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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 Program for Children 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 the 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 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. 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.

A learning disability is not the same as an Intellectual 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.

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 Please note that a person with the following diagnosis may also eligible for the DSP.

4.1.3 **Dual Diagnosis**: a diagnosis of the presence of an intellectual developmental disability and a co-occurring long term mental illness. The person may also have a co-occurring physical disability or any combination of the above three.

4.1.4 **Acquired Brain Injury:** The applicant/participant has 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.

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 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 a physician report – medical assessment (see section 6.5 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 and Department of Health and Wellness

There are circumstances when services from both DCS and the Department of Health and Wellness (DHW) 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.

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); and

3) an Adult Residential/Rehabilitation Centre (licensed).

5.1 Community Based Option (Unlicensed)

5.1.1 Direct Family Support for Adults (DFSA) Program

The DFS Program provides funding for respite and special needs to assist families to support their family member with a disability who lives at home.

5.1.2 Independent Living Support (ILS) Program

The Independent Living Support Program provides up to 21 hours a week of supports and services to persons with disabilities, who live in their own apartment or home, are semi-independent and who require minimal support. There is no overnight support available through the ILS Program.

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 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.

5.2.2 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.

5.2.3 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.

5.2.4 **Small Option Home (SOH)**

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

5.3 Adult Residential/Rehabilitation Centre (ARC/RRC)

An Adult Residential Centre and a Rehabilitation Centre provide a range of residential supports for participants with multiple needs/severe challenges. Staffing is provided 24 hours/7 days a week.

5.3.1 **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 participant's interpersonal, community oriented and activities of daily living skills. Staffing is provided 24 hours/7 days a week.

5.3.2 **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 and 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. Staffing is provided 24 hours/7 days a week.

6.0 ELIGIBILITY DETERMINATION PROCESS

6.1 Screening

A person with a disability is screened to determine their potential eligibility for the DSP prior to their completion of a full program application. This includes:

a) determining what the person is requesting, and possibly referring them to other agencies and services based on their request; and

b) providing the person with the following information about the DSP:

- financial eligibility requirements;
- functional eligibility requirements and the assessment process, including medical and consent requirements;
- a description of the DSP programs and services available; and
- information regarding the status of the current waitlist.

6.2 Intake/Initial Contact

6.2.1 A person with a disability shall be provided with detailed information on the eligibility requirements for all DSP programs during the intake process.

6.2.2 A person with a disability may be assessed for DSP supports if they have provided a medical report from their personal physician that confirms their disability.

6.2.3 If an applicant does not meet the eligibility criteria, or is ineligible as a result of the provisions in section 9.0 of this Policy, the applicant will be advised of their ineligibility before they undergo a functional and financial assessment and before an application is completed.

6.3 Program Application and Consent

6.3.1 An applicant must complete a program application and sign a consent form to allow the Department to obtain and share their information for the purposes of determining their initial and ongoing eligibility, and for the provision of services and supports.

6.3.2 If an applicant does not meet the eligibility criteria, or is ineligible as a result of the provisions in section 9.0 of this Policy, the applicant will be advised of their ineligibility in writing.

6.4 Capacity to Consent

6.4.1 An applicant/participant is required to provide consent to the DSP eligibility processes. It will be assumed that an applicant/participant has the capacity to make decisions unless it is established that they lack the capacity to do so.

6.4.2 To obtain valid consent an applicant/participant must be provided with all the

information relevant to making a 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 lacks the capacity to make a decision about their personal care, living arrangements, or health needs, a Care Coordinator will complete a capacity to consent evaluation.

6.4.4 If an applicant/participant's capacity to make a decision remains in question after a consent evaluation has been conducted, 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 an applicant/participant has a Guardian appointed by the Court for purposes of personal care, including health care decisions;

b) if an applicant/participant has a personal directive (also referred to as an advance health directive, or living will, or power of attorney);

c) to provide a copy of the Guardianship documentation or personal directive to the Care Coordinator.

6.4.6 An applicant/participant who is not the subject of a Guardianship Order, and who has not made a personal directive (which would name a delegate to make personal care decisions, or set out instructions for such decisions) and who 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 or a personal directive, the Care Coordinator must:

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

b) ensure that the identified substitute decision maker reads and signs a declaration.

6.4.8 The Care Coordinator can proceed to complete the intake eligibility process with the consent of the applicant's identified substitute 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 a capacity to consent evaluation.

6.5 Medical Assessment

6.5.1 An applicant must provide a medical report from an attending physician or nurse practitioner who is familiar with them and their medical history when applying to the DSP.

6.5.2 Applicants are responsible for any costs and fees associated with the medical assessment.

6.6 Functional Assessment

An applicant shall undergo a functional assessment conducted by a Care Coordinator. A recommendation regarding the applicant's eligibility and their assessed level of support needs shall be made by the Care Coordinator to the Casework Supervisor.

6.7 Financial Assessment

An applicant's eligibility for financial assistance shall 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. 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.

7.0 PLACEMENT

7.1 An applicant/participant shall be offered a DSP support option based on:

a) the applicant/participant's support requirements and the nature of the support option taking into account the following factors:

- the level of support that can best meet the needs of the applicant/participant;
- the service provider's expertise with the applicant/participant's disability and support requirements;

- the support requirements of other participants who are sharing the same residence; and
- the applicant/participant's accessibility requirements, if any.

7.2 If an appropriate DSP support option is not immediately available, the applicant/participant's name will be placed on the Wait List, with their consent.

8.0 WAIT LIST MANAGEMENT

8.1 Wait List Entry

The applicant/participant's name and information will be entered on the Wait List according to:

a) their priority ranking (see chart in 8.2); and

b) the date the Wait List Coordinator receives the completed wait list submission form.

8.2 Wait List Priorities

8.2.1 An applicant/participant's waitlist priority ranking for accessing the DSP is determined by the Care Coordinator, based on individual circumstances, in accordance with the chart below.

8.2.2 For an applicant/participant's name to be placed on the Wait List as a Priority 1, the approval of the DSP Casework Supervisor and the DSP Specialist is required. Persons assigned a Priority 1 on the Wait List must have their information and circumstances reviewed every six months.

8.2.3 For the purpose of the Wait List priority ranking only, a participant is defined as either a person receiving DSP services or supports or a client of a Department of Health and Wellness funded long term care facility or admitted to hospital from a long term care facility, who meets the DSP eligibility criteria.

