

**Delaware Health and Social Services  
Division of Developmental Disabilities Services  
Dover, Delaware**

**Signed Policy in Office**

**of PARC Chair**

**Title:** Individual Eligibility for Home and  
Community Based Services

**Approved By:** \_\_\_\_\_  
Division Director

**Written/Revised By:** DDDS Policy Committee

**Date of Origin:** September 1993

**Date of Current Review/Revision:** February 2004

**I. Purpose**

To establish the process for determination of individual eligibility in the Medicaid Waiver Program for Home and Community Based Services.

**II. Policy**

Eligibility for the Medicaid Waiver for Home and Community Based Services is determined pursuant to the State of Delaware's approved Waiver Request under subsection 1915C of the Title XIX of the Social Security Act.

**III. Application**

All DDDS Staff

**IV. Definitions**

- A. Home and Community Based (HCB) Services under the Medicaid Program: An array of services permitted under Section 1915 C of the Social Security Act, that allows states to offer, under a waiver of statutory requirements, home and community based services that an individual needs to avoid institutionalization.
- B. Medicaid Eligible: An individual receiving Supplemental Security Income (SSI), State Supplemental Payments (SSP), or Aid to Families with Dependent Children (A.F.D.C.) or an individual who would be eligible for SSI or A.F.D.C. if he/she were living in the community or an individual being deinstitutionalized who has limited income and resources.
- C. ICF/MR G.H.: Group Homes which are licensed as Intermediate Care Facilities for the Mentally Retarded.
- D. Medicaid Designee: Staff member identified by the Administrator-Medical Services (D.S.S.) as designee for processing HCB eligibility and billing forms.
- E. CxD: Calculations required to ensure the State's Medicaid cap is not exceeded.
- F. Adaptive Behavior Assessment: An assessment designed to quantify an individual's adaptive functioning (ABAS, AAA, etc.).
- G. Financial Eligibility: The Individual must not have resources above \$2000.00, and their combined earned and unearned income cannot be in excess of the current SSI Standard. Unearned Income includes: SSDI, SSI, Workers' or Veterans Compensation, Support and Maintenance in kind, annuities, rent, interest, Trusts, Stocks, Pensions, and dividends. Earned Income includes: Wages, net earnings from self-employment and income received from sheltered workshops.
- H. Social Services Benefits Administrator: A DDDS employee designated to coordinate and assess the Level of Care and financial eligibility of Waiver applications, on a statewide basis, with the Division of Social Services' (DSS) Medicaid Unit.

I. Management Analyst III: A DDDS employee designated as the general manager of the HCB Waiver.

V. Standards

A. An individual shall be eligible for the DDDS Home and Community-Based Services (HCBS) Waiver when they are:

1. Eligible for DDDS services

The Division of Developmental Disabilities Services provides services to those individuals whose disability meets all of the following conditions:

- (A) (i) is attributable to mental retardation (1992 AAMR definition) and/or (ii)Autism (DSM IV) and/or (iii) Prader Willi (documented medical diagnosis) and/or (iv) brain injury (individual meets all criteria of the 1992 AAMR definition including age manifestation) and /or (v) is attributable to a neurological condition closely related to mental retardation because such condition results in an impairment of general intellectual functioning and adaptive behavior similar to persons with mental retardation and requires treatment and services similar to those required for persons with impairments of general intellectual functioning;
- (B) is manifested before age 22
- (C) is expected to continue indefinitely;
- (D) results in substantial functional limitations in 2 or more of the following adaptive skill areas
  - 1) communication;
  - 2) self-care;
  - 3) home living;
  - 4) social skills;
  - 5) community use;
  - 6) self-direction;
  - 7) health and safety
  - 8) functional academics;
  - 9) leisure;
  - 10) work; and
- (E) reflects the need for lifelong and individually planned services.

Intellectual functioning and adaptive behavior is determined by using established standardized instruments approved by the Division.

2. Determined to meet ICF/MR Level of Care criteria and are financially eligible for Medicaid, and

3. In need of residential services (as identified via the “Urgent” category of the DDDS *Registry*), or a resident of Stockley Center.

B. The final determination of Level of Care and financial eligibility shall be made by the Division of Social Services.

- C. Program eligibility shall consist of the following three tests:
1. **Individual Choice:** “If a potential recipient is determined to require the level of care provided in ICF/MR services, the recipient or his/her representative will be informed of the feasible alternatives, if any, available under the waiver, and permitted to choose among the” (U.S. Federal Register, vol. 46, No. 190, Oct. 1, 1985, P.48541).
  2. The Level of Care Recommendation form (see Exhibit A) shall be completed on individuals potentially eligible for HCB waived services to recommend whether, in the absence of noninstitutional services, they would require the level of care provided in an intermediate care facility for the mentally retarded (ICF/MR). The Interdisciplinary Team shall be responsible for recommending an individual’s Level of Care.
  3. The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.
- D. A. Level of Care Recertification form- for all HCB-eligible individuals shall be completed annually by the interdisciplinary team at the annual conference.
- E. Under Delaware’s Title XIX Waiver program, the State Medicaid Unit shall be responsible for random reviews to ensure recipients continue to be in need of ICF/MR Level of Care services.
- F. Potential recipients or their legal representatives who wish to appeal their HCBS Waiver eligibility decision may also request a Medicaid Fair Hearing (Exhibit O). Persons requesting appeals shall be assisted by the case manager/social worker.

**VI. Procedures**

<u>Responsibility</u> For Medical Eligibility	<u>Action</u>
Family Support Case Manager/Community Services Case Manager	1. Completes the forms needed to determine medical eligibility (NH-10 MAP-16, MAP-25, Level of Care Recommendations, Cost Projection Data Sheet, and the Agreement for Participation in Home and Community Based Services), and forwards to the DDS Social Services Benefits Administrator.
Family Support Case Manager/ Community Services Case Manager	2. Upon entry to initial and successive residential options, ensures that the Agreement for Participation in HCB Services form is completed at the Transfer Planning Conference or to initiate HCB waived services.
DDS Social Services Benefits Administrator	3. Reviews and forwards medical portion of Waiver packet to the DSS Medicaid Medical Review Team for review.

For Financial Eligibility

Family Support Case  
Manager/Community  
Services Case Manager

4. Contacts the DDDS Social Services Benefits Administrator to notify him/her of the proposed placement and need to assess financial resources and determine financial eligibility for the HCBS Waiver program. Obtains schedule of available dates from the DDDS Social Services Benefits Administrator for meeting with the individual's family.

