The ReSource
March 30, 2006
FOR PERSPECTIVE AND ANALYSIS
The Source of information for providers of community-based services for people with differing abilities.
A member service of NYSRA.

FEDERAL TRENDS

Jeff Wise, NYSRA President & CEO

The trend in Washington continues to be that states should have more flexibility in the ways they provide services under Medicaid and Medicare. As was the case in the mid- and late-90s with federal welfare programs, states are receiving funds with fewer mandates attached to them regarding, for example, care for vulnerable populations. This can mean that new burdens sometimes are visited on those enrolled in those programs.

Moreover, the recent enactment of the Deficit Reduction Act, signed last month by President Bush, reduces the flow of dollars that are coming to the states for the provision of the services.

Much has been written about the DRA and its impact. A good summary has been prepared by the Bazelon Center, and the center's latest report on the act appears below.

NYSRA continues to harbor and voice concerns over these federal trends and the impact they have on state policy. And, ultimately, the impact they have on consumers of services.

Bazelon Center Mental Health Policy Reporter

Volume V: Issue 2 March 21, 2006

What Deficit Reduction Means for People with Mental Disabilities

The Deficit Reduction Act (DRA), P.L. 109-171, was narrowly passed by Congress (216-214 in the House on January 31) and signed by the President on -----February 8, 2006. It makes substantial changes to vital federal programs such as Medicaid, Medicare and TANF to reduce federal spending by $40 billion over five years.

The law creates new options for states under the Medicaid program. These changes could fundamentally alter the way Medicaid operates, with particularly detrimental effects on people who need a wide range of intensive mental health services. The changes are designed to save the federal government money; some also yield savings for states and some will increase state costs. All will likely have very grave consequences for millions of children and adults with mental disabilities who rely on Medicaid for necessary health and mental health care.

In addition to its negative impact, however, the DRA includes some provisions that could improve Medicaid for adults and children with mental disorders, including greater flexibility to furnish community-based services.

Overall, the DRA is plagued with ambiguous legislative language. If Congress doesn't clarify it through passage of a technical corrections bill, and if the language is interpreted adversely by the Centers for Medicare and Medicaid Services (CMS), which administers Medicaid, this law could create even more problems.

Summary of Medicaid Changes

The DRA continues the trend for Congress and the Administration to give states increased flexibility under Medicaid. Most of it comes at beneficiaries' expense. Unlike the bill that originally passed the Senate, which saved money by reducing payments to Medicare managed care plans and to pharmaceutical companies for Medicaid drugs, the law as enacted hits hard at people who depend on Medicaid.

Moreover, the law creates a fundamental shift in the program. Expansion of the approach used by the State Children's Health Insurance Program (SCHIP) of furnishing private insurance-type coverage is now extended to Medicaid. This ignores the history of Medicaid policy, which has deliberately included the types of services necessary to meet the extensive needs of people with disabilities, the elderly and those in poverty, and to ensure that all children in America (including those in low-income families) have access to early intervention and to hearing, vision and mental health services that ensure them of opportunities to succeed in life.

States that opt for a benchmark plan for some Medicaid beneficiaries will have benefit packages with very restricted coverage of mental health (limits on inpatient and outpatient stays), packages that lack any coverage of the intensive community services offered through public mental health systems.

Furthermore, the imposition of cost-sharing on people who use Medicaid services undermines the program's core value, to make health care accessible to low-income people.

In sum, the DRA opens the door to unraveling of the Medicaid program. It is important, however, to note that all of these disastrous changes are authorized and permitted, but not mandated. States, not the federal

government, will decide whether the DRA adds to the number of people who are uninsured and underinsured, or whether the Medicaid program will continue to protect the health and mental health of low-income people. Moreover, the law gives states some new options for covering children under Medicaid and expanding community-based services for some children and adults.

In its FY 2007 budget request to Congress (see the February 23 Bazelon Center Action Alert), the Administration requests further cuts in Medicaid and Medicare, including a 50% reduction in the reimbursement rate for targeted case management. It also serves notice that it will act administratively to redefine rehabilitation services and to restrict federal payment for certain school-based services and administrative costs.