8.2.4 Ranking is in descending order of priority.

Priority 1	
1.1	a) An applicant/participant who is assessed by Adult Protection as an adult in need of protection under sections 7, 9 or 10 of the *Adult Protection Act;* or b) An applicant/participant who is assessed by a DSP Care Coordinator

	as high risk, approved by the Casework Supervisor and Specialist.
1.2	An applicant/participant with an absolute or conditional discharge, referred from the East Coast Forensic Hospital of the Capital District Health Authority.
1.3	An adult applicant identified for 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	
2.1	A participant living in a program support option that does not meet their needs, with funding for extraordinary staffing. This includes participants in emergency settings or those in need/receipt of long-term, one-on-one staffing, in excess of eight (8) hours per day.
2.2	A participant who has accepted an out of region program support option, and who is waiting for transfer to the region of their choice.
2.3	A participant in hospital who has been discharged from their program support option as a result of their hospitalization.
2.4	An applicant/participant ready for discharge from an RRC.
2.5	a) An applicant referred from a hospital who meets DSP eligibility criteria; or b) An applicant who is in hospital and is approved and funded under the complex needs case planning process.
Priority 3	
3.1	a) A participant whose reassessment indicates a significant increase in their support needs, a change in their level of support, or who needs a change in their program support option; or b) A participant 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	
	A participant who requests a transfer to a preferred program support

4	option or location, in accordance with their assessment and support plan.
Priority 5	
5	An applicant requesting a DSP support option; including applicants approved and funded under the complex needs case planning process (also see priority 2 for applicants in hospital).
Priority 6	
6	An applicant from out of province who meets DSP criteria.

8.2.5 A Care Coordinator shall review Wait List information annually and provide notification to the Wait List Coordinator of any changes. Such changes may result in a change in the applicant/participant's priority ranking.

8.2.6 If changes are made to the applicant/participant's information or their priority on the Wait List changes, the date on which their name was originally entered on the Wait List shall remain unchanged.

8.2.7 When a DSP support option becomes available, the applicant/participant shall be considered for the placement based on the criteria listed in section 7.0 of this Policy, and the following:

a) the applicant/participant's waitlist priority ranking; and

b) the date the applicant/participant's name was entered on the Wait List.

8.2.8 Placements made outside of this process require the approval of the DSP Director or designate. Participants ready for discharge from the Community Transition Program, Memory Lane, Lower Sackville, Nova Scotia, and the Community Transition House, Pleasant Street, Dartmouth, Nova Scotia will fall under this variant.

9.0 INELIGIBILITY

9.1 Assessed Needs

9.1.1 If an applicant/participant's assessed support needs cannot be safely met within one of the five levels of support provided by the DSP, or with the assistance of available standard community resources, if necessary, the applicant/participant is ineligible for DSP programs.

9.1.2 Exceptions may be considered for applicants whose assessed support needs can be supported in the Direct Family Support for Adults (DFSA)

Program.

9.1.3 An applicant is ineligible for DSP programs and funding when it is determined that their assessed needs would be best supported by a residential support option under the mandate of the Department of Health and Wellness (DHW), Continuing Care Branch or a District Health Authority (DHA).

9.1.4 An applicant whose primary need for care and support is palliative is ineligible for admission to the DSP.

9.2 Involuntary Patients

An involuntary patient in a psychiatric facility is not eligible for admission or re-admission to the DSP unless they meet the DSP eligibility criteria for patients with Community Treatment Orders and Certificates of Leave (see section 4.6 of this Policy).

9.3 Behavioural or Medical Needs - Applicant

9.3.1 An applicant whose assessed behavioural or medical needs cannot be safely met by one of the five levels of support provided by the DSP, and who cannot access standard community resources is ineligible for the DSP.

9.3.2 An applicant who is an active substance abuser or whose support needs are primarily related to substance abuse withdrawal are not eligible for the DSP.

9.4 Behavioural or Medical Needs - Participant

9.4.1 If a participant's behavioural or medical needs increase after admission to the DSP, the Care Coordinator shall:

a) complete a re-assessment of the participant's support needs;

b) based on the participant's increased needs pursue standard community resources from a District Health Authority; or

c) seek an alternative support option for the participant through the Department of Community Services or a District Health Authority.

9.4.2 If the resources referred to in section 9.4 of this Policy are not readily available and the unavailability creates a significant impact on the safety and well-being of the participant, the Care Coordinator may pursue assistance with short-term interventions through section 7.6.2 of the DSP Basic and Special Needs Policy. These interventions may only be offered until such time as standard community

resources, or an alternative support option for the participant, becomes available.

9.4.3 A DSP participant may access addiction rehabilitation and recovery programs while in the DSP.

10.0 REVIEW AND REASSESSMENT OF PARTICIPANT ELIGIBILITY

10.1 A participant's support needs and eligibility are reviewed by the Care Coordinator biennially.

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 accuracy and currency of the information that has been provided on the existing DSP consent form must also be reviewed. 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 an updated physician report – medical assessment. 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 shall be conducted 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 shall update the participant's budget.

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 Wait 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 approved 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 Wait List when an alternative program support option is not immediately available, upon their request.

12.0 RESPITE IN LICENSED HOMES

12.1 The DSP is committed to providing an applicant/participant and their family with preventive services in order to facilitate an applicant/participant remaining in their own home with family support by providing *per diem* funding for a participant to access short-term respite support in cases of emergency, for vacation periods, or for sporadic breaks (e.g. weekends).

12.2 An applicant/participant who normally resides at home, and is dependent upon family members for intermittent or continuous support, may access temporary support for a planned period of time through a respite placement in a Community Home or ARC/RRC, under the following conditions:

a) the Community Home or ARC/RRC can safely accommodate additional persons in compliance with the law, including the Fire Marshal's Act and Regulations and the Homes For Special Care Act and Regulations;

b) the Community Home or ARC/RRC licensed under the Homes for Special Care Act has obtained approval to provide respite supports from the licensing division of the Department of Community Services, prior to accepting any person for respite care; and

c) the applicant/participant is eligible for the DSP.

12.3 An applicant/participant's assessment documentation, including a physician report – medical assessment and an individual assessment and support plan, must be submitted by the Care Coordinator to the Case Work Supervisor for all new applications for respite placement in a Community Home or ARC/RRC.