Contacts the individual's family and arranges for meeting with DDDS Social Services Benefits Administrator to assess financial resources and complete application for the HCBS Waiver. Informs the family of all necessary items and documents [including Social Security card, birth certificate, Medicare card, bank statements, medical insurance, life insurance policies, burial agreements and copies of all sources of income, and consent to representative payment ]for the meeting.

DDDS Social Services Benefits  
Administrator

5. Assesses financial resources and ability to pay. Reviews the Financial Responsibility Agreement (Exhibit I) and Policy Memorandum Number 37 (Exhibit J) with the family, as per the Individual Ability to Pay Policy.

If the individual receiving services is determined to be potentially eligible for Medicaid, completes the Map 5 application with the family.

If the individual receiving services is determined to be ineligible for Medicaid, informs the individual receiving services or their legally liable person/agency of care and treatment rate, as per the Individual Ability to Pay Policy. Dispenses with the remainder of this policy.

For Medicaid Certification

DDDS Social Services Benefits  
Administrator

1. Completes an Affidavit of Citizenship form and a Title XIX Awareness form, signs, dates and forwards to DSS Medicaid Office along with Map 5 application.

Family Support Case  
Manager/Community Services Case  
Manager

2. Upon receiving medical and financial approval, sends the Waiver packet to Health Information Management (H.I.M.) for filing, as per the Guidelines for Home and Community Based Waiver Documents (Exhibit P).
3. Forwards copy of Waiver Packet to the Regional Director for filing in COR.
4. Upon receipt of approved waiver packet (copy), completes Home & Community Based Waiver Services Authorization (Exhibit R). Forwards to DDSS Social Services Benefits Administrator.
5. Forwards copy of HCBS eligibility cover memo and Cost Projection Data Sheet to the appropriate Contract Manager and HCBS Waiver Secretary.

Management Analyst III

6. Determines if cost of HCBS Services will exceed C x D Cap, as per Standard C-3.

For Recertification (HCB-Eligible Only)

Case Manager/ID Team

7. At each Annual Interdisciplinary Team Conference, or when the type of residential placement or Day Program Service changes, completes the Level of Care Recertification and Cost Projection Data Sheet. Forwards to the Management Analyst III and
  - a. If the level of care is recertified by item 1 on the form, signs and files form in individual's active record (COR). Dispense with remainder of procedure).

Or

- b. If Item 2 is checked, forwards Level of Care Recertification form and cost Projection Data Sheet to the DDSS Social Services Benefits Administrator. (Follows actions 9, 10, and 11 only when item 2 has been checked).
8. Forwards Level of Care Recertification and Cost Projection Data Sheet to DSS Medicaid Office.

DDSS Social Services Benefits  
Administrator

9. Upon return of determination from DSS sends Level of Recertification form to H.I.M. as per Guidelines for Home and Community Based Waiver Documents (Exhibit P).
10. Files original Level of Care Recertification form

Health Information Management  
(H.I.M.)

## **VII. References**

U.S. Federal Register, 46, 190, 1981  
State of Delaware, Department of Health and Social Services. Request to Provide Home and Community Based Services to the Mentally Retarded of Delaware by Waiver Pursuant to Section 1915 © of the Social Security Act, 1983.  
29 Del. C. § 7940 – Financial Liability of Persons Served by the Department.  
Department of Health and Social Services Policy Memorandum #37 (revised 3/19/96). Standard Ability to Pay Fee Schedule.

## **VIII. Exhibits**

- A. Agreement for participation in Home and Community Based Services
- B. NH 10 (Review and Approval of Level of Care)
- C. Cost Projection Data Sheet
- D. MAP16 (Social Evaluation of Need for Nursing Home Care)
- E. MAP 25 (Comprehensive Medical Report)
- F. Level of Care Recommendation
- G. Title XIX Awareness form
- H. MAP 5
- I. Financial Responsibility Agreement
- J. Department of Health and Social Services Memorandum #37 (revised 3/19/96) 29 Del. C. §7940
- K. HCBS Medicaid Waiver Eligibility Memo
- L. Level of Care Recertification form
- M. Guidelines for Application to the Medicaid HCBS MR Waiver
- N. Guidelines for Home and Community-Based Waiver Documents
- O. DSS Request for Fair Hearing
- P. Home and Community Based Waiver Services Authorization



Division of Developmental Disabilities Services

Agreement for Participation in Home and Community Based Services

This agreement is established in the interest of \_\_\_\_\_ for his/her participation as an ICF/MR recipient in home and community based services. It is understood that the Division of Developmental Disabilities Services is seeking consent for this action to ensure protection of the rights of this individual. It is acknowledged that the following conditions have been met as a prerequisite to this Agreement.

IN MY OPINION, \_\_\_\_\_ does/does not have the capacity to make the choices described herein:  
*(Individual's Name)*

\_\_\_\_\_  
*Psychologist's or Psychological Assistant's Signature*

\_\_\_\_\_  
*Date*

1. The Division of Developmental Disabilities Services has made reasonable effort to answer inquires relating to the choice between home and community-based services and ICF/MR services (Stockley Center).
2. The Following options related to home and community based services have been presented and discussed:
  1. Case Management
  2. Clinical Services:
    - RN Consultative Services
    - BA Consultative Services
  3. Day Habilitation
  4. Prevocational Services
  5. Supported Employment Services
  6. Residential Habilitation:
    - Neighborhood Group Home
    - Staffed Apartment
    - Supervised Apartment
    - Shared Living
3. Options concerning the choice of HCBS Residential Providers, Day Service Providers and Clinical Service Providers (nurse and psych assistant/behavior analyst) were discussed and presented.
4. The advantages and disadvantages of these service alternatives for this individual have been discussed.
5. It is understood that parties representing the individual in the Agreement have the right to discuss the appropriateness of home and community-based services for this individual with persons of their choice at any time.
6. This Agreement has been read and explained to all parties of the Agreement who are unable to read this document:

On this date, \_\_\_\_\_, I choose \_\_\_\_\_ do not choose \_\_\_\_\_ to participate in home and community based services.  
*(Date)*

