

I have read and understand the content contained within the DSS Provider Information Manual. I understand the importance of this information and will perform to the best of my ability, the standards expected of a provider of this type of care under the CT Department of Social Services State Waiver Programs, ABI (Acquired Brain Injury), PCA (Personal Care Assistance) and CHCPE (Connecticut Home Care Program for Elders) or Money Follows the Person (MFP).

Employee Signature: _____

Employer Name: _____

Employer Signature: _____

F234-V 11/06/12

FMS-Provider Services
P.O. Box 479, East Windsor, CT 06088-0479
Phone: (860) 627-9500 Fax: (860) 627-0230

DSS PROVIDER INFORMATION MANUAL - Acknowledgement

Employee Printed Name: _____ **Date**: _____

I have read and understand the content contained within the DSS Provider Information Manual. I understand the importance of this information and will perform to the best of my ability, the standards expected of a provider of this type of care under the CT Department of Social Services State Waiver Programs, ABI (Acquired Brain Injury), PCA (Personal Care Assistance) and CHCPE (Connecticut Home Care Program for Elders) or Money Follows the Person (MFP).

Employee Signature: _____

Employer Name: _____

Employer Signature: _____

F234-V 11/06/12

Submission ID: 666641

Success!

Your FOIA request has been created and is being sent to the Center for Medicare and Medicaid Services.

You'll hear back from the agency confirming receipt in the coming weeks using the contact information you provided. If you have questions about your request, feel free to reach out to the agency FOIA personnel using the information provided below.

Contact the agency

Hugh Gilmore, FOIA Officer
410-786-5353
hugh.gilmore@cms.hhs.gov

FOIA Requester Service Center
410-786-5353

Joseph Tripline, FOIA Public Liaison
410-786-5353
joseph.tripline@cms.hhs.gov

Hugh Gilmore, FOIA Officer, North Building, Room N2-20-06
7500 Security Boulevard
Baltimore, MD 21244
FOIA_Request@cms.hhs.gov

Request summary

Request submitted on**April 4, 2023**.

The confirmation ID for your request is **666641**.

The confirmation ID is only for identifying your request on FOIA.gov and acts as a receipt to show that you submitted a request using FOIA.gov. This number does not replace the

information you'll receive from the agency to track your request. In case there is an issue submitting your request to the agency you selected, you can use this number to help.

Contact information

Name
DAVID MEDEIROS

Mailing address
39 Kings Highway, STE C
STE C
Gales Ferry, CT 06335
United States

Phone number
8604633638

Company/organization
ABI RESOURCES LLC

Email
aabiwr@live.com

Your request

Dear Office of Information Policy (OIP) team, I would like to receive information regarding Connecticut's federally funded programs, specifically the Money Follows the Person (MFP) and the Acquired Brain Injury (ABI) Waiver programs. I am seeking clarity on the role of the Connecticut Community Options Units (COUs) in managing these programs. In particular, I would like to know if COU is responsible for managing these federally funded programs or if it is the Connecticut Department of Social Services (DSS) that manages them. I am also interested in finding out if COU receives federal funds to manage these programs. I would greatly appreciate any relevant information you can provide regarding these inquiries. Thank you for your attention to this matter. Sincerely, David Medeiros

Fees

What type of requester are you?
media

Fee waiver
no

Request expedited processing

Expedited processing
no

Justification for expedited processing

Dear Office of Information Policy (OIP) team, I am writing to request expedited processing of my FOIA request for information regarding Connecticut's federal funded programs, Money Follows the Person and the ABI Waiver program. I believe that my request meets the criteria for expedited processing under 5 U.S.C. § 552(a)(6)(E)(v)(II). The information I am seeking is urgently needed to protect the health and safety of vulnerable individuals enrolled in these programs.

Submission ID: 707511

Success!

Your FOIA request has been created and is being sent to the Center for Medicare and Medicaid Services.

You'll hear back from the agency confirming receipt in the coming weeks using the contact information you provided. If you have questions about your request, feel free to reach out to the agency FOIA personnel using the information provided below.

Contact the agency

Hugh Gilmore, FOIA Officer
410-786-5353
hugh.gilmore@cms.hhs.gov

FOIA Requester Service Center
410-786-5353

Joseph Tripline, FOIA Public Liaison
410-786-5353
joseph.tripline@cms.hhs.gov

Hugh Gilmore, FOIA Officer, North Building, Room N2-20-06
7500 Security Boulevard
Baltimore, MD 21244
FOIA_Request@cms.hhs.gov

Request summary

Request submitted on**May 3, 2023**.

The confirmation ID for your request is **707511**.

The confirmation ID is only for identifying your request on FOIA.gov and acts as a receipt to show that you submitted a request using FOIA.gov. This number does not replace the