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IOWA'S
Seven Year Plan
for Delivery of Services
to persons who are
DEVELOPMENTALLY
DISABLED

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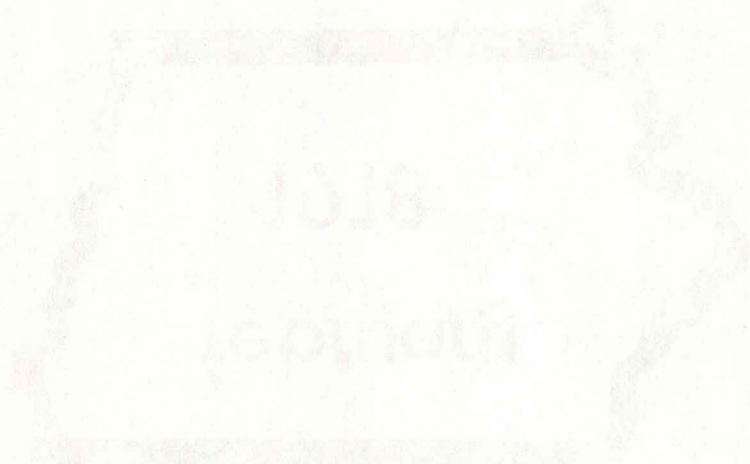

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PREFACE

Through the encouragement of Governor Robert D. Ray and the enabling legislation by Iowa's General Assembly in 1975, the Department of Social Services was given the authority to develop a plan which assures that the developmentally disabled population of this state will receive services appropriate to their needs.

This plan was developed through the cooperation of more than fifteen hundred people representing various state regulatory and service agencies with equal participation and input from the private sector. Thousands of man hours by the citizens of Iowa who have an investment in services to the developmentally disabled went into the development of this Seven Year Plan. In addition to the state plan there are sixteen district plans which reflect the needs of the D.D. population and how they plan to meet those needs.

I am sure that the reason for the tremendous cooperation and energy that has gone into the development of this plan is because the people of Iowa believe and are dedicated to the value and dignity of each human life, and want to reaffirm Iowa's faith in human rights and the dignity and worth of all persons.

Iowa's Seven Year Plan is a working document which promotes specific principles, and provides guidelines, policy statements and models to be used state-wide whether it be at the two State Hospital-Schools or in the respective geographic districts. The Department of Social Services hereby reaffirms its commitment to promote the development of a continuum of services to meet the many and varied needs of the developmentally disabled and further pledges its leadership and resources to accomplish this goal.

Victor Preisser
Commissioner

INTRODUCTION

During the past fifteen years the State of Iowa has undertaken a number of major efforts to improve the services provided to its developmentally disabled citizens.

While these past efforts have helped expand and improve the array of services available, there is still much that needs to be done to insure that each developmentally disabled person has access to all of the services they require, and that the services are provided in the most appropriate setting.

This report documents the results of an intensive two year planning process that has identified the services currently available to the developmentally disabled, explored ways to improve the coordination of the existing services, identified gaps in the current service delivery system and set out a Seven Year Master Plan for meeting these service needs. More than 1,500 concerned citizens, as well as representatives of government agencies, advocate groups, elected officials and service providers, participated in the planning effort.

This report should not be viewed as an end product, but rather as a beginning. The real test of Iowa's commitment to its developmentally disabled citizens is not in the development of a plan to improve services, but in the implementation of it.

PRINCIPLES

The service delivery system for the developmentally disabled citizens of the State of Iowa, is based on a belief in the infinite value and dignity of each human life. The primary goal of this system is to assist every developmentally disabled person, through a comprehensive array of services, to realize his or her maximum potential and to maintain a normal life style. In order to achieve this goal the service delivery system must adhere to the following principles:

1. NORMALIZATION: Making available to the developmentally disabled, patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream of society. Each service should include, within its programming, a definite progression toward a more typical, independent life style.
2. INDIVIDUALIZATION: Services must be responsive to the individual client's identified need. Development of services must be based on the individual's needs in order to secure the most effective and acceptable means of minimizing the effects of the disability.
3. ACCESSIBILITY TO SERVICES: Services must be geographically accessible and delivered so that no cultural, social, transportation or architectural barriers limit use. Services should have built-in safeguards to prevent lack of information, cost and/or lack of agency responsiveness or follow through, from blocking the client's access to those services.
4. AVAILABILITY: A comprehensive array of services, sufficient in quality and quantity, to meet all clients' needs, regardless of their age, level of disability or cultural background, must be offered to meet the identified client needs of community and district. Availability

also relies on sufficient funding being available to assure maximum utilization of the services.

5. RESPONSIVENESS (FLEXIBILITY): The system, as well as each component, must be flexible enough to insure that individual needs can be met as they are identified. The system must also be able to reach out to meet both expressed and unexpressed client needs and must be flexible enough to change as areas of client needs change.

6. VOLUNTARY CHOICE: Each individual should be allowed to choose from an appropriate array of services. Clients should not be forced to receive services against their will, or the will of their legal representative.

7. RESPONSIVENESS TO THE DEVELOPMENTAL MODEL: Services must be designed to facilitate an individual's growth through skill development to independence. The system should, through its array of services, allow progression from mastery of self-help skills through socialization skills to independent living skills.

8. MAXIMIZATION OF EXISTING RESOURCES: The system should utilize existing resources and providers, including generic service agencies, whenever possible in developing new components. This insures coordination within the system, yet avoids duplication.

9. LOCATION OF SERVICES WITHIN THE COMMUNITY: All services should be provided within the community or as close as possible to where the individual resides. (This should not be interpreted as preventing access to district and state-level resources if needed or requested.)

DEFINITIONS OF DEVELOPMENTAL DISABILITIES

A developmental disability is defined as a disability attributable to mental retardation, cerebral palsy, epilepsy, autism, (or dyslexia resulting from these) or any other conditions closely related to mental retardation in terms of intellectual and adaptive problems.

> The important phrase in the definition is "other conditions closely related to mental retardation in terms of intellectual and adaptive problems." Although the process for providing services is appropriate, the overall plan is not designed to treat the entire range of conditions in the DD population. An example of a condition not addressed in this plan are persons who are epileptic and are "normal" except for their need to have their condition controlled medically.
>
> Those persons who have cerebral palsy, epilepsy, and other disabling conditions who are not intellectually impaired and their adaptive behavior is in the realm of normal need to have their needs addressed through another program plan.
>
> The Developmentally Disabilities Council should identify the limits of this Seven Year Plan and move toward developing a plan which addresses the needs not covered by this plan, e.g. employment, education, medical assistance, etc.

The handicap must originate before age 18; can be expected to continue indefinitely; and constitutes a "substantial" handicap.

> Substantial handicap refers to such severity that it prevents the persons from participating in and benefiting from the social, economic, educational, recreational or other opportunities that are generally available to non-handicapped peers.
>
> In describing levels of retardation or other developmental disabilities, it is important to note that persons who have these disabilities are as different from one another as are persons with average intelligence. These levels are offered only as a tool to assist with the projection of persons with similar disabilities and subsequently similar service needs.

1. MENTAL RETARDATION refers to significantly subaverage intellectual functioning existing concurrently with deficits in adaptive behavior, and manifested during the developmental period.

"Subaverage refers to performance which is more than two standard deviations from the mean or average of the tests."

"The upper age limit of the developmental period is placed at 18 years and serves to distinguish mental retardation from other disorders of human behavior."

"Adaptive behavior is defined as the effectiveness of degree with which the individual meets the standards of personal independence and social responsibility expected of his age and cultural group."

Profoundly retarded persons (IQ below 20 or 24, depending on the scale used) and severely retarded persons (IQ of 20-35 or 25-39, depending on the scale used) have very noticeable delay in their development at an early age. However, training efforts have clearly shown that with very few exceptions, profoundly retarded persons can make progress in such areas as self-care, language development, self-protection, impulse control and physical movement.

The developmental delay for severely retarded persons is very similar to the profoundly retarded at an early age, but the rate of progress and development is usually much greater.

Moderately retarded persons (IQ of 36-51 or 40-54, depending on the scale used) have been shown to benefit from early training in order to obtain their fullest potential. By school age, self-help skills such as toilet use, simple dressing, self-feeding, etc., should be proceeding rapidly. Fullest potential has frequently been described for moderately retarded persons of adult age to be a degree of supervised living facility with vocational training in a sheltered workshop or work activity center.

Mildly retarded persons (IQ of 52-67 or 55-69, depending of scale used) are highly similar to non-retarded persons of the same age, differing in rate and degree of intellectual development. A mild degree of retardation is not usually apparent except during school age. Program needs for this degree of retardation up to and including adulthood should be designed for help with social, educational and vocational skills that will be necessary to live in a community and for employment.

2. CEREBRAL PALSY refers to a condition in which damage has occured to the central nervous system from birth or early infancy, which results in various degrees of disfunction in areas such as speech, mobility, coordination, paralysis and weakness. Often, there are other manifestations of organic brain damage such as sensory disorders, seizures, mental retardation, learning difficulty and behavior disorders. It is non-progressive.

3. EPILEPSY refers to various disorders characterized by recurring loss of consciousness, convulsive movements or disturbances of feeling or behavior. An episode occurs when brain cells discharge too much electrical energy.

4. AUTISM is a recognizable syndrome characterized mainly by extreme social withdrawal and belated speech development. Other symptoms may be present in autistic children to a greater or lessor degree (e.g. hyperactivity, ritualistic mannerisms, unresponsiveness to auditory or visual stimuli). Many children with autism will also be seriously impaired in general intellectual functioning.

5. DYSLEXIA Partial inability to read, or to understand what one reads silently or aloud. (This condition must occur in conjunction with mental retardation, cerebral palsy, epilepsy or autism for a person to be considered developmentally disabled.)

DEFINITIONS OF DEVELOPMENTAL DISABILITY SERVICES

1. Counseling Services: Provision of professional guidance to assist the D.D. individual and family to understand their capacities and limitations. To set goals (short and long range) including vocational, and to solve problems interfering with the D.D. individual's participation in needed services.
2. Day Care Services: Comprehensive activities providing personal care and other services to D.D. of all ages outside the home during the day. Include a variety of creative, social, physical and learning activities organized as developmental services for children or activity programs for adults. All activities are based on adequate evaluation.
3. Diagnostic Services: Provide coordinated services to identify a D.D., its cause and determine the extent that normal daily activities might be limited.
4. Domiciliary Care: Provision of out-of-home living quarters, supervision and personal care to developmentally disabled persons needing 24-hour supervision. Nursing homes, residential (custodial), state hospital-schools and county care facilities may be included in this category. (Differs from Special Living Arrangements by the degree of supervision and amount of personal care and programming provided.)
5. Education Services: Provision of a structured learning experience to individuals who are developmentally disabled based on appropriate evaluations of each individual. Designed to develop knowledge and skills and their application to daily living.
6. Evaluation Services: The total evaluation of the D.D. individual and his family to determine: (1) how to remove or minimize the disability; (2) determine services; (3) set realistic service objectives and

(4) set up individualized programs.

7. Follow-Along Services: Establishment and maintenance of a counseling relationship on a life-long basis with D.D. individuals and families, with the purpose of assuring that anticipated changes in needs are recognized and met.

8. Information and Referral Services: Provision of an up-to-date listing of appropriate resources from which a professional can select the best resources for the D.D. and the family. It is important to have a professional person between the D.D. individual and the I & R Service so counseling service may be advisable in conjunction with I & R. The I & R Service can also develop public information activities with regard to the problems of the developmentally disabled.

9. Personal Care Services: Designed to maintain health and well-being, including the provision of food, shelter and clothing required to prevent regression or complications in connection with the disability. Must be accompanied by one or more other services.

10. Protective and Other Services: A system of continuing legal, social and other services to assist those unable to manage their own resources or protect themselves from neglect or exploitation.

11. Recreation Services: Provision of activities designed to: (1) meet individual therapeutic needs in individual self-expression, social interaction and entertainment; (2) develop skills and interests for enjoyable and constructive use of leisure time and (3) improve the general well-being of the D.D. individual.

12. Sheltered Employment Services: Provision of activities (work evaluation, work adjustment, occupational skill training and paid employment) for those not able to go into the job market due to their particular disability.

13. Special Living Arrangements: Provision of living quarters for persons who need some degree of supervision and special leisure-time activities. Services are for developmentally disabled persons who can leave the place of residence for work, recreation or other reasons. Included in this category might be group homes and hostels, boarding homes, foster homes, supervised apartments and respite care.

14. Training Services: Instruction in formal and informal activities to D.D. of all ages to (1) develop skills in daily living activities (self-help and communication) and (2) for gaining vocational skills.

15. Transportation: Provision of travel and related costs involved in transporting the D.D. individuals and their families to and from service locations. May include delivery (raw materials) and pick-up (finished products) of home bound industries.

16. Treatment Services: Provision of coordinated treatments to halt or control processes that contribute to D.D. Many medical, psychological, physical and occupational treatments, as well as others, are included.

These definitions do not relate to eligibility for services. Responsibility for provision of these services is addressed on page 26. The responsibility to provide a service rests with the agency which is the primary funding source.

THE PLANNING PROCESS

Background

The need to improve the care and services provided to Iowa's retarded citizens residing at Glenwood and Woodward State Hospital-Schools, has been a long recognized service need in the State of Iowa. In 1973, the Department of Social Services developed a plan to upgrade the services at the two Hospital-Schools to the levels outlined in the Joint Hospital Commission's Standards for Residential Facilities for the Mentally Retarded. While Governor Robert D. Ray and the Iowa General Assembly were supportive of the plan, implementation was delayed because of the substantial increases in state appropriations which were required.

Late in 1974, the Department of Social Services undertook a study to determine if it would be feasible to use Title XIX Medical Assistance funds to implement the plan. The Department of Social Services had, on a number of previous occasions, reviewed the desirability and feasibility of using Medical Assistance funds at Glenwood and Woodward State Hospital-Schools; but this was not considered financially advantageous to Iowa. However, four important changes in Federal legislation governing the Medical Assistance Program occurred during 1974 and 1975 which prompted the Department to re-evaluate the potential of the Title XIX program. These changes were:

1. Federal regulations liberalized eligibility of mentally disabled individuals under SSI to include the mentally retarded.

2. Federal Program Instruction MSA-PI-75-4 (8-28-74) indicated the U.S. Department of Health, Education and Welfare could de-certify any nursing home participating in the Medicaid Program that retains inappropriately placed mentally retarded individuals in the facility. Enforcement of this could affect approximately 800 mentally retarded Iowans residing in nursing homes.

3. State Bulletin VII-MS-15 (12-9-74) eliminated the "maintenance of effort" requirement which limited the amount of Federal matching funds available to public institutions for the mentally retarded to matching only those state funds spent in excess of the state's normal expenditures. This provision expired 1-1-75 and the state may now claim reimbursement at the regular matching rate for all appropriations expended at state institutions, which greatly increases the amount of funds available.

4. SRS Program Regulation 40-4 (C-9) (4-1-75) removed the upper limit on Medicaid payments to facilities serving the mentally retarded.

In addition to these changes, an important change occurred in HEW's application of a Title XIX Program regulation to Iowa's system of funding Glenwood and Woodward State Hospital-Schools. Section 1902 (a) (2) of the Social Security Act provides that the financial participation of states in the Medical Assistance Program must be equal to the total of the non-federal share of the cost of the program, and/or must ensure that any local funds used in the program are handled in such a way that lack of funds from local sources will not result in the lowering of the amount, duration, scope or quality of care and services available through Title XIX. In the past, HEW had indicated that county participation in the cost of care at Glenwood and Woodward would have to be eliminated prior to the institutions becoming eligible to receive federal funds. As the counties were providing approximately $11 million of the $16 million operating budget for the two institutions, elimination of county funding was not considered possible. However, in April, 1975, HEW advised the Department that because the General Assembly does make an appropriation for the operation of the two institutions, the federal requirement for total state funding is met, even though the counties are later billed for a portion of the costs at the institutions. County funding of community based facilities (ICF/MR's) constitutes such a small portion of the total

expenditures through the Title XIX program that it is not considered capable of impacting the amount, duration, scope or quality of care and services available through Title XIX.

In addition to being a potential funding source for improving the services at the State Hospital-Schools, the expansion of the Medical Assistance Program to include facilities for the retarded and developmentally disabled (ICF/MR's) would also open up an additional source of funds for community-based services for the developmentally disabled. With the addition of some services, many community-based residential facilities for the mentally retarded could qualify as Medical Assistance vendors. With Medical Assistance funds paying for the care of the individuals residing at these facilities part of the local and county funds supporting these facilities could be diverted to other services for the developmentally disabled.

The improvement in the quality of services, staffing and other positive changes at Glenwood and Woodward would also make a further resource available to the communities - the expansion of the assistance given to community programs. Workshops, training programs for community-based personnel, demonstration projects and a host of other devices which were then in operation could be considerably expanded.

Because of these considerations, the Department recommended that an ICF/MR program be established in Iowa. The Department presented the results of their study to Governor Robert D. Ray and the Iowa General Assembly for their review and approval late during the first session of the 66th General Assembly. Both the Governor and the General Assembly responded positively and quickly to the Department's presentation. House File 895, the Department's appropriation bill, contained the following statement:

> It is the intent of the general assembly in making appropriations to the Glenwood state hospital-school and the Woodward state hospital-school that the department of social services will move towards the development of the two hospital-schools as intermediate care facilities for the mentally retarded.

Further legislative support was contained in House File 989 which created the "Hospital-Schools revolving fund" to be "used for projects in Glenwood and Woodward Hospital-Schools . . . (to) bring the Hospital-Schools into compliance with federal and state standards relating to physical facilities in order to have approved mental retardation Intermediate Care Facilities as authorized under Title XIX of the United States Social Security Act."

In response to the Mandate of the Legislature, the Department marshalled all of its resources in a total effort to accomplish the certification of Glenwood and Woodward by January 1, 1976. To expedite this undertaking, the Department of Social Services established a Task Force (ICF/MR Task Force) to coordinate and direct the Department's effort. This five person Task Force includes representatives from each of the two State Hospital-Schools, and the Department's Division of Mental Health Resources and Medical Services Section. One major principle of the Task Force's work was that developments at the two State Hospital-Schools must move in concert with those in the community, where a large number of providers - private and public - are already offering services to the developmentally disabled and anticipating increased resources through the Title XIX program.

In order to promote coordinated development in all realms of service delivery, the Task Force convened an ICF/MR Statewide Policy Advisory Committee in July, 1975. The group consisted of 26 individuals representing the full array of interests affected by Title XIX. Included were representatives of the Department of Social Services, delegates from the Glenwood

and Woodward State Hospital-Schools, the Divisions of Special Education and Rehabilitation Education Services of the Department of Public Instruction, the Department of Health, the Office of Developmental Disabilities, the State Health Planning Agency, the Iowa Association for Retarded Citizens, the Iowa State Association of Counties and representatives of private residential facilities for the mentally retarded. The mandate to the Advisory Committee was to recommend policy to the Department of Social Services on the overall state care system for the developmentally disabled to ensure that planning for Title XIX eligibility would complement the further development of the statewide system.