The Bazelon Center and other advocates will call upon you to help alert Congress to the ramifications of these proposals and urge that no more changes be made to Medicaid, pending rollout of the DRA over the next year.

Case Management

Section 6052 of the DRA changes Medicaid's targeted case management option and redefines the term 'case management.' (Case management is often billed under other state services, such as Clinic or Rehabilitation services, as well as under the Medicaid option of Targeted Case Management. The new definition applies in all cases).

The DRA clarifies that to be eligible for targeted case management an individual must be:

-eligible for Medicaid, and

-part of the target population for targeted case management specified in the state plan.

It is critical for mental health programs to be able to continue billing Medicaid for covered targeted case management for an eligible individual who is in the state's target population for this service, whether or not the individual is in the child welfare system or served by other programs. The DRA does not deny this coverage, but does leave open the interpretation of just how this will work in practice.

The law also specifies that Medicaid will not pay for certain services that have traditionally been furnished by child welfare system case managers. And it requires states to bill other funding sources that are 'legally obligated' to pay for targeted case management services first, before charging Medicaid.

The new definition of targeted case management follows CMS policy as issued in a January 19, 2001 policy letter, released at the end of the Clinton Administration. However, the DRA expands on the letter in its clarification of what services to children in child welfare may not be billed to Medicaid.

Under Medicaid law, case management services are services that will assist individuals in gaining access to needed medical, social, educational or other services. Specifically, under earlier policy and the DRA this includes:

Assessment

The assessment determines service needs. Activities that are included are taking client history; identifying needs and completing related documentation; and gathering information from other sources (such as family members, medical providers, etc.) to form a complete assessment,

Development of a Specific Plan of Care

The plan of care must be based on information collected through an assessment. It lists the goals and actions to address the medical, social, educational and other services the individual needs. Included are activities that ensure the person's active participation and work with the individual (or the authorized healthcare decisionmaker) and others to develop goals and identify a course of action to respond to the assessed needs.

Referral and Related Activities to Help Obtain Needed Services

Activities included are those that help link individuals with medical, social or educational providers or other programs that are capable of providing needed services, such as making referrals to providers for needed treatment and scheduling appointments for the individual.

Monitoring and Follow-up Activities

This includes activities and contacts that are necessary to ensure that the care plan is effectively implemented and is adequately addressing the individual's needs. Follow-up may be with the individual, family members, providers or other entities. The activities can be conducted as often as necessary to help determine such issues as:

-whether services are being furnished in accordance to the individual's plan;

-whether the services in the care plan are adequate; and

-whether there are changes in the eligible individual's needs or status and, if so, making necessary adjustments in the care plan and service arrangements with providers.

The DRA clarifies that case management does not include:

-direct delivery of an underlying medical, educational, social or other service to which the individual has been referred; or

-direct delivery of foster care services.

The DRA lists examples of foster care services that may not be billed to Medicaid targeted case management, specifically:

-research gathering and completion of documentation required by the foster care program;

-assessing adoption placements;

-recruiting or interviewing potential foster care parents;

-serving legal papers;

-home investigations;

-providing transportation;

-administering foster care subsidies; and

-making placement arrangements.

The DRA emphasizes that federal reimbursement is available for case management or targeted case management services only if no third party is liable to pay for such services. This standard appears to restate Medicaid's prohibition on payment for services for which another party is liable.

However, the law then states that this includes reimbursement under a medical, social, educational or other program. This statement raises concern. Many medical, social and educational programs pay for similar services, but they are underfunded and often targeted (legally or in practice) to individuals who are not Medicaid eligible. The question is, which of these programs (if any) will be determined 'liable' to pay for services by CMS when it interprets the meaning of this statement.

Of particular concern is whether this language would be seen to supersede the section of current Medicaid law (Section 1903c of the Social Security Act) that authorizes payment for services in a child's individualized education program (IEP) under the Individuals with Disabilities Education Act (IDEA). If Medicaid does not pay for such services when a child is Medicaid-eligible, it is highly unlikely that schools will include the services in the child's IEP. Specific language exempts some other federal programs (e.g. for HIV) from this third-party liability. However, no explicit exemption is included for IDEA students. This is an instance where CMS policy will be very important.