12.4 The Care Coordinator will identify the respite options in a Community Home or ARC/RRC which meets the applicant/participant's support needs.

12.5 The applicant/participant, their family and service provider must be notified by the Care Coordinator, in writing, of the terms of the respite placement, including the number of days approved for respite.

12.6 For respite re-admissions, where the Care Coordinator has determined that the applicant/participant requires the same level of support as in the past, no new assessment documentation is required. Only when there is a change in the applicant/participant's level of support, or a change in their financial circumstances, is updated documentation required (see section 11.2 of this Policy).

12.7 An applicant/participant, their family and service provider must be notified by the Care Coordinator, in writing, on an annual basis of the terms of the respite placement.

12.8 Emergency respite placements may be made by the Department upon a Care Coordinator's recommendation and approval by the DSP Casework Supervisor. In such cases, an applicant/participant's assessment documentation, including a physician report, and an individual assessment and support plan must be completed and approved within five working days of an applicant/participant's admission to the emergency respite placement.

12.9 The maximum respite utilization for an applicant/participant in any calendar year is sixty (60) days. Thirty (30) consecutive days stay is the maximum length of respite stay in a Community Home or ARC/RRC.

12.10 Exceptions to the sixty (60) day annual maximum or thirty (30) consecutive day maximum may be considered on an individual basis with the approval of the District Manager, space permitting. A Care Coordinator must provide a written request and recommendation to the District Manager outlining the exceptional circumstances which necessitate the additional respite.

12.11 Any additional costs beyond the approved per diem rate must be approved by a District Manager.

13.0 TEMPORARY AND EXTENDED ABSENCES

13.0.1 The DSP supports participants to maintain contact with their family and other supportive relationships in their community.

13.0.2 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.

13.0.3 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.

13.1 Hospitalization/Occasional Absences

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

a) 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

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

13.1.2 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.

13.1.3 The Care Coordinator shall ensure that the participant, their family (when appropriate), service providers and hospital staff are informed of any changes in the participant's residential placement.

13.1.4 A participant who is hospitalized for longer than thirty (30) days, and is waiting for a DSP support option to become available, may continue to receive the following supports and services, with the approval of the Casework Supervisor:

a) comfort allowance;

b) special needs; and

c) case management support.

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

13.2 Absences Beyond Thirty (30) Days

13.2.1 A participant who has been absent from the Province for more than thirty (30) consecutive days shall have their financial support discontinued by the Care Coordinator.

13.2.2 A participant's program support option may be maintained and funded by the DSP if they are absent for more than thirty (30) consecutive days, with the approval of the District Manager.

13.2.3 When a participant's absence extends beyond thirty (30) days and with the agreement of the participant, the service provider and the District Manager, the participant's bedroom may be used temporarily by another DSP participant, under exceptional circumstances. The participant's personal effects shall be stored in a safe, secure and easily accessible area.

14.0 DISCHARGE FROM DSP

14.1 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.

14.2 A participant must be given written notification of their right to:

a) appeal their support eligibility determination; and

b) appeal their financial eligibility determination (see section 6.1 of the Financial Eligibility Policy).

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

14.4 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.

14.5 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 without DSP case management (see section 5.10 of the DSP Financial Eligibility Policy).

15.0 APPLICATION

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

16.0 ACCOUNTABILITY

16.1 The Director is responsible for ensuring that the DSP achieves the objectives for which it was created, and is delivered within a fiscally sustainable manner.

16.2 Regional Administrators are responsible for implementing policy and ensuring compliance within their respective areas of responsibility, and the resources made available.

16.3 Managers and supervisors are responsible for complying with the policy within their respective areas of responsibility and adequately preparing their employees to carry out their respective functions.

17.0 MONITORING

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

17.2 Regional Administrators are responsible for regularly monitoring and reporting on compliance with this policy.

DEPARTMENT OF COMMUNITY SERVICES

Disability Support Program

Financial Eligibility Policy

Effective: June 2012

Updated March 2015

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1.0 POLICY STATEMENT

1.1 This policy applies to all Disability Support Program (DSP) Programs for adults. It does not apply to the Direct Family Support Program for Children or 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, a budget deficit, and subject to 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 a Wait List, upon their request, as outlined in section 8.0 of the DSP Policy.

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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, 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).

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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.

5.5 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 shall apply for any and all income for which they are eligible, including pension income, and shall apply for the maximum level for which they are eligible.

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;

b) 100% of the applicant/participant's net wages, minus $300 and 30% of the remainder (see section 5.5.6 of this Policy);

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

d) 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

e) 100% of income from an estate or trust.

5.5.4 All income, other than wages, 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 engaged in employment shall retain the first $300 of their net wages, plus 30% of their remaining net monthly wages as an employment incentive. The balance of their earnings shall be applied to their DSP support costs.

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);

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

i) payments under a victims compensation program paid by a federal or provincial government;

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

k) 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;

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

m) honorariums provided to persons serving on a board of an agency or commission;

n) earned income of a dependent child(ren) as long as the dependent child(ren) is attending an educational program not designated for student loan purposes;

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

    i. the national child benefit supplement,

    ii. the child tax benefit,

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

    iv. the child disability benefit.

p) Universal Child Care Benefit paid under the *Income Tax Act* (Canada);

q) adoption subsidy payments under the *Children and Family Services Act*;

r) payments made in support of a foster child under the *Children and Family Services Act*; and

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s) bursaries, scholarships, and stipends received for the purpose of assisting with the costs associated with attending an approved educational program.

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. 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:

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

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

i. the 1986 - 1990 Hepatitis C Settlement Agreement; or

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

iii. Pre – 1986/Post – 1990 Hepatitis C Settlement Agreement; and

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

5.6 Initial Budget 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 shall be provided to them based on a budget deficit. 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 budget must be developed.

5.6.3 The Care Coordinator shall prepare the applicant's initial budget in the following manner:

a) document the applicant's total expenses including costs associated with any services and supports provided to the

applicant by the DSP, and taking into consideration any sharing of costs;

b) document the applicant's income;

c) subtract the income from the expenses. The resulting balance will either be a:

i. budget deficit, which is the amount of financial assistance for which the applicant may be eligible; or a

ii. budget surplus, which means that the applicant is ineligible for financial assistance from the Department of Community Services.

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.

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 shall update the participant's budget.

