COMPREHENSIVE STATE PLAN

FOR
THE MENTALLY RETARDED
AND
DEVELOPMENTALLY DISABLED
IN
MINNESOTA

MARCH, 1975

MR/DD PROGRAM OFFICE
COMPREHENSIVE PROGRAM BUREAU
DEPARTMENT OF PUBLIC WELFARE
ST. PAUL, MINNESOTA

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Authority of the Commissioner of Public Welfare

The commissioner of public welfare is constituted as the "state agency" as defined by the Social Security Act of the United States (M.S, 245.04). and the laws of this state (M.S. 246.01) for all purposes related to mental health and mental hygiene. This includes promoting the enforcement of laws protecting defective children and supervision of all non-institutional services to handicapped persons (M.S. 256.01). Minnesota laws further provide that the commissioner of public welfare shall actively cooperate with other departments, agencies and institutions, local, state and federal, relating to the care and supervision of individuals, both prior to and after departure from institutions, under the supervision of said director of institutions.

M.S. 245.70 designates the commissioner of public welfare as the state agency to administer a state-wide plan for the construction, equipment, maintenance, and operation of any facilities for the care, treatment, diagnosis, or rehabilitation of the mentally retarded....which are or may be required as a condition for eligibility for benefits under any federal law and, in particular, under the Federal Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (P.L. 88-164). The commissioner of public welfare is authorized and directed to receive, administer, and expend any funds that may be available under any federal law or from any other source, public or private, for such purposes, and enter into agreements with other departments of the state, as necessary, to meet all requirements of the federal government (M.S. 256.01).

M.S. 245.072, MENTAL RETARDATION DIVISION, provides that a mental retardation division is created in the department of public welfare which shall coordinate those laws administered and enforced by the commissioner of public welfare relating to mental retardation and mental deficiency which the commissioner may assign to the division.

FOREWARD

This plan

1. Gives direction to the Department of Public Welfare goal of developing a community-based program for persons who are mentally retarded or otherwise developmentally disabled.

2. Begins to investigate alternative strategies in achieving the above goal.

3. Establishes an evolutionary strategy in how the Department of Public Welfare's goal will be achieved.

4. Provides for participation of persons from each of the four functions that make up the service delivery system (Chapter III, A & E).

The state of the art in planning for a target group of handicapped people in the general population dictates that this plan address the process of (1) assessing the needs of the target population and determining priorities in meeting those needs, and (2) defining the service delivery system and adapting it to meet the needs of the target population.

Considerable effort in the Department of Public Welfare has gone into establishing the framework for a community-focused service delivery system and funding it through local, state and federal sources. Whether Minnesota's program will become principally community-based through increased development of community alternatives to institutionalization is yet to be de-

termined by the community and legislature. The development of community alternatives is the subject of the Department of Public Welfare Comprehensive Plan and legislative budget requests.

The main thrust of services for persons who are mentally retarded or developmentally disabled is to provide assistance to enable them to live in their own homes. When this is no longer possible or desirable, efforts are directed toward placement in a community-based residential facility, providing it can carry out a plan of services to meet the person's developing needs. Placement is made in one of the state institutions when suitable community programs are not available.

While the population in the state institutions has been significantly reduced over the past 10 years, the higher level functioning persons with less complicated physical and developmental problems have been placed in community-based facilities, including some inappropriate placements in nursing homes. Development of community-based programs must address all of the needs of a developmental program and identify specific groups for such programs from both the state institutions and nursing homes.

The extent to which community-based programs are more desirable than state institutions for the more complicated physical and developmental problems has been studied. These studies indicate that approximately one-half of the existing population in state institutions could be better served in appropriate community-based programs.

Department of Public Welfare planning and legislative proposals for the 1975 session are directed toward the establishment of community alterna-

tives and the development of a service delivery system within each local area (area board).

Specific legislative requests include: (1) family subsidy over and above room and board for needed services in order to maintain children in their own homes; (2) equalization of cost to counties for care in community-based facilities and state institutions to reduce costs as a factor in making appropriate placements; and (3) loans for the construction and remodeling costs of community-based facilities. Study of certain other documents related to this phase of the plan may be helpful in understanding the techniques being used in developing the service delivery system:

Community Alternatives and Institutional Reform (CAIR) Report, a Developmental Disabilities Project.

A Report to the 1973 Minnesota State Legislature on the Status of Minnesota's Mentally Retarded Citizens Residing in State Hospitals, by Minnesota Department of Public Welfare.

Section VI, Department of Public Welfare grant-in-aid application form for area MH-MR boards.

Department of Public Welfare Policy Bulletin #5, concerning the area MH-MR board responsibilities in planning.

Memorandum to area MH-MR boards from Vera Likins, Commissioner, concerning Area Planning for Community Alternatives, dated January 13, 1975.

Outreach Training Program for Personnel Serving the Mentally Retarded in Minnesota.

(draft) Minnesota Department of Public Welfare Advocacy Procedures.

(proposed) Amendment to M.S. 252.27, concerning family subsidy.

(proposed) Minnesota Protection Act, concerning guardianship and conservatorship.

CHAPTER I

Introduction

This document is that section of the Minnesota Department of Public Welfare's Comprehensive State Plan that deals specifically with planning for mentally retarded and developmentally disabled persons in Minnesota. An effort has been made to develop a plan that is consistent with the contemporary philosophy of service for handicapped persons. This philosophy includes the principle of normalization, the developmental model, and individualization of all services to the mentally retarded and developmentally disabled.

Further, the recommendations in this plan will address themselves to these five goals adopted by the Department of Public Welfare:

1. The Department should perform a broad-based standard-setting, coordination, funding, monitoring and evaluating function.
2. The Department should reduce, as far as possible, its role in providing direct services by delegating the management and operational responsibilities for these services to the local level.
3. The Department should carry out its role in program and service delivery indirectly through long-range program and budget planning, development of licensing and funding standards, funding local community-based programs and services via grant-in-aid and reimbursement mechanisms.
4. All residential and non-residential service delivery systems for which the Department is responsible should be fiscally and administratively integrated into a single, community-based program, under local control. The reorganization and functioning

of the Central Office should be modeled upon and geared toward providing support for this local delivery system.

5. In order to carry out the functions listed above, the Department must give top priority to the continuing development and implementation of an adequate management information system which will provide needed information in areas of cost finding, rate setting, target population needs assessment, and feedback on the impact or results of the programs and service funded, so that appropriate accountability of public funds can be guaranteed.

CHAPTER II

Division of Mental Retardation and Developmental Disabilities (MR/DD Program Office)

The MR/DD Program Office was established in M.S. 245.072 and is the responsible office for planning and coordination of services to the MR/DD population in Minnesota. The role and responsibility of this office is to develop procedures and techniques that enable it to:

1. Continually assess the needs of the MR/DD population currently being served throughout the system,
2. Identify that MR/DD population in need of services who are not being serviced in the system,
3. Determine developmental services needed by area and category,
4. Define and evaluate the current delivery system and provide guidance in determining needs for increasing or decreasing certain components of the system,
5. Describe fiscal, legal, and policy support of the delivery system and determine changes needed including ways to improve the coordination among and between the four functions,
6. Manage a process model for the articulation of goals and objectives from the local level through central coordinating for the purposes of prioritizing and communicating state-wide goals and objectives identified within and for the system,
7. Examine and study existing accreditation, licensing and other standards and assist in implementation and evaluation of such monitoring functions.

