MEDICAID
HOME AND COMMUNITY BASED WAIVERS
FOR THE AGED AND DISABLED
The Indiana Plan for
Aging in Place

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1. Money Follows the Person

3. Aged and Disabled Waiver

Exhibit A—MFP Referral Packet

Exhibit B—List of Available Services for a MFP Participant

Exhibit C—Recent Notice of Action

Exhibit D—Prior Authorization Application

Exhibit E—Suggestions for Working with the Case Manager

Exhibit F—Form 45528

Exhibit G—Form 43714

Exhibit H—Form 38143—450B

Exhibit I---Area 3 Face-to-Face Meeting Form

Exhibit J—Plan of Care and CCB/CCB Approval Letter

Exhibit K—April 1, 2015, Yonda Snyder Letter

Exhibit L—ALJ Decision

Exhibit M—Hospice and Waiver letter

Exhibit N—Waiver Budgeting Notes
KEITH P. HUFFMAN

Keith P. Huffman received his undergraduate education from Adrian College, his legal education from Indiana University, and was admitted to the Bar in 1980. Mr. Huffman is a member of the National Academy of Elder Law Attorneys and previously served as the President of the Indiana Chapter of the National Academy of Elder Law Attorneys. Mr. Huffman is a member of the Ethics Committee at Bluffton Regional Medical Center, a member of the Northeast Indiana Alzheimer’s Advisory Board, chair of the Aging & In-Home Services Board of Directors, and a member of the Fort Wayne Lutheran Hospital Institutional Review Committee. Mr. Huffman is a frequent speaker on elder law topics and can be reached at huffman@dhblaw.com. The firm’s web address is www.dhblaw.com.
MONEY FOLLOWS THE PERSON DEMONSTRATION PROGRAM

This is a federal program created as part of the Deficit Reduction Act. The Affordable Care Act provides $2.25 billion of increased funding for this program. Indiana’s program is designed to move participants out of the hospital or nursing home into a “qualified residential setting.” This term includes:

1. A home owned or leased by the person or family member.
2. A leased apartment that has living, sleeping, bathing, and cooking areas.
3. Adult Foster Care (now Adult Family Care) which has four or fewer unrelated individuals living together.
4. Assisted Living.

Eligibility

- You must have a hospital/nursing home stay of at least 90 consecutive days.
- You must need long term nursing home level of care (PAS).
- You must be eligible for Medicaid at least one day prior to discharge.
- You must have health needs and a support structure to allow you to live safely in the community in a qualified residential setting.
- You must be eligible to participate in the A&D Waiver or the TBI Waiver.
- You must sign a consent form to participate.

The Indiana grant program is administered by the Indiana Division of Aging. The Division has contracted with CareStar of Indiana, LLC to provide services to eligible Hoosiers.
Application

The application process is very simple. You can complete the “Transition Candidate Inquiry Form” and fax it to CareStar at (866) 655-0781. You can also complete the form online and electronically submit it. The MFP referral packet with the application form is attached as Exhibit A.

The Transition Team has a nurse verify the applicant can safely leave the institutional setting for a qualified residential setting. The transition specialist and the transition nurse perform all of the pre-discharge activities.

The MFP Transition Team actually performs the function as case manager for the first six weeks after re-entry into the qualified residential setting. The Transition Team Specialist assigned to the individual will meet with the individual within 24 hours and then weekly for six weeks. A case manager from CareStar is responsible for coordinating services to meet the needs of the participant for the remainder of the MFP period. At a minimum, the case manager will check in quarterly during the first year. The MFP participant moves to the A&D waiver, or TBI waiver, as long as they continue to meet level of care, at the end of the year without being placed on a wait list.

The requirements for eligibility as a Medicaid recipient are verified by the Indiana AIM.

Enhanced Transportation Benefit

When an individual is found to be eligible for MFP, the Transition Team Specialist creates a service plan and a Cost Comparison Budget (CCB). The individual or an authorized representative will then have input into the planned services for that person, based on his or her needs. The Specialist also completes the pre-transition
checklist and discharge checklist. The Specialist works with family members about their role in the transition process.

The participant has access to transportation to be able to go to medical appointments, grocery store shopping, and for visiting friends. Enhanced transportation provides an additional $100 to the allotted amount for the participant to use for these activities.

Personal Emergency Response System (PERS)

This can be a medical device connected to a person’s phone and programmed to notify a response center once the help button is pushed. The response center is staffed around the clock. There are other devices used to notify the response center depending on the needs of the particular person. MFP participants will receive access to 24 hour emergency response services for increased health and safety.

Funding

The Indiana grant has been funded through 2020. There are approximately 380 Hoosiers enrolled in this program and receiving services at the end of August 2015. This means 380 Hoosiers who ordinarily would be in a nursing home are able to stay in the community. You can get more information about MFP from the Indiana Division of Aging at 1-888-673-0002. The contact person is Debbie Pierson.

Services

The available services for the MFP participant are the same services as the Aged and Disabled and Traumatic Brain Injury waivers. We have attached a list of these services. Please note this includes self-directed attendant care for the appropriate
situation. These services may also incorporate additional services/equipment under the Medicaid prior authorization program (Exhibit B).

The Environmental Modification Assessment and the Structured Family Caregiving Services were added in 2013.

Transition

Services are provided for up to 365 days. The participant is then enrolled in an Indiana Home and Community Based Services waiver program.

AGED AND DISABLED WAIVER

Recipients of the Aged and Disabled Waiver live in a community setting. They are initially approved for level of care services through a notice of action from the Division of Aging. The notice of action contains a list of approved service hours which are generally for non-medical services, such as housekeeping, public feeding assistance, respite care, etc. A recent notice of action form received by one of our clients is in Exhibit C.

The waiver recipient often needs additional services. The care provider can submit a request for prior authorization to obtain additional medical care. The prior authorization request procedure is spelled out in Chapter 6 of the Indiana Health Coverage Programs Provider Manual.

TIP: You should read Chapter 6 and be aware of the Prior Authorization rules. These services include, but are not limited to:
(1) Durable medical equipment and home medical equipment
   • Hospital bed
   • Non-motorized wheelchair
   • Home oxygen therapy
(2) Out-of-State health care
(3) Request for additional transportation services
(4) Home health nursing services
(5) Food supplements

We have enclosed the Prior Authorization Application Form for you to review (Exhibit D).

The relationship your client has with the case manager and care provider can be crucial in obtaining proper services. We have enclosed a sheet with suggestions on how to work with and apply for waiver services with your case manager (Exhibit E).

The call comes in to the Area Agency on Aging. The family is desperately in need of a Medicaid Waiver for an aged (60 or over) or disabled family member. The call is routed to the Aged and Disabled Resource Center (ADRC) options counselor.

The options counselor does a telephone triage to see if the family member appears to meet the necessary level of care for waiver services. The counselor uses the eligibility screen (Exhibit F Form 45528) to make an immediate determination of eligibility for services. A favorable immediate determination results in a face to face meeting to determine eligibility.

TIP: Give your client a copy of Exhibit F before they call their Area Agency on Aging. The family can then review pages 2 and 3 to see what essential daily functions the family member in need of services cannot do without substantial assistance (includes prompting and cuing).
The counselor then starts the assessment process in the Indiana Insite System. Frequently the Medicaid category needs to be changed if the client is already receiving some services under the enhanced Medicare Savings Program. The change is to MA A (Aged) or MA D (disabled) from:

- MA L (Qualified Medicare Beneficiary up to 150% FPL);
- MA J (Special Low Income Medicare Beneficiary benefit 151%-170% FPL); or
- MA I (Qualified Medicare Beneficiary 171%-185% FPL).

The counselor then mails the family information about eligibility for waiver services. For those who do not immediately appear to meet the necessary level of care, they receive a denial notice with their appeal rights (Exhibit G Form 43714). The folks that appear to meet the appropriate level of care receive the cover letter and a form showing they meet level of care for the waiver. The physician must state in writing, using Exhibit H Form 38143, it is safe and feasible for the patient to receive community supported in-home care.

The patient has met the initial level of care via the telephone assessment, the forms have been mailed to the patient for the Doctor to complete, and the patient is now considered “targeted” in the Indiana Insite System.

The Pre-Admission Screening process (“PAS”) is theoretically the same for waiver services and nursing home admission. The PAS System is seriously in need of updating in Indiana. The PAS manual was last updated in 2000 and is rarely used in the field. We expect the Indiana Agency of Aging will move to a more automated PAS system within the next year.

The Area Agency on Aging now assigns a case manager to the patient. Area 3 makes these assignments on the 10th and 30th of each month. The case manager then has
30 days to complete the paperwork and send the completed paperwork to the supervisor for review before it goes to the State for final approval. The case manager schedules the face-to-face meeting. These meetings usually take 1½ to 2 hours. The case manager documents level of care in the face-to-face meeting. The patient is given a list of the waiver services provided in the Area called a provider pick list (Document to be completed in the face-to-face meeting and waiver providers in Area 3 are included in Exhibit I).

If the face to face meeting goes well, the patient meets level of care. The case manager (there are 22 in Area 3) then completes the Pan of Care and the Cost Comparison Budget (Exhibit J).

The State then approves the Cost Comparison Budget. You are now able to file an application for Medicaid for your client. You will want to do this as soon as possible, as your client will not start receiving services until the RID (Recipient ID) number is obtained.

TIP: Case managers check the Insite System every month to see if their clients have Medicaid eligibility. You should immediately notify the case manager at the Area Agency on Aging when Medicaid is obtained so services will start as soon as possible.

TIP: When you represent single folks, consider an early application for the enhanced Medicare Savings Program so they will already be eligible for services when the CCB is approved by the State.

TIP: Do not let the case manager tell you the client must be approved for Medicaid before applying for waiver services.
The State then issues the Notice of Action form showing the number of hours of approved services for the at-home waiver recipient. These can be for respite care for the caregiver or for other services shown below. The average approved hours are 40-60 hours per month for at-home waiver recipients.

The service provider can then request additional Medicaid hours of care under the prior approval system. Case managers are not directly involved in approving prior approval of services.

**WHAT TO TELL YOUR CASE MANAGER WHEN YOU ARE TOLD YOU MUST FILE FOR MEDICAID BEFORE APPLYING FOR WAIVER SERVICES IN INDIANA**

Indiana adopted strict income and asset rules for aged and disabled Hoosiers on June 1, 2014. The levels for 2015 are:

<table>
<thead>
<tr>
<th></th>
<th>Income</th>
<th>Countable Resources</th>
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<tbody>
<tr>
<td>Single</td>
<td>$973</td>
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</tr>
<tr>
<td>Married</td>
<td>$1,310</td>
<td>$3,000</td>
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</table>

There is no reason to apply for Medicaid if your income/assets are above these levels. You will not be approved.

The income and asset rules change dramatically once a person enters a nursing home or has a Cost Comparison Budget approved for the Aged and Disabled Waiver.

The asset test remains at $2,000 of countable resources for single folks. The spousal impoverishment rules apply for married couples.

**How does this work? This is an example of how a married couple obtained waiver services.**

June 12, 2015

Medicaid eligibility approval obtained for client retroactive to May 1, 2015.
June 15, 2015

We spoke with client’s case manager. She mentioned Divine Home Health Care (“Divine”) will go in and do an assessment of client. If additional hours are needed, Divine submits to Medicaid what is called a prior approval/authorization requesting additional hours. Then, Medicaid will issue a notice stating how many additional hours will be allowed. The case manager said that someone from Divine will call client to set up the assessment time.

June 19, 2015

The case manager contacted the client’s spouse yesterday telling her “Divine” would be contacting them to make an appointment for an assessment of client to determine the number of hours he needs.

Divine called client’s spouse and said they cannot come in and do an assessment until Universal Nursing Service has completed the commitment and signed off. I am not sure, but I believe Home Is Where the Heart Is will reimburse us for the amount of hours client paid for May and June after the number of hours has been determined by Divine.