5.7 Budget 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
- special needs

5.7.2 Living with Family

A participant living with their family will be eligible for basic and special needs as outlined in the Direct Family Support for Adults Policy and the Basic and Special Needs Rates (Appendix A). This can include:

- Personal Allowance
- Boarding rate for shelter
- Respite
- Special needs

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5.7.3 Living Independently in Own Home/Apartment

5.7.3.1 A DSP participant who lives alone in their own home or apartment, can be eligible for basic and special needs as outlined in the Independent Living Support Program policy and the Basic and Special Needs Rates (Appendix A). This can include:

- Personal Allowance
- Shelter allowance (rent or mortgage payment)
- Special needs
- Comforts Allowance (Personal Use Allowance)
- Hours of support

5.7.3.2 DSP participants (two or more) who share accommodations will each have their own budget as outlined in the Basic and Special Needs Rates (Appendix A). This can include:

- Personal Allowance
- Shelter allowance (the participant's share of the rent or mortgage payment)
- Special needs
- Comfort Allowance (Personal Use Allowance)
- Hours of support

5.7.3.3 Each participant will contribute their own income, if any, to their individual budget. Expenses associated with their shelter costs will be shared. Depending on their circumstances, the participant's hours of support and other support services may also be shared.

5.7.3.4 Participants who share their living accommodations with another individual who is not a participant in the DSP and who is not their spouse, shall have their own budget as outlined in the DSP Basic and Special Needs Rates (Appendix A). This can include:

- Personal allowance
- Shelter allowance (the participant's share of the rent or mortgage payment)
- Special needs
- Comforts Allowance (Personal Use Allowance)
- Hours of support

5.7.3.5 Expenses associated with shelter costs will be shared. The DSP participant will contribute their income, if any, to their individual budget.

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5.7.3.6 A DSP participant who shares their living accommodations with a spouse, who is not a DSP participant, shall have their budget developed to reflect the following:

- Personal allowance
- Shelter allowance (the participant's share of the rent or mortgage payment)
- Special needs
- Comforts Allowance (Personal Use Allowance)
- Hours of support

5.7.3.7 Expenses associated with shelter costs will be shared. The DSP participant's spouse must apply their own income to the living costs of the couple, e.g. food, shelter, basic expenses.

5.7.3.8 The DSP participant will contribute their income, if any, to their individual budget. The non-participant spouse is not required to directly apply their income to the cost of supports for the participant of the DSP.

5.7.3.9 A DSP participant who shares their living accommodations with a spouse who does not meet the DSP eligibility criteria but who has limited income or no income shall have their budget developed to reflect the following:

- Personal allowance
- Shelter allowance (the non-participant's share of the rent or mortgage payment)
- Special needs

5.8 Ongoing Eligibility for Financial Assistance

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

a) have a budget deficit; and

b) be eligible for the DSP.

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

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

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5.8.4 Failure to disclose information required in section 5.8.1 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.

5.8.5 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.

5.8.6 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) wilfully 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 entitled.

5.9 Ineligibility for Financial Assistance

5.9.1 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.

5.9.2 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.

5.9.3 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;

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b) Workers Compensation Board;

c) the Government of Canada; or

d) any other statute or program.

5.10 Private Pay

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

5.10.2 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.

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

5.10.4 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.

5.10.5 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 financial decision made by the Department in relation to their application for or receipt of assistance under the *Social Assistance Act*. The legislative authority for this process is found in section 19.

6.1.2 All requests for an appeal are administered by the Appeals Unit of the Department and will be addressed in accordance with the appeal process set out in the *Employment Support and Income Assistance Act* and the Assistance Appeal Regulations.

6.1.3 The decision will include a summary of the facts and an explanation of the legislation, regulations and policy relied upon. This provides the opportunity for all parties to review and understand the rationale behind a

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decision prior to an appeal or request for an administrative review being filed.

6.2 Commencing an Appeal

6.2.1 The Care Coordinator will send the written decision relating to the application for assistance or receipt of assistance to the applicant/participant, and will notify the applicant/participant of their right to appeal that decision within thirty (30) days from the date they receive the decision.

6.2.2 The request for an appeal must be submitted by the applicant/participant to any office of the Department of Community Services within thirty (30) days from the date that the applicant/participant received the original decision.

6.2.3 The request must be made in writing in the approved form, Appeal Request form and must include:

a) the decision for which the appeal is requested; and

b) the reason for the appeal.

6.3 Administrative Review

6.3.1 The first step in the appeal process is an administrative review, which will be completed within ten (10) days of receiving the appeal from an appellant.

6.3.2 The Regional Administrator or designate must designate a Disability Support Program Supervisor or District Manager who was not involved in the original decision to conduct the administrative review**.**

6.3.3 The reviewer must examine all written material submitted to ensure that the decision being reviewed is consistent with the legislation, regulations and policy, and that the appellant's request is given a fair and timely review. There is no meeting or hearing.

6.3.4 The reviewer shall:

a) uphold, vary or reverse the original decision; and

b) immediately send the appellant the reasons in writing for upholding, varying or reversing the original decision.

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6.3.5 The appellant must advise the Regional Administrator or designate in writing, within ten (10) days of receiving the administrative review decision, if the appellant wants the appeal to proceed to a hearing before an Appeal Board.

6.3.6 If an appellant has not requested an appeal hearing within ten (10) days of their receipt of the administrative review decision, the Appeals Unit may close the file.

6.4 Appeal Hearings

6.4.1 When an appellant advises that they wish to proceed to a hearing, the appeal shall be set down for hearing before an Appeal Board. The process will be governed by the *Employment Support and Income Assistance Act* and the Assistance Appeal Regulations.

6.4.2 The Appeals Unit coordinates the appeal and sends notification of the date, time and place of the hearing by registered mail. The regional office will provide documentation for the Appeal Board to the Appeals Unit. The appellant shall be notified that if they do not attend the 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.

6.4.3 If an appellant wishes to have a hearing but cannot attend, they can either request that the appeal hearing be rescheduled or indicate that they would like the option of a hearing utilizing the telephone.

6.4.4 An appellant has the right to be assisted by a representative throughout the appeal process. Prior to appeal information being sent to a representative Departmental staff should obtain consent, preferably written, from the appellant to discuss their case with the representative.

6.5 Procedures for Appeal Board Hearings

6.5.1 Before or at the beginning of the hearing, Departmental staff will ask the appellant for copies of any documents that they plan to submit to the Appeal Board during the hearing and if they will have any witnesses.