This office, concurrent with the filing of this report, will be initiating a

CHAPTER III

The Service Delivery System

A. The Four Functions

The major theme of this plan is the description of a process model for the planning, coordination, and subsequent delivery of appropriate services to the mentally retarded and developmentally disabled. The complexity of the system dictates the use of a new and unique approach for describing its functions. Four functional categories aid in conceptualizing the organization of the wide array of services available to the target population. These functions are:

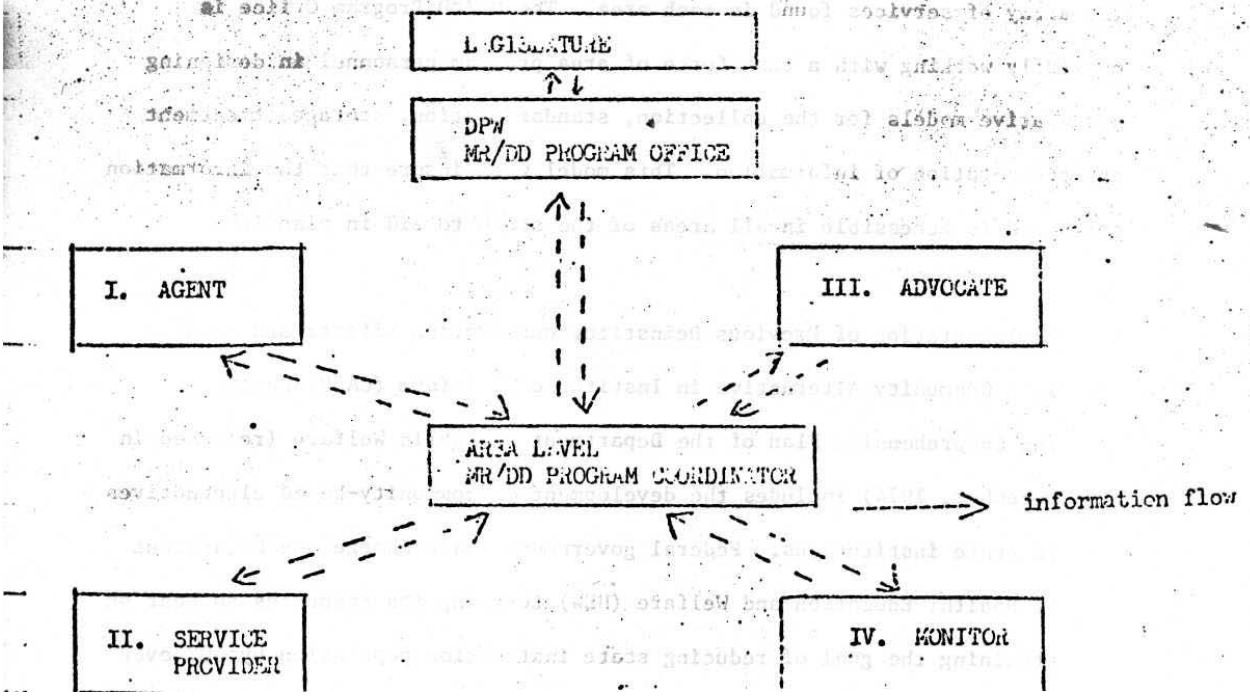
1. To act as agent for the individual. Persons who function as agents for the individual include the parent and county welfare department. This function summarily consists of assessing the needs of the individual, developing a plan for services, arranging for those services, and monitoring his progress. The agent also arranges for payment of those services.
2. To provide the service he needs. The service provision function includes all residential and day developmental programs which provide services to individuals needing assistance. These services include community-based residential facilities, state institutions, daytime activity centers, sheltered workshops, work activity centers, public schools, as well as health, medical, mental health, and recreation services available to the general public.
3. To advocate for the individual. Persons fulfilling this role include parents, relatives and interested persons. Organizations who advocate for the individual include the Minnesota Association for Retarded Citizens, United Cerebral Palsy, Minnesota Epilepsy League, Advocacy

Society, the courts, Family and Guardianship Services and Consumer Concerns.

4. To monitor those services provided. The monitor function includes governmental agencies who are responsible for licensing, certification, management, and supervision.

B. Area MR/DD Functions

Traditionally, the "total institution" approach to service delivery has caused the agent, advocacy, and monitoring functions to be subordinate to the service provider function. This plan seeks to develop a community-based service delivery system (Figure 1) for the delivery of services that will provide a balance among and between the four functions at the community level. The mechanism for achieving this balance must be the community agency with responsibility for coordination and planning, and whose structure affords representation to each of the four functions. This plan identifies the Area MR/DD Program Coordinator and the Area Board as this community agency.



Minnesota Statutes 252.28 gives the commissioner authority to determine need, location, and program for residential and day programs. Area Mental Health and Mental Retardation (MH/MR) Boards have been delegated authority to assist the commissioner in making these determinations.

Consequently, the MH/MR Area Board plays a key role in determining the quantity and quality of services available to MR/DD persons.

This role of the MH/MR Area Board mandates the development of an area service plan which addresses each of the four functional service areas. The Area MH/MR Board is the "forum" at which representatives of agencies performing each of the four functions share and solicit information about the service system. It is expected that each MH/MR Area Board will make use of their MR advisory committees required by M.S. 245.61, to conduct this activity.

An information system is a prerequisite for the planning and coordination of the array of services found in each area. The MR/DD Program Office is currently working with a task force of area program personnel in designing alternative models for the collection, standardization, storage, treatment and presentation of information. This model will insure that the information collected is accessible in all areas of the state to aid in planning.

C. Implementation of Previous Deinstitutionalization Efforts and Studies 1. Community Alternative in Institutional Reform (CAIR) Report The Comprehensive Plan of the Department of Public Welfare (released in December, 1974) includes the development of community-based alternatives to state institutions. Federal government goals charge the Department of Health, Education and Welfare (HEW) to bring its resources to bear on attaining the goal of reducing state institution population by 50% over

The Department of HEW made available certain national significance project money through Developmental Disabilities Councils to plan for an orderly development of community alternatives and institutional reform. This project was directed through the Developmental Disabilities Council staff, and a state level CAIR committee. This project, initiated in July, 1973, concludes with publication of the CAIR report in January, 1975. This report is available from the Division of MR/DD Programs, or the Office of the Developmental Disabilities Council.

This report will be used as a guide to augment Department goals and policies by various components of the service delivery system at the local and state levels of responsibility. A plan for implementing the CAIR report will be developed in cooperation with staff of the Developmental Disabilities Council soon after publication of the report.