\_\_\_\_\_  
**Individual's Signature and Date**

\_\_\_\_\_  
**Case Manager/FSS Signature and Date**

\_\_\_\_\_  
**Representative/Guardian's Signature & Date**

\_\_\_\_\_  
**Relationship to Individual**

**STATE OF DELAWARE  
DIVISION OF SOCIAL SERVICES**

REVIEW AND APPROVAL OF LEVEL OF CARE FOR THE  
MR HOME AND COMMUNITY-BASED SERVICES WAIVER PROGRAM

NAME OF APPLICANT: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

S.S.N.: \_\_\_\_\_ MA NO: \_\_\_\_\_

NAME AND ADDRESS OF NEXT OF KIN: \_\_\_\_\_  
\_\_\_\_\_

ATTENDING PHYSICIAN: \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

THE MEDICAID MEDICAL REVIEW TEAM DETERMINED THAT THE ABOVE  
RESIDENT REQUIRES THE FOLLOW LEVEL OF CARE:

ICF/MR WAIVER \_\_\_\_\_ ICF/MR \_\_\_\_\_ ICF \_\_\_\_\_ SNF \_\_\_\_\_ DISAPPROVED \_\_\_\_\_

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**PHYSICIAN CONSULTANT**

\_\_\_\_\_  
DATE

\_\_\_\_\_  
MEDICAID ADMINISTRATOR

**COST PROJECTION DATA SHEET  
FY 2002 C**

CLIENT NAME \_\_\_\_\_ RESIDENTIAL PLACEMENT \_\_\_\_\_

**PART I  
HOME AND COMMUNITY BASED SERVICES**

<u>SERVICE CATAGORY</u>	<u>ESTIMATED COSTS</u>			<u>NUMBER CLIENTS</u>	<u>WEIGHTED AVERAGE</u>	<u>TOTAL COST</u>	<u>TOTAL PER SERVICE</u>
	<u>DAILY</u>	<u>MONTHLY</u>	<u>MAX. ANNUAL</u>				
<b><u>FOSTER TRAINING HOMES</u></b>							
FOSTER TRAINING HOME II	\$14.93	\$454.12	\$5,449.45				
FOSTER TRAINING HOME III	\$38.49	\$1,170.74	\$14,048.85				
FOSTER TRAINING HOME IV	\$78.78	\$2,396.23	\$28,754.70				
RESPIRE	\$30.00						
<b><u>NEIGHBORHOOD GROUP HOMES</u></b>							
BANCROFT NEIGHBORHOOD GROUP HOME- Spec. Pop	\$259.77	\$7,642.22	\$91,706.60				
BANCROFT NEIGHBORHOOD GROUP HOME-Community	\$116.46	\$3,426.16	\$41,113.87				
CHIMES NEIGHBORHOOD GROUP HOME/P-21 & Community	\$274.29	\$7,174.97	\$86,099.63				
CHIMES NEIGHBORHOOD GROUP HOME (Prader w.)	\$258.95	\$6,773.70	\$81,284.41				
COMMUNITY SYSTEMS NEIGHBORHOOD GROUP HOME	\$172.43	\$4,868.27	\$58,419.28				
<b><u>DD</u></b>							
DELMARVA COMMUNITY NEIGHBORHOOD GROUP HOME	\$173.67	\$5,195.63	\$62,347.53				
DDDS NEIGHBORHOOD GROUP HOME I	\$156.74	\$4,262.15	\$51,145.83				
DUNGARVIN NEIGHBORHOOD GROUP HOME	\$316.17	\$8,852.76	\$106,233.12				
MARTIN LUTHER NEIGHBORHOOD GROUP HOME	\$173.25	\$4,865.44	\$58,385.25				
MARTIN LUTHER NEIGHBORHOOD GROUP HOME DD	\$229.19	\$6,971.20	\$83,654.35				
KEN-CREST GROUP HOME	\$224.85	\$5,696.20	\$68,354.40				
KEYSTONE SERVICES	\$286.15	\$7,916.82	\$95,001.80				
VOCA NEIGHBORHOOD GROUP HOME .	\$245.69	\$7,227.38	\$86,728.57				
<b><u>APARTMENTS</u></b>							
BANCROFT INC STAFFED .	\$506.34	\$15,107.08	\$181,284.91				
CHIMES STAFFED	\$312.69	\$8,179.45	\$98,153.39				
CHIMES P-21 STAFFED	\$312.69	\$8,179.45	\$98,153.39				
DELMARVA CMTY SVCS. STAFFED	\$320.15	\$9,577.82	\$114,933.85				
DDDS STAFFED	\$156.64	\$3,705.84	\$44,470.10				
DDDS SUPERVISED	\$147.98	\$4,172.54	\$50,070.51				
DUNGARVIN STAFFED P-21	\$320.99	\$8,987.72	\$107,852.64				
KEN-CREST STAFFED	\$161.58	\$4,093.36	\$49,120.32				
VOCA STAFFED	\$225.85	\$5,363.94	\$64,367.25				
<b><u>DAY PROGRAMS</u></b>							
BANCROFT POST 21 PRE.VOC.AND SUPP EMP. TRNG.	\$97.00	\$2,004.67	\$24,056.00				
CHESAPEAKE CARE RESOURCES	\$82.00	\$1,387.17	\$16,646.00				
CHIMES COMMUNITY PRE-VOC	\$106.31	\$1,922.44	\$23,069.27				
CHIMES PRE-VOC POST-21	\$133.32	\$2,477.53	\$29,730.36				
CHIMES SUPP-EMP. POST-21	\$133.32	\$2,477.53	\$29,730.36				

COMMUNITY INTEGRATED SREVICES	\$53.71	\$1,056.30	\$12,675.56
DELMARVA COMMUNITY SVCS. DAY HABILITATION	\$64.36	\$1,292.56	\$15,510.76
DE. ELWYN AUTISTIC PROGRAM	\$121.47	\$2,299.83	\$27,597.98
DE. ELWYN PRE.VOC.EMP. AND SUPPORTED EMP. TRAINING	\$43.12	\$803.11	\$9,637.32
DDDS DAY HABILITATION STATE RUN PROGRAMS	\$91.55	\$1,621.20	\$19,454.38
EASTER SEALS PRE VOC./SUPPORTED EMPL.	\$50.56	\$936.62	\$11,239.49
EASTER SEALS TOTAL CARE PRE-VOC.	\$91.00	\$1,685.78	\$20,229.30
KSI PRE.VOC.EMP. TRAINING AND SUPPORTED EMP.	\$52.80	\$1,056.00	\$12,672.00
CLINICAL SUPPORT	\$11.56	\$351.62	\$4,219.40
CASE MANAGEMENT	\$10.70	\$325.46	\$3,905.50
ACUTE CARE SERVICES	\$11.95	\$363.42	\$4,361.00

**TOTAL**

**ICF/MR SERVICES**

ICF/MR STOCKLEY CENTER	\$373.78	\$11,369.14	\$136,429.70
ACUTE CARE SERVICES	\$13.23	\$402.08	\$4,825.00

Signature & Title of Case Manager/Committee

**PART II.**

It is the determination of the State Medicaid Program Unit that there exists reasonable exception that (Check one):

The cost of home and community based services offered WOULD EXCEED the State's (CxD) Cap and therefore this client is INELIGIBLE for home and community based services under the Medicaid Program.