The Advisory Committee met for 35 hours of concentrated planning during the two week period from July 29th to August 8th, 1975 and has convened regularly since then to follow-up on implementation of its proposals. The Advisory Committee's work was initially facilitated by the Environmental Design Group, a Massachusetts-based architectural and design firm with experience in planning for Title XIX. Since mid-1976, staff from the Department of Social Services has facilitated the Advisory Committee.

The Advisory Committee recommended a strong role for the two State Hospital-Schools in a state-wide care system, functioning as specialized resource centers.

<u>Training and Transfer</u>:

The planning process provided a learning-through-experience process for those who did the staff work -- DSS's Mental Retardation (MR) Supervisors. By assigning them to work nearly full-time with the Environmental Design Group consultants during the four month planning process, they in turn were prepared to assist in a similar MR/DD planning process in Iowa's other districts. In addition, Environmental

Design Group developed a document to transfer the planning tools developed from the model district planning process to other Iowa districts.

The planning process in the model districts involved a thirteen week schedule of meetings and activities for three planning groups which is summarized in the Integrated Planning Schedule. Following is a description of these groups, their composition and their responsibilities.

Staff Task Force:

This group was composed of DSS's MR Supervisors and Iowa Association for Retarded Citizens (IARC) field representatives who were assigned as staff/trainees to the project. Under the coordination of an EDG consultant, these people provided staff support to other planning groups. This included the preparation of presentation materials, research, group facilitation, development of core group recommendations into planning format and report writing and production.

Core Planning Group:

This group consisted of key public and private district, county and local MR personnel. This included: consumer representatives, DSS District Administrators, representatives from District Area Education Agencies, Vocational Rehabilitation, Developmental Disabilities Councils, Health Planning Councils, State Hospital-Schools, local sections of IARC and private providers. This group provided continuity and integration between themselves and the input of the extended planning group. They accomplished this by attending the three major hearings and developing the resulting output into specific plans. The Core Planning Group also met in large and small groups on a weekly basis to develop, review and revise the different sections of the plan.

Extended Planning Group:

This group was composed of key district, county and local political and community leaders. Through three major hearings, this group provided guidance and recommendations for the best ways the MR planning outputs could maintain the acceptance and the support of the community at large. At the first hearing, the members gave their comments and suggestions for planning directions to the core planning group and staff task force. Their input was again heard at the second hearing when they reviewed the draft plan and gave further recommendations and direction for its revision. At the third hearing, they gave final comments, approved the plan and then began planning implementation steps.

Each of the model districts produced the following results:

* Needs Assessment - An analysis of the number of people who will need MR/DD services within the district, taking into account severity of disability, age and residential location. Also included were the number and characteristics of people currently receiving services.
* Functional Model - A graphic representation of the services available in the community, the way the client moves through them and the way services should be related to best meet client needs.
* Administrative Model - A description of the legal and organizational relationships among services. The administrative model fixes responsibility, authority and accountability for funding and programs.
* Constraints and Strategies - The barriers (financial, political, organizational, etc.) which prevent the implementation of the ideal model and the steps to be taken to overcome them.

* Priorities - The goals, objectives or activities which are either more important or must occur before others can be developed.
* Cost Analysis - A description of the approximate cost of units of service and the number of units required.
* Seven Year Master Plan - A projection of the numbers of persons to be served and additional funding required for each service over the next seven years.

A more complete description and evaluation of the model district planning process can be found in the publication Model District Planning.

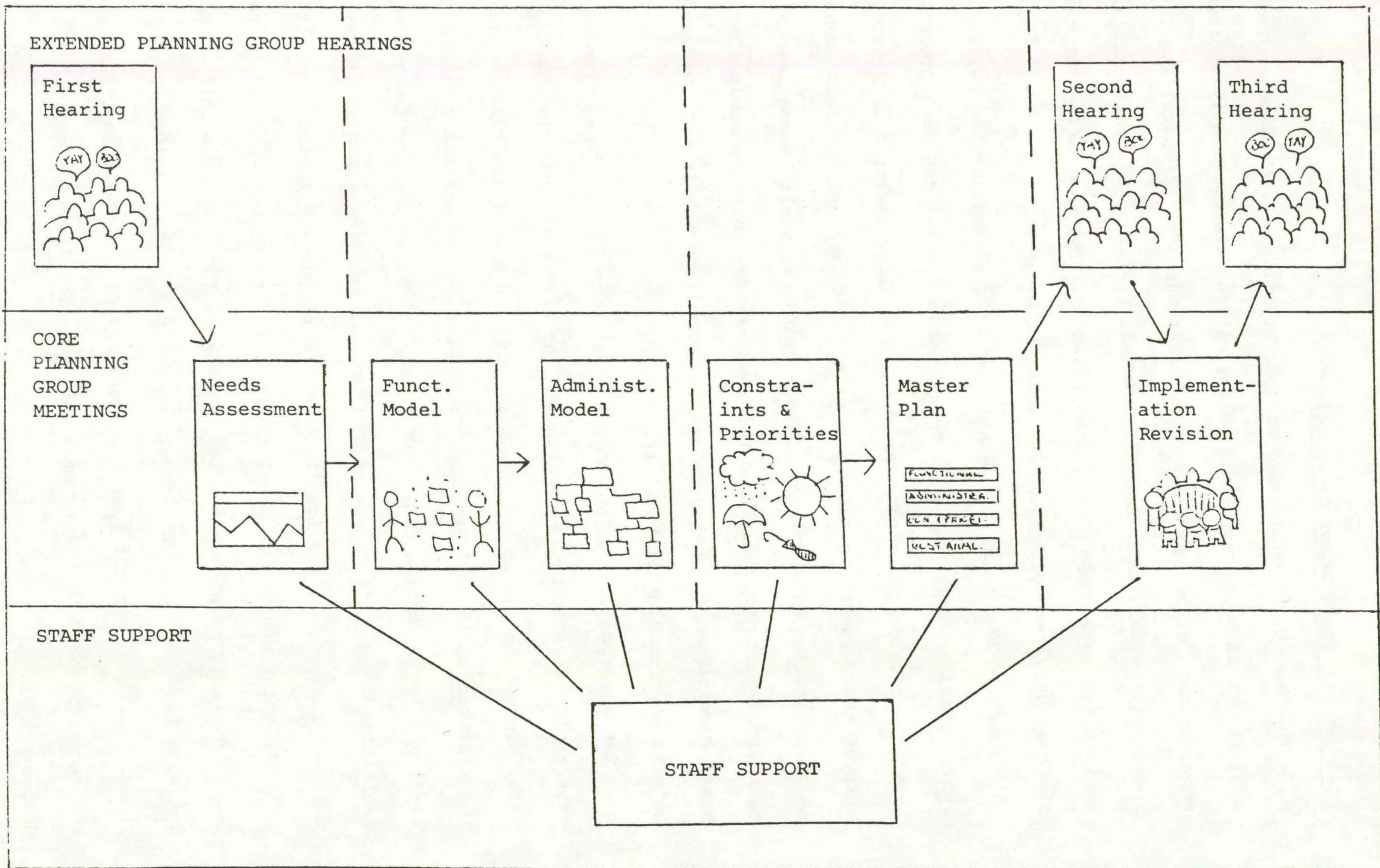
By May of 1976, the comprehensive community planning in the two model districts, Dubuque and Sioux City, was completed, and this concluded the contract with Environmental Design Group. On May 15, 1976, the Division of Community Services initiated the community planning effort in the remaining 14 districts with the goal that the community planning process be completed by October 1, 1976.

Community planning for MR/DD services followed the format, schedule and content suggested in Model District Planning, a comprehensive pamphlet-guide prepared by EDG for the Department. Similar to the model district planning process, the second phase of district planning was accomplished by three interrelated groups: the staff task force (Department employees); the core planning group (parents of developmentally disabled persons, elected officials, service providers and community leaders); and the extended planning group (the public at large).

MR specialists in the districts headed the staff task forces, and six staff members from the central office of the Department of Social Services were given temporary assignments to those smaller districts who shared MR specialists with larger districts. Three public hearings were held in each district and those citizens responding to special invitations

and public announcements became the extended planning group. For the first hearing, noted speakers in the MR field were brought in, the planning process was explained and core groups were selected. Over the planning process of eleven weeks in the summer of 1976, the core group met to determine the needs of the MR/DD population of each district, to develop a system of service delivery and to formulate a seven year master plan of community service for each district. These plans were presented at a second public hearing, input was received from the extended planning group and this input was incorporated into a revised plan which was presented at the third and final hearing. Copies of each district's plan can be obtained by contacting the appropriate district office of the Department of Social Services.

Over the winter months, county core groups were organized, and permanent MR generalist/supervisors were appointed for each district.



INTEGRATED PLANNING SCHEDULE

Planning for State Hospital-Schools

The two state-owned and operated facilities at Glenwood and Woodward will remain as major resources to the entire developmentally disabled population in either a direct or indirect manner. In fulfilling their legal requirements to provide "treatment, training, instruction, care habilitation and support" for Iowa citizens, they will bring the quality of those services to the highest level attainable.

Mandated standards are detailed in Federal Regulations 249.12 and 249.13 outlining participation requirements for the Medicaid program. Another criterion for the measurement of quality services is provided through the voluntary application of the Standards of the Joint Commission on Accreditation of Hospitals. These standards shall be considered a base from which individualized programs are developed to assure individual human development and early return to normalized family and community life outside any residential facility.

The Glenwood and Woodard facilities' function is the prevention of developmentally disabling conditions; the elimination of the condition until prevention can be achieved; and improvement of the circumstances of the affected individual and his environment to the maximum functional level until elimination can be achieved. In addition, the two state facilities shall continue to search for and implement innovative ways to improve programs and services both on the campus and in the community.

The state engages in a multitude of programs not owned and operated but financially supported for the benefit of the developmentally disabled individuals. The Hospital-Schools serve as a major resource to support those efforts by providing professional training, demonstration programs and other supports that will encourage high level development of all service deliverers in the State.

The basic human institution is the family. Glenwood and Woodward shall continue to expand family-oriented programs. By training family members, the demand for out-of-family services, either at State Resource Centers or community institutions, can be substantially reduced. The professional expertise of the two State facilities shall be directed toward expanded capacity of the family to assist its disabled members to develop to the fullest potential. Improved facilities on both campuses provide a logical environment for accelerated family improvement programs.

To provide a highly specialized and sophisticated array of services requires a resident and/or out-patient population sufficient in size to attract a diversity of qualified professionals. The Hospital-Schools, in order to provide these highly specialized services economically, must function as area-wide resource centers, requiring constant evaluation. The opportunity for them to provide a high level of services will be attained through the exchanging of ideas from many levels.

The specific planning details involved in the improvement of services are continued in a Technical Plan of Correction for each facility, which also provides a measurement of progress. Glenwood and Woodward will implement and expedite the approved Technical Plan of Correction as provided in Federal Register stating the requirements for "Intermediate Care Facilities for the Mentally Retarded to continue to participate in State Medical Programs (Title XIX, Social Security Act)."

This State Plan endorses the recommendation of the Advisory Committee that the two State Hospital-Schools have a strong role in a State-wide Care System. The Advisory Committee made the following recommendation:

> "In the comprehensive array of mental retardation services the present State Hospital-Schools shall function as specialized resource centers providing:

Direct Services
(a) for low incidence mental retardation problems,
(b) for complex, or multifaceted treatment needs,
(c) for short-term or transitional care for those who by choice or necessity cannot receive adequate services elsewhere,

Indirect Services
(a) education and training of mental retardation professionals and other mental retardation service personnel including follow-up and support,
(b) program consultation and technical assistance to mental retardation service providers,
(c) research,
(d) demonstration projects,
(e) support and monitoring of diagnostic and evaluative services to the district and local-county level."

SEVEN YEAR PLAN

FOR THE

DELIVERY OF COMMUNITY BASED SERVICES

NEEDS ASSESSMENT

The figures for the number of persons needing services and currently receiving services were compiled from the sixteen District plans which were developed during 1976. Persons counted are those with developmental disabilities. Definitions of the sixteen services may be found earlier in this state plan.

Figures at the very bottom of the chart indicate the number of individuals now receiving services, and the number who will be served in the seventh year. Considering that projections provided earlier in this state plan show 141,631 developmentally disabled persons in Iowa, one can see that approximately 26% (37,246) persons now receive services; and that by the seventh year, 50% (71,152) will be receiving services. Quality of service and appropriateness of service are not necessarily implied for those services identified as currently being provided.

The other 50% of the developmentally disabled (70,479 persons) are not projected to need the sixteen specialized services considered in this state plan. *For example, many persons with mild developmental disabilities will have their educational needs met through regular educational programs. Note: The identified need for services and related projected costs should be viewed as an initial attempt to identify clients and their service needs. These figures will need revision on a yearly basis.

COST ANALYSIS:

Information provided in the sixteen District plans was used to obtain the:

1. Current average, annual (per capita) unit cost.
2. The percentage increase necessary to provide care which meets accepted standards.
3. The new average, annual (per capita) unit cost.

*see page 28

Current and future annual cost totals for each of the sixteen services were crosschecked with the actual total amounts for each service in the sixteen District plans.

(The increases do not, however, include any increases necessary to meet inflation or cost-of-living increases.)

ICF/MR, the most intensive level of residential programming that will be available, is planned to be provided at the community level as well as the State Hospital-Schools. The projected numbers of eligible clients currently in need of community based ICF/MR care, if such care were available, are as follows:

District		
District 1	(Decorah)	233
District 2	(Mason City)	227
District 3	(Spencer)	95
District 4	(Sioux City)	145
District 5	(Fort Dodge)	101
District 6	(Marshalltown)	241
District 7	(Waterloo)	226
District 8	(Dubuque)	201
District 9	(Davenport)	159
District 10	(Cedar Rapids)	121
District 11	(Des Moines)	371
District 12	(Carroll)	97
District 13	(Council Bluffs)	161
District 14	(Creston)	49
District 15	(Ottumwa)	218
District 16	(Burlington)	146
	TOTAL	2886

FUNDING SOURCES

Listed below are both principle, current funding sources and also potential new funding sources. Sources of funding for services vary among Districts, depending on which source and which agency funds a particular service in each district. More specific information may be found in district plans, and in individual state programs and appropriation requests. The Department of Social Services is responsible for initiating letters of agreement which spell out agencies which are principally responsible for funding particular services. (Funding to an agency usually indicates legal responsibility for providing a service.)

PROBABLE FUNDING SOURCES

	County	State	Title XX (Federal)	Title XIX (Federal)	Area Education Agency	Vocational Rehabilitation (R.E.S.B.)	State Supplemental Assistance	Supplemental Security Income (Federal)	Housing and Urban Development (Federal)	Dept. of Public Instruction (State)	Community College	Local Education Agency	Other Federal, State & Private Sources
Diagnosis	x	x	x	x	x							x	x
Evaluation	x	x	x	x	x								x
Follow-Along		x	x	x									x
Treatment	x	x	x	x									x
Day Care	x	x	x	x									x
Domiciliary	x	x	x	x			x	x					x
Special Living Arrangement	x	x	x	x			x	x					x
Education					x	x					x	x	x
Training	x	x	x	x	x	x						x	x
Sheltered Employment	x	x	x			x							x
Personal Care	x	x	x										x
Recreation	x	x	x	x									x
Transportation	x	x	x		x							x	x
Counseling	x	x	x		x							x	x
Protective Services		x	x										x
Information and Referral	x	x	x	x									x

IOWA - DEVELOPMENTALLY DISABLED
PROJECTED POPULATION

Age Range	Total Population	Developmentally Disabled Population					
		Mild 2.6%	Moderate .3%	Severe/ Profound .1%	Total Retarded 3%	Other Dev. Disab. (e.g. epilepsy, C.P.) 2%	Total Developmentally Disabled 5%
0-4	231,731	6,025	695	232	6,952	4,634	11,586
5-9	277,998	7,228	834	278	8,340	5,560	13,900
10-14	290,418	7,551	871	291	8,713	5,808	14,521
15-17	259,254	6,740	778	259	7,777	5,185	12,962
18-44	837,023	21,762	2,511	837	25,110	16,741	41,851
45-64	575,645	14,967	1,727	575	17,269	11,513	28,782
65+	360,566	9,375	1,082	360	10,817	7,211	18,028
TOTAL	2,832,635	73,648	8,498	2,833	84,979	56,652	141,631

This table is the sum of the sixteen district plans. In cases where several districts used different age groupings, percentage adjustments were made so their figures could be correctly combined with all the other districts into a state plan.

STATE OF IOWA

NEEDS ASSESSMENT — COST ANALYSIS

SERVICES	Number of persons in need of service.	Number of persons currently receiving one or more services.	Number of persons not now served.	Average current unit (per capita) annual cost.	% increase to provide care which meets standards.	New average unit (per capita) annual cost of of care which meets standards.	Current, total annual cost to serve current persons.	Total annual cost to serve all persons needing service. (e.g. 7th year cost)
Diagnosis	17,806	4,098	13,708	158	53%	243	647,484	4,326,858
Evaluation	30,166	5,159	25,007	121	18%	143	624,239	4,313,738
Follow-Along	69,740	5,917	63,823	214	-	214	1,266,238	14,924,360
Treatment	17,767	3,140	14,627	1,341	40%	1,877	4,210,740	33,348,659
Day Care	9,411	760	8,651	2,644	27%	3,345	2,009,440	31,479,795
Domiciliary	4,454	3,409	1,045	6,985	43%	9,999	23,811,865	44,535,546
Sp. Lvg. Arrgmts.	13,702	2,732	10,970	3,331	42%	4,700	9,100,292	64,399,400
Education	35,083	28,169	6,914	2,154	19%	2,563	60,661,977	89,917,729
Training	9,163	1,949	7,214	2,351	11%	2,621	4,582,099	24,016,223
Sheltered Empmt.	15,353	2,176	13,177	2,950	17%	3,445	6,419,200	52,891,085
Personal Care	5,900	1,301	4,599	682	32%	897	887,282	5,292,300
Recreation	37,018	4,663	32,355	164	40%	230	764,732	8,514,140
Transportation	42,481	9,351	33,130	305	24%	379	2,852,055	16,100,299
Counseling	16,401	4,203	12,198	444	-	444	1,866,132	7,282,044
Protective Serv.	9,117	1,573	7,544	312	22%	381	490,776	3,473,577
Info. & Refer.	49,378	3,233	46,145	29	10%	32	93,757	1,580,096
TOTALS	Units of Service 382,940	Units of Service 81,833	Units of Service 301,107	---	---	---	120,288,308	406,395,849

Persons currently served (unduplicated) 37,246 (total of day care, sheltered employment, education, domiciliary & special living arrangements.)