Implementation plans and cost studies will be made. The cost study is planned for presentation to the 1975 Legislature in March, 1975. This study is also being conducted by the Developmental Disabilities Council.

The CAIR plan will be used by Area MH/MR Boards, county welfare departments, state institutions and community-based service providers and advocates. Each is expected to carry out its appropriate (function) responsibilities as provided in law and policy.

2. Community Resistance Study

The Department of Public Welfare employed Earl Craig Associates, Inc., to propose a strategy for combating community resistance to the development of community-based residential facilities and programs for mentally retarded and developmentally disabled children and adults. This report has not had

amendments to state laws concerning local zoning authority will be made by DPW and/or state advocacy groups.

The preliminary report to DPW cites suggestions in the campaign to develop facilities. Lack of clear statement of DPW commitment to the concept, red tape, lack of coordination, lack of money, public ignorance and fear about retarded persons, as well as hostility and fear of neighborhood residents, contribute to this problem. Subsequent political decisions to deny special or conditional use permits to facility developers also slow the growth process.

The preliminary report lays out a political strategy, and recommends

1. Clear statement of state policy,
2. Comprehensive plan for development of community-based facilities,
3. Staff to encourage more community programs,
4. Staff to assist developers,
5. DPW generate support through trained community organizers on the local level,
6. Use argument that retarded/developmentally disabled are no more likely to behave in socially pathological ways than any group not in group homes,
7. DPW seek legislation to remove or lessen local discretion regarding location of group homes for the retarded, and
8. Public education about the normalization principle, state commitment, policy and plans, and group homes.

D. Developmental Disabilities (DD) Council The DD Council is a state level forum for cooperative planning with other agencies, groups and activities related to the agent, provider, advocate and

Public Law 91-517 created a National Developmental Disabilities Advisory Council to the Department of Health, Education and Welfare. HEW makes grants to states to establish and staff state councils. The councils are appropriated money for the purpose of state level planning, conducting state significance projects and providing direct services that state agencies lack resources in providing.

The Minnesota DD Advisory Council functions in the State Planning Agency. Regional counterparts are attached to the Comprehensive Health (B agency) regions for planning and coordination.

Responsibilities and functions will be studied early in 1975.

E. Time Lines for Implementation of the Plan

Timetable and strategies in developing the state plan by September 1, 1976, are as follows:

Step I. February 1, 1975 to March 31, 1975

A. Submit document to representatives of the four functions and the Area MH/MR Boards in order to correct and update this description of the current status of the four functions. Representatives of each function are listed below.

Agent function - county welfare departments, field services staff, income maintenance division, coordinator of individualized program planning.

Provider function - state institutions, Residential Services Bureau, Association of Residences for Retarded in Minnesota, Minnesota Department of Health, Divisions of Vocational Rehabilitation and Special Education of the Department of Education, and Developmental

Advocate function - Minnesota Association for Retarded Citizens, United Cerebral Palsy, Minnesota Epilepsy League, Consumer Concerns Division, Advocacy Committee of the Developmental Disabilities Council, Legal Aid.

Monitor function - Licensing Divisions of DPW and MDH, Rule 52 rate setting staff, Technical Assistance Project Staff, Technical Consultation staff of MDH, Outreach Training Program staff, DAC Advisory Committee, Licensing Committee of the DD Council, and the Mental Retardation Licensing Advisory Board.

B. April 1, 1975 to April 30, 1975

Update document so that it accurately defines the current service delivery system in its four basic functions, and so that it can be used as a reference manual to the MR/DD service delivery system.

Step II. May 1, 1975 to June 30, 1975

Submit the updated document (Step I) to state-vide representatives of the four functions, and to all Area MH/MR Boards, for recommendations concerning the operation of the four functions.

Step III. July 1, 1975 to August 31, 1975

A. Study recommendations resultant from Step II to determine DPW priorities, changes and activities.

B. Study all Area MR/DD Board plans to determine DPW priorities and activities for program budget planning and legislative (July 1, 1976 through August 31, 1976) presentation.

Step IV. September 1, 1975 to December 31, 1975

Prepare DPW Comprehensive Plan for Mentally Retarded and Developmentally Disabled in Minnesota for

1. Public hearing
2. Changes that can be accomplished within authority and

3. Changes that can be accomplished by agencies and organizations through negotiation and cooperative planning

4. Reorganization

5. Reviewing legislative proposals through program budget responsibilities

6. Use within the agent, provider, advocate and monitor functions

7. General public

Step V, January 1, 1977 to January 1, 1979.

Repeat Steps I through IV to keep the Comprehensive Plan current and updated on a biennial basis.

CHAPTER IV

Status of the System by Function

A. The Agent Function

Generally, three categories of persons or agencies are identified who function as agents for the developmentally disabled person: parents or relatives, county welfare department social workers and, in the case of committed wards, the Family and Guardianship Section of the Residential Services Bureau. While the function of these individuals may vary slightly, the principle of individualized program and service planning is of paramount importance. Following is a description of agent responsibility.

1. Diagnosis of Mental Retardation

The county welfare department is responsible for the coordination of effort in diagnosing a person as mentally retarded. Legal definitions of mental retardation are available in the DPW Social Services Manual.

Parental history alone is insufficient for diagnosis of mental retardation. DPW requires the following information for the diagnosis of mental retardation:

1. Family history
2. Medical prenatal and birth history
3. Early developmental history
4. Comprehensive psychological evaluations
5. School reports indicating behaviors, as well as functional levels
6. Psychiatric evaluations if indicated by the other reports
7. Vocational evaluation reports
8. Observations and interviews about family and the environment

2. Assessment and Subsequent Planning to Meet the Client's Needs

The CWD is also responsible for assisting any person who is mentally retarded or developmentally disabled by assessing that person's needs and subsequently planning to meet these needs. These individuals' needs can be met through a variety of services available in the community.

If placement in a residential facility is necessary, planning becomes a cooperative effort of the client, his family, representatives of the residential resources (state institution or community based facility), and community day services as needed.

The CUD is financially responsible for these services, providing the Department deems the individual or parents of a child under 13 years of age unable to pay. The placement facility is then responsible for the delivery of services as determined by the individual's plan. The facility staff is required by regulations to develop this plan of services.

3. Individual Program Planning

The common theme underlying all service to the MR/DD in Minnesota is that programs and services must be specifically tailored to each individual based upon his needs. The Department of Public Welfare in 1974-75, cooperatively with the University of Minnesota, has developed a standardized behavioral assessment and program planning system entitled the Minnesota Developmental Programming System. In addition to developing the necessary instrumentation, computer-based scoring capabilities, and related materials and forms, this project also has trained a state-wide sample of representatives of all service agencies. This particular system is not mandated, but rather endorsed by the MR Program Office as meeting ICF regulations, Rule 34, and program office standards of Individualized Program Planning.