June 21, 2015

Divine met with client for an assessment of client’s needs. Divine will apply for all the present hours (54 hours) to be reimbursed by Medicaid. They also applied for ongoing physical therapy. Divine will also assist with proper caregiver—kind of a coordinator over agencies like Home Is Where the Heart Is. Divine said it would be about 7 to 10 days before they receive word of approval or rejection of the proposed hours.

July 18, 2015

Divine called client’s spouse stating client was approved for 8 hours per day for 6 days a week and 3 hours for Sunday. These hours are combined with the 25 hours a week previously approved by the Medicaid Waiver cost comparison budget.

July 19, 2015

Case manager confirmed the hours client would receive for each week. The hours are not permanent. The case is re-evaluated in 90 days by Aging and In-Home Services and in 23 weeks by Divine.
**Special Rules for the Assisted Living Waiver**

The waiver recipient in assisted living usually pays a monthly room and board expense of $733 (this changes as the SSI maximum award for a household of 1 changes). The amount will be less if the applicant does not have sufficient funds to pay his or her personal needs allowance, supplemental health insurance costs, and spousal allocation, if any. Please see the letter from Yonda Snyder, Director of the Division of Aging, dated April 1, 2015, with examples of this (Exhibit K).

The participating facility must have basic rooms available at the minimum rate. The waiver recipient is permitted to occupy a larger room or a single room and pay the additional charge for this room.

The facility is paid one of three different rates by the State, depending on level of care. The 2015 daily rates are:

<table>
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<tr>
<th>Level</th>
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<tr>
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<tr>
<td>Level 3</td>
<td>$80.93</td>
</tr>
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**Snapshot Date**

Clients sometimes have prior snapshot dates from a previous fall, illness, or surgery. The resource assessment (RA) can be determined much easier in these situations. However, in many situations, clients will not have a prior snapshot date. The resource assessment becomes tricky at this point. IHCPPM Manual Section 3320.05.00 states:

When a married person first enters a nursing home or hospital (or a combination thereof) for more than 30 consecutive days after September 30, 1989, a snapshot
(resource assessment) is taken of their assets to determine Medicaid eligibility. When the Medicaid applicant for waiver services has a prior snapshot date, you then know what resource level the married couple has to be below so the applicant can be approved.

The snapshot date for waiver applicants without a prior institutional stay is either the date of application for Medicaid or the date the Cost Comparison Budget (CCB) is approved, whichever is later (Section 3320.05.00 IHCPPM).

Example: CCB completed August 1, 2015. Medicaid application filed August 5, 2015. August 5\textsuperscript{th} is now the snapshot date, so a financial plan can now be implemented to establish eligibility as of September 1\textsuperscript{st}.

TIP: Know the waiver supervisor at your local Area Agency on Aging. Periodically let the supervisor know the clients you are applying for waivers via email. This allows the waiver supervisor to email the CCB approval to you. This helps your client get the needed services sooner.

**Special Income Level**

As of June 1, 2014, you need to consider the Special Income Level (SIL) for the waiver applicant (Section 3315.00.00 IHCPPM). When the applicant’s income exceeds $2,199 (2015 level) per month, you will want to set up and appropriately fund a Qualified Income Trust in the month before the CCB is completed so the spousal impoverishment rules apply for a married couple.

We have enclosed an interesting ALJ decision (Exhibit L). Applicant and applicant’s spouse shared a room in an assisted living facility. The facility participated in the assisted living waiver program. We applied for the waiver for one spouse and asked
for all income to be allocated to the other “Community Spouse” to allow both to stay in the same room. The request was approved!

Hospice and Waiver Services

Hospice is a Medicare benefit. An eligible Medicare beneficiary who elects the hospice benefit may also utilize the waiver program for additional services. The hospice provider must work with the waiver case manager so there is no duplication of services provided.

VA and Waiver Services

The Veterans Administration provides home health care to disabled veterans and their disabled spouse in some situations. The person may also be eligible for waiver services under Medicaid. The Medicaid case manager must work with the VA case manager to insure there is not duplication of services.
MFP Referral Packet

This set of forms must be completed to refer an individual residing in a Qualified Institution to the Indiana Money Follows the Person Program

REFERRAL INSTRUCTIONS

Thank you for your interest in the Indiana Money Follows the Person (MFP) program and possible supports. This packet collects the forms and information that the Indiana MFP program requires to begin the process to determine eligibility of a person for the program. A referral cannot be processed without this completed packet.

This packet includes the following forms:

I. Release of Information Form
   This form authorizes the disclosure of protected health information and must be signed by the applicant or their legal representative. Proof of representation may be requested.

II. Triage Form
   This form gathers minimal protected health information to allow an initial evaluation of qualifications for the Indiana MFP program. This form cannot be processed without the Release of Information form.

Please Note:

- Once submitted, this Referral will be reviewed for pre-eligibility for the Indiana MFP program
- The Indiana MFP program will be in contact with only the applicant or the Legal Representative of the applicant regarding any decisions or determinations unless otherwise authorized or directed
- Pre-eligibility is not a guarantee of Indiana MFP program eligibility, enrollment, or the provision of services

If you have questions or concerns, please contact the Indiana Money Follows the Person program

<table>
<thead>
<tr>
<th>MFP Administrative office</th>
<th>MFP Transition office</th>
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<tbody>
<tr>
<td>Indiana Division of Aging</td>
<td>CareStar of Indiana</td>
</tr>
<tr>
<td>PHONE: 1-888-673-0002</td>
<td>PHONE: 1-855-498-8170</td>
</tr>
<tr>
<td>EMAIL: <a href="mailto:da.mfp@fssa.in.gov">da.mfp@fssa.in.gov</a></td>
<td>EMAIL: <a href="mailto:mfp@carestar.com">mfp@carestar.com</a></td>
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</table>
Transition Candidate Inquiry Form

This form must be completed to refer an individual residing in a qualified institution to the Indiana Money Follows the Person program. This form obtains identification and health information for the purpose of determining preliminary eligibility for the Indiana MFP program.

**FOR PURPOSES OF THIS FORM, THE TERM “APPLICANT” REFERS TO THE RESIDENT OF THE FACILITY WHO IS INTERESTED IN TRANSITIONING HOME FROM THE FACILITY WITH THE MONEY FOLLOWS THE PERSON (MFP) PROGRAM**

<table>
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<th>Detail</th>
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<td>Facility of Residence</td>
<td>Social Security #</td>
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<tr>
<td>Address of Facility</td>
<td>Personal Phone #</td>
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<tr>
<td>Phone #</td>
<td>The Applicant Has Medicare? Yes</td>
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<td>Date Admitted to Facility</td>
<td>The Applicant Has Indiana Medicaid? Yes</td>
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<tr>
<td></td>
<td>The Applicant Has A Diagnosis or History Of An Intellectual / Developmental Disability (ID/DD)? Yes</td>
</tr>
</tbody>
</table>

**DOES THE APPLICANT HAVE A LEGAL GUARDIAN?** □ Yes  

**GUARDIAN NAME**

**GUARDIAN PHONE #**

**IS A FAMILY MEMBER OR OTHER NON-GUARDIAN REQUESTED TO BE INVOLVED IN THE MFP PROCESS?** □ Yes

**NAME OF OTHER INTERESTED PARTY**

**RELATIONSHIP TO APPLICANT**

**CONTACT INFORMATION**

**NOTES**

**Important**

- Acceptance of this form by the Money Follows the Person program in no way signifies the Applicant’s acceptance into or eligibility for the Money Follows the Person Program

- Within ten days of receipt of this form by the Money Follows the Person program, a Money Follows the Person staff person will contact the Applicant or the Applicant’s guardian and confirm that a referral is being requested.

**PERSON SUBMITTING THIS FORM**

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<tbody>
<tr>
<td>Name</td>
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<td>Date</td>
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<tr>
<td>Notes</td>
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<td>Phone</td>
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</table>
This authorization is required by the Health Insurance Portability and Accountability Act of 1996 and the referral process of the Indiana Money Follows the Person (MFP) program.

The Indiana MFP program has assigned CareStar of Indiana, LLC, the contracted responsibility to determine eligibility for the Indiana MFP program and to identify public and private services available to support the needs of individuals who are enrolled in the Indiana MFP program.

When you sign this form, you are giving the MFP program and CareStar of Indiana, LLC, your permission to request and receive information about

Name of Person Whose Records are Being Discussed in this Release:

including protected health information, and to disclose information, including protected health information, as needed, to public and private service agencies should the person become a participant of the Indiana MFP program.

Signing this form does not guarantee eligibility for or enrollment in the Indiana MFP program and a photocopy of this authorization shall be considered as effective and valid as the original. If you have any questions regarding the use or disclosure of the information, or if you wish to view the information being disclosed, you may contact the address at the bottom of this form.

The Indiana MFP program and CareStar of Indiana, LLC will protect any personal health information in accordance with federal and state privacy regulations. Any health information released to other parties may no longer be protected by privacy regulations.

This authorization will expire one-hundred and eighty (180) days after your signature date. You can withdraw the permission you have given Indiana MFP program and CareStar of Indiana, LLC at any time. You can withdraw your permission by writing a letter to the address at the bottom of this form.

I authorize any health plan, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to the above noted person to release to the Indiana MFP Program, as represented by CareStar of Indiana, LLC:

☐ The complete file(s) of the above noted person
☐ Only the following information about the above noted person: ________________________________

This release also includes the following specific records:

☐ Mental health or behavioral-health information
☐ Alcohol or other drug abuse health information
☐ HIV test results or records
☐ Records of sexual abuse, child abuse, elder abuse

☐ Records regarding any Intellectual/Developmental Disability (ID/DD) diagnosis, possible diagnosis, or history
☐ Records or information regarding services or supports provided pursuant to any Intellectual/Developmental Disability (ID/DD) diagnosis

Date Signed __________________________

Relationship to the person whose records are being released:

Signature _____________________________

Printed Name __________________________

Telephone _____________________________

PROOF OF LEGAL AUTHORITY MAY BE REQUESTED

Money Follows the Person - CareStar of Indiana
4755 Kingsway Drive, Suite 314
Indianapolis, IN 46205
1-855-498-8170

MFP :: Referral Packet

VERSION ADTBICGH 201409
MFP TRIAGE TOOL

THIS FORM OBTAINS IDENTIFICATION AND HEALTH INFORMATION FOR THE PURPOSE OF DETERMINING PRELIMINARY ELIGIBILITY FOR THE INDIANA MFP PROGRAM. IF A RELEASE OF INFORMATION FORM IS NOT COMPLETED, THIS FORM CANNOT BE PROCESSED.

Date of Referral

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<td>Home County</td>
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<tr>
<td>Date of Birth</td>
<td>Does the Applicant have a diagnosis of dementia?</td>
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<tr>
<td></td>
<td>Does the Applicant have a diagnosis of a Traumatic Brain Injury (TBI)?</td>
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<tr>
<td></td>
<td>Does the Applicant have a diagnosis of Intellectual Disability/Developmental Disability (ID/DD)?</td>
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<th>Legal Representative Information</th>
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<td>Facility Type</td>
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<td>Nursing Facility</td>
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</tr>
<tr>
<td>ICF/IID Residence</td>
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This form requests protected health information.

FOR PRIVACY REASONS:

Without a valid release of information form on record, this referral cannot be reviewed by the Money Follows the Person Program.

Without a valid release of information form on record, this referral and any accompanying information will be destroyed.

For Carestar use only:

- DD/DD Diagnosis
- Qualified days (45 or more)
- MFP-CIH
- BDDS Submitted Referral
- Referral sent to BDDS
- MFP-AD
- MFP-TBI
- Long term stay approval
- Qualified days (45 or more)
- Qualified AD, TBI Institution
- Traumatic Brain Injury — TBI
Aged and Disabled Waiver (A&D)

The A&D Waiver provides an alternative to nursing facility admission for adults and persons of all ages with a disability. The waiver is designed to provide services to supplement informal supports for people who would require care in a nursing facility if waiver or other supports were not available. Waiver services can be used to help people remain in their own homes, as well as assist people living in nursing facilities to return to community settings such as their own homes, apartments, assisted living or Adult Family Care.