6.5.2 Instead of attending the hearing in person, the appellant may send a representative to the appeal hearing. That representative will provide the Appeal Board with written proof that the appellant authorizes them to represent the appellant at the hearing.

6.5.3 If a lawyer is representing the appellant at the hearing, Departmental staff in the Region will send a copy of the appeals report to the counsel,

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provided they are a member of the N.S. Barrister's Association. If the representative is an articled clerk, staff should send the appeals report to the principal lawyer for the articled clerk as well or confirm that the clerk is acting on their behalf.

6.5.4 Departmental staff in the Region will work with the Appeals Unit to identify the person who will represent the Department at the Appeal Board hearing.

6.5.5 If a lawyer is required to represent the Department, Departmental staff in the Region will consult with the Department of Justice to engage counsel. This person will then advise the Appeal Unit that counsel has been retained.

6.5.6 The Appeal Board shall hear the appeal and has up to seven (7) days after the conclusion of the hearing to render its decision. The Appeal hearing itself will take place within thirty-eight (38) days of receipt of the appellants written notice. Assistance Appeals Regulations, Subsections 6(2), 9(1), 13(2).

6.6 Interpreting Dates

6.6.1 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 paragraphs above.

6.6.2 It also means the date a decision is communicated or an application for a review is received is not counted as the start date for the required time line. The time line for completion begins on the next day that is not a Saturday, Sunday or a holiday.

7.0 APPLICATION

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

8.0 ACCOUNTABILITY

8.1 The Director is responsible for ensuring that the program achieves the objectives for which it was created, and is delivered within a fiscally sustainable manner.

8.2 Regional Administrators are responsible for implementing this policy and ensuring compliance within their respective areas of responsibility, and the resources made available.

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8.3 Managers and supervisors are responsible for complying with the policy within their respective areas of responsibility and adequately preparing their employees to carry out their respective functions.

9.0 MONITORING

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

9.2 Regional Administrators are responsible for regularly monitoring and reporting on compliance with this policy.

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DEPARTMENT OF COMMUNITY SERVICES

Disability Support Program

Basic and Special Needs Policy

Effective: June 2012

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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 Disability Support Program (DSP) programs, except the Direct Family Support Program for Children 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) District Health Authorities (DHA)

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 Appendix A: Basic and Special Needs Rates, Appendix E: Funding Source Guidelines) 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 rates. Refer to Appendix A: Basic and Special Needs Rates for approved rates. 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 Appendix A: Basic and Special Needs Rates 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 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 would be in a budget deficit position following payment of the special need; and

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 types of recurring special needs:

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

b) long term, which are ongoing and are required by the participant for six 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 individual assessment and support plan 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 the Appendix A: Basic and Special Needs Rates consultation with the DSP Specialist is required. The DSP 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 shall refer to the appendices A to D for rates and approval levels for all special needs.

7.0 BASIC AND SPECIAL NEEDS BY ITEM OR SERVICE

7.1 Clothing

7.1.1 Regular Clothing

A participant in any residential program including Independent Living Support (ILS) and Alternative Family Support (AFS), is eligible for a monthly or semi-annual clothing allowance. This may be disbursed either monthly or twice yearly as per the participant's request.

7.1.2 Special Clothing

A participant in any DSP, including the Independent Living Support (ILS) Program, Alternative Family Support (AFS), and the Direct Family Support (DFS) 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 approved funeral rate schedule. (Appendix A: Basic and Special Needs Rates

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 7.7.2 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. See Appendix B: DSP Dental Rate Guidelines.

7.3.3 Dentures

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

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 (i.e. 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. (Appendix A: Basic and Special Needs Rates

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 entitlement, from the date the Care Coordinator is notified of the pregnancy or birth of the child, up to and including twelve 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 or 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 entitlement 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 Completion 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 District 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 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 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. (Exception Drug)

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 Appendix C: Special Diet Rate Guidelines and Appendix E: Funding Source Guidelines for a full list of special diet rates.

A participant's request for a special diet allowances 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 allowance 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 (1) 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 their 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) a 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 approved support plan 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 budget 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 approved individual support plan. 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 budget.

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. Casework Supervisor approval 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 waitlist, with their consent (see DSP Policy, section 8.0).

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 daily/nightly costs of a homeless shelter or youth facility in emergency and transitional situations, if the shelter or facility is funded through per diems.

A participant may have the daily cost of an approved residential recovery program for drug and alcohol addiction approved as a special need when it is a part of their approved support plan, and when the program is funded through per diems.

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

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 District Health

Authority or any other insured services. This assistance is not available if it is covered by an approved per diem rate or approved hours of support.

7.6.6 Respite in Direct Family Support (DFS) Program

Costs associated with providing at home respite relief to the parent, family, or guardian of a DFS Program participant, for a specific period of time, shall be funded as a special need based on the assessed needs of the participant (See DSP Direct Family Support Policy). See maximum respite approvals in Appendix A: Basic and Special Needs Rates.

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 (Set out in the DSP Policy, section 12.0).

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 approved support plan.

A participant will receive the actual cost of transportation up to the maximum allowable amount per month as per the Appendix A: Basic and Special Needs Rates 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 Appendix A: Basic and Special Needs Rates.

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 & Wellness.

7.8 Day Activities, Education, Employment

7.8.1 Day Activities

A participant of the Independent Living Support 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 skills training course such as a General Educational Development (GED), as part of their approved support plan. Funding for post-secondary courses is not provided by the DSP.

A participant who wishes to attend a post-secondary education program should have referrals made to the Labour Market Agreement for Persons with Disabilities (LMAPWD) on their behalf.

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 approved support plan, with Casework Supervisor approval.

Fees that are directly related to a return to employment, such as but not limited to drivers licenses, criminal record check/pardon applications, drivers abstract, 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 approved support plan. 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 who 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 participant's transportation expenses to and from their work placement may be approved if the participant is not already receiving a travel allowance in their budget.

8.0 LIVING ALLOWANCES – Independent Living

8.1 Personal & Shelter Allowance

A participant who rents, boards or owns their own home may be approved for the Personal Allowance (food, clothing and miscellaneous), and Shelter rates as outlined in the Appendix A: Basic and Special Needs Rates.