Comments/Recommendations:

4. Family and Guardianship Services

The Family and Guardianship Section, Residential Services Bureau, is delegated guardianship responsibilities, and provided in M.S. 246.01. Guardianship, through court order, is vested in the Commissioner of Public Welfare and includes guardianship of estate and person, mental testing, and consent to marriage.

County welfare departments (M.S. 393.01 - 393.07) are responsible for the supervision of wards of the commissioner (M.S. 393.07, Subd. 2), and when designated, to act as agents of the commissioner in the placement of his wards.

Such placement designation is carried out by the Director of Family and Guardianship Services, and the CWD concerned. This includes consultation and assistance to the counties in planning. Cooperation with the courts in determining appropriateness of guardianship and reviews of the continued need for guardianship of individuals are required. Petitions to the courts for restoration are made when such guardianship is no longer in the best interests of the ward.

Guardianship is ordered by the court when the person is in need of protection, which gives ordinary and extraordinary parental authority over the ward. This status reduces the person's rights to that of a minor child, and assigns such authority to the commissioner.

Comments/Recommendations:

5. Income of the Client

a) Income Maintenance

Dependent on income, MR/DD persons for reasons of permanent disability (as defined by Social Security amendments), are eligible for Income Maintenance payments if they are not living in an ICF/MR facility. Such payments are for room and board expenses, ordinarily considered to be living independently in his own home. Supplemental payments can be added to this by the CWD through state supplemental assistance appropriations. Department rules govern this combination of income maintenance.

Note: Mentally retarded and developmentally disabled persons needing care and services above the level of room and board, as certified by a physician (proposed DPW Form 1503-A), but below the level of a skilled nursing facility, are eligible for placement in an ICF/MR facility and, therefore, Income Maintenance does not apply.

Comments/Recommendations:

b) Supplemental Security Income (SSI)

Residents of ICF/MR facilities (except children being paid out of state appropriated cost-of-care program (M.S. 252.27), are eligible to receive $25.00 per month personal needs allowance paid through Social Security. This is administered through the Minnesota Social Security Office, and application must be made by the individual (the county welfare department, or facility staff may act for him). This meets needs over and above those provided by the residential facility.

This personal allowance cannot be used to pay for items of service that the facility is expected to provide.

Comments/Recommendations:

c) Special Personal Needs Allowance

If the resident of an ICF/MR facility is employed in a sheltered workshop, work activity center or is competitively employed part-time, DPW Policy Bulletin #40, dated 4/25/74, provides for a special personal needs allowance before he must contribute toward his care and cervices. This allowance provides for deduction of work expenses, and up to $50.00 of earned income. The remaining salary goes toward his care.

The above formula is approved by HEW for purposes of determining income that is countable in determining eligibility for SSI payments.

M.S. 252.24, Subd. 4, authorizes the board of directors of a daytime activity center(DAC) to charge a reasonable attendance fee, based on the ability of the mentally retarded person, his guardian or family to pay such fee, provided that no person shall be denied participation in the activities of the DAG because of inability to pay such a fee. Fee schedules must be approved by the Commissioner of Department of Public Welfare.

Parents and relatives may voluntarily pay more than is provided in Minnesota Statutes.

Comments/Recommendations:

6. Payment for Services

a) Parents

CWDs are required to assist parents and MR/DD persons in planning and provision of services. The parents' ability and level of payment is determined by an income/expenses formula.

Eligibility for services in residential facilities under Title XIX,

Cost of Boarding Care under provision of M.S, 252.27 (Coot of Care Program).

M.S. 252.27 provides that parents must pay up to 10% for costs of such care and services, if the DPW income/expenses formula shows this ability. This also applies to parents of a child in a state institution.

Parental obligation to pay is limited to children under 18 years of age. The 1973 Legislature amended the statutes to provide that parental obligations not exceed $60.00 per month, for care in community-based facilities or state institutions.

b) Residents

If the resident of a community-based facility or a state institution has income, estate or inheritance, in excess of the various eligibility limitations for federal or state paid care and services, Minnesota laws obligate the resident to pay up to the total amount of his care costs, until such time as he becomes eligible for such care at public expense.

Residents who are employed as a part of the individualized program plan in a sheltered workshop, work activity center, or are competitively employed, are obligated to contribute to their cost of care and services. The amount they pay is based on the excess as allowed for deduction in the Special Personal Needs Allowance (see Chapter II, A, 5). The Special Personal Needs Allowance provides for payment after deduction of work expenses and up to $50.00 per month earned income.

Comments/Recommendations:

B. The Provider Function

Minnesota offers a wide array of services available to the MR/DD population. A study conducted in February, 1973, of that population served by the state hospital system since 1900 shows a drastic trend reversal in the numbers of persons served by that system. Minnesota has adopted and is working toward the goal of providing as many services as possible in the community. This section will describe the kinds and numbers of services available, as well as where and how they are being provided.

1. Community-Based Developmental Services

The community approach expects that a person lives in a homelike facility, or in his own home, from which he leaves for work, education and recreational activities. Activities are available to the MR/DD in the community that somewhat duplicate, or substitute work/education/ recreational activities, in order to approximate normal patterns of community living and life style.

DPW Rule 34 requires such activities to be available to residents. Those physically unable to access the community must be provided with these services of equal quality in the facility.

Size, location, tradition and condition of its residents, allows the state institution to continue providing many developmental services

within the institution. Notable exceptions are the provision of vocational and educational services, the Cooperative Vocational Rehabilitation Program (CVRP), the mandatory provision of the Special Education Act, and the Foster Grandparent Program. DAC-type services and training, health and medical services, are provided by institution

a) Daytime Activity Centers (DAC)

Minnesota Statues 252.21 through 252.26, authorizes grants-in-aid to assist local units of government or nonprofit corporate organizations in the provision of DAC services to mentally retarded and cerebral palsied persons who can benefit from such services. DAC's are subject to licensing and supervision by Department of Public Welfare, as provided in M.S. 252.23 and 252.24. Specific licensing standards are in the process of development through the DAC Advisory Committee and the MR Licensing Advisory Board. These new standards will replace the use of DPW Rule 3. The DAC law further authorizes local city, town, village or county taxing authority for DAC's provide for a board of directors, eligibility criteria and attendance fees based on ability to pay.

Since passage and implementation of the mandatory TMR Act of 1971, the number of children of school age in the DAC has been significantly reduced; however, some persons continue to be served through contracts with the responsible school districts. This act has resulted in a major shift in function, more nearly carrying out the intent and provision of the DAC law, by serving pre-school children and adults.

Concurrently, the MR facilities licensing law and DPW Rule 34, require

facilities who are otherwise eligible and can benefit according to assessed needs. This has resulted in the identity of DAC's as a major developmental resource and activity in their own right.

Local county and state expenditures for DAC's are reimbursed through federal Title IV-A Social Service funds at 75% for eligible recipients.

The Minnesota Daytime Activity Centers Association (operators) is currently developing a DAC Evaluation System, under a Developmental Disability Project grant. The purpose is to develop an instrument that can produce information used to evaluate the program from service and fiscal points of view. The system will also be used by local CWD, Area MH/MR Boards, DPW and DAC operators and boards for their purposes.