Persons served in 7th yr. (unduplicated) 71,152 (total of day care, sheltered employment, education, domiciliary & one-half of special living arrangements.)

DATA COLLECTIONS AND RETRIEVAL SYSTEM

In order to ensure accurate data on numbers of developmentally disabled persons needing services and to plan for the orderly development of those services and facilities, a data collection and retrieval system is necessary.

A statewide interagency data collection-retrieval system would eliminate many of the difficulties that now exist when any one agency wishes to collect data to plan properly for the expanded delivery of services to clients or to evaluate and monitor the current services to clients. It would also be used to share information between agencies to better serve clients. If computerized, it could also provide up-to-date information to clients and providing agencies on whatever resources and programs might currently be available and thus resolve a practical difficulty of matching current needs of a client to currently available resources. It would greatly enhance follow-along capabilities.

Various state agencies still recognize the need for such a system even though there are obstacles to be overcome so that it will operate effectively yet still preserve the confidentiality of the information collected. The past attempts by the state to develop such a system were never completely successful. However, considering the great need, it is recommended that such a system be implemented and it is felt that potential problems can be resolved.

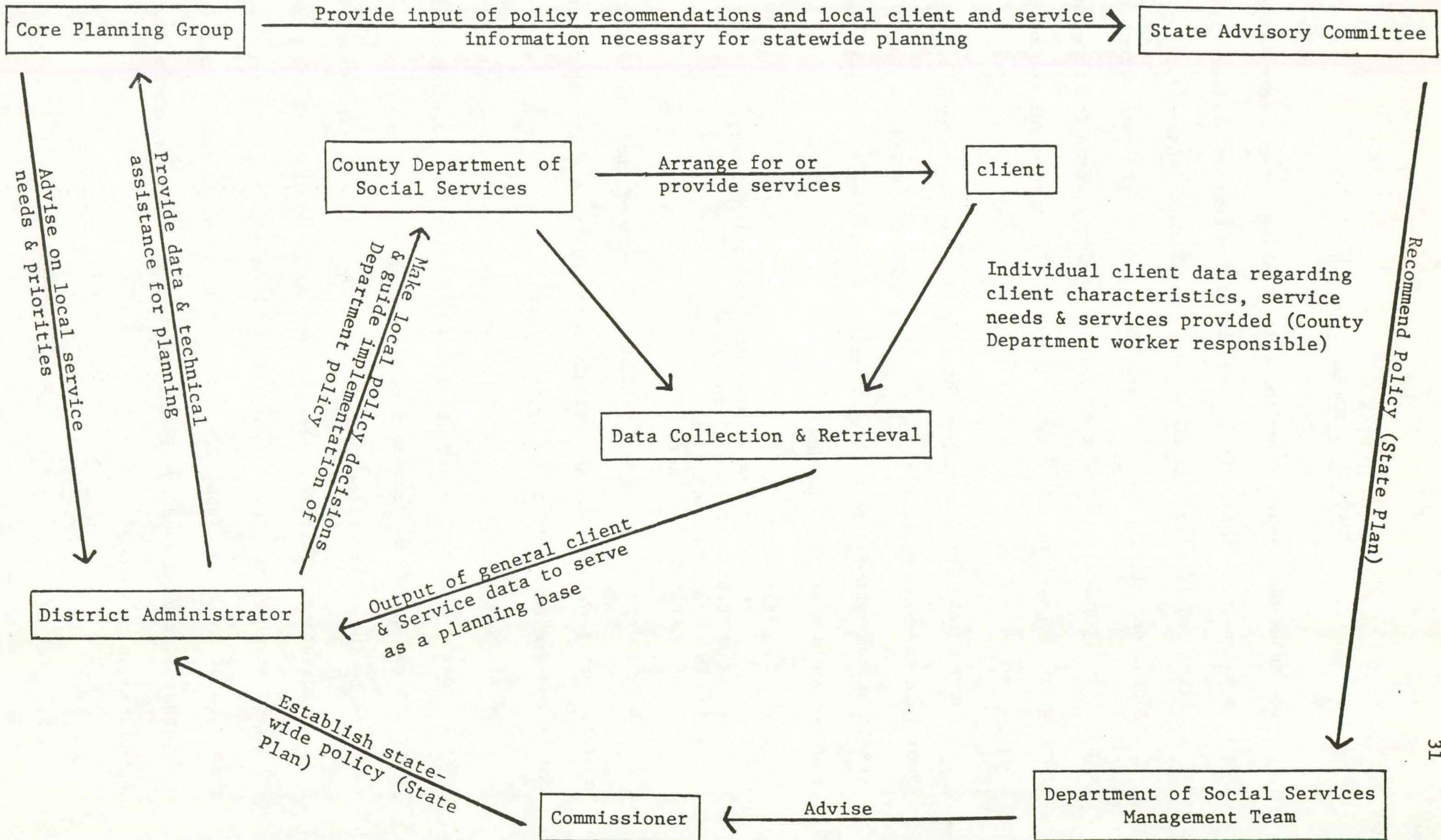
A data collection and retrieval system must:

1. Identify client groups and provide client counts.
2. Determine current life status of individuals.
3. Identify desirable life status of individuals.
4. Identify needed resources.
5. Enumerate services to be provided.
6. Identify gaps in services.

The system should also track movement and growth in individual clients,

provide general data adequate to demonstrate the positive effects of service provision and provide information and referral capabilities.

PROCESS OF PLANNING FOR SERVICES TO DEVELOPMENTALLY DISABLED PERSONS
Through the Department of Social Services



FUNCTIONAL MODEL NARRATIVE

The Functional Model shows the relationships between services as well as client flow into, within and out of the service delivery system.

On the chart, double lines indicate coordinated entry of clients and/or information into the system, while dotted lines indicate direct referral. Single lines indicate movement of clients and/or information between components of the system. Wavy lines indicate client movement out of the system.

Entry points for a multiple entry system are at the symbol labeled "Multiple Referral Sources." In a single entry point system, the client enters at the symbol labeled "Coordinating Activities." Multiple referral sources would minimally include:

A. Self
B. Area Education Agency/Local Education Agency
C. Vocational Rehabilitation
D. Department of Social Services
E. Private Providers

These referral sources are considered a part of the system in a multiple entry system, but in a single entry system are considered referral points and are not part of the system itself.

The sixteen basic services are shown on the chart in four broad categories: Basic, Support, Residential and Education and Training. Individual districts may choose to provide more than these sixteen services which are mandated by the State Policy and Implementation Advisory Committee.

Coordinating activities encompass not only coordinating the provision of direct services to clients, but also methods and activities related to provision of those services, i.e., data collection, individual assessment and planning, record keeping, interagency cooperation, program planning and placement planning.

Through letters of agreement, as indicated in the Administrative Model narrative, cooperation of provider agencies would be insured. It is hoped then that any individual provider in any of the sixteen service areas would actively participate in the coordinating activities.

FUNCTIONAL MODEL

On this chart, double lines indicate coordinated entry of clients and/or information into the system, while dotted lines indicate direct referral. Single lines indicate movement of clients and/or information between components of the system. Wavy lines indicate client movement out of the system.

Individual Assessment and Placement Planning, which are two of the coordinating activities, shall be developed according to the following guidelines:

In order to maintain a client-centered service delivery system, it is necessary to plan and provide services according to that individual's need. Ideally, this plan would be accomplished by the assessment of a multidisciplinary team, of which the client or his representative is a part. (Also, please see principle of voluntary choice on page 3.) (In the case of ICF/MR residential programs, this is mandated and specifies team members.)

An individual service plan would be written outlining measurable goals and behaviorally stated objectives. The overall objectives of the service plan should be to attain and/or maintain the optimum physical, intellectual, social and vocational functioning of which the individual is presently or potentially capable. This individual service plan will minimally:

1) determine if disability is present;
2) determine extent to which disabilities limit daily living and work activities;
3) determine how the disabling condition can be corrected or minimized by service;
4) determine the nature and scope of services needed;
5) select service objectives;
6) devise a program of action.

Ongoing Evaluation

Review of the individual service plan should be provided at least semi-annually or at the specific request of a team member. Re-evaluation should include:

1) review of the individual's progress toward meeting the planned objectives;
2) assessment of appropriateness of the individual plan of care;
3) assessment of continuing service needs.

Placement Policy

A subcommittee of the State Policy and Implementation Advisory Committee has developed a completed Placement Policy, which is part of this State Plan.

The following issues are among those which the Placement Policy covers:

1. Responsibility to secure or see that services are provided will be fixed;
2. Responsibility for seeing that a comprehensive diagnosis and evaluation is secured according to procedures in each District plan will be determined;
3. Assure that an individual care/program plan is developed and carried out and by whom;
4. Responsibility for providing follow-along and placement services will be determined (which will include policies regarding both admission and discharge);
5. Responsibility for securing funding to implement individual care/program plan must be assigned.

The heads of State and District agencies will be responsible for their appropriate clients and services as specified in the letters of agreement between state agencies.

Changes in legislation may be needed to implement the Placement Policy developed by the subcommittee.

PLACEMENT POLICY

Philosophies

To successfully implement the placement and discharge policies there must be integrated interagency cooperation based upon the following philosophies:

1. NORMALIZATION: Making available to the developmentally disabled, patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream of society. Each service should include, within its programming, a definite progression toward a more typical, independent life style.
2. INDIVIDUALIZATION: Services must be responsive to the individual client's identified need. Development of services must be based on the individual's needs in order to secure the most effective and acceptable means of minimizing the effects of the disability.
3. ACCESSIBILITY TO SERVICES: Services must be geographically accessible and delivered so that no cultural, social, transportation or architectural barriers limit use. Services should have built-in safeguards to prevent lack of information, cost and/or lack of agency responsiveness or follow through, from blocking the client's access to those services.
4. AVAILABILITY: A comprehensive array of services, sufficient in quality and quantity, to meet all clients' needs, regardless of their age, level of disability or cultural background, must be offered to meet the identified client needs of community and district. Availability also relies on sufficient funding being available to assure maximum utilization of the services.
5. RESPONSIVENESS (FLEXIBILITY): The system, as well as each component,

must be flexible enough to insure that individual needs can be met as they are identified. The system must also be able to reach out to meet both expressed and unexpressed client needs and must be flexible enough to change as areas of client needs change.

6. VOLUNTARY CHOICE: Each individual should be allowed to choose from an appropriate array of services. Client should not be forced to receive services against their will, or the will of their legal representative.

7. RESPONSIVENESS TO THE DEVELOPMENTAL MODEL: Services must be designed to facilitate an individual's growth through skill development to independence. The system should, through its array of services, allow progression from mastery of self-help skills through socialization skills to independent living skills.

8. MAXIMIZATION OF EXISTING RESOURCES: The system should utilize existing resources and providers, including generic service agencies, whenever possible in developing new components. This insures coordination within the system, yet avoids duplication.

9. LOCATION OF SERVICES WITHIN THE COMMUNITY: All services should be provided within the community or as close as possible to where the individual resides. (This should not be interpreted as preventing access to district and state-level resources if needed or requested.)

10. IMPLEMENTATION RESPONSIBILITY: A person within each District must be assigned the authority and responsibility to insure that each developmentally disabled person's needs within that District are adequately met.

PLACEMENT POLICY

The District Administrator (D.A.) is ultimately responsible for assuring provision of services to all developmentally disabled persons who reside within his district.* It is recognized that all necessary resources and services are not at present wholly or equitably available in every district. When gaps do exist, the D.A. will assist private and public agencies in developing resources towards the eventual goal of comprehensive services. In meeting this obligation, the D.A. will insure that the following occur with each client: (1) a comprehensive diagnosis and evaluation; (2) development and execution of an individual ~~case~~ program plan; and (3) follow-along services. The D.A.'s chief agent in carrying out these responsibilities of placement, diagnostic evaluation, individual case plan and follow-along is the MR Supervisor/Generalist who will be a Qualified Mental Retardation Professional (as defined in the Title XIX, ICF/MR Regulations).

The MR Supervisor/Generalist will work closely with the local county administrator or case worker where the primary responsibility for actual placements and provision of services rests. Early and continuous coordination and cooperation with, and involvement of County Boards of Supervisors in program planning and implementation, who have a legal responsibility for services to the mentally retarded, is a critically related responsibility of the D.A. or his designee.

The district will work out arrangements locally so that appropriate agencies, such as AEA's, local school systems, Vocational Rehabilitation and other state and private agencies are involved. To participate they are mandated by the Code, Rules or Letter of Agreement, in the appropriate placement, diagnosis and evaluation, planning and follow-along of developmentally disabled clients. Some district plans may call for the purchase

of these services by DSS or arrange for their provision through 28E agreements. The D.A. may also provide for some of these service responsibilities through another unit within the Department, such as the State Hospital-Schools, as long as responsibilities are clearly identified. Under any of the above described circumstances the D.A. remains accountable for the provision of quality services and will minimally provide a facilitation function. This placement policy shall be in effect throughout the placement period and end only when subsequent case assessment warrants withdrawal of follow-along services.

*For individuals who have no legal settlement, the Commissioner shall assign case responsibility to the appropriate District Administrator.

MINIMUM REQUIREMENTS OF A DIAGNOSIS AND EVALUATION

In every instance the initial placement plan shall begin with a current diagnosis and evaluation as the basis for placement consideration.

The D. and E. shall be conducted by an interdisciplinary team. The team shall consist of a physician, social worker, psychologist, educational-vocational counselor and other professionals depending on the individual's needs. At least one member of the team shall be a Qualified Mental Retardation Professional. The goal is that all members of the team shall become Qualified Mental Retardation Professionals through training programs.

The evaluation shall include a comprehensive medical, social, psychological and educational-vocational evaluation. The comprehensive evaluation shall include:

a. Diagnosis, summaries of present medical, social and where appropriate, developmental findings, medical and social family history, mental and physical functional capacity, prognoses, range of service needs and amount of care required.

b. An evaluation of the resources available in the home,

family and community.

c. An explicit recommendation with respect to admission to the appropriate facility or program.

Re-evaluation shall be completed, at least on an annual basis, to determine progress made, needed changes and to re-assess how and where the client's needs can best be met. The re-evaluation "team" shall consist of a physician, social worker, psychologist, program staff and any other disciplines necessary, based upon client disabilities and needs.

DEFINITION: Diagnosis and evaluation assessment is an empirical process that determines if, and to what degree, a person has developmental deficits, and what interventions and services are needed to enable the person to move toward increasingly independent functioning. The individual assessment identifies the present developmental level of the person, the conditions that impede his development and, where possible, the etiology of the disability.

PRINCIPLES: Diagnosis and evaluation assessment is necessary in order to develop an effective individual case plan. The interpretation of the complete battery of tests and examinations that are needed for comprehensive diagnosis and assessment require interdisciplinary teamwork. Systematic appraisal of the pertinent facts that are determined by an initial interdisciplinary assessment and any periodic reassessments should be the basis for all services offered to a client. There should be a clear focus of responsibility for synthesizing, interpreting and utilizing the results of the assessment components provided by different practitioners or agencies. The cultural and ethnic background of the client should be given full attention in the selection and interpretation of the tests and examinations used. The agency should be fully cognizant of the life style of the client and his family, and the time demands on the family during the assessment phase should be realistic.

MINIMUM COMPONENTS OF AN INDIVIDUAL PROGRAM PLAN

In order to maintain a client-centered service delivery system, it is necessary to plan and provide services according to that individual's need. This individual program (IPP) plan will be developed following a diagnosis and evaluation by a multidisciplinary team, of which the client or his representative is a part. (In the case of the ICF/MR program, this is mandated and team members are specified.)

An individual program plan will be written outlining measurable goals and behaviorally stated objectives. The overall objectives of the program plan shall be to attain and maintain and make available the optimum physical, intellectual, social and vocational functioning of which the individual is presently or potentially capable of. This individual program plan will minimally:

1. determine if disability is present;
2. determine extent to which disabilities limit daily living and work activities;
3. determine how the disabling condition can be corrected or minimized by service;
4. determine the nature and scope of services needed;
5. select service objectives;
6. devise a program of action including specific review times;
7. identify follow-along responsibility.

The ICF/MR regulations say that an individual plan for care shall include diagnosis - symptoms, complaints or complications indicating the need for admission; a description of the functional level of the individual; written objectives; orders as appropriate for medications, treatments, restorative and rehabilitative services, therapies, diet, activities, social services and special procedures designed to meet the objectives; and plans for continuing care, including provisions for the review and necessary modifications of the plan and, if appropriate, discharge.

DEFINITION: The individual program plan is a written plan of

intervention and action that is developed and modified at frequent, specified intervals, with the participation of all concerned. It specifies objectives and goals and identifies a continuum of development, outlining projected progressive steps and the developmental consequences of services.

PRINCIPLES: An individual program plan should be developed for each person accepted for service, regardless of chronological age or developmental level. The plan should be based on individual assessment data and on other data that assists in understanding the client's situation, and it should be developed by the relevant staff of the agency serving the client, with the participation of the staff of other agencies and his family. A plan developed prior to the onset of services by the agency should be reviewed and updated so as to meet the current needs of the client. Long- and short-term objectives should be stated separately and within a time frame, and they must be expressed in behavioral terms that provide measurable indices of progress, and that enable the effectiveness of interventions to be evaluated. Modes of intervention for the achievement of the stated objectives must be specified, and agencies capable and responsible for delivering the needed services should be identified.

The individual program plan must be modified as goals and objectives are, or are not, attained. Review and appropriate revision of the plan must be a continuous and self-correcting process. The plan must help all concerned to coordinate their efforts and activities so as to maximize services to the client.

IMPLEMENTATION OF INDIVIDUAL PROGRAM PLAN

When the decision on placement has been made in accordance with an individual's program plan, the Department of Social Services MR/DD placement policy requires that the responsibility for implementation of the placement

or program plan rests with the District Administrator. An individual ~~case~~ program plan shall include the individual's care/treatment/training assessment and related implementation recommendations. Coordination of the implementation efforts that include staff of other state agencies is the ultimate responsibility of the District Administrator. The Commissioner of the Department of Social Services will seek the support of all key state agencies with human services responsibility with the implementation efforts of the Department in the MR/DD program.

ONGOING EVALUATION: Review of the individual program plan should be provided at least semi-annually or at the specific request of a team member. Re-evaluation should include:

1. review of the individual's progress toward meeting the planned objectives;
2. assessment of appropriateness of the individual plan of care;
3. assessment of continuing service needs.

DEFINITION: Client program coordination is the process by which responsibility for implementation of the client's individual program plan is established. The client program coordinating process includes providing support, procuring direct services, coordinating services, collecting and disseminating data and information and monitoring the progress of the client.