The real test of whether the new definition will limit services that are vital to recovery is how it is interpreted by CMS in implementing regulations. The Bazelon Center and our campaign allies will closely monitor development of these rules in the months ahead.

Third-Party Payment Issue Applies to Other Mental Health Services

A separate but similar provision to that in the Targeted Case Management section of the law would apply to all Medicaid services. Section 6036 requires that other parties that are 'by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service' be billed before Medicaid. This language seems more directly aimed at health plans and health insurers and not at public programs. However, final interpretation will be made by CMS.

States May Switch People into Private Health Plans

Section 6044 of the DRA allows states to modify the Medicaid benefit package for some beneficiaries. States can obtain an amendment to their state plan to shift people into what is called 'benchmark coverage' or 'benchmark-equivalent coverage.' This coverage is the same as that in the State Children's Health Insurance Program (SCHIP).

States are limited in whom they may switch into these benchmark plans, which typically have significantly lower mental health benefits than current Medicaid. They may not shift the following categories of people:

-pregnant women with mandatory eligibility for Medicaid;

-blind or disabled individuals (including those on SSI or SSDI);

-dually eligible (Medicaid and Medicare) people;

-institutionalized individuals and beneficiaries qualifying for long-term care services;

-people with terminal illnesses or hospice patients;

-medically frail people and those who have special medical needs;

-children in foster care who are receiving services under Title IV-B and children receiving foster care or adoption assistance under Title IV-E.

This leaves groups of children, seniors and parents vulnerable to being switched into less adequate plans.

States may also choose to exempt other categories of Medicaid beneficiaries from being moved into benchmark plans if they pick up this option.

This leaves at risk other adults who, while they may have very serious mental health care needs, are not defined as a 'person with a disability,' and all children who are not in foster care.

These provisions thus represent, potentially, a huge step backward for certain low-income children and single adults who need mental health care. However, if states do not take this option (or exclude from it all children as well as adults who have serious mental illnesses) then there will not be a problem.

Effect on EPSDT

States that pick up the option to use benchmark plans must nonetheless make available to all children under age 19 an additional 'wrap around' benefit, consisting of early and periodic screening, diagnostic and treatment services (EPSDT) as defined in current Medicaid law. This means children under age 19 must continue to receive any medically necessary Medicaid-covered service, whether or not that service is covered or defined in the state Medicaid plan.

However, the statute says nothing about whether children between 19 and 22 have lost their EPSDT protection. Current EPSDT protections could still apply to these youth.

For children entitled to the 'wrap around' benefit, the law creates dual benefit packages (the benchmark benefit and the additional wraparound benefit). This could leave some children falling through cracks. Some families will not know they can obtain the wraparound benefit; others may find their child inappropriately denied the additional benefit and still others may receive the wraparound benefit but encounter discontinuity in providers and treatment plans.

Additionally, no specificity is given or standard used to determine what would be considered 'wrap around.' Accessing it will likely prove difficult for families and an administrative maze for the benchmark-plan insurers.

Benchmark Plan Coverage

The benchmark plans that can be used as models for the new benefit include:

-the standard Blue Cross/Blue Shield preferred provider plan (equivalent to FEHBP, the federal employees health benefits plan);

-a state employee plan;

-the HMO plan in the state with the largest non-Medicaid enrollment; or

-coverage approved by the Secretary of Health and Human Services.

Benchmark-equivalent coverage is defined as a benefit that has an aggregate actuarial value at least equivalent to one of the above benchmark plans. However, for mental health services and prescription drugs (as well as vision and hearing services), the benchmark-equivalent coverage need be only 75% of the actuarial value. The statute sets forth a standard to determine the actuarial value.

Services covered under any of these plans need only include:

-inpatient and outpatient hospital services;

-physicians' surgical and medical services;

-laboratory and x-ray services;

-well-baby and well-child care, including age-appropriate immunizations; and

other appropriate preventive services, as designated by the Secretary of HHS.

Clearly this package fails to cover critical services for people who need mental health care. It would be particularly inappropriate and inadequate for children and adults with serious mental disorders.