DPW is responsible for supervision and the provision of program consultation. Arrangements are being made for the provision of consultation through the area MR coordinators.

Eligibility criteria is not clearly established for DAC cervices. The law provides for services to MR and CP persons who can benefit from the level of services provided. However, assessment of need, and diagnosis of mental retardation or cerebral palsy is not currently required for eligibility purposes. This situation is not consistent with Department policy that all placements in residential facilities, including state institutions, be arranged through the appropriate CWD.

Comments/Recommendations:

b) Special Education

Public school special education services are mandatory for mentally retarded and other developmentally disabled children of school age (5 to 21).

Minnesota Statutes 120.17 HANDICAPPED CHILDREN, provides for special instruction by or through the local public school districts. Mandatory special education services for educable children became effective in 1965, followed by mandatory programs of instruction for trainable mentally retarded children, effective July 1, 1972.

The Special Education Section of the Department of Education, in cooperation with the Division of Mental Retardation and Developmental Disabilities, established guidelines for the mandatory TMR provisions of the Special Education Act. These guidelines define "trainable" as a retarded child of school age who is not educable, but can benefit socially, physically and/or psychologically from special instruction. In effect, any retarded child who is not educable, is considered trainable, unless they are demitted from school attendance under provision of M.S. 127.071, and guidelines of the Department of Education.

Children living in their own homes, someone else's home, or in any community-based residential facility or state institution, must be provided with public school educational services by the school 'district in which he/she is currently living. The child's home school must pay the costs of such services if provided by another school district. Schools may purchase or contract for appropriate services (i.e., a DAC), until more appropriate arrangements are made by the school board. Schools are expected to cooperate for the provision of a full sequence of services when districts have less than the minimum number of eligible children.

Implementation of the mandatory provisions of the Special Education Act has resulted in approximately 50% eligible children receiving services while residing in the state institutions during the 1972-73 school year; 70% during the 1973-74 school year; and nearly 100% during the current 1974-75 school year. (There are approximately 1,400 school age children in state institutions.)

Because school districts must now pay for the education of children whose legal residence is in the district, but who reside in state institutions, the school boards are now seriously considering a number of options, among which is to provide such services in the child's home school district. This has renewed interest in getting the child returned from the state institution and placed in his own home or *in* a community-based residential facility. This process requires cooperative planning between state institution staff, the CWD, parents and the school board.

strengthen community interest in serving mentally retarded as close to home as possible.

Comments/Recommendations:

c) Vocational Rehabilitation Services

A variety of vocational rehabilitation services is available to MR/DD persons.

Vocational diagnostic services are available from vocational rehabilitation counselors. Such services include arrangements over a period of time in various sheltered workshops in the state. Such services are also available to residents of state institutions through the Cooperative Vocational Rehabilitation Program (CVRP), operating for six years.

Following diagnostic services, a variety of arrangements may be made to assist the person in attaining his work potential:

1. Assistance in securing part-time or full-time competitive employment,
2. Employment in a sheltered workshop,
3. Therapeutic work activities in a work activity center (M.S. 246.56).

Minnesota Statutes 121.714, Subd. 4, provides for certification of all long-term sheltered employment and work activity programs by the Commissioner of Education. Such certification is required for funding through the Division of Vocational Rehabilitation, Department of Education. Funding is based on the Minnesota State Plan for Rehabilitation Facilities.

United States Department of Labor regulations apply to these services. This includes the payment of minimum wages, if subminimum wage certificates are not issued by the Minnesota State Department of Labor and Industry, based on the individual's productive limitations imposed by his disability. These limitations determine whether the person is engaged in:

— Long Term Sheltered Employment Program: provides for paid employment over an indefinite period of time, for severely handicapped persons unable to meet production standards required in competitive employment. The wages paid in long term sheltered employment are in excess of 25% of the applicable minimum.

- Work Activity Program: provides for purposeful developmental activity, having a productive or work component for which wages are paid. The level of productivity is less than that required in sheltered employment (generally 25% of the applicable minimum). This program may be transitional in nature or may be considered as an appropriate outcome.

Unless operated by a governmental agency, the long term sheltered employment or work activity program is a legally

federal, state and local statutes. The make-up of the facility's governing body must be in accordance with the requirements of M.S. 121.71 through 121.715 (long term sheltered workshop/work activity law).

When the work activity program is a cooperative effort (M.S. 246.56) between two distinct organizations, there must be a written agreement (i.e* between a sheltered workshop and a DAC or a state institution), which details the responsibilities of each organization concerning staff supervision and training, contract negotiations, payroll checks, production records, and client supervision and programming.

Comments/Recommendations:

d) Health and Medical Services

Normal health care and medical needs are provided, or we seek to provide, from normal community sources. This is consistent with the principles of normalization, and should be provided to the extent possible, to mentally retarded and developmentally disabled persons. Securing such health services from community sources is encouraged by Department policies and DPW Rule 34.

ICF/MR regulations require the provision of medical and nursing services from within the facility (staff or contract), or by agreement with local persons, hospitals, clinics, that services will be provided as needed.

Retarded persons may have special health and medical needs due to physical disabilities. Such multiple handicaps require higher levels of care and treatment by medical and paramedical professionals. If such multiple handicapping conditions prevent the person from acting for his own protection in emergencies, he must be placed in a facility that meets institutional provisions of the Life Safety Code, which is required of all facilities housing 16 or more persons. If his condition does not prevent his acting for his own protection in emergencies, he can be placed in a residential facility for less than 16 persons which must meet the residential provision of the Life Safety Code.

The planning and provision of appropriate health and medical services is the responsibility of the CWD, in accordance with DPW policy manual and federal regulations under the Medical Assistance Program, Title XIX, Social Security Act, and specific regulations of ICF/MR.

Comments/Recommendations:

e) Other Community Activities

A variety of community-based experiences should be available to the mentally retarded and developmentally disabled segment of the population. Availability and actual participation in the community will influence the mental health of the individual.

Community activities should include free choice and organized group activities that aid learning to participate as normally as possible; Community organization should consider shopping, eating out, movies, going to church, recreation, ball games, and bowling, as important and sensitive issues in the lives of the mentally retarded and developmentally disabled population.

Comments/Recommendations;

2. Community-Based Residential Facilities

a) Planning

Planning of community-based residential facilities (admission, licensing, accreditation, location, determination of need, operational policies, payment, and problem solving) issues overlap the Residential Services Bureau (state institutions). This involves formal and informal relationships of DPW staff (Medical Assistance, Licensing Division, other program divisions, Community Programs Division, guardianship, rate determination), and the Minnesota

Minnesota Epilepsy League, Association of Residences for the Retarded in Minnesota, Minnesota Department of Health, Developmental Disabilities Council, Department of Education, Minnesota Daytime Activity Centers Association, Daytime Activity Centers Advisory Committee, and the Mental Retardation Licensing Advisory Board.

b) Clientele

Approximately 2200 mentally retarded and developmentally disabled persons are served in all types of licensed community-based residential facilities, with a significantly Larger population of types B and C in community facilities. At the same time, there is a proportionately larger population of type A in state institutions.