8.2 Emergency Food Orders

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

8.3 Excess Shelter

A participant must secure shelter within the approved DSP rates. Excess shelter rates may be approved as a special need when:

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 approved support plan 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.

A request for excess shelter requires approval of the Casework Supervisor. Appendix A: Basic and Special Needs Rates.

8.4 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.

8.5 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.

8.6 Furniture

A participant may be eligible for funding for the start-up and replacement costs of basic household items and furniture, in accordance with approved rates, where no other alternative is available. See Appendix D: Independent Living Furniture, Set-Up, and Replacement Rate Guidelines.

8.7 Homemaker Services

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

8.8 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 (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.

8.9 Moving Allowances

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

8.10 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.

8.11 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.

8.12 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 approved support plan.

8.13 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 approved support plan.

9.0 COMFORT ALLOWANCE (formerly Personal Use Allowance)

Participants receive a monthly comfort allowance as a special need to purchase items for their personal comfort and enjoyment.

When the comfort allowance is paid in trust and managed by a service provider, the service provider must document the balance of each participant's comfort allowance on the monthly invoice/account provided to the Department. Upon the participant's death, any remaining balance in service provider managed accounts shall be returned to the Department.

10.0 APPLICATION

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

11.0 ACCOUNTABILITY

11.1 The Director is responsible for ensuring that the program achieves the objectives for which it was created, and is delivered within a fiscally sustainable manner.

11.2 Regional Administrators are responsible for putting this policy in place and ensuring compliance within their respective areas of responsibility, and the resources made available.

11.3 Managers and supervisors are responsible for complying with the policy within their respective areas of responsibility and adequately preparing their employees to carry out their respective functions.

12.0 MONITORING

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

12.2 Regional Administrators are responsible for regularly monitoring and reporting on compliance with this policy.

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 threshold beyond which the participant can no longer safely remain in their home.

Appellant
A Disability Support Program (DSP) applicant/participant who is formally appealing a level of support decision before a DSP Review Committee, or any decision relating to their application for assistance or assistance received, to the Appeal Board established pursuant to the *Employment Support and Income Assistance Act*.

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).

Applicant/participant with Complex Needs
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 a District Health Authority.

Approved Budget
A participant's financial status which forms the basis for DSP financial assistance and has received the appropriate supervisory approval.

Approved Staffing Complement
The full number of staff working at a residential support option, as determined through the rate review process. This also refers to extra staffing that may be approved on a short term basis, through the special needs process.

Assessment
A process of collecting information using a consistent methodology in order to determine an applicant/participant's eligibility for supports from the DSP. Assessment identifies the applicant/participant's needs, and assists DSP staff in making informed decisions around what supports can best meet their needs. This is the foundation for basing decisions related to the provision of supports and services.

See Functional 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 requirement.

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.

Budget Deficit
When an applicant/participant's financial needs, calculated pursuant to legislation and Departmental Policy, exceed their income.

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, DSP 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.

Casework Supervisor/Senior Caseworker
A Department of Community Services, DSP employee responsible for overseeing the work and decisions made by a Care Coordinator, and other assigned duties. This may be called a Senior Caseworker in some offices.

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, especially 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.

Community Based Option
A DSP which supports persons with disabilities residing in the community, either living independently and supported by the Independent Living Support Program, or in a family home supported by the Direct Family Support Program or the Alternative Family Support Program.

Range of Supports
The range of at-home, residential and day program supports for persons with disabilities who may be eligible for the DSP.

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.

Department
The Department of Community Services (DCS) is one of the Departments of the Province 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)/District Health Authorities (DHA)
Services and programs provided by the nine district health authorities and the IWK Health Centre which fall under the jurisdiction of the Nova Scotia Department of Health and Wellness and the Nova Scotia District Health Authorities.

Director
The 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 (IDD)
- Long Term Mental Illness (LTMI)
- Physical Disability (PD), or
- Dual Diagnosis of IDD, LTMI or PD

Eligibility
The determination of whether an applicant/participant meets the DSP criteria to receive DSP assistance.

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 necessitating 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/Support Level 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.

The information gathered for purposes of the assessment comes from a variety of sources including the applicant/participant, their family and supports, direct observation and collateral contacts.

The assessment yields a clear and complete profile of an applicant/participant's strengths, and assists in identifying the applicant/participant's goals and support needs. The information gathered supports the development of a comprehensive individual support plan.

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
A person who is approved by the court to take legal responsibility for the personal affairs of another person (guardianship of the person) or for the financial affairs and property of another person (guardian of the estate). A parent is automatically "guardian of the person" for their child unless something happens to change that.

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 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.*

House Arrest
An informal expression, generally used to describe a court-ordered confinement to a dwelling place. In connection with a conditional sentence, it means that the offender is required to remain in his or her home for all, or certain designated hours of the day, for a set period of time.

Independent/Independence
The degree to which applicant/participants are able to manage, on their own, their activities of daily living, as well as instrumental activities of daily living.

Individual Program Plan (IPP)
See Individual Support Plan.

Individual Support Plan (ISP)
The ISP 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 ISP's. Members of the participant's support network may also contribute to the ISP.

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 ISP.

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**.**

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 strengthen their individual abilities and build capacity to become an active member in the community to the greatest extent possible.

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 provides policy direction for the programs. The Hospital Insurance Program is administered directly by the Department of Health. The cost of providing these services to Nova Scotians is met through the general revenues of the province.

Minister of Community Services
The Minister of Community Services or a Representative of the Minister's choosing.

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 Care
Active and compassionate care provided to an individual who is terminally ill. There are three stages in the palliative process:

1. **"Early" and "Intermediate" Stage Palliative Care** – Individuals in the early and intermediate stage of the palliative process normally would be considered "stable", where deterioration is proceeding at a slower pace, and minimal or occasional assistance is required due to terminal illness.

2. **"End Stage" Palliative Care** – Terminally ill individuals are in the end stage of the palliative process and are dealing with end of life (dying) issues. Time frame for the end stage may be measured in terms of days or weeks of dying. Time frames are difficult to determine however, and in some cases this end stage may be longer than a few weeks or as short as one or two days. There are typically day-to-day changes with deterioration proceeding at a dramatic pace.

3. **"End of Life - Life Expectancy of Less Than Six Months" -** The typical prognosis for a participant in this grouping would be a life expectancy of less than 6 months.