Services

Adult Day Services (ADS), Adult Family Care (AFC), Assisted Living (AL), Attendant Care, Case Management, Community Transition Services, Environmental Modifications, Environmental Modification Assessment, Health Care Coordination, Homemaker, Home Delivered Meals, Nutritional Supplements, Personal Emergency Response Systems (PERS), Pest Control, Respite, Specialized Medical Equipment & Supplies, Structured Family Caregiving, Transportation, Vehicle Modifications

Adult Day Services (ADS) - Adult Day Services are community-based group programs designed to meet the needs of adults with impairments through individual plans of care. These structured, comprehensive, non-residential programs provide health, social, recreational, and therapeutic activities, as well as supervision, support services, and personal care. These services must be provided in a congregate, protective setting and meals and/or nutritious snacks are required.

Adult Family Care (AFC) Adult Family Care is a comprehensive service in which the participant of services resides with an unrelated caregiver in order for the participant to receive personal assistance designed to provide options for alternative long term care to individuals who meet nursing facility level of care and whose needs can be met in a home-like environment. The participant and up to three(3) other participants who are elderly or have physical and/or cognitive disabilities who are not members of the provider's or primary caregiver's family, reside in a home that is owned, rented, or managed by the Adult Family Care provider. Participants selecting the AFC service may also receive Case Management Services, Adult Day Services, Specialized Medical Equipment and Supplies and Health Care Coordination through the waiver. TBI participants may also receive: Behavior Management, Structured Day Program, Individual and Group and Supported Employment.

Assisted Living (AL) – Assisted Living Service is defined as personal care, homemaker, chore, attendant care and companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a residential facility which is licensed by the Indiana State Department of Health, in conjunction with residing in the facility. This service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence,
and to provide supervision, safety and security. Participants may also receive Case Management Services, Specialized Medical Equipment and Supplies and Health Care Coordination through the waiver.

**Attendant Care (ATTC)** - Attendant Care services primarily involve hands-on assistance for aging adults and persons with disabilities. These services are provided in order to allow older adults or persons with disabilities to remain in their own homes and to carry out functions of daily living, self-care, and mobility.

**Case Management** - Case Management is a comprehensive service comprised of a variety of specific tasks and activities designed to coordinate and integrate all other services required in the individual’s care plan. Case Management is required in conjunction with the provision of any home and community-based service.

**Community Transition Services** - Community Transition Services include reasonable, set-up expenses for individuals who make the transition from an institution to their own home where the person is directly responsible for his or her own living expenses in the community and will not be reimbursable on any subsequent move. Reimbursement is limited to a lifetime cap for set up expenses up to $1,500.

**Environmental Modifications** - Environmental Modifications are minor physical adaptations to the home, as required by the individual’s Plan of Care/Cost Comparison Budget. The modifications must be necessary to ensure the health, welfare and safety of the individual and enable the individual to function with greater independence in the home, and without which the individual would require institutionalization. Maintenance is limited to $500 annually for the repair and service of environmental modifications that have been provided through the waiver. There is also a lifetime cap of $15,000.

**Environmental Modification Assessment** is a service which determines the scope and specifications for environmental modifications necessary to enable an individual to function with greater independence within their home, and without which they would require institutionalization. The Assessor reviews the feasibility and writes the specifications which serve as the criteria for obtaining and evaluating bids. Upon completion of the work the Assessor conducts a post-project inspection to assure project completion.

**Health Care Coordination** - Health Care Coordination includes medical coordination provided by a Registered Nurse to manage the health care of the individual including physician consults, medication ordering, and development and nursing oversight of a healthcare support plan. Skilled nursing services are provided within the scope of the Indiana State Nurse Practice Act. The purpose of Health Care Coordination is stabilization; prevention of deteriorating health; management of chronic conditions; and/or improved health status.

**Homemaker** - Homemaker services offer direct and practical assistance consisting of household tasks and related activities. The services assist the individual to remain in a clean, safe, healthy home environment and are provided when the individual is unable to meet these needs or when an informal caregiver is unable to meet these needs for the individual.
Home Delivered Meals – Home Delivered Meals are nutritionally balanced meals that help prevent institutionalization because the absence of nutrition in individuals with frail and disabling conditions presents a severe risk to health. No more than two meals per day will be reimbursed under the waiver.

Nutritional Supplements – Nutritional Supplements include liquid supplements, such as “Boost” or “Ensure” to maintain an individual’s health in order to remain in the community. Supplements should be ordered by a physician based on specific life stage, gender, and/or lifestyle. There is an annual cap of $1,200.

Personal Emergency Response Systems (PERS) - Personal Emergency Response Systems (PERS) are electronic devices which enable certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable help button to allow for mobility. The system is connected to the person’s phone and programmed to signal a response center once a “help” button is activated. The response center is staffed 24 hours daily/ 7 days per week by trained professionals.

Pest Control - Pest Control services are designed to prevent, suppress, or eradicate anything that competes with humans for food and water, injures humans, spreads disease and/or annoys humans and is causing or is expected to cause more harm than is reasonable to accept. Pests include insects such as roaches, mosquitoes, and fleas; insect-like organisms, such as mites and ticks; and vertebrates, such as rats and mice. There is an annual cap of $600.

Respite - Respite services are those services that are provided temporarily or periodically in the absence of the usual caregiver. Service may be provided in an individual’s home; the private home of the caregiver, or in a Medicaid certified nursing facility. For those individuals receiving the service of Adult Family Care, funding for respite is already included in the per diem amount and the actual service of respite may not be billed. The level of professional care provided under respite services depends on the needs of the individual. An individual requiring assistance with bathing, meal preparation and planning, specialized feeding, such as an individual who has difficulty swallowing, refuses to eat, or does not eat enough; dressing or undressing; hair and oral care; and weight bearing transfer assistance should be considered for respite home health aide under the supervision of a registered nurse. An individual requiring infusion therapy; venipuncture; injection; wound care for surgical, decubitus, incision, ostomy care; and tube feedings should be considered for respite nursing services (RNUR).

Specialized Medical Equipment & Supplies - Specialized Medical Equipment and Supplies are medically prescribed items required by the individual’s Plan of Care/Cost Comparison Budget, which are necessary to assure the health, welfare and safety of the individual, which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization. Individuals requesting authorization for this service through the waiver must first exhaust eligibility of the equipment or supplies through the Indiana Medicaid State Plan. There should be no duplication of services. Maintenance is limited to $500 annually for the repair and service of items that have been provided though the waiver.
Structured Family Caregiving is a service through which a participant receives care in their own home or the home of a principal caregiver. The principal caregiver cannot be the participant’s spouse, the parent of a participant who is a minor, or the legal guardian of the participant. Only agencies may offer Structured Family Caregiving. All Structured Family Caregiving settings must be approved and supervised by the provider agency and all paid caregivers are trained and paid by the provider.

Transportation—Transportation Services enable individuals served under the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. Transportation services under the waiver shall be offered in accordance with an individual’s plan of care and whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, if applicable, and shall not replace them.

Vehicle Modifications - Vehicle Modifications are the addition of adaptive equipment or structural changes to a motor vehicle that permit an individual with a disability to be safely transported in a motor vehicle. Vehicle modifications, as specified in the Plan of Care/Cost Comparison Budget, may be authorized when necessary to increase an individual’s ability to function in a home and community based setting to ensure accessibility of the individual with mobility impairments. These services must be necessary to prevent or delay institutionalization. The necessity of such items must be documented in the plan of care by a physician’s order. Vehicles necessary for an individual to attend post secondary education or job related services should be referred to Vocational Rehabilitation Services. Maintenance is limited to $500 annually for repair and services of items that have been funded though the waiver and there is a $15,000 lifetime cap

** Indicates Aged and Disabled services only
NOTICE OF ACTION
State Form 46015 (RS / 4-02) / HCBS 5

Funding Program: Aged & Disabled Waiver
Mailing date of notice 09/16/2015

Applicant Identification
Name: [Redacted]
Address: 4411 Park Place Dr.
Fort Wayne, IN 46845-
Medicaid #: [Redacted]
County : 02 Allen

Cost Comparison Budget (CCB) Identification
CCB Serial Number: 201507150103AA03
CCB Start Date: 09/01/2015
CCB Type: New Application
CCB End Date: 06/30/2016

Decision Information
As of the indicated Decision Date, your request to BEGIN services (listed below) has been Approved.
Level of Care: Nursing Facility / Intermediate Care

Reason for Decision
Approval of Initial Cost Comparison Budget
Meets eligibility criteria to receive Medicaid services authorized by 42 CFR 441.300 Subpart G and the approved Aged and Disabled Waiver request.

The Indiana Family and Social Services Administration has taken the actions indicated on this form, in regards to your application for services, or change to current services, under the Funding Program indicated above.

This document contains Protected Health Information which is governed by the Health Insurance Portability and Accountability Act (HIPAA) and may only be disseminated to authorized individuals!

SERVICES APPROVED

AREA 3: AGING AND IN-HOME SERVICES OF NORTHEAST INDIANA, INC, 2927 Lake Avenue; Fort Wayne (CMFR) - CASE MANAGEMENT
Units NOT used in one month can NOT be used in another month.

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### PARK PLACE SENIOR LIVING LLC, 4411 PARK PLACE DRIVE; FORT WAYNE (AL2) - Assisted Living - Level 2

Units NOT used in one month can NOT be used in another month.

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**Signature of FSSA Representative:**

![Signature of FSSA Representative]

<table>
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<tr>
<th>Case Mgr 9 digit authorization #</th>
<th>Case Mgr 6 digit I.D. #</th>
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<tr>
<td>201245660</td>
<td>03926</td>
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Date: 09/16/2015

Casemgr => TINKEL, KARIN (260) 745-1200 waiver@agingihs.org

Area 03 2927 Lake Avenue Fort Wayne, IN 46805

This Notice of Action was automatically generated by the Cost Comparison Budget approval process.
Your Appeal Right as an Applicant for HCBS Benefits

Funding Program: Aged & Disabled Waiver

Mailing date of notice 09/16/2015

<table>
<thead>
<tr>
<th>Applicant Identification</th>
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</thead>
<tbody>
<tr>
<td>Name: [Redacted]</td>
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<tr>
<td>Address: 4417 Park Place Dr.</td>
</tr>
<tr>
<td>County: 02 Allen</td>
</tr>
<tr>
<td>Case Manager: TINKEL, KARIN</td>
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| Medicaid # [Redacted] |

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<th>Cost Comparison Budget (CCB) Identification</th>
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<table>
<thead>
<tr>
<th>Decision Information</th>
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</thead>
<tbody>
<tr>
<td>As of the indicated Decision Date, your request to BEGIN services has been Approved.</td>
</tr>
<tr>
<td>Decision Date</td>
</tr>
<tr>
<td>Level of Care</td>
</tr>
<tr>
<td>Reason for Decision</td>
</tr>
<tr>
<td>Approval of Initial Cost Comparison Budget</td>
</tr>
<tr>
<td>Meets eligibility criteria to receive Medicaid services authorized by 42 CFR 441.300 Subpart G and the approved Aged and Disabled Waiver request.</td>
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<tr>
<td>Signature of FSSA Representative: Donna Stewart</td>
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</tbody>
</table>

IF YOU WISH TO APPEAL THIS DECISION, PLEASE READ THE INFORMATION ABOVE, SIGN AND DATE BELOW, AND RETURN THE HEARINGS & APPEAL COPY OF THIS FORM TO THE ADDRESS GIVEN IN THE INSTRUCTIONS.

I wish to appeal the above decision, for the following reasons: ___________________________________________________________

__________________________________________________________

Signature of Applican/Guardian: ________________________________

Date Signed: ________________________________

FSSA - HEARINGS AND APPEALS COPY
Your Appeal Right as an Applicant for HCBS Benefits

If you question the indicated decision, you should discuss this matter with your Case Manager.