The aggregate cost of home and community based services offered WOULD NOT EXCEED the States's (CxD) Cap, and therefore, this client MAY BE ELIGIBLE for home and community services under the Medicaid Program.

\_\_\_\_\_  
Date

\_\_\_\_\_  
State Medicaid Administrator

STATE OF DELAWARE  
DEPARTMENT OF HEALTH AND SOCIAL SERVICES  
DIVISION OF SOCIAL SERVICES

SOCIAL EVALUATION OF NEED FOR NURSING HOME CARE

Name

I.D. No.

Birthdate

Social Security No.

Home Address

Next of Kin  
Address

Telephone:

I. **SOCIAL HISTORY** (include family relationships; education; employment and experience; lifestyle; interests; present living arrangements and explanation as to necessity of nursing home care.)

II. **Present Condition and Emotional State.**

III. **Plan of Social Care in Nursing Home (focus on: problem - activity - goal).**

Worker \_\_\_\_\_

Date \_\_\_\_\_

STATE OF DELAWARE  
DIVISION OF SOCIAL SERVICES  
COMPREHENSIVE MEDICAL REPORT

NOTICE TO PHYSICIAN: The following information is for use in connection with the patient's application. Please make your report COMPLETE and LEGIBLE enough for a reviewing physician to determine the nature and severity of impairment.

NAME: \_\_\_\_\_ D.O.B. \_\_\_\_\_ SEX \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

1. Physical Measurements: Height: \_\_\_\_\_ Weight: \_\_\_\_\_

2. HISTORY:

A. Past History

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

B. Date of onset of present illness or injury

C. Is there a previous history of this illness? \_\_\_\_\_

If "Yes", describe

\_\_\_\_\_  
\_\_\_\_\_

3. PRESENT CONDITION (ALL MAJOR IMPAIRMENTS)

A. Subjective **Symptoms:**

\_\_\_\_\_

B. Objective Findings: (Give report of X-rays, lab., or diagnostic tests, etc., with dates. Use separate sheet if necessary.)

\_\_\_\_\_  
\_\_\_\_\_

C. Patient is: Ambulatory \_\_\_\_ Confined to: Wheelchair \_\_\_\_ Bed \_\_\_\_ Home  
\_\_\_\_ Hosp. \_\_\_\_\_

D. Mental Status: \_\_\_\_\_

4. DIAGNOSES: \_\_\_\_\_

5. PROGNOSIS:

6. REHABILITATION and/or MAINTENANCE GOALS: \_\_\_\_\_

7. TREATMENT: A. Therapy and response: \_\_\_\_\_

B. Date of first visit: \_\_\_\_\_ Frequency of visits: \_\_\_\_\_

C. Date when you last examined this patient: \_\_\_\_\_

D. Diet: \_\_\_\_\_

E. Medications: \_\_\_\_\_

F. Recommended Activities: \_\_\_\_\_

8. PROGRESS: Patient's condition is:

Improving \_\_\_\_\_ Static \_\_\_\_\_ Deteriorating \_\_\_\_\_ Terminal \_\_\_\_\_

REMARKS:

Physician's Name: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DATE \_\_\_\_\_

Recommend Nursing Home Care \_\_\_\_\_yes \_\_\_\_\_no

**Level of Care Recommendation**

Name: \_\_\_\_\_ Case Number \_\_\_\_\_

Initial Placement/Enrollment Date in a Community Service Option: \_\_\_\_\_

Date of ID Team/Intake Conference: \_\_\_\_\_ Date of Assessment: \_\_\_\_\_

(Check One)

\_\_\_\_\_1. The individual's scores on the Adaptive Behavior Scales indicate that, in the absence of home and community based services, the individual would require the level of care provided in an ICF/MR. (If checked, do not complete the remainder of this form.

\_\_\_\_\_2. The individual's scores on the Adaptive Behavior Scales indicate that, in the absence of home and community based services, the individual would not require the level of care provided in an ICF/MR; however, the interdisciplinary team does not concur with this indication and concludes that ICF/MR level of care is necessary.

\_\_\_\_\_3. The individual's scores on the Adaptive Behavior Scales indicate that, in the absence of home and community based services, the individual would not require the level of care provided in an ICF/MR and the interdisciplinary team concurs with this indication.

\_\_\_\_\_  
Signature, Case Manager/Eligibility Coordinator/Placement Committee Chairperson  
\*\*\*\*\*

STATE MEDICAID PROGRAM'S DETERMINATION:  
(Check one)

\_\_\_\_\_ The individual does require the level of care provided in an ICF/MR in the absence of home and community-based services.

\_\_\_\_\_ The individual does not, require the level of care provided in an ICF/MR in the absence of home and community based services.

\_\_\_\_\_  
Signature, Physician/D.S.S./Medicaid

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature, Social Worker/D.S.S./Medicaid

\_\_\_\_\_  
Date

AWARENESS FORM - TITLE XIX

HOME AND COMMUNITY BASED LONG-TERM CARE SERVICES OPTION

I have read, or have had read to me, the following:

The Department of Health and Social Services now offers a program of home and community based long-term care services to individuals who are currently either living in a long-term care institution or at risk of living in an institution. Instead of living in an institution, you maybe eligible to receive long-term care services in your home. In order to be eligible for this program, the following conditions must be met.