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 Allowance
A monthly allowance provided for participants living in a community based option (such as Direct Family Support or Independent Living Support). The participants' basic requirements (food and shelter) are not covered by an approved *per diem*. This allowance is provided to cover basic needs such as food, clothing and other miscellaneous requirements such as laundry and cleaning supplies. The amount of this allowance is established by the Department of Community Services.

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.

Personal Use Allowance
See Comforts 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.

Project 50
A program in which a participant volunteers for up to 25 hours a month and receives an allowance.

Rate Review
The process by which operational and capital funding is assessed by the Department to determine *per diem* rates for DSP residential service providers.

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.

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 on an annual basis or as often as required.

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 Provider 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.

Disability Support Program (DSP) Specialist
A Department of Community Services, DSP employee, responsible for the regional delivery of DSP Programs.

Shelter Allowances
A monthly allowance provided to a participant who is renting, boarding or owns his/her own home in programs such as Direct Family Support and Independent Living Support. This allowance is provided to cover costs for shelter up to the maximum rate as set by the Department.

Short-Term
A period of time that does not exceed six (6) consecutive months.

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 (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 District Health Authorities such as mental health outreach services or home care nursing services. These resources are typically available to all residents of Nova Scotia.

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 (4) 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. But 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) And 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 of 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 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 or Community Services to perform need assessments.

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.

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

Basic and Special Needs Rates

ITEM / SERVICE Policy # = blue	RATE & APPROVAL LEVEL
Basic Requirements: For participants living in residential settings whose basic requirements (food, shelter and clothing) are not covered by an approved per diem.	
Personal Allowance* (8.1)	$255 per month. This allowance is provided to cover basic needs such as food, clothing and other miscellaneous requirements such as laundry and cleaning supplies.
Shelter Allowance* (8.1)	Boarding - $223 per month. Rent/Own Home – up to $535 per month for individuals. Families of two are eligible for up to $570 per month and families of three or more are eligible for $620 per month.
Clothing – Regular (7.1.1) When clothing funds are received in trust, service providers are required to maintain records of distribution to participants and make them available to DCS upon request.	$30 per month, approved by Care Coordinator. Applies to participants in residential programs including Alternative Family Support. For the Independent Living Support Program $18 per month is included and issued under Personal Allowance and $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 DSP Programs).
Comforts Allowance (Personal Use Allowance)	
Comfort Allowance (Personal Use Allowance) (9.0)	$115 per month, approved by Care Coordinator.
Funeral and Burial	

APPENDIX A - Basic and Special Needs Rates

Professional Services and Merchandise (7.2)	Up to a maximum total of $2700 + taxes. 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 + taxes. 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 embalming preparations, out of province transfer.	Approved by Casework Supervisor.
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 Appendix B: DSP Dental Rate Guidelines.
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 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 Completion Fee (7.3.12)	$25 up to actual for the completion of the medical assessment (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 budget when it is part of a cost effective support plan, approved by Care Coordinator.
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 (7.3.15) Glasses Eye Exams (7.3.15)	Glasses and eye exams provided once every 2 years. Most economical option to meet need - up to $500 every 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 Appendix C: Special Diet Rate Guidelines. 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 entitlement 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.
Medical Care (Rehabilitation and Treatment Services)	
Counseling (7.4.1) Occupational Therapy, Physiotherapy and Speech Therapy (7.4.2)	Short-term interventions (up to 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 (8.2)	$25 per participant, approved by Care Coordinator.
Utility connection charges (8.13) Electrical connection is included in Shelter under Basics	Actual costs, approved by Care Coordinator.
Excess Shelter (8.3)	Up to $200 per month, approved by Casework Supervisor.
Extermination Services (8.4)	Actual cost of the most economical option as per DSP approval levels.
Fire/Liability Insurance (8.5)	Actual cost calculated at 1/12 for each month, or full annual premium. Two quotes required, approved by

APPENDIX A - Basic and Special Needs Rates

	Care Coordinator.
Furniture (8.6)	See Appendix D – Independent Living Furniture, Set-up, and Replacement Rate Guidelines. Up to $500 + HST, approved by Care Coordinator. $500 - 1000 + HST, approved by Casework Supervisor.
Homemaker Services* (8.7)	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 (8.8)	As part of an approved individual support plan. As per DSP approval levels.
Security/Damage Deposits (8.10)	Maximum one half (1/2) of the approved rent, approved by Care Coordinator.
Telephone* (8.12) *Applicable to Independent Living Programs	Telephone installation, equipment and services as part of an approved support plan, approved by Care Coordinator.
Shelter-Related Arrears (8.11)	Assessed individually. Approved by Casework Supervisor.
Moving Expenses – Within Region (8.9)	As part of an approved individual support plan. $200 approved by Care Coordinator.
Homeless Shelters and Recovery Programs	
Homeless Shelters (7.6.3) Residential Recovery Program (7.6.3) Youth Facility (7.6.3)	Actual cost, approved by Casework Supervisor. Actual cost, approved by Casework Supervisor. 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 participants in the Direct Family Support Program. Up to $800 per month approved by Casework Supervisor, Up to $2200 (maximum) per month approved by District Manager. Applies to AFS program for AFS family respite. Up to 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.
Regular Transportation (7.7)	Up to $150 per month based on 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 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)	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 month period, includes seat confirmations, approved by Care Coordinator. Max total of $100 per twelve month period for participants attending Senior High School.
Employability Related Expenses	Max total of $500 per twelve month period, approved

(7.8.4)	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

Appendix B – DSP Dental Rate Guidelines

Procedure Code	Description	Fee (GP) @ 100%	Fee (SP) @ 100%
02118	Radiographs – Eight Films	52.00	70.00
02131	Occlusal Radiograph - Single Film	28.00	37.00
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
	Caries/Trauma/Pain Control (plus retention band)		

Appendix B – DSP Dental Rate Guidelines

Procedure Code	Description	Fee (GP) @ 100%	Fee (SP) @ 100%
20121	- first tooth	100.00	111.00
20129	- each additional tooth (same quadrant)	100.00	111.00
	Smoothing of Fractured Surfaces		
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

Appendix B – DSP Dental Rate Guidelines

Procedure Code	Description	Fee (GP) @ 100%	Fee (SP) @ 100%
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
	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		

Appendix B – DSP Dental Rate Guidelines

Procedure Code	Description	Fee (GP) @ 100%	Fee (SP) @ 100%
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
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