Type A: Mentally retarded persons, including children under age 6, severely handicapped persons, and residents who are aggressive, assaultive or security risks, or who manifest severe hyperactive or psychotic-like behavior.

Type B: Retarded persons who are moderately retarded requiring habit training.

Type C: Retarded persons who are in vocational training programs and adults who work in sheltered employment situations.

Type D: Retarded persons who are living independently or living at home and attending school or who are employed; or otherwise making it on their own but need social services, counseling or financial assistance.

c) Description

Community-based residential facilities serving 2194 persons operate as nonprofit corporate organizations or private proprietary facilities, and must be licensed under M.S. 252.28 (DPW Rule 34), if caring for more than 4 MR/DD persons. Prior to issuance of a program license

be licensed by the Minnesota Department of Health for purposes of health, safety and sanitation (Supervised Living Facility standards became effective January, 1975).

Programs in state operated institutions, serving 3718 persons, are considered in tandem with community-based residential facilities when planning the state-wide capability for mentally retarded/DD persons. Both state and private facilities must meet the same licensing and accreditation standards.

Community facilities are eligible for certification as Intermediate Care Facilities/Mentally Retarded (ICF/MR) providing they meet the various federal and state requirements concerning individualized program planning, types of persons served, staffing, provision of services both in and away from the primary living unit, size of living units, organization and administration of program staff, Life Safety Code, physical condition and mobility of residents, and homelike atmosphere and opportunity.

d) Certification

When certified as ICF/MR, the chargeable rates for such services are determined under the provisions of DPW Rule 52. Rates are required under both licensing and ICF/MR regulations. In May, 1974, payments for care in community-based facilities paid under Title XIX and Cost of Care were made under a plan of central disbursement.

Residents of ICF/MR facilities (and state institutions) are eligible for Supplementary Security Income of $25.00 per month for clothing and personal allowances. In addition, a special personal allowance

rehabilitation allowance for residents who are employed in. a sheltered workshop, activity center, or employed part-time in competitive employment, for which they are paid. This allowance includes work expenses, plus up to $50.00 additional allowance of earned income.

Nonprofit residential facilities, including those operated by local units of government, are eligible for grants-in-aid up to 25% of the cost of remodeling or new construction, under provisions of Minnesota Laws 19.73, Chapter 673 and DPW Rule 37. Nonprofit and profit organizations, including; local units of government, are eligible for Minnesota Housing and Finance Agency (effective January 1, 1975) guaranteed loans up to 100% of construction costs, over a 40-year loan period for small, home-type residential facilities. Currently, such loans are limited to facilities for 15 or less, housing persons who can act for their own safety, and therefore, must meet the residential provision of the Life Safety Code. (Certificate of self-preservation is required.)

Also, both profit and nonprofit ICF/MR facilities can apply for federally insured loans to upgrade the facility to meet Life Safety regulations (Department of Housing and Urban Development - HUD -P.L. 93-204, as amended by Section 232, National Housing Act).

Planning for persons who are mentally retarded or developmentally disabled, and are in need of any type of social services, is the legal responsibility of the county welfare departments. When placement of a person is indicated in a residential facility, such placement is

responsible for such care, and the resident continues to be a client of that county welfare department. The facility operator then becomes responsible for the development of an individualized program plan for that person which includes specific assessment of health and developmental needs, and the establishment of measurable goals and periodic evaluation.

Facility operators have a primary responsibility to develop individualized program plans with the county welfare department, parents, relatives or guardian. Community resources that may be available, or made available, must be used according to the individual plan. Priority for such social and developmental services such as recreation, work activity center, daytime activity center, is that they be provided in the community (normalization principle), although mental and physical limitations may preclude for certain individuals that some or all such services and activities be provided within the facility.

Residential services to mentally retarded and developmentally disabled persons take place in community-based facilities for 4 or more, ranging in size of up to 130. Primary living units are not to exceed 16 persons under provisions of DPW Rule 34, although some do at the present time.

Facilities established since 1972 must be located near community resources for social and developmental purposes. Application of the normalization principle requires utilization of community resources for normal types of community activities: recreation,

such experiences, daytime activity centers, sheltered workshops, work activity centers, special education classes, and part-time employment opportunities must be made available to residents of community-based residential facilities.

For these reasons, it is important that determination of need and location of a facility be accomplished with the assistance, advice and cooperation of local planning bodies and service providers. Local groups (county welfare department, area MH-MR staff, professional and parental representatives) have been established... and convened through the area boards for such purposes. A more formal structure for such activities is being developed.

e) Future Need

The capability of community-based residential facilities must be increased before the population of the state institutions can be decreased. Community facilities must also be able to deliver quality services to retarded persons to prevent their becoming candidates for the state institutions. The Community Alternatives and Institutional Reform (CAIR) project, sponsored by the State Developmental Disabilities Council, will be used as a guideline for Area level and State level planning.

It is important to consider that 89% of the mental retardation and developmental disability population in state institutions fall into type A. This has implications for the type, size and location of future community-based services for the state institutional population, because current capabilities of community-based facilities are addressed more toward type B and C.

Comments/Recommendations:

3. Institution Based Developmental and Residential Services

a) State Institutions, serving 3718 children and adults, operate under the direct control of the Commissioner, DPW, and Assistant Commissioner, Residential Services Bureau. State appropriations for the operation of the institutions are offset by a variety of federal resources, the principle one of which is Title XIX, Medical Assistance, for Intermediate Care Facilities for Mentally Retarded (ICF/MR). Programs must be licensed under M.S. 252.28 and DPW Rule 34, and by the Minnesota Department of Health Standards for Supervised Living Facilities (effective January 1, 1975), under authority of M.S. 144.50.

State institutions are eligible for certification as ICF/MR providing they meet various federal and state requirements (see Court Order; Welsch vs. Likins) concerning individualized program planning, types of persons served, staffing ratios, provision of services both in and away from the primary living units, size of living units, organization and administration of program staff, Life Safety Code, physical condition and mobility of residents, and homelike atmosphere and opportunity.

When certified as ICF/MR, state institutions earn federal dollar

to the State Treasury, at the rate of 58% cost of care for eligible residents. Practically all retarded residents are eligible for ICF/MR reimbursement. The placing agency (county welfare department) is obligated to pay $10.00 per month per client in state institutions, while at the same time they are obligated to pay 21.5% of the cost of community-based residential facilities. . This provides financial incentive to make placements in the state institutions.

The care level for residents ranges all the way from total life support (such as feeding, clothing, toileting, bathing), on up to developmental training in life skills (such as working, making purchases, and adaptive behavior), so that they are acceptable in a community setting. The major task involves determining the level of independent function to which it is possible to develop the individuals so that the residents can function as independently as possible in the community or state institution.