PRINCIPLES: Upon acceptance for service by an agency, each client should be assigned a client program coordinator whose duty is to insure the provision and the effective continuation of necessary services. The client program coordinator should be responsible for the development and implementation of the client's individual case plan, and for assuring that all relevant staff within or without the agency, as well as the client and his family, focus their efforts on attaining the objectives specified in the plan.

The client program coordinator's function should be terminated only when responsibility for service to the client has been effectively assumed by another agency, at which time a new client program coordinator should be assigned by the agency assuming responsibility. The client or the family is to be involved at each level of development and implementation of the individual program plan and should maintain a voluntary choice as defined in the PHILOSOPHIES of this policy.

Leave of absences from facilities shall be time limited as prescribed in the individual program plan. Periodic joint assessments of the placement shall be made by the placing facility staff, the D.A. or designee, program staff and other appropriate individuals and should provide a basis for a decision as to when to end leave status. These periodic joint assessments should also address the issues outlined in the ONGOING EVALUATIONS section on the preceding page.

RESPONSIBILITY FOR CASE MANAGEMENT

As necessary throughout an individual's involvement in the Department's service system, shifts in administrative responsibility for case management will automatically occur, depending upon where the individual is actually physically located. When an individual is residing in an institution (e.g. State Hospital-School) or other residential facility, that facility will have responsibility for case management of the individual's program plan. During this time, the appropriate community-based staff and administrative resources will have responsibility for quality assurance of the case management process and will stand ready to act on recommendations from the facility that are incorporated in the individual's program plan and placement consideration. Success of the entire placement process is predicated upon a jointly coordinated effort on the individual's behalf

by home-community resources and residential resources in accordance with the above responsibility schema.

DISCONTINUATION OF SERVICES

Discontinuation of services is the discharge from a residential facility or cessation of services from an agency. In either case it means the discontinuation of administrative and service responsibility on the part of the agency and the removal of the person's name from the population roles or caseload of that agency.

Preferably, this decision shall be reached by a mutual agreement of the client, guardian or parents and the staff when the goals and objectives for the client have been achieved. It is the responsibility of the agency to assist the client in obtaining additional services from other agencies if it is indicated. An agency shall not simply discontinue services without assisting the client when needed and indicated. Even when a client voluntarily leaves a facility or withdraws from services against staff advice, and is considered harmful to his or other's welfare or safety, the staff shall notify appropriate agencies and individuals so necessary legal or protective steps may be taken. Any of the above action does not imply discontinuance of follow-along services by the local Department of Social Services office.

EMERGENCY PLACEMENTS

In emergencies requiring placement into or movement out of a facility, the District Administrator shall be contacted. The District Administrator may make whatever emergency placement is necessary without going through the entire placement procedure. Within two weeks of the emergency placement, the normal placement procedures shall be completed and the individual

program plan shall be developed or updated as necessary.

MINIMUM COMPONENTS OF DUE PROCESS

The individual or parent/guardian must be informed of the due process, which shall include the following:

1. Obtain consent of individual or parent/guardian before a diagnostic evaluation takes place.

   a. Involve individual or parent/guardian in discussion of evaluation findings and recommendations.
   b. When there is a question of the individual's ability to act responsibly on his own behalf and there is no parent or guardian, a process shall be initiated to insure the individual's rights are protected.

2. Involve individual or parent/guardian in the development of the Individual Program Plan.

3. Notify individual or parent/guardian of need for change in placement or services.

   a. Inform of reason and need for change.
   b. Inform of what changes are recommended.
   c. Inform of other possible alternatives.
   d. Secure approval.

4. Inform individual or parent/guardian of existing and established appeal process available to them and of services available from the District Administrator.

5. The individual has a right to be placed in the least restrictive environment.

6. The individual has the right to treatment.

IMPLEMENTATION PRIORITIES

It is recognized that all services required within this placement and discharge process are not presently available wholly or equitably across the state. Therefore, it will be necessary to establish priorities and goals as follows:

1. Once this policy is in effect, no client shall enter an ICF/MR without benefit of this procedure.

2. Newly identified clients will fall under the requirements of this policy.

3. Identify existing diagnostic-evaluation services available to each specific district.

4. Develop a procedure or mechanism to utilize existing diagnostic-evaluative follow-along services.

5. Initiate steps to fill gaps identified in #3.

6. Gradually begin to implement this policy for clients in the Hospital-Schools, Department of Social Services caseloads and Area Education Agencies.

CHART OF CLIENT FLOW THROUGH COMPREHENSIVE CARE + EVALUATION

BEGINNING OF PROCESS

CLIENT OR CLIENT REPRESENTATIVE REQUESTS SERVICE

REFERRED TO DSS QMRP FOR INITIAL INTERVIEW

DSS QMRP CONVENES BASIC EVALUATION TEAM:
- QMRP SOCIAL WORKER (CONVEYOR)
- QMRP PHYSICIAN
- QMRP PSYCHOLOGIST
- QMRP EDUCATOR
- INDIVIDUAL AND/OR FAMILY
- ADVOCATE (IF NOT FAMILY MEMBER)
- SERVICE PROVIDERS TO THE INDIVIDUAL (E.G. VOC. REHAB., EARLY CHILDHOOD SPECIALISTS)

INDIVIDUAL HAS COMPLEX PROBLEMS REQUIRING OTHER PEOPLE ON TEAM

NO

YES

ADDS OTHER PROFESSIONALS AS NEEDED

INDIVIDUAL TEAM MEMBERS DIAGNOSIS INDIVIDUAL'S PROBLEMS (MEDICAL, SOCIAL, PSYCHOLOGICAL, EDUCATIONAL)

INDIVIDUAL TEAM MEMBERS ESTABLISH OBJECTIVES AND METHODS FOR ALLEVIATING PROBLEMS

ALL MEMBERS OF TEAM MAKE RECOMMENDATION AND DEVELOP COMPREHENSIVE OPTIMAL SERVICE PLAN

ARE SERVICES AVAILABLE

NO

DEVELOP INTERIM PLAN WITH DEADLINES FOR REEVALUATION

REPORT FILED FOR COMMISSIONER OF DSS AND M.R. SUPERVISOR WITH JUSTIFICATION FOR INTERIM PLAN

INFORMATION STATISTICALLY REPORTED FOR PURPOSES OF: SYS. MANAGEMENT PLANNING AND PROGRAM DEVELOPMENT

CONTINUED PLANNING

YES

DEVELOP FINANCIAL PLAN FOR PROGRAM PAYMENT

IMPLEMENT SERVICE PROGRAM ASSIGN FOLLOW-ALONG QMRP IF DIFFERENT THAN TEAM MEMBER

ADD SERVICE PROVIDER QMRP TO EVALUATION TEAM

SIGNIFICANT PROGRAM OR BEHAVIORAL CHANGE

NO

PLANNED REEVALUATION DEADLINE IN PLAN

NO

TEAM REEVALUATION AT ONE YEAR REVISE PLAN

YES

TEAM REEVALUATION ON DEADLINE DATE REVISE PLAN

YES

TEAM REEVALUATION IMMEDIATELY REVISE PLAN

NEEDS ADDITIONAL SERVICES?

NO

MAIN STREAM

YES

ADMINISTRATIVE MODEL

The Administrative Model depicts the administrative relationships between the various local, district and state agencies involved in provision of services to the developmentally disabled.

Double lines on the chart indicate direct lines of authority and responsibility. Note that existing offices are indicated by labeled boxes on the chart. The unlabeled shapes indicate that no office exists at that level but functions are carried out from another level (i.e., the Department of Health has offices at state and local levels but not at the district level). The cloud-shaped symbols indicate those advisory and planning groups whose membership comes from a variety of sources.

Single lines indicate those interagency relationships which must be formalized through written letters of agreement. The dotted lines indicate relationships which are advisory at this time. In the future, these relationships may also need to be formalized through written agreements.

All agencies and groups shown on the chart have a role in providing coordinated services to the developmentally disabled. Some are mandated to provide services, but all must actively participate to insure comprehensive service provision. (Please refer back to the chart on page 52.)

The state level agencies are depicted on this chart as they currently exist. The only significant difference is the addition of letters of agreement between the agencies to insure cooperation. The relationships of agencies on the chart below the state level (those below the wavy line) may be altered only if the principles and conditions developed by the State Policy and Implementation Advisory Committee are followed. These are as follows:

1. The Administrative Model must be consistent with existing

governmental agencies' authority and responsibility. If provision of services of the existing governmental agencies is to be carried out by another agency or new agency, there must be in place a 28E contract or Purchase of Service contract.

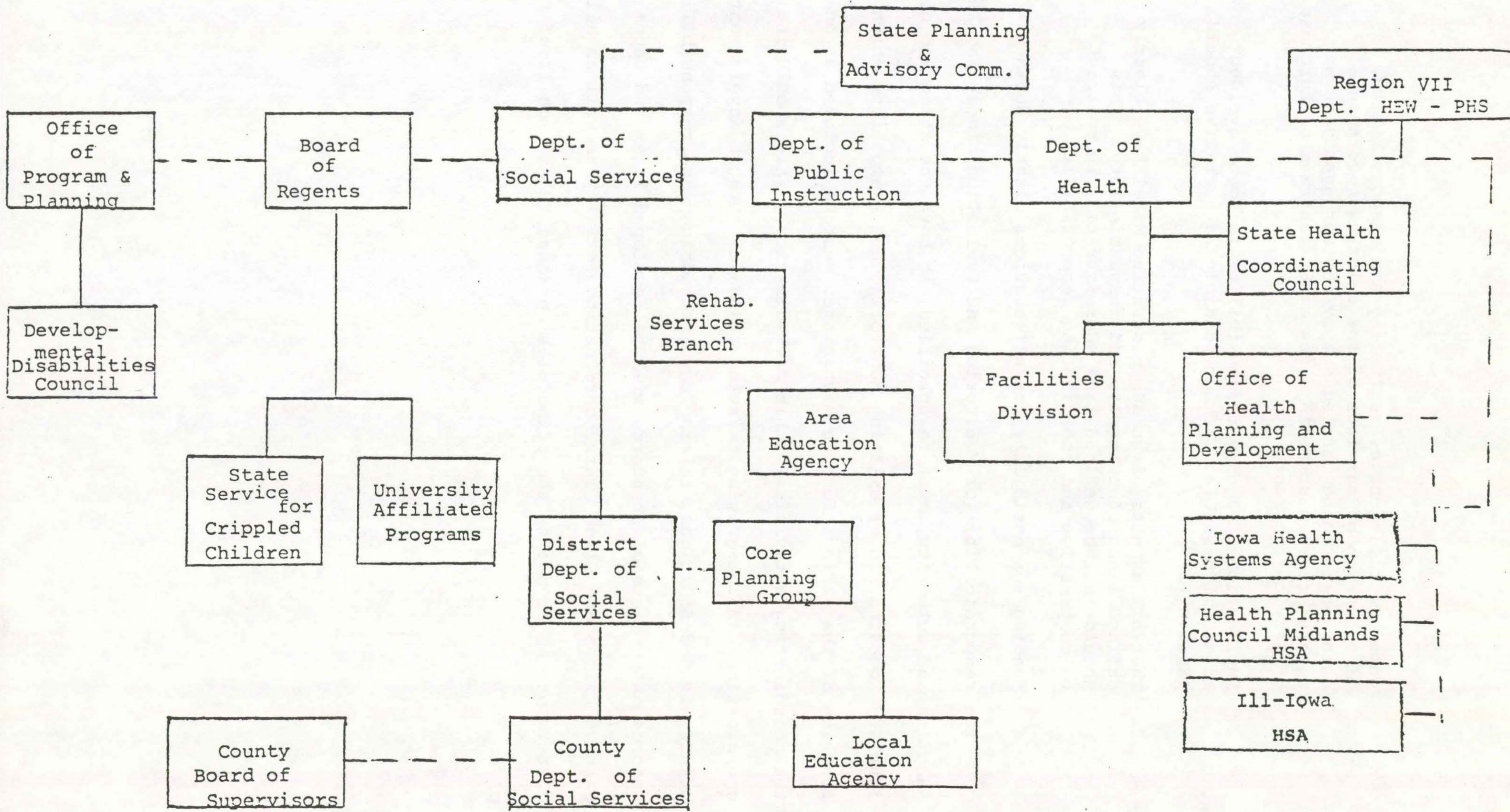
2. Duplication of agency responsibility is to be avoided if at all possible. If not possible, a narrative should explain why.

3. That all aspects of an Administrative Model have clearly defined lines of authority and responsibility. This should include defined line administration in contrast to cooperative and coordinating responsibility.

4. Funding responsibility for all services clearly defined.

The responsibility for Monitoring and Evaluation, including legal sanction and authority, must be specified, at both the state and district levels. Coordination of existing Monitoring and Evaluation, which is a function of the various funding mechanisms, must be included as one of the coordinating activities within each district. This should include coordinating and integrating existing standards through development of standardized definitions, terminology, methodology and responsibility for enforcement. Lists of standards will be developed later and become a part of this State Plan. This coordinating activity as well as all others, must insure adherence to the principles outlined in Section II of this plan.

A D M I N I S T R A T I V E   M O D E L



ADMINISTRATIVE MODEL

The Administrative Model depicts the administrative relationships between the various local, district and state agencies involved in provision of services to the developmentally disabled.

Solid lines on the chart (see pp. 52) indicate direct lines of authority and responsibility. The dotted lines indicate relationships which are advisory or supportive. The relationships between the Department of Social Services and the Department of Health, Department of Public Instruction, Board of Regents, Office of Programming and Planning, and the State Policy and Implementation Advisory Committee have been formalized through written Letters of Agreement. These Letters of Agreement specify the duration and purposes of the agreements, the responsibilities for services to the developmentally disabled of each agency, and the special conditions of support, cooperation, and coordination agreed upon by the named agencies.

All agencies and groups shown on the chart have a role in providing coordinated services to the developmentally disabled. Some are mandated to provide services, but all must actively participate to insure comprehensive service provision.

The state level agencies are depicted on the top line of this chart as they currently exist. The relationships of agencies below the state level, all those below the top line of this chart, may be altered only if the principles and conditions developed by the State Policy and Implementation Advisory Committee are followed. These are as follows:

1. The Administrative Model must be consistent with existing governmental agencies' authority and responsibility. If provision of services of the existing governmental agencies is to be carried out by another agency or new agency, there must be in place a 28E contract or Purchase of Service contract.

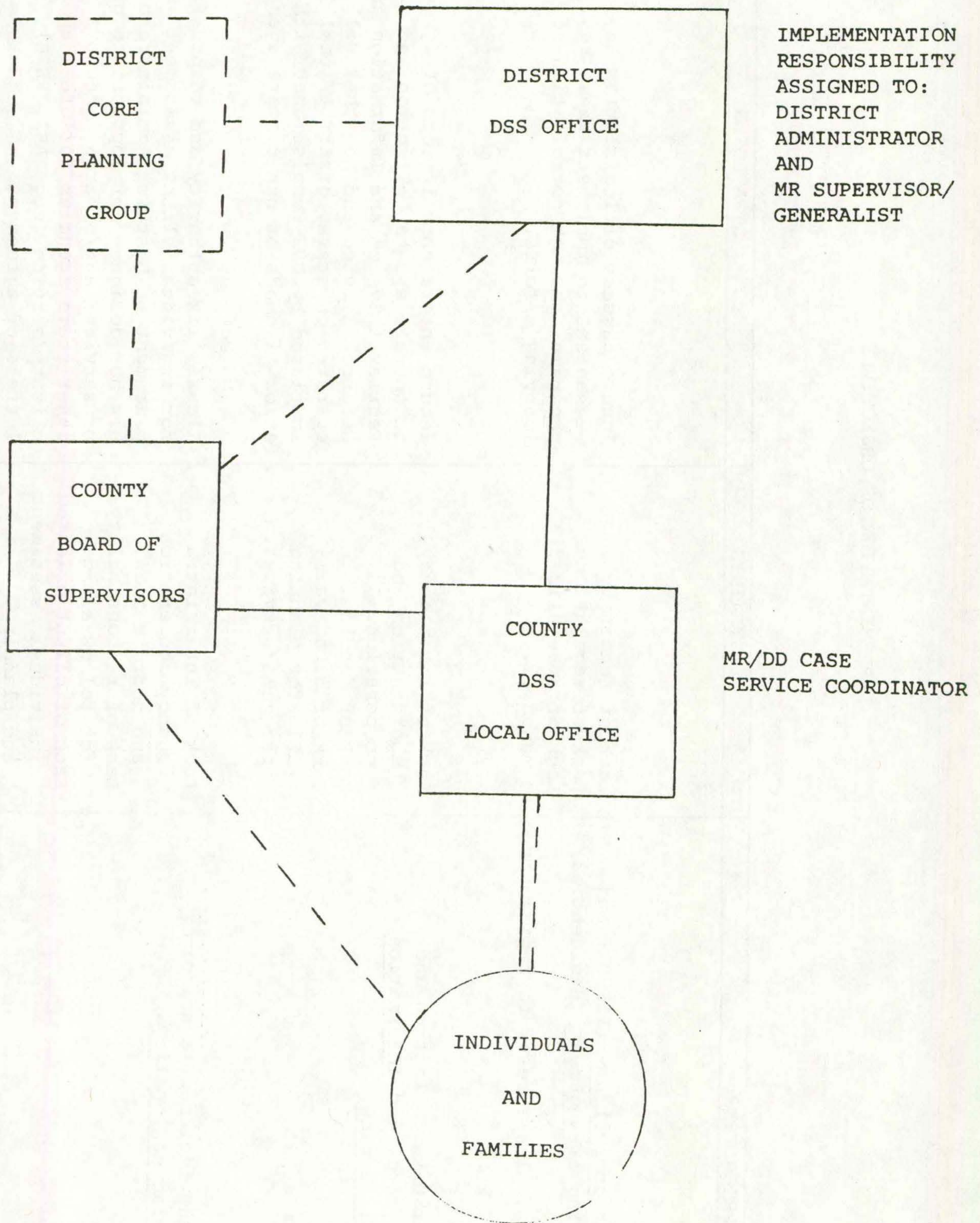
2. Duplication of agency responsibility is to be avoided if at all possible. If not possible, a narrative should explain why.

3. That all aspects of an Administrative Model have clearly defined lines of authority and responsibility. This should include defined line administration in contrast to cooperative and coordinating responsibility.

4. Funding responsibility for all services clearly defined.

The responsibility for monitoring and evaluation, including legal sanction and authority, must be specified, at both the state and district levels. Coordination of existing monitoring and evaluation, which is a function of the various funding mechanisms, must be included as one of the coordinating activities within each district. This should include coordinating and integrating existing standards through development of standardized definitions, terminology, methodology and responsibility for enforcement. Lists of standards will be developed later and become a part of this State Plan. This coordinating activity as well as all others, must insure adherence to the principles outlined in Section II of this plan.

* The diagram shown here is that part of the Administrative Model (page 53) which deals specifically with the Department of Social Services. The accompanying narrative provides a more detailed explanation of how the Department will implement the plan.