States have the option to provide a wraparound benefit to any of the beneficiaries who are moved into benchmark plans, offering the possibility that individuals who need mental health care could be protected.

Expanded Access to Home- and Community-Based Services

Section 6086 gives states, at their option, the ability to provide home- and community-based services (H&CBS) to elderly individuals and people with disabilities with incomes up to 150% of the federal poverty level without requiring a waiver or demonstrating cost neutrality. A state need only amend its Medicaid plan to provide any of the services now covered under H&CB waivers. However, states may use stricter level-of-care eligibility criteria for individuals it chooses to include.

Under the DRA, this option applies not only to populations currently eligible for H&CB waivers, individuals with physical and developmental disabilities and those over age 64 in an Institution for Mental Diseases in states that have covered IMD services as a state option, and individuals of any age in a nursing facility that is not an IMD, but also to adults from ages 22 through 64 who have a mental disorder. This is because the provision previously in place for H&CB waivers regarding cost-neutrality between the new community services and a covered Medicaid institutional service does not apply. Accordingly, it is now irrelevant that adults between 24 and 65 are not covered for institutional services in an IMD.

However, this option could lead to a very limited program. The DRA allows states to limit the number of people served and to maintain waiting lists. It fails to set a standard for the pace at which a state must work to shorten waiting lists. States electing this option may also chose to provide the services in limited areas without having to meet Medicaid's state-wideness requirement.

States that select this option can then cover (for people it selects as eligible) a range of community services that includes supported employment, respite care, family support and other community services. Services permitted under this option, however, must be services that could have been covered through the H&CB waiver authority.

Optional Buy-In for Children with Severe Disabilities

The Family Opportunity Act, championed by Senators Charles Grassley (R-IA) and Edward Kennedy (D-MA) and Representatives Pete Sessions (R-TX) and Henry Waxman (D-CA) and long advocated by the Bazelon Center, has been included in the DRA (Section 6062). However, it is a scaled-back version of the original bill.

As enacted within the DRA, the Family Opportunity Act would help address many problems that families face when they are unable to access needed health care for their children who have severe disabilities. Rather than relinquishing custody to the child welfare system to obtain the intensive services Medicaid offers or staying impoverished to meet the Medicaid income-eligibility requirements, more families could get the assistance they need for their child by purchasing Medicaid coverage from the state. This will help families stay intact and allow parents to maintain a job and even accept raises.

However, the program is a state option. States may offer parents with incomes up to 300% of the federal poverty level ($58,500 for a family of four) the opportunity to buy into Medicaid on a sliding-scale basis if their child under age 18 has a severe mental illness or other severe disability meeting the SSI standard of disability.

States can phase the program in over four years:

-children 0 to 6 years old can be eligible in 2008;

-children 7 to 13 years old, in 2009, and

-children 14 to 18 years old, in 2010.

States may elect to cover children at a faster pace and in families with higher incomes. But they must do so only with state funds, with no federal financial participation.

Parents who are offered employer group health insurance for which the employer pays 50% of the annual premium must elect such coverage if they want to buy into Medicaid. Medicaid then would pay for services that are not covered by the private health plan but are covered under Medicaid. In these cases, a state must reduce its premium by an amount that reasonably reflects the contribution the family has paid for the private coverage.

If parents do not have access to employer group health insurance that meets this criterion, then Medicaid would be the primary payer.

States may charge a premium up to the full cost of the coverage, so long as it does not exceed 5% of family income for those with incomes up to 200% of the federal poverty level, or 7.5% of family income for those between 200% and 300% of the poverty level. In cases of undue hardship, states may waive the premium. Also, states are forbidden to terminate a child's Medicaid eligibility based on failure to pay the premium until the failure continues at least 60 days from the premium's due date.

Home-and Community-Based Services Waivers for Children

The DRA also deals with a long-standing problem in states' ability to secure waivers to provide home- and community-based services for children with serious mental disorders. Currently, these children cannot be covered unless they are at risk of placement in a hospital. However, many children with serious mental disorders are at risk of placement in a residential treatment center, not a hospital.

