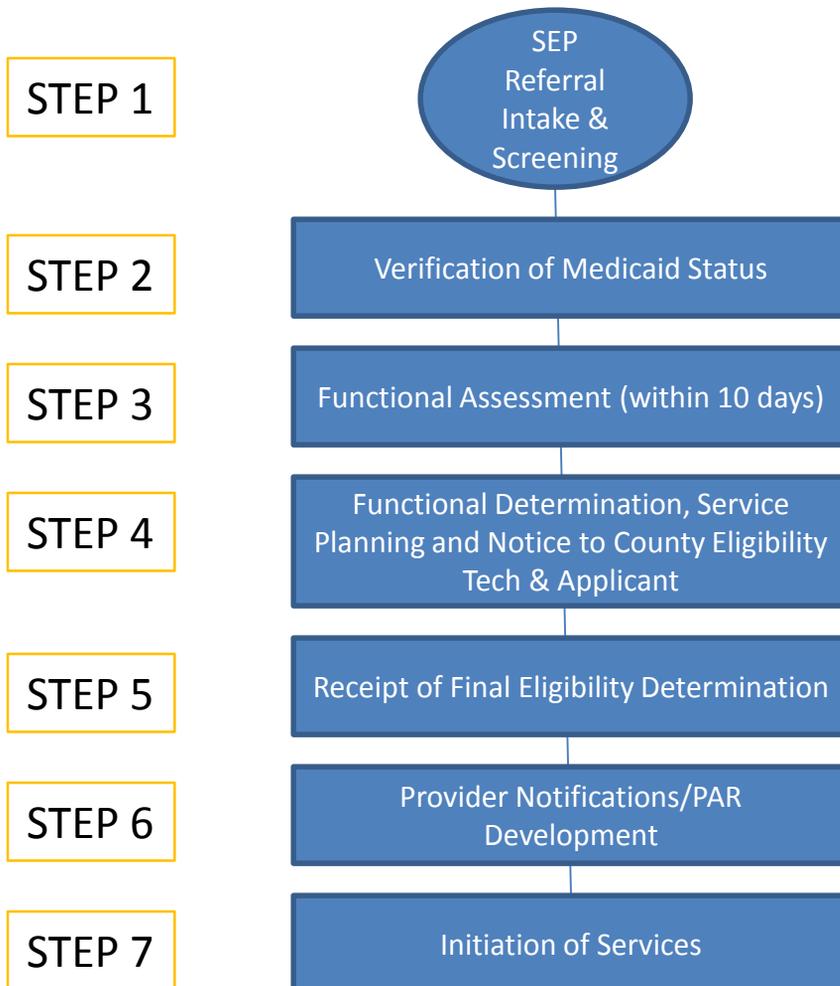


Home and Community Based Services Adult Waivers

General Participation Requirements (4):

1. Must be determined financially eligible (and disability determination if appropriate)(County);
2. Applicant's physician or other licensed medical professional with access to the medical record must submit an attestation of need for Medicaid Long Term Services and Supports (PMIP form);
3. Must meet functional Level of Care (LOC) as reflected by the ULTC 100.2; and
4. Must meet waiver targeting criteria. (For HCBS-EBD, be elderly, blind or physically disabled.)

Client Access to HCBS-EBD



STEP 1

Referrals from:

- Community (applicant, family, advocate, physician, County Department of Human/Social Services , ARCH, CCB, etc.)
- Hospital
- Nursing Facility

Intake and Screening includes:

- demographic info
- Medicaid status inquiry
- basic discussion of need
- primary care physician identification
- referral to other non-Medicaid supportive services (LEAP, Meals on Wheels, AAA, etc.)

A Professional Medical Information Page (PMIP – a medical attestation of the need for LT services and supports) is sent to the identified primary care physician.

STEP 2

Verification of Medicaid Status

- If applicant presents evidence of current Medicaid coverage, Step 3
- If applicant does not have Medicaid, referral to County Department of Human/Social Services
- If applicant has submitted Medicaid application, verification and status request made of the County Eligibility office

NOTE: If the referral originated from the County, hospital or NF this verification is not required.

Eligibility/County Department of Human/Social Services

Once a complete application for Medicaid is received:

- 45 days to make final determination of eligibility (includes functional eligibility from the SEP)
- 90 days to make the final determination pending Disability Determination

STEP 3

Functional Assessment

Once verification of Medicaid application is secured from the County OR if the applicant presents a valid Medicaid card:

- Functional Assessment scheduled
 - Within 10 days for a community-based referral*
 - Within 2 days for a hospital-based referral
 - Within 5 days of a NF-based referral

NOTE: Hospice referrals are prioritized

*Scheduling is dependent on the availability of the client/applicant and may be delayed past the stated timeframes.

STEP 4

Functional Determination

Uniform Long Term Care 100.2 functional assessment conducted

- In the client's/applicant's residence
- Conversation-based (typically)
- Observation

Service Planning

Includes:

- Targeting criteria evaluation
- ADL supports/HCBS
- non-waiver supportive service needs (including LTHH)
- documentation of current non-waiver services received
- client/applicant provider choices
- Client rights and responsibilities

County Notification*

Outcome sent to County Eligibility Technician (via fax, email, courier)

- * PMIP must be returned reflecting a positive attestation of need.

STEP 5

Receipt of Final Eligibility Determination

Final eligibility is dependent upon approval/receipt of:

- Financial
- Functional
- Licensed Medical Professional Attestation of Need
- Targeting Criteria

STEP 6

Provider Notifications

SEP case manager contacts client-chosen providers about scheduling services.

When necessary, providers schedule appointments with clients to develop service-specific care plans which are sent to the SEP for review and approval.

PAR Development

SEP case manager develops and submits PAR to Xerox (financial intermediary vendor) via snail mail.

SEP receives notice to check the system for PAR status update.

STEP 7

SEP case manager notifies HCBS providers to begin services.