IMPLEMENTATION OF OBJECTIVES

PRIORITIES	CONSTRAINTS	STRATEGIES	TIME
			Yr. 1 start July 1977
To implement domiciliary (ICF/MR) and special living arrangement (Residential/ MR). (for details, please refer to legislative requests)	Lack of funding. Lack of regulations. Lack of specialized manpower.	Insure passage of legislation and mechanisms to implement these residential programs; through coordination of lobbying efforts.	1977
To implement Data Collection and Retrieval System; and Information and Referral Service.	Lack of interagency coordination and cooperation. Lack of funding. Lack of data available for planning programs/services.	Secure interagency letters of agreement to operate a Data Collection and Retrieval System and Information and Referral Service and how they will operate, on state, district/local levels, initiated by DSS Commissioner with cooperation of heads of other state agencies.	1977
To design and implement a uniform structure placement policy.	Lack of inter/intra agency cooperation and coordination. Lack of responsibility for follow-along. Lack of client oriented individual assessment and planning.	Clearly fix authority and responsibility for individual client assessment and placement on District Administrator and his/her designee for appropriate client or service; and/or area directors of other state agencies for other appropriate clients/service (e.g. AEA, RESB), through letters of agreement.	1977
To review and update districts' plans and make recommendations for updating of State Plan.	———	———	Spring 1978

PRIORITIES	CONSTRAINTS	STRATEGIES	TIME
To develop and implement diagnosis and evaluation.	Lack of funding. Lack of specialized trained manpower.	Coordination and maximizing resources and available funding.	Spring 1978
To emphasize development of supportive services to keep people in own homes (transportation, day care, personal care, counseling, and recreation) or to provide day programs while in residential alternatives.	Lack of specific programs designed to deliver services.	Develop funding requests for following biennium.	Spring 1978

At this time, no further priorities or strategies are given for years two through seven. Those will be redefined by District and State Planning Groups. Services prioritized here, such as residential services, will continue to be developed during later years. Likewise, continued coordination and cooperation of agencies will be necessary, as will maximization of existing resources.

SUMMARY

The goal of state planning is to achieve in each of the sixteen districts, the provision of the sixteen services as defined previously. This involves the State and the District setting short and long range goals for the development of these services.

Each district may have needs and priorities that are special to that district, and this plan allows districts to implement them. Services may be developed at different times within the various districts, because of particular gaps in services in some areas, the importance of a service elsewhere, or the feasibility for development in a particular district. The district plans should be considered as extensions of this State Plan.

This State Plan recognizes that the sixteen services listed herein can only be fully provided through the coordination and cooperation of Iowa departments, boards and agencies as well as other public and private groups at various levels. Cooperation and input from all levels will be needed to bring about funding mechanisms and legislation which will provide for coordinated implementation of this plan.

The State Policy and Implementation Advisory Committee will establish a schedule for the review of the state and district plans on an annual basis, as well as minimum expectations and components of district plans.

Lists of standards for care for various kinds of facilities are currently being developed and will become a part of this plan.

Implementation of this State Plan will require the assistance of all concerned Iowans who realize that the provision of the services outlined here is a clear and fundamental right of persons who are developmentally disabled. These same parents, interested citizens and agency personnel who developed these goals must continually review progress that has been made and redefine new objectives and strategies at least annually.

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ICF/MR STATE PLANNING AND ADVISORY COMMITTEE

William C. Ketch, State Coordinator
Seven Year Plan
Services to the Developmentally Disabled

Private Agencies/Consumer-Groups

Linda McDonald	Iowa Association Regional Council of Governments
William Howard	Iowa State Association of Counties
David Johnston	United Cerebral Palsy
Riley Nelson	Iowa Association of Private Residential Facilities for the Mentally Retarded
Lloyd Munneke	Iowa Association of Rehabilitation Facilities
Dean Lillis	Health Facilities Association
Helen Henderson	Iowa Association for Retarded Citizens

Public Agencies

Richard Fischer	Iowa Department of Public Instruction
Bonnie Horn Koehler	Iowa Health Systems Agency
Thomas Hulme	Board of Regents
Kathy Clark	County Care Facilities
Robert Burke	County Boards of Supervisors - East
Wayne Taylor	County Boards of Supervisors - Central
Rita Kline	County Boards of Supervisors - West
Thomas Benedict	Vocational Rehabilitation
Clell Hemphill	Developmental Disabilities
John Wild	Iowa Department of Health - Licensing
Leona Riggenberg	Iowa Department of Health - Surveying
Craig Redshaw	Iowa Department of Health - Health Planning

Iowa Department of Social Services

Jay Barfels	District Administrator - East
Arthur Anderson	District Administrator - West
Vacant	Mental Retardation Supervisor - East
Michael Hanna	Mental Retardation Supervisor - West
Nicholas Grunzweig	Division of Mental Health Resources
Owen Franklin	Woodward State Hospital-School
William Campbell	Glenwood State Hospital-School'
Eugene Fitzsimmons	Division of Community Services
Pennie Bjornstad	Medical Services Section
James Bethel	Division of Management and Planning

District Core Planning Groups

William Kurth	District I - Decorah
Alice Benke	District II - Mason City
Robert Hoogeveen	District III - Spencer
Steve King	District IV - Sioux City
Dee Krueger	District V - Fort Dodge
William Bowman	District VI - Marshalltown
Gary Mattson	District VII - Waterloo
Donald Casteel	District VIII - Dubuque
Michael McAleer	District IX - Davenport
Elodie Maternach	District X - Cedar Rapids
Jon Doidge	District XI - Des Moines
Everett Crane	District XII - Carroll
Marland Gammon	District XIII - Council Bluffs
Robert Smith	District XIV - Creston
Herman Kurtz	District XV - Ottumwa
Tish Cory	District XVI - Burlington

Iowa Department of Social Services - Staff Assistance*

Michael Lammer	District I
John Brown	District II
John Lapitz	District III
Michael Hanna	District IV
Jack Slauson	District V
Gordon Grotjohn	District VI
Allan Natvig	District VII
Constance Banks	District VIII
Patty Lane	District IX
Carol Munn	District X
Eve Hickman	District XI
Nancy Richardson	District XII
Ronald Pfeifer	District XIII
June Robison	District XIV
Joy Jolley	District XV
Allan Christensen	District XVI

*Non-Voting Members

Revised 7/27/78

CP-A36466 2/71

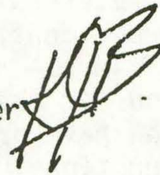
State of Iowa

DEPARTMENT OF SOCIAL SERVICES

INTEROFFICE MEMORANDUM

Date: September 13, 1976

To: Members of the ICF/MR State Advisory Committee

From: Kevin J. Burns, Commissioner 

Subject: Response to Committee Recommendations and Concerns

The Committee presentation on August 31, 1976, was enlightening and significant in terms of delineating key items and areas requiring Department administrative action.

Essentially, I find no disagreement with the basic recommendations of the Committee. For example--I strongly support the concept of one staff person available at the district level with primary responsibility for facilitation of the final state plan and implementation process. I see the District Administrator being the logical person to assume this responsibility.

Inasmuch as the staff of Mental Retardation Supervisors has carried the major responsibility to date in guiding local groups through the planning process, it should continue this key role, being directly responsible to the District Administrator for developing and maintaining good working relationships between the grass roots level where service is consumed and Department administrative levels where policy decisions and directions evolve. Each district should retain or acquire such a staff person, well-versed in community organization methodology.

Certainly, the plan to require periodic reports to the Commissioner is administratively proper. The report should, above all, be factual and present as succinctly as possible any barriers to the implementation process. While solutions to such barriers may not always be non-complex, bringing the circumstances to the attention of all concerned certainly has to be the first step in any eventual solution. I am in agreement with the process outlined for identifying barriers and monitoring the progress of district implementation.

I am also in agreement with the proposed supporting advisory structure which retains the local community leadership and skill disclosed throughout the planning process. As implementation of plans progress, these ideas should be incorporated in the process.

Your recommendation concerning respect of individual district plans in the final state plan is, as you have stated, contingent upon the district plans being in compliance and in concert with Departmental goals, objectives, legal restraints, and policies. Comment upon those plans and this particular recommendation is reserved until all district plans have been submitted and reviewed by the Department.

I want to thank you for the fine job accomplished to date and for the recommendations you have provided to enable the Department to continue its proper role and function in the ongoing process.

KJB/JNB/vrc

STATE TOTALS

POPULATION PROJECTIONS FOR 1980
BY
AGE, SEX, AND DEVELOPMENTAL DISABILITY

AGE GROUP	POPULATION TOTAL	POPULATION MALE	POPULATION FEMALE	MENTAL RETARDATION TOTAL	MENTAL RETARDATION MALE	MENTAL RETARDATION FEMALE	EPILEPSY TOTAL	EPILEPSY MALE	EPILEPSY FEMALE	CEREBRAL PALSY TOTAL	CEREBRAL PALSY MALE	CEREBRAL PALSY FEMALE	AUTISM* TOTAL	AUTISM* MALE	AUTISM* FEMALE	TOTAL WITH DISABILITIES TOTAL	TOTAL WITH DISABILITIES MALE	TOTAL WITH DISABILITIES FEMALE
TOTAL	2932716	1419278	1513438	87968	42572	45396	58641	28378	30263	11718	5670	6048	262	134	128	158589	76754	81835
0-4	214009	109467	104542	6420	3284	3136	4279	2189	2090	855	437	418	84	43	41	11638	5953	5685
5-9	220872	112821	108051	6625	3384	3241	4417	2256	2161	883	451	432	88	45	43	12013	6136	5877
10-14	229106	116905	112201	6873	3507	3366	4582	2338	2244	915	467	448	90	46	44	12460	6358	6102
15-19	271934	136348	135586	8157	4090	4067	5437	2726	2711	1087	545	542	0	0	0	14681	7361	7320
20-24	280244	139549	140695	8406	4186	4220	5603	2790	2813	1120	558	562	0	0	0	15129	7534	7595
25-29	260931	131636	129295	7827	3949	3878	5217	2632	2585	1043	526	517	0	0	0	14087	7107	6980
30-34	194474	93214	101260	5833	2796	3037	3889	1864	2025	777	372	405	0	0	0	10499	5032	5467
35-39	164037	81607	82430	4920	2448	2472	3280	1632	1648	655	326	329	0	0	0	8855	4406	4449
40-44	143742	70724	73018	4311	2121	2190	2874	1414	1460	574	282	292	0	0	0	7759	3817	3942
45-49	137573	66571	71002	4127	1997	2130	2751	1331	1420	550	266	284	0	0	0	7428	3594	3834
50-54	147276	71873	75403	4418	2156	2262	2945	1437	1508	588	287	301	0	0	0	7951	3880	4071
55-59	147277	70555	76722	4417	2116	2301	2945	1411	1534	588	282	306	0	0	0	7950	3809	4141
60-64	137355	64432	72923	4119	1932	2187	2746	1288	1458	548	257	291	0	0	0	7413	3477	3936
65+	383856	153546	230310	11515	4606	6909	7676	3070	4606	1535	614	921	0	0	0	20726	8290	12436

* THE POPULATION PROJECTIONS FOR AUTISTIC DISABILITIES ARE CALCULATED FOR THOSE INDIVIDUALS AGE FOURTEEN (14) OR UNDER ONLY

BED NEED FORMULA

The Department of Social Services is committed to the fundamental philosophy of the principle of normalization which states "the utilization of means which are as culturally normative as possible in order to establish and/or maintain personal behaviors and characteristics which are as culturally normative as possible." The Department further subscribes to the concept of de-institutionalization and promotes the integration of the developmentally disabled insofar as possible into the mainstream of normal community living.

In order to carry out this commitment, the Iowa Department of Social Services requires the following ICF/MR Bed Need Formula. There is a need for approximately 1,500 ICF/MR beds at the community level. In addition, there currently is a need to continue the approximately 1,500 ICF/MR certified beds at the two State Hospital-Schools.

The Department's planning is for a reduction of beds at the State Hospital-Schools. This proposed reduction will bring the State Hospital-Schools to a total of 982 beds - 550 at Glenwood and 432 at Woodward. The reduction will be affected at a rate which will accomplish these totals within three to five years. The rate of reduction will be reviewed annually.

The above reduction policy shall be reflected in the ongoing changes in the plans for correction.

RESIDENTIAL NEEDS FOR THE RETARDED

-BY TYPE OF FACILITY

-BY DISTRICT

DISTRICT	-----MODERATELY, SEVERELY, PROFOUNDLY RETARDED----- TOTAL**	STATE INSTS.	ICF/MR	OTHER*	--MILDLY-- RETARDED TOTAL**
Burlington	195	38	59	97	127
Carroll	152	30	46	76	99
Cedar Rapids	585	115	176	292	380
Council Bluffs	322	63	97	161	209
Creston	97	19	29	49	63
Davenport	352	69	106	176	229
Decorah	163	33	49	81	106
Des Moines	994	195	298	497	646
Dubuque	374	74	112	187	243
Fort Dodge	187	36	56	94	122
Marshalltown	185	36	55	93	120
Mason City	260	51	78	130	169
Ottumwa	240	47	72	120	156
Sioux City	287	56	86	144	187
Spencer	233	46	70	116	154
Waterloo	372	73	112	186	242
STATE TOTAL	5,021	982	1,506	2,511	3,264

*Other includes RCF/MR, Group Homes, Foster Homes, other living arrangements that are extrafamilial.

**Total includes all types of extrafamilial residential placements without mention of percent in each type. Residential Need Totals are based upon 6% of mildly retarded (2.6%), 50% of moderately retarded (0.3%) and 90% of severely/profoundly retarded (0.1%).

LETTER OF AGREEMENT

Parties to the Agreement

The State of Iowa Office for Planning and Programming and the Iowa Department of Social Services.

Duration of the Agreement

From the date of Oct. 1, 1977 until rescinded in writing by either party or until superseded by a new agreement.

Purpose of Agreement

1. To establish some common assumptions regarding the planning for and delivery of services to Developmentally Disabled persons.
2. To enumerate overall responsibilities of each agency party to this agreement for services to Developmentally Disabled persons.
3. To describe special conditions of support, cooperation and coordination which must exist between the parties to this agreement.

Common Assumptions

The parties to this agreement mutually affirm the following principles:

1. NORMALIZATION: Making available to the Developmentally Disabled, patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream society. Each service should include, within its programming, a definite progression toward a more typical, independent life style.
2. INDIVIDUALIZATION: Services must be responsive to the individual

client's identified need. Development of services must be based on the individual's needs in order to secure for him the most effective and acceptable means of minimizing the effects of his disability.

3. ACCESSIBILITY TO SERVICES: Services must be geographically accessible and delivered so that no cultural, social, transportation or architectural barriers limit use. Services should have built-in safeguards to prevent lack of information, cost and/or lack of agency responsiveness or follow through from blocking the client's access to those services.

4. AVAILABILITY: A comprehensive array of services, sufficient in quality and quantity, to meet all clients' needs, regardless of their age, level of disability or cultural background, must be offered to meet the identified client needs of community/district. Availability also relies on sufficient funding being available to assure maximum utilization of the services.

5. RESPONSIVENESS (FLEXIBILITY): The system, as well as each component, must be flexible enough to insure that individual needs can be met as they are identified. The system must also be flexible enough to change as the needs of the system must be able to reach out to meet both expressed and unexpressed client needs.

6. VOLUNTARY CHOICE: Each individual should be allowed to choose from an appropriate array of services he will utilize. He should not be forced to receive services against his will or the will of his legal representative unless otherwise provided by law.

7. RESPONSIVENESS TO THE DEVELOPMENTAL MODEL: Services must be designed to facilitate an individual's growth through skill development to independence. The system should, through its array of services, allow progression from mastery of self-help skills through socialization skills to independent living skills.

8. MAXIMIZATION OF EXISTING RESOURCES: The system should utilize existing resources/providers, including generic service agencies, whenever possible, in developing new components. This insures coordination within the system, yet avoids duplication.

9. LOCATION OF SERVICES WITHIN THE COMMUNITY: All services should be provided within the community or as close as possible to where the individual resides. (This should not be interpreted as preventing access to district/state-level resources if needed/requested.)

Responsibilities of the Office for Planning and Programming for Services Related to Developmentally Disabled Persons

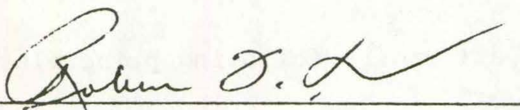
The Office for Planning and Programming through its State Planning Council for Developmental Disabilities will serve an advocacy role relative to the needs of Developmentally Disabled persons and the services designed to meet these needs - identifying persons unable to secure needed services, advocating with agencies to provide needed services and otherwise identifying gaps in services. The Office for Planning and Programming and the State Planning Council will also be involved in needs assessment, and will develop an annual plan for meeting the service needs of the Developmentally Disabled. In addition, the State Planning Council will monitor agencies giving direct service to the Developmentally Disabled in Iowa.

Responsibilities of the Department of Social Services for Services Related to Developmentally Disabled Persons

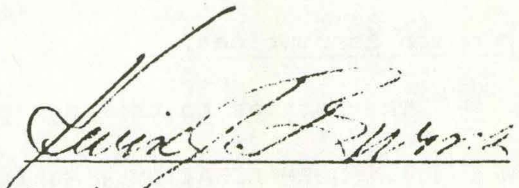
A variety of services fall within the legal responsibility of the Department as presented in Chapters 217-256 of Title XI of the Code of Iowa. These responsibilities include ongoing casework services, financial support programs and the placement of children, juveniles and adults in alternative living situations. The Department also must do needs assessment relative to Developmentally Disabled persons, must provide funding for certain needed services and must update the Department of Social Services Seven Year Plan for Services to Developmentally Disabled Persons on an annual basis.

Special Conditions of Support, Cooperation and Coordination

The Office for Planning and Programming (State Planning Council for Developmental Disabilities) and the Department of Social Services have many common concerns related to serving Developmentally Disabled persons and agree to coordinate needs assessment so that common definitions and population data will be used as planning basis and further to coordinate the two state plans in order to make maximum impact on meeting the needs of this common client group.

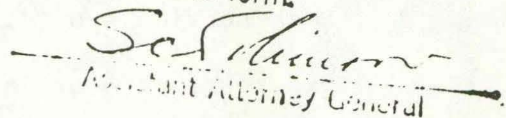


Director
Office for Planning and Programming



Commissioner
Iowa Department of Social Services

Approved as to form:



Assistant Attorney General
9-23-77

LETTER OF AGREEMENT

Parties to the Agreement

The Iowa Department of Social Services and the Iowa State Department of Health.

Duration of the Agreement

From the date of October 1, 1977 until rescinded in writing by either party or until superseded by a new agreement.