Section 6063 of the DRA creates a five-year demonstration, starting in FY2007, to allow up to 10 states (awarded on a competitive basis) to test the cost-effectiveness of providing H&CB alternatives to psychiatric residential treatment centers.

The demonstration received an appropriation of $218 million spread over five years ($21 million in 2007; $37 million in 2008; $49 million in 2009; $53 million in 2010 and $57 million in 2011).

The waivers funded through this demonstration are subject to the same requirements as existing 1915c waivers, including budget-neutrality rules. At the end of the demonstration period a state may continue the home- and community-based services for children already enrolled in the program.

Increased Cost-Sharing and New Premiums

States now have significant new authority, effective as of January 1, 2007, to impose premiums (including an enrollment fee or similar charge), deductions and co-payments for groups of Medicaid-eligible individuals and for services. Prior law limits cost sharing to a co-payment of no more than $3 for any service. Moreover, for the first time Medicaid beneficiaries can be denied coverage for failure to pay their premium within 60 days and denied a service if they fail to pay co-payments.

The statute is unclear as to whether adults with family incomes below 100% of the federal poverty level will be exempted from premiums.

Although some groups are exempt from premiums, none are exempted from cost-sharing.

Documentation of Nationality Now Required

Section 6037 requires individuals to present documentation of citizenship or nationality when they apply for Medicaid benefits or when their eligibility needs to be checked and recertified (see the February 28 Bazelon Center Action Alert, Danger:Red Tape Ahead!). To be eligible for Medicaid services, an applicant will have to show a U.S. passport, certificate of U.S. nationality (or other document specified in the immigration and nationality act) or a birth certificate and a picture ID. (Whether the document must be an original is not stated, but a photocopy may be unacceptable.)

This requirement goes into effect June 31, 2006.

BARRIERS TO EMPLOYMENT FOR PEOPLE WITH SCHIZOPHRENIA

Courtsey of American Journal of Psychiatry March 2006

There is growing interest in identifying and surmounting barriers to employment for people with schizophrenia. Examination factors associated with participation in competitive employment or other vocational activities in a large group of patients with schizophrenia who participated in the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) study, a multi-site clinical trial comparing the effects of first- and second-generation antipsychotics.

Baseline data on more than 1,400 patients with a diagnosis of schizophrenia were collected before their entry into the CATIE study. Multi-nomial logistic regression was used to examine the relationship between participation in either competitive employment or other vocational activities and sociodemographic characteristics, schizophrenia symptoms, neurocognitive functioning, intrapsychic functioning, availability of psychosocial rehabilitation services, and local unemployment rates.

Altogether, 14.5% of the patients reported participating in competitive employment in the month before the baseline assessment, 12.6% reported other (noncompetitive) employment activity, and 72.9% reported no employment activity.

Participation in either competitive or noncompetitive employment was associated with having less severe symptoms, better neurocognitive functioning, and higher scores on a measure of intrapsychic functioning that encompassed motivation, empathy, and other psychological characteristics.

Competitive employment, in contrast to other employment or no employment, was negatively associated with receipt of disability payments as well as with being black. Greater access to rehabilitation services was associated with greater participation in both competitive and noncompetitive employment.

Overall employment of persons with schizophrenia seems to be impeded by clinical problems, including symptoms of schizophrenia and poorer neurocognitive and intrapsychic functioning. However, participation in competitive employment may be specifically impeded by the potentially adverse incentives of disability payments and by race and may be promoted by the availability of rehabilitation services.

CRIMINAL BACKGROUND CHECKS IN OMRDD ONE YEAR LATER

OMRDD has announced that as they start the second year of the required criminal background check process in all OMRDD certified sites, and in an effort to continue on their successful path (to date they have processed 38,000 individuals) they would like to hear from the provider community. A number of sessions have been scheduled around the state. All sessions will be from 10:15am – 3:00pm at the following locations:

-April 3: New York City Regional Office (NYCRO), 75 Morton Street, New York
-April 6: New York School for the Blind, Batavia, New York
-April 24: Central New York DDSO, Syracuse Auditorium, Syracuse, New York
-April 25: Pilgrim Psychiatric Center, 998 Crooked Hill Road, Long Island

These sessions will include the following topics: CBC implementation, a legal and regulatory overview, and issues dealing with technology, family care and compliance requirements. There will be ample time set aside for questions and comments.