This includes evaluating the individual's level of functioning, and providing training in life style so that the individual can function in the least restrictive setting, and function in a more independent fashion.

There are 41 Program Units licensed under DPW Rule 34, which are located in state institutions in: Brainerd, Cambridge, Faribault, Fergus Falls, Hastings, St. Peter, Moose Lake, Rochester, Willmar and St. Paul, Each of the facilities serves a designated region of the state.

While DPW attempts to have persona utilize the facility in their region, some residents are placed either at the request of parents (because the parents have moved from one region to another), or, in unusual circumstances, where care and treatment would be more appropriate, in another facility. This placement is closely supervised by DPW, so that the best interests of the person are served.

It is expected that residents in state institution program units receive the necessary training and return to their home or nearby community. Two factors influence utilization of state institutions: 1) the level of care and training is not available in community-based facilities, and 2) an appropriate community-based facility does not exist.

State institution programs are a resource to the county welfare departments in carrying out their primary responsibility as agent for the individual in the planning and provision of appropriate services. Counties provide services also to mentally retarded, developmentally disabled, living in their own homes, community-based facilities as well as state institutions. Many MR/DD persons are able, within their life cycle, to benefit from placement from one setting to another.

The historic practice of concentrating retarded persons in state institutions is giving way to providing more services in the community, so that such persons may live in his own home or a community-based facility, where they can get the kinds of

anticipated that the population in state institutions will be significantly reduced in the course of the next few years. The remaining population may be served in fewer facilities, and local administration of them may be more desirable and appropriate in light of community-based responsibility and interest.

b) Program Resources

Volunteer groups and organizations have a long history of services and participation in programs at the institution. These citizens have supplemented institution staff in many varied services that are important to the residents, but cannot be provided nor duplicated by staff, because of their unique role. Their interest and activity has lead to opening the doors of the institutions to public scrutiny and interest in the dehumanizing conditions that residents exist. Their volunteered assistance is one of the bright lights in the history of state institutions.

Cooperative Vocational Rehabilitation Programs (CVRP), which originate from the Division of Vocational Rehabilitation, provides vocational services which evaluate the resident's vocational potential, and gets them involved and active in various work activity in the institution, sheltered workshops and employment in the community.

Foster Grandparent Program employs eligible persons to provide daily one-to-one relationship for two hours each day to residents. This program is administered by the Minnesota ARC through state appropriations and federal grants.

Special Education Services, now mandatory for residents under 21 years of age, are provided in the institutions and in community, by the local school districts. This, since 1971, has relieved overburdened staff in institution-directed educational services, to concentrate on the neglected adult population. Such efforts are directed toward the preparation of children and adults for community living.

Title I, Elementary and Secondary Education Act, P.L. 89-313, administered through the Department of Education, is significantly reduced from its original few years of service, because the children in the institutions had not, until 1971, been provided with educational services from the local public schools. Since 1971, the number of eligible children for Title I services has been reduced considerably because of the provision of educational services through the public school system. These children are now counted, for eligibility purposes, by the public schools, and therefore, the institutions no longer conduct and operate such programs. Notable among Title I programs that have operated is Project TEACH.

c) Communications

Communications between the Director and staff of the Technical Assistance Project (TAP) within the Division of MR/DD, and the chief executive officers of the state institutions and the Assistant Commissioner, Bureau of Residential Services, involves: 1) policies that affect them, 2) problems they experience, 3) assistance in remodeling facilities, A) interpreting regulations and standards, 5) requests for assistance, and 6) assistance in formulation of policies that will facilitate program goals and

Staff of the Division of Mental Retardation and Developmental Disabilities conduct on-site study and evaluation of state institution programs on a scheduled basis, and make official reports to the Assistant Commissioner, Bureau of Residential Services, and the Chief Executive Officers of the institutions. Interim review of policies and plans is done as needed.

Staff of MR/DD Division also take the lead in closing out program units and concurrent development of alternative services.

d) Planning

Planning is basically focused on reducing the institution population and the orderly development of community alternatives.

e) Clientele

Parents and families of retarded persons seek assistance in providing training and care for the retarded person. Often, the needs of the individual retarded/DD person are such that the parents and families are unable to cope with their relative. In attempting to provide for their needs, the families of the retarded persons, currently numbering approximately 3700 persons, turn to community agencies for help and assistance. The agents for the individuals are the 87 county welfare departments, who turn to the state residential facilities for assistance in planning for individual retarded persons for evaluation and assessment and for 24-hour care and training. The county welfare departments also look to the state facilities for assistance in providing in-service training for staff, and for providing in-service training of staff in community facilities who also care for county welfare clients.

For the parents and families, the facilities provide information in the training of the retarded person in their own home. The facilities provide respite care or vacation placement for retarded persons so that the families are able to be relieved of the day-to-day pressures and are able to take a vacation and meet family emergencies when no facilities or services are available at the; community level. The major activity is the training and care of retarded persons when the families cannot find the necessary services in the community.

The client is the retarded person in the institution. Services are provided for individuals who have a low functioning intellectual level, who have difficulty in adapting to learning everyday living skills such as eating, dressing, care of personal hygiene, grooming, physical developments, receptive and expressive language, interacting with other people, working for pay, caring for one's clothing/living area, food preparation, making purchases, and whose behavior in addition to the above, or related to the above, makes the person unacceptable in a community setting. In addition, many retarded persons referred to the state institutions have physical and health problems and therefore are in need of habilitative medical care.

The average daily population for fiscal year 1971-72 was 4208; for 1972-73 it was 4004; and for 1973-74, 3750. It is estimated that for fiscal year 1974-75 there will be 3650; for 1975-76, 3575; and for 1976-77, 3500. The decrease in institutionalized retarded will probably continue if the number of persons entering continues to decrease slowly but releases continue at about the came level as at present. This projection assumes that opportunity for placement in

one of the factors also that will probably influence these estimates is that we have recently begun to see an increase in readmissions to the state institutions of individuals who were placed in the community in recent years.

An unknown factor that could very well influence the estimated figures are the new standards established for intermediate care facilities/ mentally retarded (ICF/MR). There are an unknown number of retarded persons residing in community group homes that are licensed as board and care facilities, which may not be able to meet the newly defined standards for ICF/MR.

Individuals placed in such board and care facilities that cannot meet the ICF/MR certification standards would be ineligible to receive federal subsidy under Title XIX for the care received. Unless alternate facilities are quickly developed to provide facilities that would meet the ICF/MR standards, or other mechanisms for funding these individuals were developed, we should consider the very real possibility that the average daily resident population at the state institutions during the 1975-77 years might plateau at a somewhat higher level, possibly around 3650. Another factor influencing the development of alternative locations for residential services is determined by the population density of a given county or region of the state.