1. I must want to accept home and community based services instead of nursing home placement.
2. I must be financially eligible for Title XIX services.
3. It must be proven by criteria developed by the Department of Health and Social Services /Division of Social Services/Medicaid that I am in need of intermediate or skilled level nursing care services.
4. I **understand** that I will not be eligible for this Option if the cost of my care in the community as determined by Division of Social Services /Medicaid would exceed that of institutional care.
5. If I am accepted for this Option, I understand that all services on my behalf must be approved and authorized by the Division of Social Services /Medicaid Case Manager.
6. I understand that I will not be eligible for the Option if the maximum number of clients to be served under the Option has been reached.

I understand that I have the choice of either institutional or home and community based services if the above stated conditions are met.

I do ( ) do not ( ) wish to apply for the Title XIX Home and Community Based Long-Term Care Services Option.

Client/Representative

Date

EXHIBIT H

**INSERT EXHIBIT H (Long Term Care Medicaid Application)**

DEPARTMENT OF HEALTH AND SOCIAL SERVICES  
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES

FINANCIAL RESPONSIBILITY AGREEMENT

The signature below confirms that I/we have been fully advised of my/our financial responsibility for the cost of services provided by the State of Delaware, Department of Health and Social Services, Division of Developmental Disabilities Services, as established by 29 Del. C. §7940.

- 1) Before admission: I will fully disclose all information with regard to my financial status and will turn over said assets to the State of Delaware, Division of Developmental Disabilities Services; as payment for services provided. I further agree that any insurance benefits for which I am eligible or will accrue because of my admission will be applied toward the cost of my care.
- 2) After admission: Any income or assets, which I now have or may acquire in the future, including Social Security, Supplemental Security Income (SSI), other pensions, proceeds from property settlements, inheritances, any health insurance benefits; or other related income will be turned over to the Division of Developmental Disabilities Services to be applied toward the cost of care.
- 3) Should I become certified for Medicaid, my financial resources will be used in accordance with Medicaid Regulations.
- 4) I understand that the Division will oversee my financial affairs for me and that I will be given the balance in my account upon request, and at the time of my discharge or death, if my assets held by the Division are greater than my accumulated bill/obligation, the balance will be refunded to me or my estate.

\_\_\_\_\_  
Signature of Individual

\_\_\_\_\_  
Social Security #

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent (if individual is a minor) or Substitute Decision-maker/Legal Guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**PARC Approved: 02/10/04  
27/Admin**

POLICY MEMORANDUM NUMBER 37

March 1, 2002

SUBJECT: STANDARD ABILITY TO PAY FEE SCHEDULE

I. PURPOSE

To establish a uniform ability to pay schedule and to supplement existing collection policy or agreements to standardize Departmental collection efforts for recovery of accounts receivable that amount to less than the full cost of care due, in accordance with Delaware Code, Title 29, Section 7940.

II. DEFINITIONS

1. The "Cost of Services Rendered" in this policy shall mean the "Cost of Care" as used in Delaware Code, Title 29, Section 7940 and DHSS Policy Memorandum Number 12.
2. Disposable income for determination of ability to pay shall be gross income less a standard deduction and taxes paid.
3. Standard deduction shall be based on 100% of the poverty level.

III. EXCLUSIONS

This Policy Memorandum is not applicable to persons supported by Medicaid, Medicare, CHAMPUS, or private insurance with the exception of deductibles, coinsurance and charges for non-covered services of those payers who have contracts with DHSS facilities.

IV. FOREWORD

1. Respective Divisions shall continue to pursue recovery of the full cost of services rendered in accordance with the Department of Health and Social Services Policy Memorandum Number 12, as applicable.
2. Facilities should make every effort to assure that clients and legally liable persons are aware of and understand their fiscal liability, their right to request an adjustment to that liability, and the procedures to appeal the ability to pay determination.
3. Division Directors will develop procedures under the guidelines in Section VI for implementation of this policy within their respective Divisions.

POLICY MEMORANDUM NUMBER 37

March 1, 2002

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V. PROCEDURES

A. INPATIENT SERVICES

The facility administration shall request, preferably before or, in case of emergency, after the patient is admitted or treated, a written agreement with those persons receiving or to receive care and/or treatment from the facility and, where appropriate, of the liable person(s) for the recovery of the full cost of care.(Appendix A) Liability of persons other than the patient shall be governed by the provisions of 29 Del. C. 7940 (a).The following procedures shall be implemented when a written agreement for the recovery of the full cost of services rendered cannot be obtained.

1. DHSS Ability to Pay Worksheet (Appendix B) should be completed for the person receiving care and for any other person liable under 29 Del. Code, 7940 (a), to determine disposable income and the minimum annual fee due based on the ability to pay. (Instructions on completion of the worksheet are printed on the reverse side of the form.)
2. The liability will automatically be waived for anyone with disposable income less than \$6,000.
3. The liable person shall be informed, in writing, of his/her liability, due dates of payment, and appeal procedures. (Appendix C).
4. All other payment agreements, in force prior to implementation of this Ability to Pay Fee Schedule, shall be gradually phased-out, for conformance, at the time of automatic review, which is at least every two (2) years. (Delaware Code, Title 29, Section 7940, Paragraph (d).

B. COMMUNITY-BASED & OUTPATIENT SERVICES

The Divisions shall determine the ability to pay of their clients for community-based and outpatient services and shall maintain a record of this information which will be available at all service locations. The ability to pay will be determined, utilizing a sliding scale. The scale will be set using a range from 200% to 275% of the poverty level, with anyone whose gross income is at 200% or less of the poverty level, receiving the services free of charge. The percentage of charges to be paid will increase 20% for each 15% of the poverty level, the gross income increases with anyone whose gross income is above 260% of the poverty level paying 100% of the charge. The ability to pay sliding scale will be applied to the fees which are developed and implemented by the individual divisions of DHSS for each of the services they provide. The attached Table A shows the actual income levels to be used for family levels from 1 to 10.

TABLE A

Family Size % Poverty	Poverty Level	Annual Income Up To 200%	Annual Income Up To 215%	Annual Income Up To 230%	Annual Income Up To 245%	Annual Income Up To 260%	Annual Income Over 260%
1	\$8,860	\$17,720	\$19,049	\$20,378	\$21,707	\$23,036	\$23,036
2	11,940	23,880	25,671	27,462	29,253	31,044	31,044
3	15,020	30,040	32,293	34,546	36,799	39,052	39,052
4	18,100	36,200	38,915	41,630	44,345	47,060	47,060
5	21,180	42,360	45,537	48,714	51,891	55,068	55,068
6	24,260	48,520	52,159	55,798	59,437	63,076	63,076
7	27,340	54,680	58,781	62,882	66,983	71,084	71,084
8	30,420	60,840	65,403	69,966	74,529	79,092	79,092
9	33,500	67,000	72,025	77,050	82,075	87,100	87,100
10	36,580	73,160	78,647	84,134	89,621	95,108	95,108
% of Charge To Be Paid		-0-	20%	40%	60%	80%	100%

Note: Federal guidelines related to specific programs take precedent over this policy.