As space is limited, pre-registration is required and we ask that attendance be limited to those two individuals from each organization who are most involved with the criminal background process. For the April 3 or April 6 session, you must register by March 27, 2006; for the April 24 or April 25 session, you must register by April 14, 2006. To register for one of these sessions, please visit the OMRDD website (www.omr.state.ny.us) and click on Catalog of Training Development. Near the bottom you will see a category By Invitation Only. Clicking on that will bring you to the CBC: One Year Later registration form. For more information you may contact Sue Ann Hart, Director of the CBC Unit, at (518) 377-3846.

OMRDD Criminal Background Checks Emergency Regs

NYSRA received word that OMRDD has filed new emergency regulations related to criminal history record checks which are effective March 27, 2006. The regulations replace the emergency regulations effective December 27, 2005 which have now expired.

The new emergency regulations, which are available on the OMRDD website or by request to NYSRA, contain two minor revisions compared to the December 27 regulations as follows:

- The regulation limits the rosters that must be maintained and submitted. Only those employees and volunteers who are subject parties (as opposed to all employees and volunteers) must be listed.

In addition, former subject parties must only be listed if they stopped being subject parties (e.g. no longer an employee) during the past year. (p. 19; Sec. 633.22(j)(2)(i) and (iii))

- Beginning in 2007, the annual statement submitted by approved providers must be signed by the person primarily responsible for local operations, instead of the chief executive officer. (p. 24, Sec. 633.22(p)(2)).
Other requirements remain the same.

OMRDD offers that if you have any questions on the new regulations, please contact Barbara Brundage, Director, OMRDD Regulatory Affairs Unit at (518)474-1830 or barbara.brundage@omr.state.ny.us. If you have any other questions related to criminal history record checks, please contact the CBC Unit at cbc.unit@omr.state.ny.us.

Timothy's Law Passes Assembly

Courtsey of American Journal of Psychiatry March 2006

Thomas O'Clair came back to Albany on Wednesday, as the state Assembly once again passed legislation named after his dead son.

It has been five years since Timothy O'Clair, who was almost 13 years old, committed suicide in his Rotterdam home.
"Who knows what Tim could have grown to be?" his father asked at a Capitol news conference, echoing the words of a Kenny Chesney country song, "Who You'd Be Today." O'Clair said the song "makes me cry every time I hear it."
"We couldn't get Tim the care he needed," O'Clair said.
"Timothy's Law" is an attempt to make insurers provide that mental health coverage for other families. The "mental health parity" legislation would require insurance companies to cover mental illness and substance abuse treatment in the same way they do physical illnesses. Assemblyman Paul Tonko, D-Amsterdam, prime sponsor of the bill, said it has "languished far too long," and that its passage is a matter of "fairness, justice and who we are as a society."

The bill passed the Assembly later Wednesday by a vote of 134 to 9, said Thomas Lynch, Tonko's legislative director. It also has passed the Assembly in previous years. Before 2001, similar legislation passed with a different name.

In 2004, a version of the bill passed the Senate at the end of the session, but was never referred to a conference committee. Mark Hansen, a spokesman for Senate Majority Leader Joseph Bruno, R-Brunswick, said the Senate version of the bill has an exemption for businesses with 50 or fewer workers. Without such an exemption, he said, the bill "would likely result in many businesses not offering health insurance." Matthew Maguire, communications director for The Business Council of New York State, made a similar point. He said, "The insurance industry projects a 3.5 percent increase on premiums if Timothy's Law is enacted," meaning "health insurance could be put out of reach for some 900,000 New Yorkers." There is no requirement that employers offer health insurance.

Maguire said the state does, however, have more than 40 insurance mandates, and 109 more have been proposed in the Legislature within the past year.

Assemblyman Alexander "Pete" Grannis, D-Manhattan, appearing with O'Clair and Tonko at the news conference, said "tragedies have a direct and indirect cost." Many states and companies have found that providing mental health coverage can save money, he said, because "if you catch it early you avoid the cost later on."