Purposes of Agreement

1. To establish some common assumptions regarding the planning for and delivery of services to Developmentally Disabled persons.
2. To enumerate overall responsibilities of each agency party to this agreement for services to Developmentally Disabled persons.
3. To describe special conditions of support, cooperation and coordination which must exist between the parties to this agreement.

Common Assumptions

The parties to this agreement mutually affirm the following principles:

1. NORMALIZATION: Making available to the Developmentally Disabled, patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream society. Each service should include, within its programming, a definite progression toward a more typical, independent life style.
2. INDIVIDUALIZATION: Services must be responsive to the individual client's identified need. Development of services must be based

on the individual's needs in order to secure for him the most effective and acceptable means of minimizing the effects of his disability.

3. ACCESSIBILITY TO SERVICES: Services must be geographically accessible and delivered so that no cultural, social, transportation or architectural barriers limit use. Services should have built-in safeguards to prevent lack of information, cost and/or lack of agency responsiveness or follow through from blocking the client's access to those services.

4. AVAILABILITY: A comprehensive array of services, sufficient in quality and quantity, to meet all clients' needs, regardless of their age, level of disability or cultural background, must be offered to meet the identified client needs of community/district. Availability also relies on sufficient funding being available to assure maximum utilization of the services.

5. RESPONSIVENESS (FLEXIBILITY): The system, as well as each component, must be flexible enough to insure that individual needs can be met as they are identified. The system must also be flexible enough to change as the needs of the system must be able to reach out to meet both expressed and unexpressed client needs.

6. VOLUNTARY CHOICE: Each individual should be allowed to choose from an appropriate array of services he will utilize. He should not be forced to receive services against his will or the will of his legal representative.

7. RESPONSIVENESS TO THE DEVELOPMENTAL MODEL: Services must be designed to facilitate an individual's growth through skill

development to independence. The system should, through its array of services, allow progression from mastery of self-help skills through socialization skills to independent living skills.

8. MAXIMIZATION OF EXISTING RESOURCES: The system should utilize existing resources/providers, including generic service agencies, whenever possible, in developing new components. This insures coordination within the system, yet avoids duplication.

9. LOCATION OF SERVICES WITHIN THE COMMUNITY: All services should be provided within the community or as close as possible to where the individual resides. (This should not be interpreted as preventing access to district/state-level resources if needed/requested.)

It is recognized that the ability of the agencies party to this agreement to delivery the optimum of services is always tempered by the availability of State and Federal funding. The principles of service here presented are none-the-less accepted as goals.

Responsibilities of the State Department of Health for Services Related to Developmentally Disabled Persons

The Department of Health is the agency with authority to interpret and determine compliance with Federal and State regulations governing Intermediate Care facilities for the mentally retarded. The Department of Health is also the agency with authority to certify intermediate care and certain residential care facilities for mentally retarded persons based on bed need data and community support.

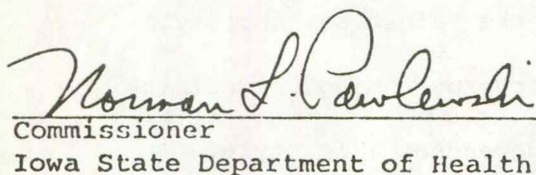
Responsibilities of the Department of Social Services for Services Related to Developmentally Disabled Persons

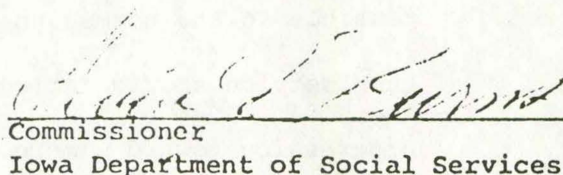
The Department of Social Services has far ranging responsibilities for

services to Developmentally Disabled persons (as specified in the Code of Iowa -- Title XI Chapters 217-256). The responsibilities which relate to Health care are specified in Title XIX Section 1902(a)(5) of the Social Security Act and 249A Code of Iowa. These responsibilities include implementing the Iowa Plan for the Medical Assistance Program and issuing provider agreements to intermediate care facilities for the mentally retarded (as well as all other intermediate care facilities).

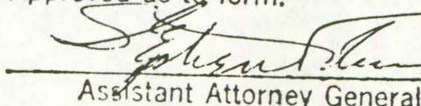
Special Conditions of Support, Cooperation and Coordination

Due to the common involvement of the Department of Health and the Department of Social Services in intermediate care and residential care facilities for mentally retarded persons, it is agreed that the Department of Social Services, through its District Offices, will be given the opportunity by the Health Department to review all new license requests for intermediate and residential care facilities for the mentally retarded. The Department of Health also agrees to seek input from the Department and its planning committees in arriving at bed need formulas for facilities serving Developmentally Disabled persons. The Department of Health and the Department of Social Services further agree to support the implementation of the Seven Year Plan for Delivery of Services to persons who are Developmentally Disabled as attached.


Commissioner
Iowa State Department of Health


Commissioner
Iowa Department of Social Services

Approved as to form:


Assistant Attorney General

9-23-77

LETTER OF AGREEMENT

Parties to the Agreement

The Iowa Department of Social Services, hereafter referred to as the Department and the Iowa Department of Public Instruction, hereafter referred to as Public Instruction.

Duration of the Agreement

From the date of 11-1-77 until rescinded in writing by either party or until superseded by a new agreement.

Purposes of Agreement

1. To establish some common assumptions regarding the planning for and delivery of services to Developmentally Disabled persons.
2. To enumerate overall responsibilities of each agency party to this agreement for services to Developmentally Disabled persons.
3. To describe special conditions of support, cooperation and coordination which must exist between the parties to this agreement.

Common Assumptions

The parties to this agreement mutually affirm the following principles:

1. NORMALIZATION: Making available to the Developmentally Disabled, patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream society. Each service should include, within its programming, a definite progression toward a more typical, independent life style.
2. INDIVIDUALIZATION: Services must be responsive to the individual client's identified need. Development of services must be based

on the individual's needs in order to secure for that person the most effective and acceptable means of minimizing the effects of the disability.

3. <u>ACCESSIBILITY TO SERVICES</u>: Services must be geographically accessible and delivered so that no cultural, social, transportation or architectural barriers limit use. Services should have built-in safeguards to prevent lack of information, cost and/or lack of agency responsiveness or follow through from blocking the client's access to those services.

4. <u>AVAILABILITY</u>: A comprehensive array of services, sufficient in quality and quantity, to meet all clients' needs, regardless of their age, level of disability or cultural background, must be offered to meet the identified client needs of community/district. Availability also relies on sufficient funding being available to assure maximum utilization of the services.

5. <u>RESPONSIVENESS (FLEXIBILITY)</u>: The system, as well as each component, must be flexible enough to insure that individual needs can be met as they are identified. The system must also be flexible enough to change as the needs of the system must be able to reach out to meet both expressed and unexpressed client needs.

6. <u>VOLUNTARY CHOICE</u>: Each individual should be allowed to choose from an appropriate array of services that will be utilized. The person should not be forced to receive services against the will of the individual or the will of the individual's legal representative. However, complusory education requirements as defined in Chapter 299 of the Iowa Code must be recognized in educational placements.

7. RESPONSIVENESS TO THE DEVELOPMENTAL MODEL: Services must be designed to facilitate an individual's growth through skill development to independence. The system should, through its array of services, allow progression from mastery of self-help skills through socialization skills to independent living skills.

8. MAXIMIZATION OF EXISTING RESOURCES: The system should utilize existing resources/providers, including generic service agencies, whenever possible, in developing new components. This insures coordination within the system, yet avoids duplication.

9. LOCATION OF SERVICES WITHIN THE COMMUNITY: All services should be provided within the community or as close as possible to where the individual resides. (This should not be interpreted as preventing access to district/state-level resources if needed/requested.)

Responsibilities of Public Instruction for Services Related to Developmentally Disabled Persons

Within the limits of available funding, Public Instruction agrees to provide staff and training resources necessary to address education and the employability* needs of Developmentally Disabled persons. Education services will include, as appropriate, educational diagnostic and evaluation services

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*"Employability refers to a determination that the provision of vocational rehabilitation services is likely to enable an individual to enter or retain employment consistent with his capacities and abilities in the competitive labor market; the practice of a profession; self-employment; homemaking; farm or family work (including work for which payment is in kind rather than in cash); sheltered employment; homebound employment; or other gainful work."

(Taken from Federal Register, Vol. 39, No. 325, Part II, Page 42474, Thursday, December 5, 1974.)

as provided by psychologists, speech clinicians and audiologists as well as academic instruction, speech and language therapy and special programming for handicapped children who require special education. These educational services will be available for persons from 0 up to 21 years of age (up to 24 years of age under certain circumstances).

Employability services as provided through the Rehabilitation Education and Services Branch of Public Instruction will include vocational counseling and as appropriate, other resources including:

1. Complete medical diagnosis and vocational evaluation.
2. Medical, surgical, psychiatric and hospital services.
3. Prosthetic devices such as artificial limbs, braces, hearing aids and etc.
4. Occupational tools, equipment and licenses as required for particular jobs.
5. Vocational type training in schools, rehabilitation centers, workships, on-the-job, or through other special arrangements.
6. Financial assistance to cover living costs and transporation while in training.
7. Continued vocational and personal guidance and counseling as well as assistance in finding a job or sheltered workshop situation (and post employment follow-along).

The services of RESB are available to appropriate adolescent and adult Developmentally Disabled persons with severly handicapped persons having highest priority for services.

<u>Responsibilities of the Department of Social Services for Services Related to Developmentally Disabled Persons</u>

Due to the fact that the Department may establish a life-long relationship

with a client while Public Instruction may have a shorter term relationship centering around certain specific needs, the Department and its workers should be included in all planning for Developmentally Disabled persons where on-going service needs are anticipated.

A variety of services fall within the legal responsibility of the Department as outlined in Chapters 217-256 of Title XI of the Code of Iowa. These include:

1. Ongoing casework services designed to promote generate personal and family functioning.
2. Financial support programs (under Department control) - General Relief, AFDC, Title XIX and services provided through Title XX funding.
3. Placement of children, juveniles and adults in various alternate living situations including the assumption of certain legal rights in many cases.

In addition, there are a variety of services which can be provided either directly or through special purchase arrangements from other public or private agencies under Department sponsorship. These include, but are not restricted to: Special Day Care, Therapeutic Recreation and Residential Treatment Program. The financing of sheltered workshop programs, adult educational programs, transporation and certain residential programs can, under different individual circumstances, be funded by either Rehab. or the Department.

Special Conditions of Support, Cooperation and Coordination

Public Instruction and the Department agree to provide support and assistance to field administration and staff involved in:

1. Inter-agency staffing of Developmentally Disabled clients needing services.

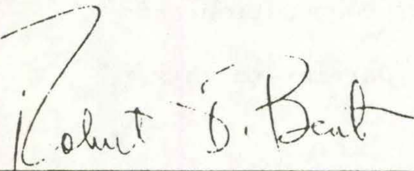
2. Securing a current diagnosis and evaluation for each Developmentally Disabled client needing services.

3. Individual Program Planning.

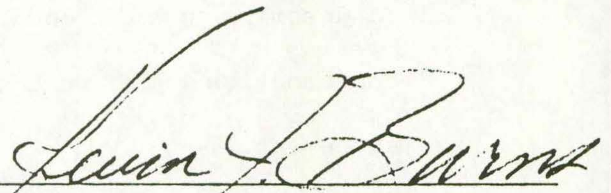
4. Follow-up/Follow-along.

The parties to this agreement futher agree to encourage the sharing of individual client information necessary for cooperative planning in a manner consistent with the regulations of each agency governing client confidentiality and to cooperate in general needs assessment and data collection activities necessary for responsible agency service planning.

The Department and Public Instruction also agree to support the implementation of the Seven Year Plan for delivery of services to persons who are Developmentally Disabled as attached.

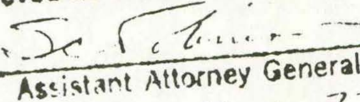


State Superintendent of Public Instruction, Iowa State Department of Public Instruction



Commissioner, Iowa Department of Social Services

Approved as to form:



Assistant Attorney General

10-1-77

LETTER OF AGREEMENT

Parties to the Agreement

The Iowa Department of Social Services and the Iowa State Board of Regents.

Duration of the Agreement

From the date of December 20, 1977 until rescinded in writing by either party or until superseded by a new agreement.

Purposes of Agreement

1. To establish some common assumptions regarding the planning for and delivery of services to Developmentally Disabled persons.
2. To enumerate overall responsibilities of each agency party to this agreement for services to Developmentally Disabled persons.
3. To describe special conditions of support, cooperation and coordination which must exist between the parties to this agreement.

Common Assumptions

The parties to this agreement mutually affirm the following principles:

1. NORMALIZATION: Making available to the Developmentally Disabled, patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream society. Each service should include, within its programming, a definite progression toward a more typical, independent life style.
2. INDIVIDUALIZATION: Services must be responsive to the individual client's identified need. Development of services must be based

on the individual's needs in order to secure for him the most effective and acceptable means of minimizing the effects of his disability.

3. ACCESSIBILITY TO SERVICES: Services must be geographically accessible and delivered so that no cultural, social, transportation or architectural barriers limit use. Services should have built-in safeguards to prevent lack of information, cost and/or lack of agency responsiveness or follow through from blocking the client's access to those services.

4. AVAILABILITY: A comprehensive array of services, sufficient in quality and quantity, to meet all clients' needs, regardless of their age, level of disability or cultural background, must be offered to meet the identified client needs of community/district. Availability also relies on sufficient funding being available to assure maximum utilization of the services.

5. RESPONSIVENESS (FLEXIBILITY): The system, as well as each component, must be flexible enough to insure that individual needs can be met as they are identified. The system must also be flexible enough to change as the needs of the system must be able to reach out to meet both expressed and unexpressed client needs.

6. VOLUNTARY CHOICE: Each individual should be allowed to choose from an appropriate array of services he will utilize. He should not be forced to receive services against his will or the will of his legal representative.

7. RESPONSIVENESS TO THE DEVELOPMENTAL MODEL: Services must be designed to facilitate an individual's growth through skill

development to independence. The system should, through its array of services, allow progression from mastery of self-help skills through socialization skills to independent living skills.

8. MAXIMIZATION OF EXISTING RESOURCES: The system should utilize existing resources/providers, including generic service agencies, whenever possible, in developing new components. This insures coordination within the system, yet avoids duplication.

9. LOCATION OF SERVICES WITHIN THE COMMUNITY: All services should be provided within the community or as close as possible to where the individual resides. (This should not be interpreted as preventing access to district/state-level resources if needed/requested.)

Responsibilities of the Board of Regents for Services Related to Developmentally Disabled Persons

The Board of Regents, through its facilities at the University of Iowa Hospitals and Clinics in Iowa City (especially through the Department of Orthopedics, the Department of Pediatrics and its Division of Developmental Disabilities, the Department of Psychiatry's Division of Child Psychiatry and the Child Development Clinic at Hospital School), through related agencies such as Iowa State Services for Crippled Children and through the Iowa Braille and Sight-Saving School at Vinton and the Iowa School for the Deaf at Council Bluffs, provides diagnostic, evaluation and ongoing educational and medical services for Developmentally Disabled persons.

Responsibilities of the Department of Social Services for Services Related to Developmentally Disabled Persons

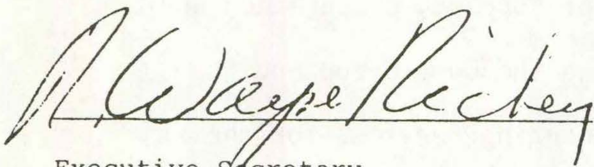
A variety of services fall within the legal responsibility of the

Department as outlined in Chapters 217-256 of Title XI of the Code of Iowa and include ongoing casework services, financial support programs and placement of children, juveniles and adults in alternative living situations.

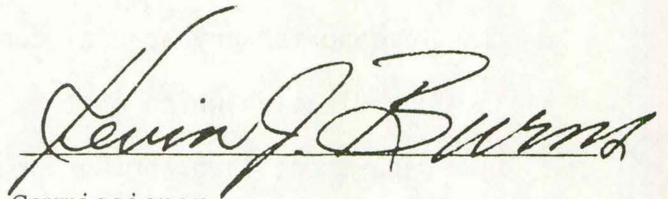
Special Conditions of Support, Cooperation and Coordination

Due to the special medical and educational needs of many Developmentally Disabled persons, the previously mentioned facilities under the control of the Board of Regents fill an important link in the continuum of services needed by these persons. The diagnosis and evaluation capabilities available through programs operated from University Hospitals are of particular importance.

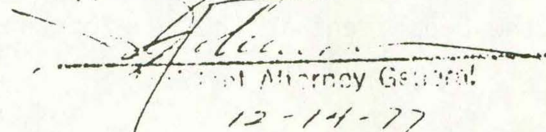
The Department of Social Services and the Board of Regents agree to work toward optimum coordination of resources necessary to assure delivery of diagnosis, evaluation and special medical and educational services to Developmentally Disabled persons and further to support in principle the goals of the Seven Year Plan for Delivery of Services to Persons who are Developmentally Disabled. The Board of Regents also agrees to direct the previously named facilities to share, to the extent permitted by federal and state law, demographic client data with the Department to facilitate annual service planning.



Executive Secretary
Iowa State Board of Regents



Commissioner
Iowa Department of Social Services



Approved as to form:

Attorney General

12-14-77

LETTER OF AGREEMENT

Parties to the Agreement

The Core Planning Group of District __________ hereafter referred to as the Core Group and the Iowa Department of Social Services, __________ District Office, hereafter referred to as the Department.

Duration of the Agreement

From the date of ____________________ until rescinded in writing by either party, until superseded by a new agreement or until the purposes giving rise to this agreement have been accomplished.

Purposes of the Agreement

1. To outline and clarify the responsibilities and authority of the Core Group relative to the Department and to services for the Developmentally Disabled.
2. To outline and clarify the responsibilities and authority of the Department relative to the Core Group and to services for the Developmentally Disabled.
3. To describe any special conditions of support, cooperation and coordination which must exist between the Core Group and the Department in planning for and implementing services for the Developmentally Disabled.

Responsibilities and Authority of the Core Group

The Core Group is responsible for giving advice, guidance and assistance to the Department in the development of a 7-year plan for services to the

Developmentally Disabled persons within the District (to include ICF/MR Title XIX planning and such other MR/DD planning as requested by the Department and accepted by the Core Group). In addition, the Core Group will provide assistance and guidance in the implementation of the Plan and will participate in the review and update of the Plan on an annual basis. In support of these responsibilities the Core Group will:

1. Meet regularly as a group and/or as special work committees to accomplish needed results.
2. Assist in the collection of information and data for needs assessment from service consumers and service providers.
3. Encourage and support cooperation and coordination among public and private agencies providing services to Developmentally Disabled clients.
4. Assist in identifying and securing sources of funding for needed services.
5. Make recommendations regarding service and funding needs to Title XX planning committees, Health Planning groups and agencies, and other citizens groups or agencies involved in planning for and/or funding services for the Developmentally Disabled.
6. Provide feedback to citizens and agencies in the communities represented by individual Core Group members regarding planning done and needs identified.
7. Make recommendations to the District Administrator of the Department regarding priorities for the Department in the provision of services to the Developmentally Disabled, funding resources to be used or approached by the Department,

and implementation schedules to be used in developing, facilitating, providing and funding services.