Your Right to Appeal and Have a Fair Hearing:

The Notice of Action provides an explanation of the decision made on your application for services or changes in your services. If you disagree with the decision, you have the right to appeal by submitting a request for a Fair Hearing. Your Home and Community Based Services (HCBS) benefits will continue if your appeal is received within the required time frame described below under “How to Request an Appeal”. If you appeal and your benefits are continued and you lose the appeal, you may be required to repay assistance paid on your behalf pending the release of the appeal hearing decision.

How to Request an Appeal:

1) If you wish to appeal this decision, the appeal request must be received by close of business not later than:
   (1) 33 calendar days following the effective date of the action being appealed; or
   (2) 33 calendar days from the date of the notice of agency action, whichever is later.

To file an appeal, please sign, date and return the Hearings & Appeals copy of this form to:

   Indiana Family and Social Services Administration
   Office of Hearings and Appeals
   MS 04
   402 W. Washington St., Room W392
   Indianapolis, IN 46204

   or via facimile to 317-232-4412

If you are unable to sign, date, and return this form to the above mentioned address, you may have someone assist you in requesting the appeal.

2) You will be notified in writing by the Indiana Family and Social Services Administration, Hearings and Appeals office of the date, time, and location for the hearing. Prior to, or at the hearing, you have the right to examine the entire contents of your case record maintained by the Case Manager.

3) You may represent yourself at the hearing or you may authorize a person to represent you, such as an attorney, relative, or other spokesperson. At the hearing you will have full opportunity to bring witnesses, establish all pertinent facts and circumstances, advance any arguments without interference and question, or refute any testimony or evidence presented.
### Indiana Health Coverage Programs

#### Prior Authorization Request Form

<table>
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<tr>
<th>Plan Name</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional</td>
<td>P: 800-269-5720 F: 800-689-2759</td>
</tr>
<tr>
<td>Hoosier Healthwise</td>
<td>P: 866-408-7187 F: 866-406-2803</td>
</tr>
<tr>
<td>MHS Hoosier Healthwise</td>
<td>P: 877-647-4848 F: 866-912-4245</td>
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<tr>
<td>Healthy Indiana Plan</td>
<td>P: 866-398-1922 F: 866-406-2803</td>
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<td>P: 844-293-6309 F: 844-407-6454</td>
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<tr>
<td>ADVANTAGE and MDwise</td>
<td>P: 800-784-3981 F: 800-689-2759</td>
</tr>
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</table>

- Check the box of the plan in which the member is enrolled.

**EXHIBIT D**

#### Please complete all appropriate fields.

**Patient Information**
- Medicaid ID/RID#:
- DOB:
- Patient Name:
- Address:
- City/State/ZIP Code:
- Patient/Guardian Phone:
- PMP Name:
- PMP NPI:
- PMP Phone:

**Ordering, Prescribing, or Referring (OPR)**

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<th>OPR Physician NPI#</th>
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- Medical Diagnosis
  - Use of ICD Diagnostic Code Is Required

**Requesting Provider Information**
- Requesting Provider NPI#:
- Tax ID#:
- Service Location Code:
- Provider Name:

**Rendering Provider Information**
- Rendering Provider NPI#:
- Tax ID#:
- Name:
- Address:
- City/State/ZIP Code:
- Phone:
- Fax:

**Preparer's Information**
- Name:
- Phone:
- Fax:

**Dates of Service**
- Start:
- Stop:
- Procedure/Service Codes:
- Modifier(s):
- Requested Service:
- Taxonomy:
- POS:
- Units:
- Dollars:

**Notes:**

PLEASE NOTE: Your request MUST include medical documentation to be reviewed for medical necessity.

Signature of Qualified Practitioner ___________________________ Date: __________

IHCP Prior Authorization Request Form
Version 3.2, May 2015
Page 1 of 1
Tips to Promote Working Partnerships Between Families and Medicaid Case Managers

Date: ___________________________
Client: ___________________________
Type of Waiver: ____________________
Current Plan/Renewal Date: ________

Case Manager Information
Name: ___________________________
Phone: ___________________________
Cell Phone: _______________________
Fax: _____________________________
e-mail: __________________________

Family/Guardian Information
Name(s) of Family Members:

Service Provider Information
Agency Name: ___________________
Point of Contact: _________________
Address: _________________________
Phone: __________________________
Cell Phone: _______________________ 
Fax: _____________________________
e-mail/Other: _____________________

Indiana Institute on Disability and Community
Indiana's University Center for Excellence in Developmental Disabilities
Research, Education, and Service
Family Tips Checklist

I will work on my responsibilities by...
- Monitoring my client's well-being.
- Advocating for my client to improve quality of life.
- Keeping my client and their families informed.
- Filling out reports to the best of my ability.
- Filing requests and reports on time.
- Maintaining a professional demeanor.
- Keeping information about my client confidential.
- Networking and developing community resources.
- Let my client and/or families know they can request a new case manager, if they would like.

I can work on communications with my clients and their families by...
- Knowing the person and family members by name. Conveying the belief that the family/guardians are an important part of the team.
- Establishing a method for ongoing communication.
- Listening to my client, families/guardians with respect and an open mind, even if I do not agree.
- Participating in discussions and sharing relevant information, while keeping in mind confidentiality of information.
- Being honest, if I do not know it is okay (I can find out and report back).
- Asking for clarification.
- Responding to requests in a timely manner.
- Being sensitive to the cultural diversity of the individual and family.
- Providing information in a format understandable to my clients, their families and/or guardians.

Communicating with the Case Manager...
- Positive communication with Case Managers is important and I can do this by:
  - Listening to the Case Manager with respect and an open mind, even if I do not agree.
  - Participating and sharing during discussions.
  - Being honest.
  - Asking questions when I do not understand.
  - Reading all correspondence from FSSA, Case Managers and the Service Provider.
  - Establish a method for ongoing communication.
  - Providing positive feedback; and expressing my concerns in a timely manner.

Case Manager Tips Checklist

Things I can do to help the Case Manager...
- Participate in all meetings.
- Share information that is pertinent about myself and/or my family.
- Participate in developing the ISP's and PCD's.
- Monitor my (son's/daughter's) progress and overall well being.

If you are getting ready to interview/hire a Case Manager for yourself or your son/daughter, or if you need to switch Case Managers, here are some questions to consider asking a “potential” Case Manager during the interview process...
- Why did you decide to become a Case Manager?
- How long have you been a Case Manager?
- How many people are on your case load?
- What does a good Case Manager do?
- Do you live in this area? How big is your territory?
- How do you communicate with families and your clients?
- How do you communicate with service providers?
- What connections do you have in our community that might benefit us?

Family Tips Checklist (cont.)

- How often do you contact your clients/families?
- What is the best way to contact you?
- What if you are on vacation and there is an emergency?
- How will you get to know me and my family members?

I can work on communications with my clients and their families by...
- Knowing the person and family members by name. Conveying the belief that the family/guardians are an important part of the team.
- Establishing a method for ongoing communication.
- Listening to the Case Manager with respect and an open mind, even if I do not agree.
- Participating and sharing during discussions.
- Being honest.
- Asking for clarification.
- Responding to requests in a timely manner.
- Being sensitive to the cultural diversity of the individual and family.
- Providing information in a format understandable to my clients, their families and/or guardians.

Resources...
- IPMG Corporate Office/Powerful Parents and Consumers Liaison
  8585 Broadway
  Suite 860
  Merrillville, IN 46410
  Phone: (866) 872-4764
  Fax: (219) 738-9947

- The Arc of Indiana
  107 N. Pennsylvania St., Suite 800
  Indianapolis, IN 46202
  Phone: (317) 977-2375
  Phone (Toll Free): (800) 382-9100
  Fax: (317) 977-2385
  Email: theard@arcind.org
  Web: www.arcind.org

- Governor's Council for People with Disabilities
  150 West Market Street, Suite 629
  Indianapolis, IN 46204
  Phone: (317) 236-7770
  Fax: (317) 238-5712
  Email: GPCCD@gpccd.org
  Web: www.gpccd.org

- Indiana Institute on Disability and Community
  3853 East Ninth Street
  Bloomington, IN 47408
  Phone: (812) 855-6508
  Indiana only: (800) 825-4733
  Fax: (812) 855-9530
  Email: wihua@indiana.edu
  Web: www.indiana.edu

- Indiana Protection and Advocacy Services (IPAS)
  4701 N. Keystone Ave., Suite 222
  Indianapolis, IN 46205
  TTY: (800) 838-1131
  Web: www.in.gov/ipas/index.htm

- The Bureau of Developmental Disabilities Services (BDDS) is a part of the State of Indiana's Division of Disability and Rehabilitative Services within the Family and Social Services Administration. For more information about BDDS and to find a BDDS office near you, please visit www.in.gov/fssal/Files/BODSOfficeLocationsSummary.pdf.
Section 1: Severe Medical Conditions - See Description

The focus of this section is on the need for nursing facility care as determined by unstable complex medical conditions.

1. Direct assistance (see definition #1) from others is needed with any of the following conditions at least five (5) days per week:
   - A. Treatment of extensive (stage 3 or 4) Decubitus Ulcers (see definition #2)
     *Note:* Describe size and stage in the comments section.
   - B. A Comatose condition (see definition #3)
   - C. Management of severe pain (see definition #4) requiring frequent injections

2. Direct assistance (see definition #1) from others is required with any of the following prescribed medical equipment/interventions at least three (3) days per week:
   - A. Ventilator / Respirator (see definition #5)
   - B. Suctioning (see definition #6)
   - C. Tube feeding/Gastrostomy care (see definition #7 & #8)
   - D. Central venous access or I.V. (see definition #9)

3. Direct assistance (see definition #1) from others is required for special routines or prescribed treatments that must be followed at least five (5) days per week:
   - A. Tracheostomy (see definition #10)
   - B. Acute rehabilitation condition (see definition #11) requiring Physical Therapy, Occupational Therapy, and/or Speech Therapy. General strengthening exercise programs are excluded.
   - C. Administration of continuous oxygen (see definition #12) for a new or recent condition when the individual's overall condition requires the significant involvement of skilled nursing personnel.

4. Direct assistance (see definition #1) from others is required to administer physician prescribed medicine (excluding vitamins) by intramuscular, intravenous, or subcutaneous injection (see definitions #9A, #14 & #15) more than one (1) time per day, other than insulin injections for an individual whose diabetes is under control.

5. Medical observation and physician assessment due to a changing, unstable physical condition is required more often than every thirty (30) days.
   *Note:* Assessor must document the specifics.

6. Direct assistance (see definition #1) from others is required for the safe management of an uncontrolled Grand Mal seizure disorder (see definition #6) (i.e., at least weekly seizure activity)
   - Nothing in Section 1 applies

If one (1) or more conditions exist in Section 1, then the applicant is eligible for Nursing Facility Admission and may be eligible for Medicaid Waiver Services under the Aged and Disabled or TBI Waiver.

To be eligible for CHOICE, there must also be (2) or more conditions existing in Sections 2A or 2C.

If no conditions exist in either of those sections, then applicant may be eligible for CHOICE if justification for at least 2 or more impaired age-appropriate daily activities is described in the Section 2A or 2C comments.
Section 2A: Substantial Medical Conditions Including Activities of Daily Living - See Description

1. □ The person has experienced a significant deterioration in overall condition of health in the last six (6) months.
   
   **Note:** Assessor must document the specifics, including time frames and dates.

2. □ The person requires daily recording of the kind and amounts of fluids and solids intake and output.
   
   **Note:** Assessor must document reason this is required. (example: significant weight loss, unstable blood sugar, fluid restriction).

3. □ The person requires direct assistance (see definition #1) with the administration of oxygen (either continuous or as needed) for a chronic or stable condition.

4. □ The person requires supervision and direct assistance (see definition #1) on a daily basis to ensure that physician prescribed medications (see definition #13) is taken correctly.