VI. ADMINISTRATIVE DETERMINATION

Division Directors are authorized to make administrative adjustments to the monthly fee calculated by the facility in lieu of submission to the Appeals Committee, if circumstances justify such adjustments. Administrative adjustment should be made only where the individual(s) have extraordinary expenses over which they have no control (i.e., medical bills, etc.). The procedures for administrative determination shall be as follows:

1. Division Directors should establish a Review Panel, consisting of three members: the Division Director or Deputy Director, an Institutional Representative and a Community-Based Representative.
2. Upon receipt of a written request appealing the ability to pay determination, the facility administration shall notify the individual that the appeal has been received and will forward the appeal request to the Division Director's office within five (5) working days for administrative review.
3. The Review Panel will meet no less than once a month to review the appeals received and make their determination.
4. The Review Panel shall notify the facility and the individual who is making the appeal concerning their determination within five (5) working days of the review.
5. If the Review Panel concurs with the original determination, the appeal will be forwarded to the Appeals Committee for final review.

VII. APPEALS

After implementation of Ability to Pay Fee Schedule, any person aggrieved by any decision with respect to the payment of fees, refusal of admission or discharge for other than medical reasons, may appeal by petition to the Appeals Committee in writing, stating the substance of the decision appealed, the facts in support of the appeal and the relief sought.

The Appeals Committee consist of the Chairpersons of the:

- o Advisory Council on Mental Retardation;
- o Advisory Council on Alcoholism, Drug Abuse and Mental Health;
- o Advisory Council for Delaware Hospital f/t Chronically Ill;
- o Public (Physical) Health Advisory Council.

1. The Appeals Committee shall hold a hearing within sixty (60) days and shall render its decision promptly. The Committee's decision shall be final and binding.
2. The Secretary's Office will receive the appeal information, schedule the hearing and notify the Appeals Committee and the individual appealing of the date and location of the hearing.
3. The appeals hearings will be chaired on a rotating basis with each member of the committee serving as chairperson for a period of three (3) months.

Note: Appeals Committee - Delaware Code, Title 29, Section 7940, Paragraph (m).

#### VIII. COLLECTION

Collection efforts and write-off procedures shall be in conformance with DHSS Policy Memorandum Number 19.

#### IX. ADMINISTRATION

An Ability to Pay Committee shall be available to help resolve implementation/interpretation problems. It will set up such rules and regulations as are deemed necessary, pursuant to the authority granted by 29 Del. C. 7940 (j).

1. A permanent committee shall be assigned to monitor and administer the Ability to Pay Fee Schedule.
2. The Ability to Pay Committee shall consist of:
  - (a) Two representatives each from the Divisions of Alcoholism, Drug Abuse and Mental Health; Mental Retardation; and Public Health;
  - (b) One representative from the Division of Management Services, who shall serve as Chairman.

X. EFFECT

1. This policy shall become effective on March 1, 2002.
2. Any part thereof which is inconsistent with any Federal, State or local law shall be null and void.

A handwritten signature in black ink that reads "Vincent P. Meconi". The signature is written in a cursive style and is positioned above a solid horizontal line.

Vincent P. Meconi  
Secretary  
Department of Health & Social Services

Attachment

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APPENDIX A  
LETTERHEAD

Patient Name \_\_\_\_\_

Date: \_\_\_\_\_

Dear \_\_\_\_\_,

This is to advise you that the charge for services rendered at (facility) is \$ \_\_\_\_\_ per day. The patient and/or any persons legally liable under Title 29, Section 7940 of the Delaware Code will be billed for these services.

Please complete and return this form to \_\_\_\_\_ by \_\_\_\_\_.  
Financial Services Rep. (Date)

Check if Applicable:

\_\_\_ 1. I have the following insurance coverage which should be billed:

- Blue Cross
- Medicare
- Other Insurance
- Medicaid

Group # \_\_\_\_\_ Policy # \_\_\_\_\_  
Name of Person Insured \_\_\_\_\_

\_\_\_ 2. I will make full payment as billed.

\_\_\_ 3. I am unable to pay the full amount.

Date \_\_\_\_\_ Signature \_\_\_\_\_

If #3 is checked, please submit the following information for our review to determine an appropriate payment based on your ability to pay.

1. A copy of your most recent Federal and State Income Tax returns.
2. A copy of all W-2 Forms submitted with your tax returns.
3. Other documents which show your current income.

You will be notified in writing of our determination. We will be unable to make any adjustments to the amount which you are required to pay if the information is not submitted.

Thank you for your cooperation.

Sincerely,

APPENDIX B

PATIENT NAME:

DATE:

ADDRESS:

GUARANTOR NAME:

ADMISSION DATE:

ADDRESS:

INSURANCE COVERAGE:

PREPARED BY: \_\_\_\_\_

APPROVED BY: \_\_\_\_\_

1. GROSS INCOME

\$ \_\_\_\_\_

LESS:

2. STANDARD DEDUCTION \_\_\_\_\_

3. TAXES WITHHELD

FICA \_\_\_\_\_

FEDERAL INCOME \_\_\_\_\_

STATE INCOME \_\_\_\_\_

CITY WAGE \_\_\_\_\_

4. TAX (REFUNDS)/PAYMENTS \_\_\_\_\_

5. TOTAL DEDUCTIONS (SUM OF LINES 2-4)

\$ \_\_\_\_\_

6. DISPOSABLE INCOME (LINE 1 LESS LINE 5)

\$ \_\_\_\_\_

7. MINIMUM ANNUAL FEE DUE BASED ON ABILITY  
TO PAY. (10% OF LINE 6)

\$ \_\_\_\_\_

8. MONTHLY PAYMENT. (LINE 7 DIVIDED BY 12)

\$ \_\_\_\_\_

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DHSS  
ABILITY TO PAY WORKSHEET  
INSTRUCTIONS

LINE 1. Gross income is obtained from a copy of the Tax Return, if one was filed, or from a copy of other payment sources (if non-taxable, such as Welfare payments, Pension payments, or other income).