Continued support of state institutions is needed to provide services because many communities have been unable to provide needed services to the types of residents we have in the institutions. Care and

state facilities over the years, are needed because historically, very little was provided to assist parents in the care and training of retarded persons at the community level. The institutions, historically, provide services away from the community, and segregate retarded people from the mainstream of social living. As services develop in the communities through school programs for the educable and later for the trainable retarded, DAC's, etc., parents are assisted in the care of retarded persons. For these reasons, we have seen a gradual decline in population in state institutions since 1962.

f). Future Need

Retarded persons will continue to have need for varying levels of supervised living facilities, training and assistance in daily living activities. It is expected that this activity will be shifted to a community network of residential services provided at the local area level under jurisdiction and administration of local agencies.

C. The Advocate Function

Customs, laws, public policies and court decisions, uphold the rights of the retarded and other developmentally disabled persons to care, protection, planning services, and the provision of educational, vocational, health, social and self-care training as personally needed. Some examples are:

1. Minnesota Guardianship Laws (and proposed Minnesota Mental Retardation Protection Act, which would replace the guardianship laws)
2. Mandatory Special Education Act, M.S. 120.17
3. Right to Treatment Act, M.S. 1969, Section 253.17, Subd. 9
4. Minnesota Hospitalization and Commitment Act, M.S. 253A.01 to 253A.21
5. Court Order, Welsch vs, Likins, Judge Larson, 1974
6. Patients' Bill of Rights

An advocate represents the rights and interests of the handicapped individual who is unable to do so for himself. Critical to the advocacy function is freedom from conflict of interest. The advocate must be solely concerned with the best interest of the client. Protection is offered to an advocate under the proposed DPW policy on advocacy to assuage fear of recrimination.

Following is a list of exemplitive groups and individuals serving as advocates of mentally retarded and developmentally disabled persons:

1. The Minnesota Federation of the Handicapped
2. Epilepsy League
3. United Cerebral Palsy Association
4. The Association for Retarded Citizens
5. Minnesota ARC Advocacy Project
6. Legal Advocacy Project, Legal Aid
7. Consumer Concerns Service (established by the Commissioner as an independent service arm of the system) who identifies, pursues, and meets clientele needs as the client himself views them, distinct from the views of society, professional, or service providers.
8. Citizen advisory groups established in state and service agencies

D. The Monitor Function

Monitoring is defined as direct evaluation of a service according to a preconceived expectation. This expectation may be a rule, regulation, or an expectation based on defined needs of a handicapped individual. Agency administration, licensing, certification, rate setting and placement are monitoring activities.

The monitoring function sequence is as follows:

1. Information gathering: Accomplished through a visit to a facility,

2. Evaluation: Accomplished by a comparison of information gathered regarding potential services to meet the perceived needs of his child.

3. Response: The response may be issuance of a license or certificate, or placement of a child by a parent or social worker.

Formal monitoring functions are summarized in Figure 2.

Comments/Recommendations:

Rules and regulations which govern the mental retardation plan for residential facilities are part of the monitoring function. They are briefly described below:

1. DPW Rule 34

These Department of Public Welfare (DPW) regulations govern the operation of any individualized developmental program of residential or domiciliary service for more than four mentally retarded individuals. The purpose of the licensing law and these regulations is to implement the Right to Treatment Act and to establish and protect the human rights of mentally retarded persons to a normal living situation through the development and enforcement of minimum requirements for the operation of residential facilities and services. These regulations are promulgated under M.S. 252.28 which charges the Commissioner of Public Welfare with the responsibility for licensing of residential programs and services for mentally retarded persons, and determining the need and location of such facilities

Service/Function	Information Gathering	Expectation	Response
DAC			
Licensing	Application and site visit	Licensing Rule 3	License
Funding	GIA application	Regional weight	GIA
Vocational Rehab			
Health & Medical			
Residential Services			
Licensing, DPW	Application and site visit, local licensing review	Rule 34	License
SHD, Licensing	Application and site visit	SLF regs	License
Building Code	Submission of blue prints	Uniform Building Code	Permit
Life Safety Code	Submission of blueprints or site visit	LSC	Approval
Rate Setting DPW	Submission of historical costs	Rule 52	Establishm of a rate
CWD	Application to county board	Various	Establishm of a rate
Certification	Application and site visit	ICF/MR	Certificat
CWD			
Placement	ARRM Central Referral, site visit, determination of services offered	Individualized Program Plan	Placement Decision

Figure 2. Summary of the Monitoring Function

Legend:

DPW - Department of Public Welfare
SHD - State Health Department
CWD - County Welfare Departments

regulations which include ICF/MR facilities - Section 1122 of the Social Security Act,)

2. MDH Supervised Living Facilities Standards

A supervised living facility (SLF) is a facility licensed by the Minnesota Department of Health (MDH) in required combination with DPW Rule 34 and/or Rule 80.* These regulations establish minimum standards for the construction, equipment, maintenance, and operation of such facilities, insofar as they relate to sanitation and safety of the building; and to the health, treatment, comfort, safety and well-being of the persons accommodated for care. The purpose of an SLF is to provide a non-institutional homelike setting for residential programs for the mentally retarded, the mentally ill, the chemically dependent, and children. These regulations are promulgated under M.S, 144,50 to 144.58, inclusive, Law for Licensing Hospitals and Related Institutions, Consequently, SLF regulations meet federal requirements that ICF/MR facilities comply with the standards of safety and sanitation which are applicable to nursing homes under state law. SLF standards also meet federal requirements under provisions of the National Protection Association's Life Safety Code in two classes:

> Class A SLF's include homes for ambulatory and mobile persons who are capable of taking appropriate action for self-preservation under emergency conditions as determined by program licensure provisions. Class A SLF's shall be in conformance with provisions of Chapter 13 of the 1973 Edition of the Uniform Building Code, as amended for Group H occupancies. Physically handicapped persons shall be housed at the street level.

*DPW Rule 80 establishes the rules of operation for residential facilities and

Class B SLF's Include homes for ambulatory, non-ambulatory, mobile or non-mobile persons who are not mentally or physically capable of taking appropriate action for self-preservation under emergency conditions as determined by program licensure provisions. Class B SLF's shall be in conformance with provisions of Chapter 9 of the 1973 Edition of the Uniform Building Code, as amended for Group D occupancies.

3. Uniform Building Code

"The Building Code Division, Minnesota Department of Administration, has adopted the Uniform Building Code (1973) in Minnesota. This code as applied to SLF's provides appropriate assurance of life safety from fire for all mentally retarded persons who reside In SLF's.

4. Life Safety Code

The Fire Marshal Division, Department of Public Safety, will adopt the Life Safety Code in Minnesota this year. It should be noted that the Life Safety Code is already adopted by reference in the SLF regulations. The significance of this adoption by the Fire Marshal is that the Life Safety Code will incorporate the concepts and language contained in regulations promulgated by DPW, by MDH, and the Building Code Division of the Department of Administration.

5. DPW Rule 52

DPW Rule 52 defines a system for the determination of a per diem welfare rate for all ICF/MR facilities with core than four beds participating in the Title XIX program, and is designed to promote efficiency and economy and to treat all providers of ICF/MR care on a uniform basis. This rate setting procedure has been defined to comply with the state statute that requires that cost differences between individual providers