Appendix B – DSP Dental Rate Guidelines

Procedure Code	Description	Fee (GP) @ 100%	Fee (SP) @ 100%
	DENTURES, PARTIAL, CAST WITH ACRYLIC BASE		
53201 53202	Partial Dentures - Cast Frame / Connector - Maxillary - Mandibular	894.00 + Lab 894.00 + Lab	IC IC
	DENTURES, ADJUSTMENTS		
54201	Denture adjustments, partial or complete denture, minor - one unit	73.00 + Lab	93.00 + Lab
	DENTURES, REPAIRS, RELINING AND REBASING		
55101 55102	Repairs, Complete Denture - No Impression Req'd - Maxillary - Mandibular	56.00 +Lab 56.00 +Lab	87.00+Lab 87.00+Lab
55201 55202	Repairs, Complete Denture - Impression Required - Maxillary - Mandibular	101.00 +Lab 101.00 +Lab	174.00+Lab 174.00+Lab
55301 55302	Repairs, Partial Denture - No Impression Required - Maxillary - Mandibular	56.00 +Lab 56.00 +Lab	87.00+Lab 87.00+Lab
55401 55402	Repairs, Partial Denture - Impression Required - Maxillary - Mandibular	139.00 +Lab 139.00 +Lab	174.00+Lab 174.00+Lab
55501	Dentures/Implant Retained Prosthesis, Prophylaxis and polishing - one unit	31.00 + Lab	94.00 + Lab
56211 56212	Reline, Complete Denture - Maxillary - Mandibular	243.00 243.00	304.00 304.00
56221 56222	Reline, Partial Denture - Maxillary - Mandibular	206.00 213.00	304.00 304.00
56231	Reline, Complete Denture (Processed) - Maxillary	326.00 +Lab	526.00+Lab

Appendix B – DSP Dental Rate Guidelines

Procedure Code	Description	Fee (GP) @ 100%	Fee (SP) @ 100%
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
	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

Appendix B – DSP Dental Rate Guidelines

Procedure Code	Description	Fee (GP) @ 100%	Fee (SP) @ 100%
	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
	Gingivoplasty and/or Stomatoplasty, Oral Surgery		
73211	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 + materials
46120	Partial Mandibular – No Impression	62.00	31.00	93 + materials
46210	Partial Maxillary – with Impression	90.00	45.00	135 + materials
46220	Partial Mandibular – with Impression	90.00	45.00	135 + 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 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

Appendix C – Special Diet Rate Guidelines

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 Supervisory 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
Gastric / Ulcer or Bland Diets	Treatment is based on eliminating foods which cause distress.	No additional funding
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 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.

Item of Special Need/Service	RRC	ARC	GH RCF DR S/O	AFS	ILS	DFS
Clothing						
Regular	PD	SN	SN	SN	Basics	Basics
Special	PD	SN	SN	SN	SN	SN
Comforts Allowance (Personal Use Allowance)	SN	SN	SN	SN	SN	SN
Funeral and Burial	SN	SN	SN	SN	SN	SN
Medical						
Dental	SN	SN	SN	SN	SN	SN
Emergency Response Devices	N/A	N/A	N/A	SN	SN	SN
Foot Care / Podiatry	SN	SN	SN	SN	SN	SN
Guide Dog Allowance	N/A	N/A	SN	SN	SN	SN
Hearing Aid Hearing Aid Batteries	SN SN	SN SN	SN SN	SN SN	SN SN	SN SN
Incontinent Supplies	PD	PD	SN	SN	SN	SN
Medical Equipment	SN	SN	SN	SN	SN	SN
Medical Insurance	SN	SN	SN	SN	SN	SN
Medical Supplies	PD	PD	SN	SN	SN	SN
Optical Care	SN	SN	SN	SN	SN	SN
Orthotics	SN	SN	SN	SN	SN	SN
Non-Prescription Meds	PD	SN	SN	SN	SN	SN
Prescription Meds	PD	PD	Pharma	Pharma	Pharma	Pharma
Special Diets	PD	PD	SN/PD	SN	SN	SN
Wheelchair Repairs	ES	ES	ES	ES	ES	ES
Medical Care (Rehabilitation and Treatment Services)	PD	PD	SN	SN	SN	SN

APPENDIX E – FUNDING SOURCE GUIDELINES

Item of Special Need/Service	RRC	ARC	GH RCF DR S/O	AFS	ILS	DFS
Support Services						
Extra Staffing	SN	SN	SN	SN	SN	SN
Homemaker Services	N/A	N/A	N/A	SN	SN	SN
Nursing Care	PD	PD	SN	SN	SN	SN
Personal Care	PD	PD	SN	SN	SN	SN
Residential Respite	N/A	N/A	N/A	SN	N/A	SN
Shelter / Utility / Food						
Electricity Hook-Up	N/A	N/A	N/A	N/A	SN	N/A
Emergency Food	N/A	N/A	N/A	N/A	SN	N/A
Excess Shelter	N/A	N/A	N/A	N/A	SN	N/A
Extermination Services	N/A	N/A	N/A	N/A	SN	N/A
Fire/ Liability Insurance	N/A	N/A	N/A	N/A	SN	N/A
Food/ Shelter Expenses to Attend Non-Routine Specialist Appointments Outside the Community	SN	SN	SN	SN	SN	SN
Furnishings	N/A	N/A	N/A	PD	SN	N/A
House Repairs	N/A	N/A	N/A	N/A	SN	N/A
Moving Expenses Within Region	SN	SN	SN	SN	SN	N/A
Security / Damage Deposit	N/A	N/A	N/A	N/A	SN	N/A
Shelter-Related Arrears	N/A	N/A	N/A	N/A	SN	N/A
Telephone	N/A	N/A	N/A	N/A	SN	N/A
Telephone Hook Up	N/A	N/A	N/A	N/A	SN	N/A
Transportation						
Ambulance	SN	SN	SN	SN	SN	SN
Regular Transportation	SN	SN	SN	SN	SN	SN
Transportation for Medical Attention (not an Ambulance)	SN	SN	SN	SN	SN	SN
Education / Employment /Day Programs						
Education / Employment / P50	SN	SN	SN	SN	SN	SN
Transitional Day Programs	N/A	N/A	N/A	N/A	N/A	SN

PD = Per Diem **ES = Easter Seals** **SN = Special Needs** **Pharma = Pharmacare**