LINE 2. Standard Deduction

Household Size	Amount	Household Size	Amount
1	\$8,860	6	24,260
2	11,940	7	27,340
3	15,020	8	30,420
4	18,100	9	33,500
5	21,180	10	36,580

LINE 3. Taxes withheld are obtained from a copy of W-2 forms.

LINE 4. Amount of tax refunds or payments are from Federal and State tax returns.

LINE 5. Total deductions equals the sum of Lines 2 through 4.

LINE 6. Disposable income. Gross income (Line 1) less total deductions (Line 5).

LINE 7. Minimum annual fee. Is 10% of disposable income (Line 6 X .1). (The minimum annual fee will be automatically waived if disposable income is less than \$6,000.)

LINE 8. Monthly payment. Annual payment (Line 8) divided by 12.

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APPENDIX C  
LETTERHEAD

NAME:

DATE:

ADDRESS:

PATIENT NAME:

DEAR \_\_\_\_\_:

We have reviewed the information which you supplied and have calculated your minimum monthly payment according to Delaware Law 29 Del. C. 7940 and Department of Health and Social Services Policy Memorandum Number 37. You are responsible for a monthly payment of \$\_\_\_\_\_ for the services rendered to the above named patient. A copy of our calculation has been enclosed for your benefit. Payments are due by the 20th of the month for the previous month's care.

You have the right to appeal the determination, in writing, to the Appeals Committee stating the substance of the decision being appealed, the facts in support of the appeal, and the relief sought.

Appeals should be submitted to:

Appeals Committee Administrator

\_\_\_\_\_ (Facility Name)

\_\_\_\_\_ (Facility Address)

Thank you for your cooperation in this matter.

Sincerely,



DELAWARE HEALTH  
AND SOCIAL SERVICES  
Division of Developmental Disabilities Services

OFFICE OF BUDGET, CONTRACTS, & BUSINESS SERVICES

**MEMORANDUM**

TO: Shelly Glover, Director  
Health Information Management

FROM: Deborah Wright  
Client Benefits Administrator

RE: HCBS Waiver Eligibility

DATE: \_\_\_\_\_

The following individual is now enrolled in the HCBS Medicaid MR Waiver Program. Please file the attached forms as per waiver guidelines.

- 1. Individual's Name: \_\_\_\_\_
- 2. Provider's Name: \_\_\_\_\_
- 3. Provider's Address: \_\_\_\_\_  
\_\_\_\_\_
- 4. Type of Residence: \_\_\_\_\_
- 5. Day Program: \_\_\_\_\_
- 6. HCBS Effective (Placement)Date: \_\_\_\_\_
- 7. LOC/CPDS EffectiveDate: \_\_\_\_\_
- 8. Medicaid Number: \_\_\_\_\_
- 9. Client's Birth Date: \_\_\_\_\_
- 10. Financial Eligibility Date: \_\_\_\_\_

cc: Regional Director  
Contract Manager  
Waiver File  
Fiscal File

### Level of Care Recertification

Consumer \_\_\_\_\_ Case Number \_\_\_\_\_

Initial Placement/Enrollment Date in a Community Service Option: \_\_\_\_\_

Date of ID Team/Intake Conference: \_\_\_\_\_ Date of Assessment \_\_\_\_\_

(Check One)

- \_\_\_\_\_ 1. Information provided through the interdisciplinary assessment process indicates that, in the absence of home and community-based services, the consumer continues to be in need of ICF/MR level of care.
- \_\_\_\_\_ 2. The interdisciplinary team recommends that in the absence of home and community-based services, the consumer would no longer require the level of care provided in an ICF/MR. Therefore, the interdisciplinary team wishes to recommend a review of the eligibility determination. (If checked, the Division of Developmental Disabilities Services (DDDS) Placement Coordinator shall forward to Medicaid for determination.)

\_\_\_\_\_  
Signature, Case Manager

\_\_\_\_\_  
Date

#### STATE MEDICAID PROGRAM'S DETERMINATION:

(Check One)

\_\_\_\_\_ The consumer does require the level of care provided in an ICF/MR in the absence of home and community-based services.

\_\_\_\_\_ The consumer does not require the level of care provided in an ICF/MR in the absence of home and community-based services.

\_\_\_\_\_  
Signature, Physician/DSS/Medicaid

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature, Social Worker/DSS/Medicaid

\_\_\_\_\_  
Date

**HCBS WAIVER GUIDELINES**

1. Placement is proposed and facilitated according to the Matching Individuals for Community Residential Placement policy.
2. Once a proposed match is confirmed by the Placement Review Committee, the Case Manager will initiate the process for application to the HCB Waiver.
3. **Medical Approval:**  
To obtain medical approval for the MR Waiver, the case manager completes the following forms and sends to the DDDS Social Services Benefits Administrator, (Deborah Wright):
  1. Agreement for Participation in Home and Community Based Services
  2. Cost Projection Data Sheet
  3. NH-10: Review and Approval of Level of Care
  4. MAP 16: Social Evaluation of Need for Nursing Home
  5. MAP 25: Comprehensive Medical Report
  6. Level of Care Recommendation
4. Upon receipt of the forms, the DDDS Social Services Benefits Administrator will review and send to the Medicaid Administrator for review and assignment of Level of Care.
5. **Coordination of Waiver Application with Social Security:**  
As part of the waiver application process, the Social Services Benefits Administrator will make any necessary applications to the Social Security Administration, including Request to change Representative Payee to DDDS, Certification for Adult Residential Care, and Application for SSI, if applicable. The case manager will ensure completion of the following:
  1. Consent to Representative Payment
  2. Change of Status Form (to be completed at time of move to residential placement)
6. **Financial Approval:**  
The Case Manager will advise the family/guardian of the need to set up an appointment with the Social Services Benefits Administrator to complete the financial portion of the HCB Waiver application. The Case manager will review with the family all of the items that will be required at this appointment, including the following:
  1. Copy of Birth Certificate
  2. Copy of Social Security Card
  3. Copy of Guardianship Papers, (if applicable)
  4. Verification of all income. This includes:
    - Copies of pay stubs (most recent three (3) months)
    - Copies of benefit award letter (i.e., Social Security, SSI, VA, RR, etc.)
    - Any other income verification (i.e., annuities, pensions, etc.)