5. □ The person requires 24 hours a day supervision and/or direct assistance (see definition #1) to maintain safety due to confusion and/or disorientation that is not related to or a result of mental illness.

6. □ The person requires direct assistance (see definition #1) with turning or repositioning every 2-4 hours to prevent skin breakdown per medical plan of care.

7. □ The person requires passive range of motion exercise (see definition #17) on a daily basis per medical plan of care.

8. □ To maintain a stable medical condition, the person requires monitoring of the health care plan on a 24 hour a day, seven day a week basis by a licensed nurse.

9. □ The person is unable to eat without direct assistance (see definition #1).
   
   **Note:** This does not include meal preparation.

10. □ The person is unable to transfer from a bed or chair without direct assistance (see definition #1).

11. □ The person is unable to change clothes without direct assistance (see definition #1). This does not include needing help with tying their shoes or grooming.
   
   **Note:** If the individual is able to perform this activity with adaptive equipment (i.e., velcro closures or stocking pullers), do not check.

12. □ The person is unable to bathe without direct assistance (see definition #1).
   
   **Note:** This does not include needing help with washing back, feet, or grooming.

13. □ The person is unable to manage bowel and/or bladder function without direct assistance (see definition #1).
   
   **Note:** If able to self catheterize or self apply and change an incontinency product, do not check.

14. □ The person is unable to ambulate or use a wheelchair without direct assistance (see definition #1). This includes the individual who is currently experiencing frequent falls despite the use of an assistive device (care or walker).
   
   **Note:** If able to safely ambulate with an assistive device, or appropriately self propel a wheelchair, do not check.

□ Nothing in Section 2a applies

If three (3) or more conditions exist in Section 2A, then the applicant is eligible for Nursing Facility Admission or Medicaid waiver services under the Aged and Disabled Waiver or the TBI Waiver. If two (2) or more conditions exist in Section 2A, then the applicant is eligible for CHOICE.
This document contains Protected Health Information which is governed by the Health Insurance Portability and Accountability Act (HIPAA) and may only be disseminated to authorized individuals!

Section 2B: Substantial Mental Health Condition

1. ☐ The person requires daily supervision and/or direct assistance (see definition #1) to maintain safety due to confusion, disorientation, and/or behaviour as a result of a mental illness.

2. ☐ The person has experienced a substantial mental health condition within the last six (6) months as evidenced by at least one (1) of the following:
   - Has a diagnosis of a major mental illness limited to schizophrenia, schizoaffective disorders, psychotic disorders not otherwise specified (formerly atypical psychosis), delusional (formerly paranoid) disorder, and mood (formerly affective) disorders of the bipolar and major depressive type; or
   - Required hospitalization for a psychiatric condition; or
   - Required outpatient treatment or partial hospitalization for a mental health condition.

☐ Nothing in Section 2b applies

If two (2) conditions exist in Sections 2A & 2B or 2B & 2C, then the applicant is eligible for CHOICE Program services only.

Section 3A: Informal Supports

1. ☐ The person has no friends or relatives who are able or willing to provide needed assistance, support, and personal or chore services.

2. ☐ Friends or relatives who have been providing needed assistance are no longer able or willing to continue to provide help.

3. ☐ Friends or relatives who have been providing needed assistance are not able or willing to increase the amount of help needed to meet changing conditions.

☐ Nothing in Section 3a applies

Section 3B: Instrumental Activities of Daily Living

Assistance is needed because the person is unable on a consistent basis to do the following tasks independently due to a serious physical, emotional, or mental health problem:

☐ A. Take care of nutrition, including preparing a light meal (e.g., snack or T.V. dinner)

☐ B. Light work around the house, such as washing dishes

☐ C. Shop for Groceries

☐ D. Travel in a van, taxi, bus, or car

☐ E. Take medicines

☐ F. Answer the telephone even with special equipment

☐ G. Call the telephone operator even with special equipment

☐ H. Take care of grooming and personal hygiene

☐ I. Financial management of basic necessities (e.g., food, clothing, shelter)

☐ Nothing in Section 3b applies

Sections 3A & 3B do not determine eligibility for CHOICE, Nursing Facility Admission, or Medicaid Waiver Services. However, if one (1) or more conditions exist in Section 3A and/or Section 3B, then the applicant may qualify for other state and federal programs.
<table>
<thead>
<tr>
<th><strong>Funding Program: Aged &amp; Disabled</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Last Name</strong></td>
</tr>
<tr>
<td>[redacted]</td>
</tr>
<tr>
<td><strong>Medicaid number</strong></td>
</tr>
<tr>
<td>[redacted]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>A. TERMINATION / INTERRUPT / RESTART (complete this section if services are terminated / interrupted / restarted)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Serial #</strong></td>
</tr>
<tr>
<td>[redacted]</td>
</tr>
<tr>
<td><strong>Stop Date</strong></td>
</tr>
<tr>
<td><strong>Date case closed</strong></td>
</tr>
<tr>
<td>[redacted]</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>B. DENIAL – (complete this section if denied services)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date Denied - applicants only</strong></td>
</tr>
<tr>
<td>03/23/2015</td>
</tr>
<tr>
<td><strong>Date of application</strong></td>
</tr>
<tr>
<td>[redacted]</td>
</tr>
<tr>
<td><strong>Diagnosis</strong></td>
</tr>
<tr>
<td>29010 Dementia</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Name of case manager</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>SCHNELLENBERGER, AMANDA</td>
</tr>
<tr>
<td><strong>Case manager 4 digit I.D. number</strong></td>
</tr>
<tr>
<td>03918</td>
</tr>
<tr>
<td><strong>Case manager telephone number</strong></td>
</tr>
<tr>
<td>(260) 745-1200</td>
</tr>
</tbody>
</table>

**CL does not meet nursing facility level of care at this time.**

**This document contains Protected Health Information which is governed by the Health Insurance Portability and Accountability Act (HIPAA) and may only be disseminated to authorized individuals!**
Your Appeal Right as an Applicant for HCBS Benefits

Funding Program: Aged & Disabled

Mailing date of notice 03/23/2015

Applicant Identification

<table>
<thead>
<tr>
<th>Name:</th>
<th>Medicaid #</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>02 Allen</td>
<td>County</td>
</tr>
<tr>
<td>SCHNELLENBERGER, AMANDA</td>
<td>Case Manager</td>
<td>Case Manager</td>
</tr>
</tbody>
</table>

Date Entry Worksheet (DEW) Identification

<table>
<thead>
<tr>
<th>DEW Serial Number: 03AA03 20301</th>
<th>DEW Type: Denial</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEW Date: 03/23/2015</td>
<td>Decision Date 03/23/2015 DENIED</td>
</tr>
</tbody>
</table>

Decision Information

As of the indicated Decision Date, your request for services is being DENIED.

<table>
<thead>
<tr>
<th>Level of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for Decision</td>
</tr>
<tr>
<td>J) INITIAL DENIAL-NOT MEET LEVEL OF CARE</td>
</tr>
</tbody>
</table>

Signature of FSSA Representative: Name of FSSA Representative:

IF YOU WISH TO APPEAL THIS DECISION, PLEASE READ THE INFORMATION ABOVE, SIGN AND DATE BELOW, AND RETURN THE HEARINGS & APPEAL COPY OF THIS FORM TO THE ADDRESS GIVEN IN THE INSTRUCTIONS.

I wish to appeal the above decision; for the following reasons:

Signature of Applicant/Guardian: Date Signed:

APPLICANT COPY
Your Appeal Right as an Applicant for HCBS Benefits

If you question the indicated decision, you should discuss this matter with your Case Manager.

Your Right to Appeal and Have a Fair Hearing:

The Worksheet for Data Entry provides an explanation of the decision made on your application for services or changes in your services. If you disagree with the decision, you have the right to appeal by submitting a request for a Fair Hearing. Your Home and Community Based Services (HCBS) benefits will continue if your appeal is received within the required time frame described below under “How to Request an Appeal”. If you appeal and your benefits are continued and you lose the appeal, you may be required to repay assistance paid on your behalf pending the release of the appeal hearing decision.

How to Request an Appeal:

1) If you wish to appeal this decision, the appeal request must be received by close of business not later than:
   (1) 33 calendar days following the effective date of the action being appealed; or
   (2) 33 calendar days from the date of the notice of agency action, whichever is later.

To file an appeal, please sign, date and return the Hearings & Appeals copy of this form to:

Indiana Family and Social Services Administration
Office of Hearings and Appeals
MS 04
402 W. Washington St., Room W392
Indianapolis, IN 46204

or via facimile to 317-232-4412

If you are unable to sign, date, and return this form to the above mentioned address, you may have someone assist you in requesting the appeal.

2) You will be notified in writing by the Indiana Family and Social Services Administration, Hearings and Appeals office of the date, time, and location for the hearing. Prior to, or at the hearing, you have the right to examine the entire contents of your case record maintained by the Case Manager.

3) You may represent yourself at the hearing or you may authorize a person to represent you, such as an attorney, relative, or other spokesperson. At the hearing you will have full opportunity to bring witnesses, establish all pertinent facts and circumstances, advance any arguments without interference and question, or refute any testimony or evidence presented.
Dear Doctor ______________________

Your assistance is needed in determining your patient’s particular impairment level and service needs. For the Medicaid Waiver and C.H.O.I.C.E. programs we need your consent that in-home services will be safe and feasible for this individual. It is for this purpose that we request that you complete the enclosed form(s) and return to our office as soon as possible.

Your Patient, ______________________, is being evaluated or re-evaluated for in-home services under one of the following programs:

____ C.H.O.I.C.E. (Community and Home Options to Institutional Care for Elderly and Disabled)
This program will assist eligible individuals in remaining in their home/community setting as an alternative placement in a nursing facility/institution.

____ Medicaid Waiver
These programs assist Medicaid recipients who are at risk of institutionalization to stay in their own homes or community settings.

____ Pre-Admission Screening
Established under Public Law 21, Acts of 1982, this program mandates that all persons seeking nursing home admission in Indiana must participate in the PAS Program or incur a penalty of one year of ineligibility for Medicaid services.
It is essential that you designate on the form the level of care the individual requires.

Your time and cooperation are appreciated. If you have questions, please call ______________________ (CM printed name) at 260-745-1200, ext. ______.

______________________________  ______________________
Case Manager                        Date

LETTER_MEDICAL_INFO.DOC  03/07
PHYSICIAN CERTIFICATION FOR LONG-TERM CARE SERVICES

State Form 39143 (R5/6-93) Form 450B/PAASARR2A
Indiana Family and Social Services Administration (IFSSA)

CONFIDENTIAL

ASSESSMENT TYPE
☐ Initial Assessment
☐ Re-Screening
☐ ARR

MEDICAID STATUS
☐ Medicaid Pending
☐ Medicaid Recipient
☐ Non-Medicaid

Name of contact

Upon completion return to:
☐ Area PAS agency
☐ IFSSA

I - RECIPIENT IDENTIFICATION

Name of applicant (last, first, middle) Date of birth (mo., day, yr.) Sex Name of county

Name of nursing facility or ICF / MR Facility admission date (mo., day, yr.) Medicaid number

Address of facility (street and number) Re-admission date from hospital Level of care transfer date

City, state and ZIP code Requested length of care Facility provider number(s)

Admitted from:
☐ c.Home ☐ f. Out-of-state
☐ a. Acute Hospital ☐ d. Nursing Facility
☐ b. Psychiatric Bed ☐ e. ICF/MR
☐ g. Other

II - PHYSICIAN'S MEDICAL EVALUATION

Federal and state regulations require a physician's medical evaluation, plan of treatment and explicit recommendation for care prior to admission or continued care in a nursing facility, the C.H.O.I.C.E. program, or the Medicaid Home and Community-Based Waiver program.