Constituency of the Core Group

Membership in the Core Group must be formalized to the extent necessary to insure a creative balance among consumer, interested citizens, political (Mayors, local Boards of Supervisors and/or State Legislators) and agency (public and private) personnel. As of the date of this agreement, membership in the Core Group will be considered to be fixed, with changes or additions to the membership subject to approval by the majority.

Authority of the Core Group

The Core Group shall not be a legally constituted body and shall have no direct powers or authority in regard to decision making, contracting or the commitment of funds. As previously stated, the role of the Core Group is advisory and assistive only.

Responsibilities and Authority of the Department

The Department has primary responsibility for the development, implementation and needed updating of a 7-year plan for services to the Developmentally Disabled who reside within the District. In support of these responsibilities the Department will:

1. Provide the necessary technical assistance to insure the maintenance of and sense of direction of the Core Group.
2. Provide information available through the Department to assist in needs assessment, service provider identification and funding source identification.
3. Provide staff time to carry out tasks identified by the Core Group and approved by the District Administrator of the

Department which are in support of planning, funding, or providing services to the Developmentally Disabled.

4. Insure that all of the policies and programs of the Department which are available and appropriate for the Developmentally Disabled are properly presented to the Core Group and that the Core Group is given the opportunity to review and comment prior to implementation.
5. Insure that all policies, programs and services so approved are in fact developed and provided to the client group concerned.
6. Give serious consideration to all recommendations made by the Core Group to the Department and be prepared to offer the full rationale for not following recommendations if such a decision is ever made.
7. Assume an active role in fostering cooperative planning among the various public and private agencies which service Developmentally Disabled persons -- this will include the development of Intergovernmental Cooperation Agreements, letters of agreement and a commitment to interdisciplinary team planning with each Developmentally Disabled person needing services.
8. Insure that workers in the Department do -
   a. Make necessary arrangements to insure that a valid diagnosis and evaluation is available for each Developmentally Disabled person needing services.
   b. Include the input of the client or his representative as well as other concerned professionals in the development of an individual program plan.
   c. Provide follow-up or follow-along services necessary to insure that client needs are being met on an on-going basis.

Authority of the Department

The authority for the Department to provide services, fund services and make planning and implementation decisions regarding programs for Developmentally Disabled persons is granted in various sections of the Code of Iowa from Chapter 217 through 256.

Conditions of Support, Cooperation and Coordination Which Must Exist Between The Parties to this Agreement

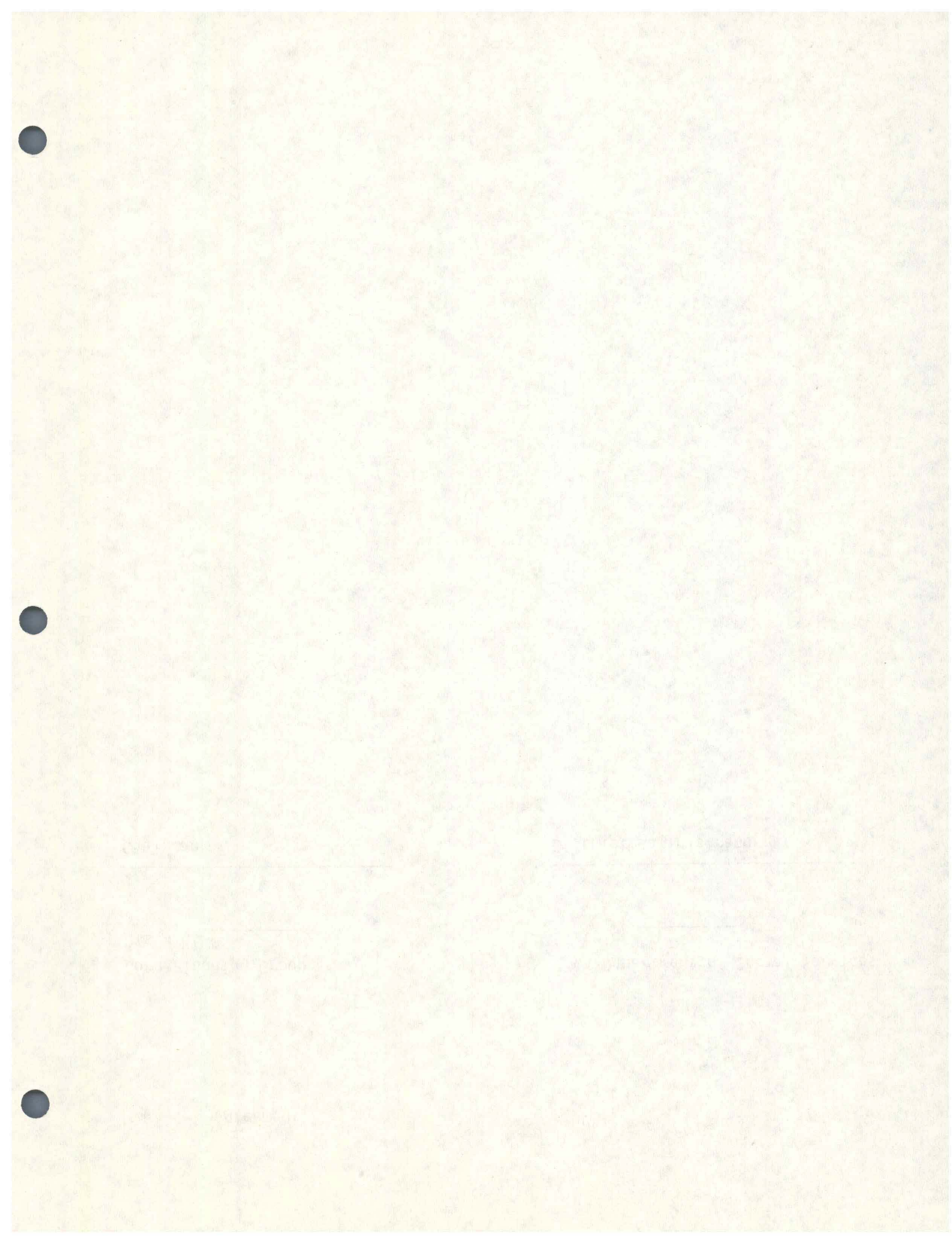
The Core Group and the Department affirm a belief that a Developmentally Disabled individual has all the rights of a normal person as guaranteed by the Constitution and Bill of Rights of the United States and that each Developmentally Disabled person has a right to receive services in the least restrictive environment available which will allow maximum development of abilities.

The Core Group and the Department further agree to:

1. Continue to develop, refine and update service need and service provider information necessary for accurate ongoing planning.
2. Work toward the best utilization of services presently available within the community.
3. Coordinate efforts to secure funding for additional services.
4. Coordinate efforts toward improving community awareness and acceptance of the needs of Developmentally Disabled persons.
5. Participate in the development, implementation and subsequent updating of a state-wide 7-year plan for services for the Developmentally Disabled.
6. The District 7-year plan for services for Developmentally Disabled persons (as attached) is considered a part of this

agreement.

Core Planning Group	Iowa Department of Social Services
District ________	District ________
______________________________	______________________________
Chairman	District Administrator



INTERGOVERNMENTAL COOPERATION
AGREEMENT

This agreement is entered into this _________ day of ______________, 1977, by and between the Iowa Department of Social Services, Des Moines Area - District XI to be referred to hereafter as the Department and the Iowa Department of Public Instruction, Rehabilitation Education and Services Branch - Des Moines - Region XI to be referred to hereafter as Rehab.

Authority for Agreement

Granted under Chapter 28E, Code of Iowa 1975 which authorizes the making of agreements between public agencies for the carrying out of their obligations and services.

Manner of Financing

No exchange of funds will occur between the parties to this agreement, no special payment or receipt of funds is authorized by this agreement, and no special budget will be prepared or financial records kept pursuant to this agreement. Each party simply agrees to use funds for purposes and in a manner consistent with their individual State and Federal guidelines.

Administration

The signators to this agreement will serve as co-administrators of the agreement.

Acquisition, Holding and Disposal of Property

No real or personal property will be acquired, held or disposed of under the terms of this agreement.

Term of Agreement

This agreement is for a period of ________ years(s) beginning __________ and ending ______________. The agreement may be terminated by either party

upon 30 days notice due to noncompliance by a party, change in regulations governing one or both parties or by mutal consent.

Purpose of Agreement

The purpose of this agreement is to clarify the respective roles of these two Public Agencies in meeting the needs of Developmentally Disabled adolescents and adults who reside within Boone, Story, Dallas, Polk, Jasper, Madison Warren and Marion Counties in the State of Iowa.

Common Understandings

The signators to this agreement mutually affirm the principles, findings and commitments as presented in "The Developmental Disabilities Services - Seven Year Master Plan" which has been developed by the ICF/MR Core Planning Group of District XI (as these principles and commitments are consistent with State and Federal law governing the respective agencies). This includes a commitment to facilitate the development and use of community based facilities for the provision of services for the Developmentally Disabled and a commitment to team planning and regular follow-along to be provided by staff of the agencies which are parties to this agreement.

Conditions of Agreement

The Department will assume primary responsibility for the identification of Developmentally Disabled persons, however, Rehab. through its work in schools or through referrals from the medical community will also be in a position to identify Developmentally Disabled persons in need of services.

In each case, the Mental Retardation Coordinator or adults or children's service specialist of the County Department of legal settlement (if within District XI) will be notified and plans will be made to call together a team of professionals and the client or his representative to develop an Individual Program Plan and assign responsibility for follow-along.

Due to the fact that the Department may establish a life-long relationship with a client while Rehab. may have a shorter term relationship centering around certain specific goals, the role of "convener" (as presented in the District Seven Year Plan) will be assumed by a Department worker (County Mental Retardation Coordinator or other service worker).

While this agreement focuses primarily on services to adults, it is recognized that most of the responsibilities of the Department are not restricted by age and that the responsibilities of Rehab. may be exercised with considerable flexibility in regard to age in order to better facilitate vocational planning. In all cases involving a client under 21 years of age, however, a representative of Heartland Area Education Agency (Special Ed. Consultant or School Social Worker) will be a member of the interdisciplinary planning team.

While each of the parties to this agreement as well as other public agencies not party to this agreement may have specific responsibilities under law which they are required to exercise, no program will be initiated for an adult or adolscent Developmentally Disabled client by a worker of either agency party to this agreement without consulting with the other and generally with the added involvement of one or more other agency or community representatives

If disagreements develop between workers of the agencies represented by this agreement around planning for a client, every effort will be made to settle the disputes at the lowest level of authority possible. Only after a complete impasse in local problem solving is reached will a matter be presented (in a thoroughly documented written form) to the signators of this agreement.

Provision of Services

Rehab. will maintain a staff of counselors adequate to provide coverage of all counties within District XI. Special attention will be given to public schools and other educational institutions within the District. These counselors will interview persons referred or otherwise identified as Developmentally

Disabled in order to establish eligibility for Rehab. services and to make an initial determination that services available through Rehab. might improve employability.* Severely disabled persons will have highest priority for Rehab. services.

It is also understood that before any specific commitments are made or any training programs are begun, the Rehab. counselor will contact the appropriate Department worker in order to begin coordinated planning. These two persons in consultation with the client and/or his representative (and a Heartland representative if the client is under 21) may make an initial decision regarding needed diagnostic and evaluation work and then make plans for assembling an interdisciplinary team to develop an Individual Program Plan with the client.

As the planning proceeds, the involvement of Rehab. may be substantial, moving from interviews, guidance and counseling to arrangment for a complete medical diagnosis and vocational evaluation. Referral to the Iowa State Vocational Rehabilitation Center in Des Moines might also be made.

Other services potentially available through Rehab. are:

1. Medical, surgical, psychiatric and hospital services.
2. Prosthetic devices such as artificial limbs, braces, hearing aids, and etc.
3. Occupational tools, equipment and licenses as required for particular jobs.

*"Employability refers to a determination that the provision of vocational rehabilitation services is likely to enable an individual to enter or retain employment consistent with his capacities and abilities in the competitive labor market; the practice of a profession; self-employment; homemaking; farm or family work (including work for which payment is in kind rather than in cash); sheltered employment; homebound employment; or other gainful work."

(Taken from Federal Register, Vol. 39, No. 235, Part II, Page 42474, Thursday, December 5, 1974)

4. Vocational type training in schools, rehabilitation centers, workshops, on-the-job, or through other special arrangments.
5. Financial assistance to cover living costs and transportation while involved in training.
6. Continued vocational and personal guidance and counseling as well as assistance in finding a job or sheltered workshop situation (and post employment follow-along).

It is understood that most of these services are purchased by Rehab. from other sources rather than being directly available through Rehab. and are thus available not only subject to a deomonstrated need but also subject to the availability of financial resources and the absence of similar benefits from other sources for which the client might be eligible.

It is also understood that once personal and/or vocational goals have been achieved and a reasonable follow-up/follow-along time has expired, the involvement of Rehab. will cease. This is not to say that a case could not be reopened in the event of future need.

The Department will also provide adequate staff to respond to the needs of Developmentally Disabled persons in this eight county area. In most cases, the Department staff person with this responsibility will be the County Mental Retardation Coordinator or a service worker assigned to this special responsibility (in some counties several persons may share responsibility). The Department worker will have primary responsibility for coordinating the development of an Individual Program Plan for each Developmentally Disabled adult client in the county of his/her responsibility. The Department worker will thus assume the role of "convener" as previously indicated. This worker will seek to identify Developmentally Disabled persons needing service and will attempt to involve all appropriate agency and community professionals

and other interested persons (including always clients and/or thie representative) in Individual Program Planning.

In all cases involving planning for a person under 21 years of age, a staff person of the Area Education Agency will be involved, and in all cases involving an older juvenile or adult, a Rehab. counselor will be involved in planning.

A variety of services fall within the legal responsibilties of the Department as outlined in Chapters 217-256 of Title XI of the Code of Iowa. These include:

1. Ongoing casework services designed to promote general personal and family functioning.
2. Financial support programs (under Department control) - General Relief, AFDC, Title XIX and services provided through Title XX funding.
3. Placement of juveniles and adults in various alternate living situations including the assumption of certain legal rights in many cases.

In addition, there are a variety of services which can be provided either directly or through special purchase arrangements from other public or private agencies under Department sponsorship. These include but are not restricted to: Special Day Care, Therapeutic Recreation and Residential Treatment Programs. The financing of sheltered workshop programs, adult educational programs, transportation and certain residential programs can, under different individual circumstances, be funded by either Rehab. or the Department.

It is anticipated that in many cases, initial responsibility for the funding of these services will rest with Rehab. and that the Department will become

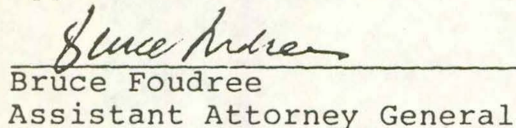
involved after basic programing has been completed and a long-term (possibly life-long) plan of developmental programing has begun.

It is also hoped that workers of both agencies will do cooperative planning in order to make maximum use of funds available at any given time through either agency, anticipating as much as possible the funding cycles and possible future funding restrictions of each agency.

Mr. Victor Nielsen
Regional Manager (AEA Area XI)
Rehabilitation Education
and Services Branch
Iowa Department of Public Instruction

Mr. William Ketch
District XI Administrator
Iowa Department of Social Services

Approved as to form:



Bruce Foudree
Assistant Attorney General

INTERGOVERNMENTAL COOPERATION
AGREEMENT

This agreement is made and entered into this ________ day of __________, 1977, by and between the Heartland Area Education Agency 11 located at Ankeny, Iowa, hereinafter referred to as "Heartland", and the Iowa Department of Social Services District XI Office located in Des Moines, hereinafter referred to as the "Department."

Authority for Agreement

Granted under Chapter 28E, Code of Iowa 1975 which authorizes the making of agreements between public agencies for the carrying out of their obligations and services.

Manner of Financing

No exchange of funds will occur between the parties to this agreement, no special payment or receipt of funds is authorized by this agreement, and no special budget will be prepared or financial records kept pursuant to this agreement. Each party simply agrees to use funds for purposes and in a manner consistent with their individual State and Federal guidelines.

Administration

The Heartland Supervisor of Social Work Services and the Department Developmentaly Disabilities Supervisor will serve as co-administrators of this agreement under the general supervision of the signators.

Acquisition, Holding and Disposal of Property

No real or personal property will be acquired, held or disposed of under the terms of this agreement.

Term of Agreement

This agreement is for a period of ________ year(s) beginning ____________ and ending ________________. The agreement may be terminated by either party upon 30 days notice due to noncompliance by a party, change in regulations governing one or both parties or by mutual consent.

Purpose of Agreement

The purposes of this agreement are to:

1. Clarify the respective roles of Heartland and the Department in meeting the needs of the Developmentally Disabled of the District.
2. Identify the specific responsibilities of each party in meeting these needs.
3. Establish a format for cooperation in meeting these needs.

Common Assumptions of Parties to this Agreement

1. The Developmentally Disabled individual has all the rights of a normal person as guaranteed by the Constitution and Bill of Rights of the United States.
2. Placement in alternate living situations and the arrangment of services for clients will be in the least restrictive appropriate setting, e.g., within the home community, within the District and in the absence of appropriate community or District based facilities, elsewhere in the State. Out of state placements are within the authority and responsibility of the Department; however, payment of educational costs can be certified by the Heartland Special Education Director only upon prior approval of the State Superintendent of

Public Instruction.

3. As financial resources allow, a wide range of educational, social and habilitation services will be developed within the community to meet the needs of the Developmentally Disabled.
4. The assistance of a community professional in the role of convener will be available from social service workers from county offices of the Department and/or Heartland for each Developmentally Disabled person to provide assistance in securing needed services.
5. As appropriate, each Developmentally Disabled client will be assisted by a convener in securing a current and thorough Diagnosis and Evaluation.
6. As appropriate, an Individual Program Plan will be developed for each Developmentally Disabled client.
7. This plan will be developed by the client or his representative and an interdisciplinary team of professionals concerned with his future or in collaboration with LEA/AEA staffings.
8. Each Individual Program Plan will be based on a developmental model and will attempt to maximize coordination of educational and other service components and will further attempt to maximize client participation in regular community activities.
9. The convener will insure that client progress relative to the plan is monitored and that regular evaluations of client progress will be made with involvement of the client or his representative and the interdisciplinary team of professionals who developed the plan.