5. Copies of three (3) most recent current account statements for any open accounts (checking, savings, trust funds, etc.)
  6. Copies of deeds for burial plots and/or pre-paid burial plans
  7. Copies of any/all life insurance policies. This must include cash value pages.
  8. Copies of health insurance cards and verification of premiums paid.
- 
7. The family, with assistance from the Case Manager, will contact the Social Services Benefits Administrator, and an appointment will be set up to complete the financial application to the HCB Waiver.
  8. The Social Services Benefits Administrator will meet with the family to complete the financial application. The Social Services Benefits Administrator will review information and determine if all necessary items are present. If all necessary information and documents are present, the application will be completed, and signed by the family. If all necessary information and documents are not present, the family will be advised of what information is still needed, and advised to set up another appointment when all information or documents are gathered.
  9. Upon completion of the financial application to the HCB Waiver, the Social Services Benefits Administrator will determine whether an in-person application with Medicaid and the family is necessary. If necessary, Social Services Benefits Administrator will arrange. If not necessary, Social Services Benefits Administrator will forward application to Medicaid.

**DELAWARE HEALTH AND SOCIAL SERVICES**  
**DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES**

**Guidelines for Home and Community-Based Wavier Documents**

The following process should be used for sending documents, specifically waiver documents, to Health Information Management, effective immediately.

All original documents should be sent to HIM upon completion and copies should be made for the COR. The original document will have the 'live' signature; signed in ink. These documents are:

1. **ELP**; including the **Annual Conference Summary**.
2. **Cost Projection Data Sheets** – These should be done four times per year **AND** every time the service changes. The service and subsequent per diem rate should be circled.
3. **Level of Care Certification/Re-Certification**.
4. **Agreement for Participation** – This is an initial, one-time document.

HIM will track the information received and when needed, they can provide original documents for audits, case managers, fiscal analysts, etc. HIM will also begin analysis of summaries for service accuracy.

All documents should be sent to Health Information Management at the time they are completed. Information can be sent in any of the following ways:

- State mail, SLC S820A, # 34
- Hand Deliver
- Postal Service address -           Stockley Center  
  ATTN: HIM  
  26351 Patriots Way  
  Georgetown, De 19947

**\*\*\*\*\*As a reminder, all ORIGINAL HEALTH RELATED documents, i.e., assessments, updates and evaluations should also be sent to HIM with a copy remaining in the COR. The analysis and tracking process will assist in maintaining compliance as well as accounting for each individual.**

IMPORTANT NOTICE

You can ask for a fair hearing if you do not agree with what we have told you in this notice. A hearing will give you a chance to explain why you do not agree.

If you want to have a hearing, you must ask for it in writing. (For Food Stamps, you can ask for a hearing in person or by phone.) If you ask for a fair hearing before the date the change in your benefits takes effect, you may get the same benefits that you have received. These benefits may continue until the hearing officer decides your case. (Food stamps benefits may only continue until the month your benefits must be recertified.)

You can still ask for a hearing for 90 days from the date this notice says your benefits will change. But your benefit will not stay the same until your hearing.

You may have someone, such as a lawyer or a friend, help you with your fair hearing. If you want free legal advice, you can call Community Legal Aid Society, Inc., at their toll free number in New Castle County, 1-800-292-7980; in Kent County, 1-800-537-8383; or in Sussex County, 1-800-462-7070. You can also call Legal Services Corporation of Delaware, in Dover, 734-8820; or Wilmington, 575-0408 for free legal advice.

The State Hearing officer will decide at your hearing if our action was right or wrong. If the officer decides that we are right, you may owe us the extra benefits you received before the hearing.

CASE NUMBER \_\_\_\_\_

**I AM REQUESTING A FAIR HEARING FOR THE FOLLOWING REASON (S):**

I do not agree with what DSS told me in this notice. (**You may explain why** you disagree below.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SIGNED \_\_\_\_\_

ADDRESS \_\_\_\_\_

DATE \_\_\_\_\_

PHONE \_\_\_\_\_

I WANT to continue receiving the benefits I now receive, if eligible

I DO NOT want to continue receiving the benefits I now receive.



HOME AND COMMUNITY BASED WAIVER SERVICES  
AUTHORIZATION

DATE: \_\_\_\_\_

TO: Office of Budget, Contracts & Business Services  
Division of Developmental Disabilities Services  
Woodbrook Professional Center  
1056 S. Governor's Avenue, Suite 3  
Dover, Delaware 19904

FROM: \_\_\_\_\_

PHONE: \_\_\_\_\_

\*This needs to accompany a signed Financial Agreement.

<p><b>G. SERVICE PROVIDER:</b> _____</p> <p>—</p> <p>_____</p> <p>—</p> <p>Address: _____</p> <p>_____</p> <p>_____</p> <p>Phone: _____</p> <p>Tax I.D.# or Federal E.I. #: _____</p>	<p><b>CONSUMER'S NAME:</b> _____</p> <p>Address: _____</p> <p>Town &amp; Zip Code: _____</p> <p>Phone: _____</p> <p>DOB: _____</p> <p>Social Security Number: _____</p>
---	---

**WAIVER SERVICE TO BE PROVIDED:**

- Foster Training Home: \_\_\_\_\_ \$ \_\_\_\_\_
- Neighborhood Group Home: \_\_\_\_\_ \$ \_\_\_\_\_
- Apartment: \_\_\_\_\_ \$ \_\_\_\_\_
- Day Program: \_\_\_\_\_ \$ \_\_\_\_\_
- Clinical Support: \_\_\_\_\_ \$ \_\_\_\_\_
- Case Management: \_\_\_\_\_ \$ \_\_\_\_\_
- Acute Care Services: \_\_\_\_\_ \$ \_\_\_\_\_
- Elective Services: \_\_\_\_\_ \$ \_\_\_\_\_
- Private Insurance: Premium of \$ \_\_\_\_\_ (monthly/quarterly)

**FINANCIAL ELIGIBILITY:**

Assessment Completed:  Yes  No    Qualifies for Waiver:  Yes  No    Date Assessed: \_\_\_\_\_

Individual Co-Pay:     Yes, amount \$ \_\_\_\_\_ or \_\_\_\_\_ %     No     Current Medicaid/Waiver/Medicare Consumer  
Please circle one.

**PARC Approved: 02/13/04  
28/Admin**