Grannis is chairman of the Insurance Committee.
O'Clair also cited the lost productivity involved when families are left to fend for themselves.

More than 320 organizations, including many dealing with mental health issues, have endorsed the Assembly bill.

The New York State Catholic Conference is one of them. It issued a statement saying: "The case of Timothy O'Clair, for whom Timothy's Law is named, clearly illustrates the ultimate cost that barriers to treatment can exact. Equal coverage for a patient's illness or condition should occur whether that illness or condition is mental or physical."

Hansen said the Senate leadership would consider the matter, but is now focused on the state budget.

OCFS BID ANNOUNCEMENT
"PARTNERSHIP FOR YOUTH (APY) WIA"

The NYS Office of Children and Family Services invites County Youth Bureaus(including New York City Dept. of Youth and Community Development in partnership with Local Workforce Investment Boards and existing Workforce Investment Act service providers to submit proposals to enhance workforce investment programs. Estimated Funds: 1,500,00. Funds will be available to selected County Youth Bureaus and NYC Dept. of Youth and Community Development. Application Deadline is April 19, 2006. For more information contact Matt Murell at (518) 402-3830 or visit the below webiste to view complete profile.
https://ocfsws.ocfs.state.ny.us/obl/index.asp?menu=28&grantid=227

JOB OPPORTUNITIES

Executive Director: Dynamic visionary with successful leadership record sought for CEO position at organization serving individuals with disabilities. REHAB Programs Inc., has an annual budget of over $23.5 million, employs 500 people and provides educational, clinical, vocational and residential services to over 2300 individuals in the Mid-Hudson region of New York State. Position requires a master's degree in business, management or health/human services field, plus extensive similar senior management experience. Familiarity with pertinent NYS regulations and reimbursement systems required. Excellent salary and benefits.

Send resume with salary requirements to: Director of Human Resources, REHAB Programs, Inc., 70 Overocker Road, Poughkeepsie, NY 12603; Fax: (845) 473-1270. E-Mail: karensimon@rehabprograms.org

Vision Rehabilitation Teacher, Part-time: Provides vision Rehabilitation teaching for both adults and children in home setting, refers and networks with related agencies. Responsible for developing individualized treatment plan, case management and presentations in the community. Requires Bachelor's Degree in related field, training including Braille I leading to professional R.T. certification. ACVREP certification desirable. Agency will provide on the job training toward cert. Salary commensurate with experience. Send resume/refs. to E.D., Association for the Blind and Visually Impaired of Jefferson Co., 321 Prospect St., Watertown, NY 13601 or for more information call (315) 782-2451.

Sullivan ARC Article 16 Clinic Program Director: Large multi-service human service agency serving consumers with a range of developmental disabilities has an exciting opportunity for a professional interested in working in a cutting edge agency. We are looking for a motivated professional to assist in the daily operation of an outpatient clinic and provide leadership/direction to specific areas of oversight. Minimum of a bachelor's degree in a human service field with management/supervisory experience required.

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NYSRA AND RRTI CALENDAR

April 2006

April 7
RRTI Seminar: Creating a Positive Work Environment, NYC

April 13
Clinic Committee (DD Division), Albany

April 26
Waiver Services Committee (DD Division), Albany

April 19
NYSRA OPTS Conference Call, 3PM

May 2006

May 3
Development Disabilities Division, Albany

May 4
Employment Options (Voc. Division), Albany

May 15
Vocational Division, NYC

May 17
Partnerships for Youth in Transition Committee (Voc. Division), Albany

ASSISTIVE TECHNOLOGY EXPO

The New York State Governor's Expo on Assistive Technology entitled ***"Technology Opens Doors",*** is scheduled for Thursday, **May 11, 2006** at the Empire State Plaza Convention Center in Albany, New York. The Expo will feature over 100 vendor demonstrations and informational booths showcasing the latest in assistive technology and universal design! In conjunction with the exhibits, presentations on assistive technology will take place in meeting rooms throughout the day. Visit www.atexpo2006.com for more information. If you have questions, contact Michelle Murray at (518)474-2825.