Patient Evaluation (check all applicable boxes below. * requires explanation in "Clinical Summary")

☐ Ambulatory ☐ Contractures ☐ Colostomy / Ileostomy ☐ Self Fed
☐ Wheelchair ☐ Incontinent (bladder) ☐ Other Ostomy ☐ I.V. Fluids / Nutrition *
☐ Cane or Walker ☐ Incontinent (bowel) ☐ Aphasic ☐ Tube Fed - Type_
☐ Bedfast ☐ Catheter ☐ Agitated / Combative ☐ Decubiti (size, stage, treatment) *
☐ Ventilator Dependent ☐ Tracheotomy ☐ Confused / Disoriented ☐ Other *

Primary diagnosis (include dates)

Secondary / tertiary diagnosis (include dates)

Patient's overall prognosis

Plan and Treatment (check all applicable boxes below. ** requires explanation in "Clinical Summary")

☐ Medications (describe below) ☐ Regular Diet ☐ Minimum Nursing Intervention ☐ Independent with ADLs
☐ Restorative Services * ☐ Other (specify) ☐ Moderate Nursing Intervention * ☐ Assisted with ADLs
☐ Sterile Dressing * ☐

Medications (dosage and frequency)

Clinical summary (attach additional information as necessary)

LEVEL OF CARE PHYSICIAN CERTIFICATION

Level of care recommended Complete for all Applications Complete for Home Care (if applicable)
☐ Skilled ☐ Intermediate ☐ Medicaid Home and Community Based Waiver service
☐ ICF/MR - Large/Small ☐ Other (specify) ☐ C.H.O.I.C.E.

I certify that community supported in-home care is ☐ safe and feasible ☐ not safe or feasible in regard to health and safety of this patient. If not safe or feasible, explain.

Signature of physician (stamps are NOT acceptable) Date signed (month, day, year) Typed or printed name of physician

III - STATE DEPARTMENT AUTHORIZATION

This certification is for:
☐ Admission ☐ Transfer ☐ Continued Care Comments
☐ Approved ☐ Disapproved Effective Medicaid reimbursement date

Authorized signature ☐ IFSSA ☐ Area PAS agency Date signed (month, day, year)

1. Does the individual have a documentable diagnosis of senile or presenile dementia (including Alzheimer's Disease or related disorder) based on criteria in DSM-III-R, without a concurrent primary diagnosis of a major mental illness or a diagnosis of mental retardation or developmental disability?
   - [ ] Yes
   - [ ] No

2. Does the individual have a documentable diagnosis of a major mental illness limited to the following disorders: schizophrenic, schizoaffective, mood (bipolar and major depressive type), paranoid or delusional, panic or other severe anxiety disorder; somatoform or paranoid disorder, personality disorder; atypical psychosis or other psychotic disorder (not otherwise specified; or another mental disorder that may lead to a chronic disability)?
   - [ ] Yes
   - [ ] No

3. Does the person have a diagnosis of mental illness not listed above?
   - [ ] Yes
   - [ ] No
   List diagnosis: _________________________________________________________

4. A. Has the person had any recent (within the last two years) history of outpatient care or supportive services for a condition of mental illness?
   - [ ] Yes
   - [ ] No

   If "Yes", explain: __________________________________________________________

   __________________________________________________________

   __________________________________________________________

   __________________________________________________________

   __________________________________________________________

5. Is there any presenting evidence of mental illness including possible disturbances in orientation, affect of mood? (If the problem is attributed to a condition of dementia, explain and check "No")
   - [ ] Yes
   - [ ] No

6. Does the individual have a diagnosis of mental retardation, developmental disability (MR/DD) or other related condition?
   - [ ] Yes
   - [ ] No

7. Is there any history of a MR/DD or related condition in the individual's past?
   - [ ] Yes
   - [ ] No

8. Is there any presenting evidence (cognitive or behavior characteristics) that may indicate that the person has MR/DD or related condition?
   - [ ] Yes
   - [ ] No

   If "Yes", explain: __________________________________________________________

   __________________________________________________________

   __________________________________________________________

   __________________________________________________________

   __________________________________________________________

   __________________________________________________________

   __________________________________________________________

   __________________________________________________________

   __________________________________________________________

   __________________________________________________________

   __________________________________________________________

Signature of assessor __________________________ Title / Position __________________________ Date signed __________________________

Should the applicant be approved for the Aged & Disabled Waiver, the Medically Fragile Children Waiver, the TBI Waiver or the AL and AFC Waiver, and choose nursing facility placement at any time while on the Waiver, the PASRR Level I assessment and Level II (if required) must be completed prior to admission. The applicant must sign that he/she has read and understands this policy.

I understand that if level of care is approved for the Aged & Disabled Waiver, the Medically Fragile Children Waiver, the TBI Waiver, or the AL and AFC Waiver, and if, for whatever reason, I need nursing facility placement, it will be necessary to complete the PASRR Level I assessment and the Level II (if required) prior to nursing facility admission.

Signature of applicant __________________________ Date signed __________________________
 Depending on the medical needs and/or geriatric needs, an individual with a developmental disability may meet the level of care criteria for the Aged & Disabled Waiver, the Medically Fragile Children Waiver, or the TBI Waiver. However, if the individual has specialized services needs, he/she MAY be appropriate for the ICF/MR Waiver. **THE A & D WAIVER, THE MEDICALLY FRAGILE CHILDREN WAIVER, THE TBI WAIVER, AND THE AL AND AFC WAIVER ARE NOT APPROPRIATE AS AN INTERIM MEASURE FOR AN INDIVIDUAL WHO IS AWAITING AN ICF / MR WAIVER SLOT AS THE ALTERNATIVE PLACEMENT IS A NURSING FACILITY RATHER THAN AN ICF / MR FACILITY. While the PASRR Level II process is not required for determination of eligibility for the A & D Waiver, the Medically Fragile Children Waiver, the TBI Waiver, or the AL and AFC Waiver, the individual MUST have medical needs to meet Indiana's nursing facility level of care criteria. To determine that the individual meets the nursing facility criteria rather than the ICF/MR level of care criteria, additional information may be necessary. The following information will aid in identifying whether an individual's needs are appropriate for the A & D Waiver / Medically Fragile Children Waiver / TBI Waiver / AL and AFC Waiver or whether further evaluation is necessary to determine if the individual's needs are appropriate for the ICF / MR Waiver.**

**CHECK ALL THAT APPLY:**

- Person is over 60 years of age (see IDDARS Comments Sheet, this is NOT an exemption).
- Person is under 60 years of age, but conditions of aging may adversely affect participation in specialized services (explain in comments).
- Person does not desire to participate in specialized services (comments must explain how this was determined).
- History of Service Participation (list in comments).
- Person is school-aged or preschool aged, receiving services through the school system (list services in comments).
- Health / Medical issues (must be explained in comments).

**COMMENTS (may use attachments to this form)**

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**NOTE:** If none of the above apply, a D & E will be needed for level of care determination. Regardless of how many of the above apply, OMPP may request a D & E to clarify level of care.

SEE ATTACHED COMMENTS FROM IDDARS REGARDING INDICATORS THAT SPECIALIZED SERVICES MIGHT NOT BE REQUIRED FOR AN INDIVIDUAL.
INDICATORS OF PERSONS WHO DO NOT REQUIRE SPECIALIZED SERVICES

Service coordinators and nursing facility staff are challenged to ascertain those activities which have meaning and value to individuals who routinely decline to participate in any or all offered activities. It must be determined that these apparent choices are not based on fear, lack of experience, low self-esteem, or behavioral manipulation, as opposed to duly considered and informed choice. Documentation of activities to appropriately present service options to these individuals is required.

The following indicators are considerations for determining that an individual does not require specialized services. In and of themselves, their presence does not constitute an exemption or release from participation. It is suggested that the indicators be used as considerations in guiding the decision making process. It is recommended that staff approach this determination as a question of quality, not quantity (i.e. presence of 3 of 4 indicators).

**AGE** - It does not seem appropriate to "push" older persons into participation in specialized services. Although the age factor varies from person to person, it is appropriate to consider relaxing expectations on persons who are 60 years old or older. There may be individuals in their 70s or 80s who willingly or even avidly embrace specialized services, as well as individuals in their late 40s or 50s who decline participation. Therefore, each person must be considered relative to his or her own circumstances.

**DESIRE** - Some individuals are motivated and desire to participate in the opportunities and experiences afforded by specialized services. A few individuals may not. Before accepting this apparent lack of desire as a rationale that the individual does not require specialized services, it is essential that the service coordinator work with nursing facility staff and families to ascertain what activities have value and meaning to individuals. A person may decline to participate out of fear, lack of experience, habit, or other unstated reasons. The process of assuring that an individual does not desire to participate must be creatively explored and thoroughly documented.

**HISTORICAL LACK OF PARTICIPATION IN / ACCESS TO SERVICES** - It is not uncommon to find individuals, especially older persons, who due to geographical isolation, family preference, or lack of service availability have never been in educational, vocational, or other day services. It is not appropriate to require a person over sixty, who has no experience with receiving services, to suddenly "need" specialized services.

**HEALTH / MEDICAL / NEUROLOGICAL** - Health and medical concerns are the most common consideration in determining that persons do not require specialized services. The following factors can be used to analyze the impact of medical concerns:

- Diagnosis;
- Medical history;
- Physician's orders;
- Frequency of orders;
- Evidence of deterioration while participating in specialized services;
- Stamina.

Again, the presence of a particular diagnoses, set of physician's orders, or even history of deterioration during participation does not automatically constitute rationale that the person does not need specialized services. Services may need to accommodate medical treatment issues or be modified to permit participation. Some neurological impairments make it difficult, if not impossible, for an individual to benefit from specialized services. Additional assessment may clarify the expectation of benefit.
Aging & In-Home Services of Northeast Indiana, Inc.
Case Management Services Department
Initial Checklist for Targeted A & D Waiver

Date Targeted ___________________ Date submitted ___________________
Client ____________________ County ________________
Case Manager ___________________ Supervisor ___________________
IS THIS A DENIAL ______ Senate Bill 30 Yes ______ No _______
LOC CODE: ______ A00 ______ A71 ______ A10 ______ A60 ______ A90 ______ A91 ______ A63 (MFP)

**Case Manager completes the following using dates:**

- Complete Target Notice & CSR (complete a CSR documenting the day received, the target date & the date the assessment is to be completed)
- Contact client within 3 business days to discuss targeting and redetermine eligibility

**If not proceeding with service at this point, complete CSR and update Status and:**

- WL tabs, print CSR and status, change pend notes to WVRadmin AD and turn in file to Supervisor.
- Check ‘in-home services client’ box on client tab in INsite and set up
  - Appt to be completed within the next 5 business days.
  - confirm physician and mail 450B to be completed and signed
  - Application – print from INsite and have client sign
  - ACCM – complete in INsite
  - Income tab – complete in INsite
  - Eligibility Screen (mark as ‘medical model waiver’ on General tab) – complete/finalize
    - **Complete Form 11 (with required signature of client or guardian)**
    - have Form 11 sec 2 signed by BDSS (if triggered by “yes” on Form 11–questions 6–8 this is for MR-DD indicators)
    - Agency folder given to client
    - HIPAA Release to Authorize PHI – client signs- leave WHITE copy with client
    - HIPAA Acknowledgement of Receipt of Privacy Practices, signed by client
    - FSSA Release for MA Agency Portal, signed by client
    - Give client Consumer Guide for Choosing Providers
    - Give Caregiver BRI Care Consultation Brochure and Referral form to complete
    - PICK LIST for CMGT with client signature (choice of Case Manager offered)
    - PICK LIST for Choice of Vendors offered - for each service – with client signature
    - Home Visit form – signed by client (leave white copy with client)
    - Voter registration offered and documented (completed ones to clerical within 4 days)
  - Complete IA CSR and 90-Day checklist (bill to: WVRADM-AD, face to face visit)
    - review Medicaid Info on IndianaAIM (click on Red Indiana icon on CCB tab)
    - if requesting an RFA- use RFA checklist – do not include this service on IA ccb
  - Complete Safety Screening tool
  - Complete and sign IA Cover Letter
  - enter Cost Comparison Budget (CCB) using LOC code at top of page
  - Acquire applicant / guardian signatures
  - Finalize CCB— Turn in only completed signature page and service needs memo
  - Complete CMGR portion of LOC Review Form in INsite – enter DD Eligibility comments
    - if client has a DD diagnosis
  - Status History - Review for accuracy – do not print
  - Self-Directed ATTC - if requesting self-directed ATTC, complete checklist on Waiver tab
  - IA packet containing the above forms submitted to supervisor