10. A high level of respect for client confidentiality will be maintained by staff of both parties to this agreement through the use of signed release of information statements; however, free and unrestricted flow of client information will be developed among the appropriate professional staff of both parties.

11. While acceptance of and respect for the primary or exclusive roles of each of the parties to this agreement (as spelled out in the following conditions) will prevail, neither party will necessarily surrender client advocacy capability under any circumstances.

Conditions of the Agreement

1. Identification of Developmentally Disabled Persons

   Both Heartland and the Department will assume responsibility for the identification of the Developmentally Disabled in the community; however, Heartland will have primary responsibility to degree allowable under State Department of Public Instruction rules for the identification of Developmentally Disabled children (0 up to 21 years of age) as identified in Chapter 281 of the Code of Iowa. The Department, through its work with families, will assist in the identification of Developmentally Disabled children between 0 - 5 years of age and between 5 - 21 years of age which are the Department's clients, and will have sole responsibility for the identification of Developmentally Disabled adults.

2. <u>Role of Convener</u>

A convener will normally be a professional staff person from Heartland or the Department or from another public or private agency as designated by the Department who will assume responsibility for assuring that:

a. A current Diagnosis and Evaluation is available for a Developmentally Disabled client.

b. An interdisciplinary team of professionals is called together to meet with the client or his representative to develop a plan for services to assist the client in reaching his individual goals.

c. Follow-up and follow-along monitoring of individual client progress is done.

d. Regular evaluations of client progress are made involving the client or his representative and the interdisciplinary team of professionals who developed the plan.

For clients from 0 up to 21 years of age, the role of convener will normally be assumed by a Heartland Special Education Consultant or a school social worker. Where, due to the nature of client disability or family situation, the Department social worker could assume the convener role. It is also possible that the convener role could be assumed by a worker in another public or private agency under certain conditions. In all cases involving a child (0 up to 21 years of age), close coordination with the school or special education situation

will be maintained in order to best insure continuity of educational program.

3. Diagnosis and Evaluation:

   Heartland and the Department mutually agree that a currently valid Diagnosis and Evaluation will be available for each person wishing or needing staffing by an interdisciplinary team. If the team determines that additional evaluation work is needed for a client, arrangements for this will also normally be facilitated by the Convener.

4. Involvement with Interdisciplinary Teams:

   Heartland and the Department mutually agree to the concept of team planning for Developmentally Disabled clients and further agree, as needed, to provide staff to serve as Conveners and as members of interdisciplinary teams for both planning and follow-up responsibilities.

5. Individual Program Plan:

   Heartland and the Department mutually agree irrespective of the agency of employ that a Convener will facilitate the development of an individual program plan by an interdisciplinary team for each appropriate Developmentally Disabled client containing a minimum of the following items:

   a. An ideal plan of service based only on client need.
   b. An interim plan based on services currently available and consistent with the rules and regulations that govern Heartland and the Department.
   c. An outline of steps to be taken to achieve the ideal plan.

d. Prognosis.

e. General goals and long range objectives.

f. Specific goals defined with a designation of persons responsible for carrying them out.

   Note: Goals will be stated in terms that are measurable.

g. A schedule of dates for review of progress and re-evaluation.

6. Framework for Settling Disagreements, Role Conflicts or Other Problems Relative to Staff Implementation of this Agreement:

   Problem resolution will be based on the principle that all conflicts should be settled at the lowest level of authority possible. This would normally infer that the immediate supervisors (line or functional) of the parties involved in disagreement would have primary responsibility for mediating a dispute. Failure of this level would necessitate referral (in written form) of the matter to the next higher level of authority in each agency. Failure again at resolution would involve referral of the matter in a thoroughly documented form to the two signators of this agreement.

Provision of Services

The following services will fall within the area of responsibility of Heartland:

1. Diagnosis and Evaluation:

   Heartland shall be prepared to provide educational diagnostic specialists including psychologists, speech clinicians, educational audiologists and others to provide a written

evaluation of each child identified as Developmentally Disabled. The evaluation will include, but is not necessarily limited to:

a. A family/social history.

b. Psychological evaluation.

c. A speech and language evaluation.

d. A hearing evaluation.

e. A diagnostic/educational evaluation.

f. Visual examination.

g. The child's health history.

As needed and in coordination with the Department, additional or supplementary diagnostic and evaluation services may be arranged with Woodward State Hospital-School or other public or private providers of professional services.

2. Instructional Programs:

Heartland, in cooperation with local school districts, agrees to provide needed educational programs for all Developmentally Disabled children including, but not necessarily restricted to:

a. Academic instruction.

b. Speech and language therapy.

c. Special programming for handicapped children who require special education.

In addition, regardless of the level of mental disability, Heartland agrees, in cooperation with local school districts, to provide instruction and training in self-help, self-care and adaptive skills based on a developmental concept.

Instructional programs may be provided in any of the following ways:

a. Self-contained special classes providing services on a full-time basis.

b. Integrated classes, resource rooms and itinerant instruction provided on a part-time basis.

c. Home services and hospital services provided for children whose conditions preclude their attendance at school.

The transporation of a child between his daily living situation and the educational setting will normally be provided by a local education agency assisted as necessary by Heartland.

The following services will fall within the area of responsibility of the Department as authorized by the Code of Iowa, Chapters, 217-256 of Title XI:

1. The Department will be involved in the placement of Developmentally Disabled children and adults in alternate living situations as appropriate. This may involve assumption of legal custody or arranging guardianship as authorized in the Code of Iowa, Chapter 222.

2. The Department will provide needed supportive services to Developmentally Disabled children and their families which fall outside the responsibility of Heartland. These services may include day care, special diagnostic services, family counseling or any of the many direct services, purchased services or financial support services available through the Department (code of Iowa, Chapter 234).

3. The Department will make available all appropriate service and financial support programs (under Department control) to the adult Mentally Disabled client. These programs may include (among others) special Day Care, Therapeutic Recreation, Sheltered Workshop, Transporation and residential treatment programs (Code of Iowa, Chapter 234-).

Dr. Robert Gibson Director of Special Education Heartland Education Agency	Mr. William C. Ketch District XI Administrator Department of Social Services

Approved as to form:

Bruce Foudree
Assistant Attorney General

INTERGOVERNMENTAL COOPERATION AGREEMENT

This agreement is made and entered into this ____________ day of ______________, 1977 by and between the ____________ County Board of Supervisors with offices in __________, Iowa, hereinafter referred to as "The Board" and the Iowa Department of Social Services District ____________ Office located in ______________, Iowa, hereinafter referred to as "The Department."

Authority for Agreement

Granted under chapter 28E, Code of Iowa 1975 which authorizes the making of agreements between Governmental levels and/or agencies thereof for the carrying out of their obligations and services.

Manner of Financing

No direct exchange of funds will occur between the parties to this agreement, and no special budget will be prepared or financial records kept in direct support of this agreement. Any and all financial arrangements called for in this agreement will be handled through previously existing and/or otherwise legally based payment mechanisms.

Administration

The Chairman of the Board or his designee and the District Administrator of the Department or his designee will serve as co-administrators of this agreement.

Acquisition, Holding and Disposal of Property

No real or personal property will be acquired, held or disposed of under the terms of this agreement except as may occur as a result of either party

to the agreement exercising its legal right to so acquire, hold or dispose of property in pursuit of fulfilling the intent of this agreement.

Terms of Agreement

This agreement is for a period of ________ year(s) beginning __________ and ending ____________. The agreement may be terminated by either party upon 60 days written notice due to noncompliance by a party, change in regulations governing one or both parties or by mutual consent.

Purpose of Agreement

The purposes of this agreement are to:

1. Outline the basic responsibilities of the Board for services to Developmentally Disabled persons.*
2. Outline the responsibilities of the Department relative to services to Developmentally Disabled persons.
3. Describe any special conditions of support, cooperation, and coordination which must exist between the Board and the Department in planning for, financing and implementing services for the Developmentally Disabled.

Responsibilities of the Board

The responsibilities of the Board relative to services for the mentally retarded and similarly disabled persons are spelled out in Chapter 222 of the Code of Iowa. Among these responsibilities are:

1. Provide legal services through the county attorney in appointing guardians for and arranging commitments of mentally retarded persons as appropriate.

*Definition - A developmental disability is defined (current Federal definition) as a disability attributable to mental retardation, cerebral palsy, epilepsy, autism (or dyslexia resulting from these), or any other conditions closely related to mental retardation in terms of intellectual and adaptive problems.

2. Pay for (or provide local funds for) needed diagnostic, evaluation and/or treatment services for Developmentally Disabled persons with legal settlement within the county.
3. Provide for other services as appropriate as specified in Chapter 252 of the Code of Iowa.

Responsibilities of the Department

The responsibilities of the Department relative to services for Developmentally Disabled persons are enumerated in various chapters of the Code of Iowa from 217 through 256 and include:

1. Arranging for appropriate residential placement and treatment.
2. Provision of needed case work services to individuals and families.
3. Provision of appropriate financial support programs which are under Department control.

Special Conditions of Support, Cooperation and Coordination

The Board and the Department agree to coordinate and support a service delivery system for Developmentally Disabled persons which reflects community based planning (ICF/MR Core Planning Group, Title XX Advisory Committee and others) and is consistent with the following principles:

1. NORMALIZATION: Making available to the Developmentally Disabled patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream society. Each service should include, within its programming, a definite progression toward a more typical, independent life style.

2. INDIVIDUALIZATION: Services must be responsive to the individual client's identified need. Development of services must be based on the individual's needs in order to secure for him the most effective and acceptable means of minimizing the effects of his disability.

3. ACCESSIBILITY TO SERVICES: Services must be geographically accessible and delivered so that no cultural, social, transportation or architectural barriers limit use. Services should have built-in safeguards to prevent lack of information, cost, and/or lack of agency responsiveness or follow through from blocking the client's access to those services.

4. AVAILABILITY: A comprehensive array of services, sufficient in quality and quantity, to meet all clients' needs, regardless of their age, level of disability, or cultural background, must be offered to meet the identified client needs of community/district. Availability also relies on sufficient funding being available to assure maximum utilization of the services.

5. RESPONSIVENESS (FLEXIBILITY): The system, as well as each component, must be flexible enough to insure that individual needs can be met as they are identified. The system must also be flexible enough to change as the needs of the system must be able to reach out to meet both expressed and unexpressed client needs.

6. VOLUNTARY CHOICE: Each individual should be allowed to choose from an appropriate array of services he will utilize. He should not be forced to receive services against his will or

the will of his legal representative.

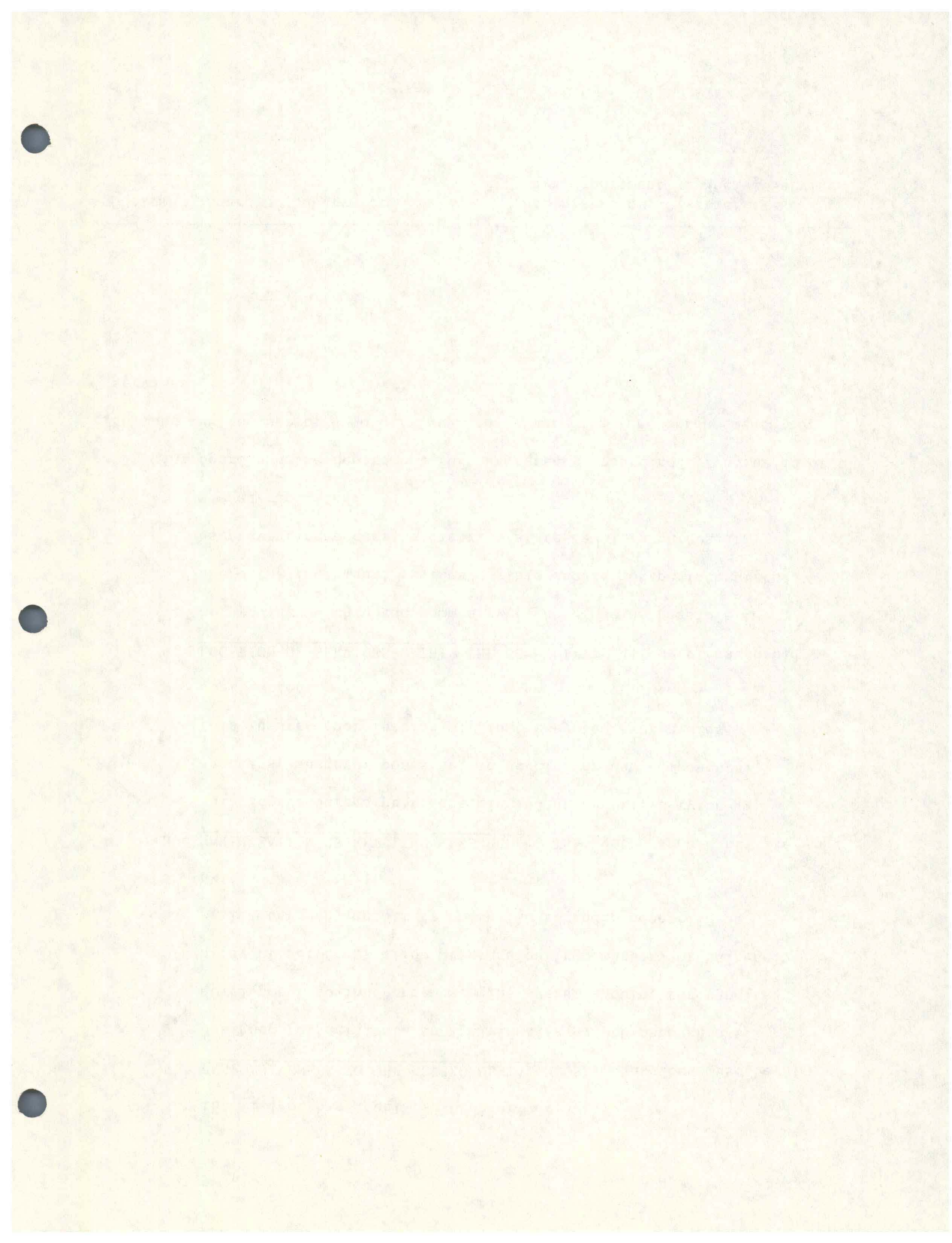
7. RESPONSIVENESS TO THE DEVELOPMENTAL MODEL: Services must be designed to facilitate an individual's growth through skill development to independence. The system should, through its array of services, allow progression from mastery of self-help skills through socialization skills to independent living skills.

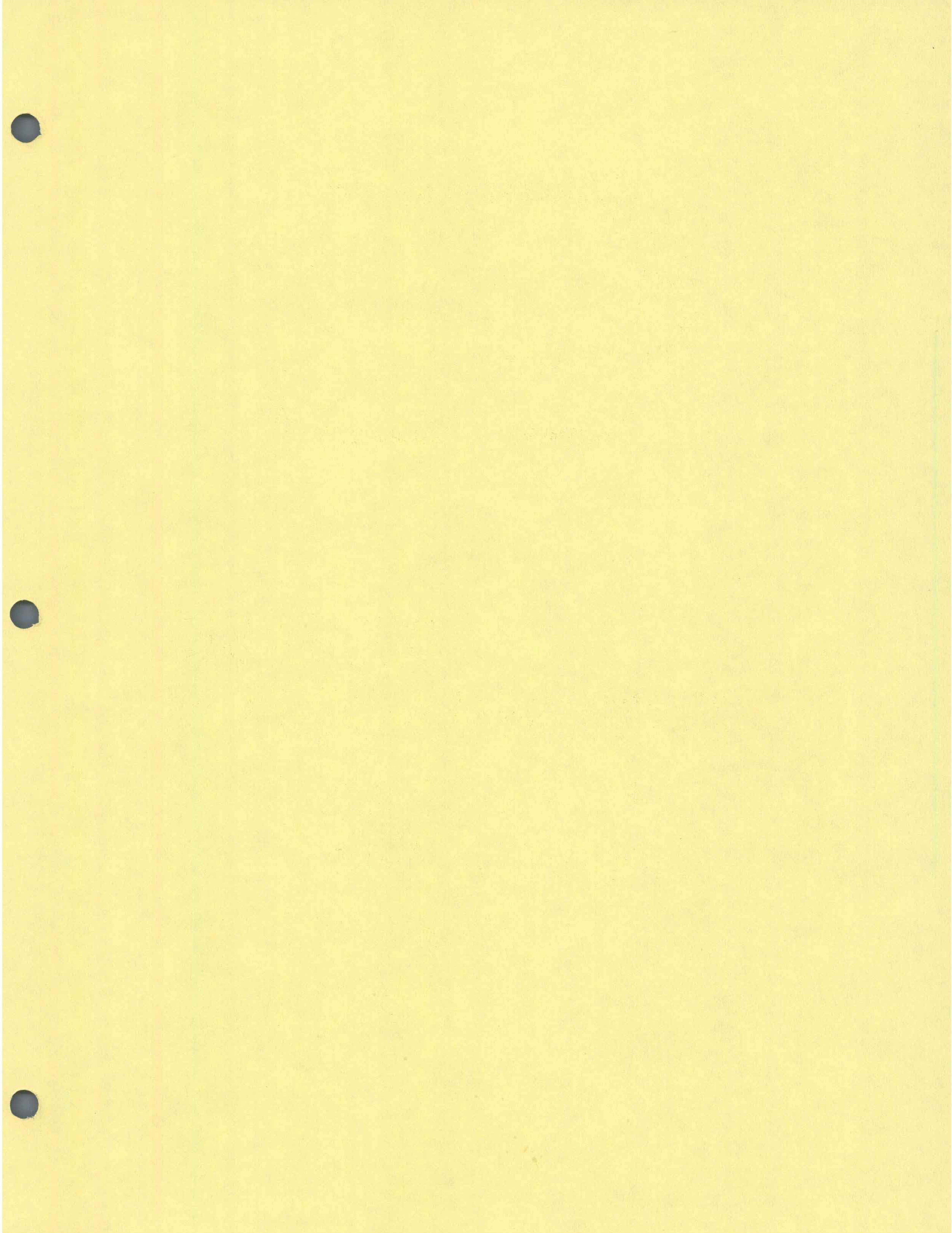
8. MAXIMIZATION OF EXISTING RESOURCES: The system should utilize existing resources/providers, including generic service agencies, whenever possible, in developing new components. This insures coordination within the system, yet avoids duplication.

9. LOCATION OF SERVICES WITHIN THE COMMUNITY: All services should be provided within the community or as close as possible to where the individual resides. (This should not be interpreted as preventing access to district/state-level resources if needed/requested.)

The Board and the Department further agree to coordinate funding in order to make maximum use of Federal/State/County matching fund arrangements for services.

______________________________	______________________________
Chairman, Board of Supervisor	Administrator, District __________
______________ County	Iowa Department of Social Services





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