**CMGT HRS Billing:** Bill CMGT time to PEND- Bill Travel to Non-Billable/Non-client- Activity code-Travel 1

J:\Forms\Ckist A&D Target_ALL0814.docx
INITIAL A&D

**********************************************************
SUPERVISOR (sign) __________________
LEVEL OF CARE
Marks CCB reviewed before export
Marks export test "OK" for CCB
Packet to Dixie

LEVEL OF CARE
Supervisor (sign) ____________
Review packet
Verifies CCB has been moved
Reviews, signs and dates 450B
Completes LOC Form and prints
LOC Review Form is OK to Export

**********************************************************
DIXIE:
Transmit LOC Review Form (note export date)
Transmit CCB to State (note export date); if doesn't transmit in 2-3 days, notify Tina B
Hold Packet for CCB Approval Letter from State
Gives packet with CCB approval letter and LOC approval (state only) to Supervisor

CM reviews and gives Packet to case manager

CASE MANAGER - Initial Packet Approved by State - Confirm Waiver Start Date
***Do Not Start Services Until Final CCB Approval and NOA is Received and Spend Down removed***
CM receives packet back from Supervisor with written notice from State
verifying Slot #, & CCB & LOC approval.
See attached confirmation letter for any special instructions re: eligibility, spend-down, Mgd Care

*****DO NOT PROCEED FURTHER UNTIL ALL ITEMS ON CONFIRMATION LETTER ARE RESOLVED****
CM will enter the confirmation date (Waiver Start Date from attached letter)
Start Date cannot be before NF discharge date
Packet to Supervisor

DIXIE verifies confirmation exports to State and hold packet for approval
When confirmation approval letter received: Print "approved" ccb
Packet to Supervisor

SUPERVISOR reviews and gives Packet to case manager.

CASE MANAGER - the following is completed once State has approved confirmation of the INITIAL CCB
Contacts and confirms services with vendor and client
Update status codes on Client Tab in INsite
Remove any non-wavier waiting list entries on Wtg List Tab in INsite
CM changes payor source on case notes
All "PEND" notes prior to Spend down end date or MAW Start Date change to WVRADM_AD
All "PEND" notes after Spend down end date or MAW start date change to AD
For Clients on active CHOICE or SSBG please terminate those services immediately or after spend
down has been removed and notify providers
if client is transferring programs (e.g.: MFP to AD, DD to TBI, etc.) coordinate start date with
AIHS supervisor and state program reps
CM Returns packet to Supervisor

SUPERVISOR reviews and gives Packet to Dixie

Mail to Client:
• "Approved" copy of CCB
• NOA with State signature
• LOC Form and Cover letter
• Client Needs Memo
Processes and files packet

Send to Nutrition
- Copy of NOA

J:\Forms\Cklst A&D Target_ALL0814.docx
Homepointe

(Official business-name: ANTHONY WAYNE REHABILITATION FOR HANDICAPPED AND BLIND, INC.)

8515 Bluffton Road
Fort Wayne, IN 46809-3022
Primary Contact-Person: Margaret Cantey
Primary Phone-Number: (260) 744-6145
Fax-Number: (260) 444-0006

New Horizons Home Health Services

(Official business-name: ZOE, INC.)

621 Broadway Street
New Haven, IN 46774-
Primary Contact-Person: Robin Snyder
Primary Phone-Number: (260) 493-1401
Fax-Number: (260) 493-1577

Absolute Angels

(Official business-name: HEAVENLY DAYS INC.)

17217 Black Creek Court
Harlan, IN 46743-9773
Primary Contact-Person: Christina L. Stark
Primary Phone-Number: (260) 715-7777
Fax-Number: (260) 572-2444

Angel Corps

(Official business-name: ANGEL CORPS, INC.)

528 W. WASHINGTON BLVD.
Fort Wayne, IN 46802-
Primary Contact-Person: ROBIN NORMAN
Primary Phone-Number: (260) 426-4357
Fax-Number: (260) 426-0485

Lutheran Life Villages Home Care

(Official business-name: LUTHERAN LIFE VILLAGES HOME HEALTHCARE, INC.)

6701 S. Anthony Blvd.
Fort Wayne, IN 46816-
Primary Contact-Person: Bonnie Wacker, Director
Primary Phone-Number: (260) 918-6572
Fax-Number: (260) 447-7369

Seasons Homecare

(Official business-name: HERMANN VENTURES, LLC)

1101 Husky Trail
Warsaw, IN 46582-1954
Primary Contact-Person: Curt Hermann
Primary Phone-Number: (574) 268-9000
Fax-Number: (574) 268-2268

Brightstar PSA of Fort Wayne

(Official business-name: ZEEDUB LLC)

4807 Illinois Rd
Fort Wayne, IN 46804-1165
Primary Contact-Person: Stephanie Zishka
Primary Phone-Number: (260) 918-0933
Fax-Number: (260) 918-0931

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Signed: ________________________________ Dated: __________________________

Printed Name of Signer: ________________________________

Client Name (printed): ________________________________

(If different from the Signed-By person)
AFFORDABLE HOME CARE LLC
7435 Covington Hollow Lane
Fort Wayne, IN 46804-
Primary Contact-Person: Hahn March
Primary Phone-Number: (765) 238-1381
Fax-Number: (888) 681-9011

LEAGUE FOR THE BLIND AND DISABLED, INC.
5821 South Anthony Blvd.
Fort Wayne, IN 46816-
Primary Contact-Person: Charlene Gooden
Primary Phone-Number: (260) 441-0551
Fax-Number: (260) 441-7760

HOME NURSING SERVICES
528 W. Washington BLVD.
Fort Wayne, IN 46802-
Primary Contact-Person: Gina Yonkman
Primary Phone-Number: (260) 424-1237
Fax-Number: (260) 424-2565

PARAGON HOME CARE, INC.
3512 Stellhorn Road, Suite A
Fort Wayne, IN 46815-
Primary Contact-Person: Lisa Sims
Primary Phone-Number: (260) 492-9777
Fax-Number: (260) 486-6600

GREAT LAKES PERSONAL CARE SERVICES LLC
2009 W. Glen Park, #B
Griffith, IN 46319-3735
Primary Contact-Person: Candice Kelly Casey
Primary Phone-Number: (877) 954-5727
Fax-Number: (866) 941-6921

STARLINE COMMUNITY SERVICES, INC
321 S. Spring Street
Mishawaka, IN 46544-
Primary Contact-Person: Cecilia Ndungu
Primary Phone-Number: (574) 289-0031
Fax-Number: (877) 568-1659

FAMILY HOME CARE
(Official business-name: FAMILY HOSPICE OF NORTHEAST INDIANA, INC.)
108 S Jefferson Street
Berne, IN 46711-1547
Primary Contact-Person: SueAnn M. Reynolds
Primary Phone-Number: (260) 589-8598
Fax-Number: (260) 589-8079

WOODVIEW HOME CARE LLC
3417 East State Blvd.
Fort Wayne, IN 46805-4830
Primary Contact-Person: Suzie Ebbing
Primary Phone-Number: (260) 969-2000
Fax-Number: (260) 969-0323

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<tbody>
<tr>
<td>HEALTH FORCE OF INDIANA</td>
<td>334 North Enterprise Drive</td>
<td>Teresa Miller</td>
<td>(888) 436-9551</td>
<td></td>
</tr>
<tr>
<td>STAY HOME SENIOR CARE, INC.</td>
<td>119 1/2 W. Maumee Street, Suite A</td>
<td>Doug Molyneux</td>
<td>(260) 668-8737</td>
<td>(260) 665-3185</td>
</tr>
<tr>
<td>HOME SWEET HOME PRIVATE SENIOR CARE LLC</td>
<td>6500 S. St. Rd 1</td>
<td>Jody Hill</td>
<td>(260) 488-2844</td>
<td></td>
</tr>
<tr>
<td>TRINITY HOME HEALTH CARE, INC.</td>
<td>3502 Stellhorn Rd.</td>
<td>David Warnecke, RN</td>
<td>(260) 492-5804</td>
<td></td>
</tr>
<tr>
<td>COMFORT KEEPERS</td>
<td>3968 NEW VISION DRIVE</td>
<td>JULIA A. ANDERS</td>
<td>(260) 483-4547</td>
<td></td>
</tr>
<tr>
<td>MAXIM COMPANION SERVICES</td>
<td>4646 West Jefferson Blvd., Suite 100</td>
<td>Sean Sparks, Acct Mgr</td>
<td>(260) 498-8834</td>
<td>(260) 436-3914</td>
</tr>
<tr>
<td>COMPANION CARE COMPANY</td>
<td>8604 Allisonville Road, Suite 280</td>
<td>Marty Worline</td>
<td>(317) 926-3823</td>
<td>(317) 926-3856</td>
</tr>
</tbody>
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<th>Fax Number</th>
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</thead>
<tbody>
<tr>
<td>SUNSHINE HOME HEALTH CARE</td>
<td>222 West Wayne Street</td>
<td>(260) 483-6878</td>
<td>(260) 471-9234</td>
</tr>
<tr>
<td>INDIVIDUAL SUPPORT SERVICES INC.</td>
<td>1006 W. Mill Street</td>
<td>(765) 354-9004 Extension 204</td>
<td>(765) 354-9965</td>
</tr>
<tr>
<td>UNIQUE PERSONAL SERVICE CARE</td>
<td>3410 Hawkechee Drive</td>
<td>(260) 705-2728</td>
<td>(260) 203-2101</td>
</tr>
<tr>
<td>HOMEPOINTE HEALTHCARE</td>
<td>8515 Bluffton Road</td>
<td>(260) 744-6145</td>
<td>(260) 207-5663</td>
</tr>
<tr>
<td>BRIGHTSTAR OF FORT WAYNE</td>
<td>4807 Illinois Road</td>
<td>(260) 918-0933</td>
<td>(260) 918-0931</td>
</tr>
<tr>
<td>SUNSHINE HOME CARE SERVICES</td>
<td>222 West Wayne Street</td>
<td>(260) 483-6878</td>
<td>(260) 471-9234</td>
</tr>
<tr>
<td>EMPOWERED PERSONAL CARE AGENCY LLC</td>
<td>855 E. Mishawaka Rd, Lot 107</td>
<td>(574) 343-7892</td>
<td>(574) 343-2328</td>
</tr>
</tbody>
</table>

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Client Name (printed): ____________________________________________________________
### Medicaid Waiver Provider List

**Available for Homemaker funded by Aged & Disabled**

**County:** Allen

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Address</th>
<th>Contact Person</th>
<th>Phone Number</th>
<th>Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>HELP AT HOME, INC.</td>
<td>307 W. Van Buren Street, Grant Bldg.</td>
<td>Jean Heller</td>
<td>(260) 244-1951</td>
<td>(260) 244-6289</td>
</tr>
<tr>
<td>HOME IS WHERE THE HEART IS, LET ME HELP YOU HELP YOURSELF A</td>
<td>5634 W. Jefferson Blvd, Suite 7</td>
<td>Tina D. Bishop - Benson</td>
<td>(260) 348-5125</td>
<td>(260) 432-7217</td>
</tr>
<tr>
<td>Home Care Services</td>
<td>6202 Constitution Hill, Suite C</td>
<td>Carol Sparks, Dir of Reimbmnt</td>
<td>(260) 459-2907</td>
<td>(260) 459-2984</td>
</tr>
<tr>
<td>ACTI-KARE RESPONSIVE IN-HOME CARE</td>
<td>8026 Seiler Road</td>
<td>Erin A. Conn</td>
<td>(260) 245-0367</td>
<td>(260) 846-6313</td>
</tr>
<tr>
<td>ADVANTAGE PERSONAL SERVICES</td>
<td>169 Riverside Drive</td>
<td>Sherrie Frye, RN</td>
<td>(260) 358-1004</td>
<td>(260) 358-1041</td>
</tr>
<tr>
<td>TOGETHER HOMECARE</td>
<td>8395 Keystone Crossing, Suite 314</td>
<td>John Cosgrove</td>
<td>(317) 677-7000</td>
<td>(317) 677-7002</td>
</tr>
<tr>
<td>LEL HOME SERVICES, LLC</td>
<td>5555 W. 73rd Street</td>
<td>Kim D. Eicher</td>
<td>(317) 387-1443</td>
<td>(317) 356-6661</td>
</tr>
</tbody>
</table>

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Printed Name of Signer: ____________________________

Client Name (printed): ____________________________

(If different from the Signed-By person)

07/16/2015 Page:5
<table>
<thead>
<tr>
<th>Medicaid Waiver Provider List</th>
<th>Available for Homemaker funded by Aged &amp; Disabled County: Allen</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACCESSABILITIES, INC.</strong></td>
<td>8398 Mississippi</td>
</tr>
<tr>
<td></td>
<td>Gary, IN 46410-</td>
</tr>
<tr>
<td></td>
<td>Primary Contact-Person: Renee Ramon-Doughman</td>
</tr>
<tr>
<td></td>
<td>Primary Phone-Number: (219) 755-4049 Fax-Number: (219) 769-1048</td>
</tr>
<tr>
<td><strong>HELP AT HOME INC.</strong></td>
<td>9025 Coldwater Road, Suite 400</td>
</tr>
<tr>
<td></td>
<td>Fort Wayne, IN 46825-</td>
</tr>
<tr>
<td></td>
<td>Primary Contact-Person: Erica Pearson</td>
</tr>
<tr>
<td></td>
<td>Primary Phone-Number: (260) 451-8383 Fax-Number: (260) 451-8319</td>
</tr>
<tr>
<td><strong>ALPHA HOME PHYSICAL THERAPY INC.</strong></td>
<td>4455 Southport Crossing Way</td>
</tr>
<tr>
<td></td>
<td>Indianapolis, IN 46237-3698</td>
</tr>
<tr>
<td></td>
<td>Primary Contact-Person: Doug Klink</td>
</tr>
<tr>
<td></td>
<td>Primary Phone-Number: (317) 888-4033 Fax-Number: (317) 888-4618</td>
</tr>
<tr>
<td><strong>COMMUNITY HOME HEALTH CARE, INC.</strong></td>
<td>2700 S. Lafayette Street, Suite 210</td>
</tr>
<tr>
<td></td>
<td>Fort Wayne, IN 46806-</td>
</tr>
<tr>
<td></td>
<td>Primary Contact-Person: Rose Comer Squires</td>
</tr>
<tr>
<td></td>
<td>Primary Phone-Number: (260) 441-8302 Fax-Number: (260) 441-8502</td>
</tr>
<tr>
<td><strong>INDIANA MENTOR</strong></td>
<td>(Official business-name: NATIONAL MENTOR HEALTHCARE, LLC)</td>
</tr>
<tr>
<td></td>
<td>6008 Brandy Chase</td>
</tr>
<tr>
<td></td>
<td>Fort Wayne, IN 46815-7601</td>
</tr>
<tr>
<td></td>
<td>Primary Contact-Person: Dan Mohnke</td>
</tr>
<tr>
<td></td>
<td>Primary Phone-Number: (317) 581-2380 Fax-Number: (317) 581-2378</td>
</tr>
<tr>
<td><strong>AMERICAN HOMECARE OF INDIANA INC.</strong></td>
<td>7506 W. US Highway 40, Suite A</td>
</tr>
<tr>
<td></td>
<td>Indianapolis, IN 46229-4221</td>
</tr>
<tr>
<td></td>
<td>Primary Contact-Person: Sajid Hameed</td>
</tr>
<tr>
<td></td>
<td>Primary Phone-Number: (317) 997-9918 Fax-Number: (317) 992-8012</td>
</tr>
<tr>
<td><strong>SENIOR HELPERS</strong></td>
<td>(Official business-name: FOREMAN CARE CORP)</td>
</tr>
<tr>
<td></td>
<td>808 Michigan Ave., Suite B</td>
</tr>
<tr>
<td></td>
<td>Logansport, IN 46947-2608</td>
</tr>
<tr>
<td></td>
<td>Primary Contact-Person: Dave Foreman</td>
</tr>
<tr>
<td></td>
<td>Primary Phone-Number: (574) 992-8012 Fax-Number: (574) 992-8015</td>
</tr>
<tr>
<td><strong>HOME HELPERS</strong></td>
<td>(Official business-name: HARTWIGER ENTERPRISES INC.)</td>
</tr>
<tr>
<td></td>
<td>287 E. High Circle Drive</td>
</tr>
<tr>
<td></td>
<td>Warsaw, IN 46580-</td>
</tr>
<tr>
<td></td>
<td>Primary Contact-Person: Aimee Hartwiger</td>
</tr>
<tr>
<td></td>
<td>Primary Phone-Number: (574) 372-2273 Fax-Number: (574) 267-4535</td>
</tr>
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(if different from the Signed-By person)
Medicaid Waiver Provider List
Available for Homemaker funded by Aged & Disabled
County: Allen

DIVINE HOME HEALTHCARE, INC.
(Official business-name: PIONEER GROUP, LLC)
5215 North Bend Drive
Fort Wayne, IN 46804-1651
Primary Contact-Person: Firas Abolgar
Primary Phone-Number: (260) 804-2223 Fax-Number: (260) 969-0554

FORTE RESIDENTIAL, INC.
703 North Huntington St., Suite 105
Syracuse, IN 46567
Primary Contact-Person: Tom Van Meter, Pres.
Primary Phone-Number: (574) 528-6398 Fax-Number: (260) 757-6066

AT HOME AND AT PLAY SENIOR SUPPORT SERVICES LLC
3001 Fairfield Ave.
Fort Wayne, IN 46807
Primary Contact-Person: Brenda Carter
Primary Phone-Number: (260) 918-7529 Fax-Number: (260) 432-1850

RESCARE HOMECARE INDIANA
(Official business-name: RESCARE, INC.)
3711 Rupp Drive, Suite 106
Fort Wayne, IN 46815
Primary Contact-Person: Barbara Porter
Primary Phone-Number: (260) 484-2414 Fax-Number: (260) 484-2071

ADVANTAGE HOME HEALTH CARE, INC.
169 Riverside Drive
Huntington, IN 46750
Primary Contact-Person: Lyn Estell, RN
Primary Phone-Number: (765) 284-1211 Fax-Number: (765) 284-1239

INTERIM HOMESTYLE SERVICES OF FORT WAYNE
(Official business-name: NORTHERN INDIANA INTERIM HOMECARE COMPANY LLC)
310 E. Dupont Rd, Suite 1
Fort Wayne, IN 46825-2048
Primary Contact-Person: Carol Dudley
Primary Phone-Number: (260) 969-5991 Fax-Number: (260) 710-5090

FORTE HOME HEALTH CARE INC.
808A S. Huntington Street
Syracuse, IN 46567-1810
Primary Contact-Person: Andrew Doctor
Primary Phone-Number: (574) 457-4379

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(if different from the Signed-By person) 07/16/2015 Page: 7
**Medicaid Waiver Provider List**

Available for Homemaker funded by Aged & Disabled

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<th>Primary Phone Number</th>
<th>Fax Number</th>
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</thead>
<tbody>
<tr>
<td>INTERIM HEALTHCARE OF FORT WAYNE</td>
<td>310 E. Dupont Rd, Suite 1 Fort Wayne, IN 46825-2048</td>
<td>Pat Brown</td>
<td>(260) 482-9406</td>
<td></td>
</tr>
<tr>
<td>BRIDGES OF INDIANA, INC.</td>
<td>21 North 11th St. Terre Haute, IN 47807-2743</td>
<td>Rick Spalding</td>
<td>(812) 478-0724</td>
<td>(812) 235-8037</td>
</tr>
<tr>
<td>BLESSED HANDS HOME CARE AGENCY, LLC</td>
<td>3221 S. Michigan Street South Bend, IN 46614-1715</td>
<td>Jasmine Lampkin</td>
<td>(574) 383-0406</td>
<td>(574) 231-4514</td>
</tr>
<tr>
<td>MAXIM HEALTHCARE SERVICES, INC.</td>
<td>4646 W. Jefferson Blvd., Ste 100 Fort Wayne, IN 46804-</td>
<td>John Hickey</td>
<td>(260) 432-1166</td>
<td>(260) 436-3914</td>
</tr>
<tr>
<td>ATTENTIVE RESOURCES, LLC</td>
<td>3354 Garland Avenue Fort Wayne, IN 46805-1724</td>
<td>Katherine L. Price, CEO</td>
<td>(260) 407-0037</td>
<td>(855) 728-6764</td>
</tr>
<tr>
<td>CTI HOME CARE SERVICES</td>
<td>2012 Ironwood Circle, Suite 230 South Bend, IN 46635-1888</td>
<td>N'gomo Edwin Otiato, Admin.</td>
<td>(574) 387-4049</td>
<td>(574) 387-4062</td>
</tr>
<tr>
<td>ADDI HOME CARE SERVICES, LLC</td>
<td>519 Oxford Street Fort Wayne, IN 46806-4177</td>
<td>Edna Isiorho</td>
<td>(260) 745-5161</td>
<td>(260) 745-5260</td>
</tr>
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Client Name (printed): ____________________________

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Medicaid Waiver Provider List
Available for Homemaker funded by Aged & Disabled
County: Allen

RETRO HOME CARE SERVICES
(Official business-name: RETRO HOME CARE SERVICES, INC.)
1715 N. Shadeland Ave, Suite A
Indianapolis, IN 46219-2733
Primary Contact-Person: Michelle A. Cherry
Primary Phone-Number: (317) 869-0981
Fax-Number: (888) 449-2412

CARING HEARTS PERSONAL CARE SERVICE LLC
7784 E. 150 N
Pierceton, IN 46562-9720
Primary Contact-Person: Sherri Luke
Primary Phone-Number: (260) 229-8956
Fax-Number: (574) 594-2724

INDIANA MENTOR
(Official business-name: NATIONAL MENTOR HEALTHCARE, LLC)
8925 N. Meridian St., Suite 200
Indianapolis, IN 46260-2385
Primary Contact-Person: Dan Mohnke
Primary Phone-Number: (317) 581-2380
Fax-Number: (317) 253-2729

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<th>Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>MID-LAND MEALS</td>
<td>3313 Concord Road, Lafayette, IN 47909</td>
<td>Elaine Brovont</td>
<td>(765) 477-7189</td>
<td>(765) 477-1598</td>
</tr>
<tr>
<td>AREA 3: AGING AND IN-HOME SERVICES</td>
<td>2927 Lake Avenue, Fort Wayne, IN 46805</td>
<td>Beth Krudop</td>
<td>(800) 552-3662</td>
<td>(260) 456-1066</td>
</tr>
<tr>
<td>OF NORTHEAST INDIANA, INC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>INDEPENDENT LIVING SYSTEMS LLC</td>
<td>5200 Blue Lagoon Drive, Miami, FL 33126</td>
<td>Lucy Hernandez</td>
<td>(305) 262-1292</td>
<td>(305) 675-0238</td>
</tr>
<tr>
<td>INDEPENDENT LIVING SYSTEMS LLC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MOM'S MEALS</td>
<td>3210 SE Corporate Woods Drive, Ankeny, IA</td>
<td>Intake</td>
<td>(866) 716-3257</td>
<td>(515) 266-6120</td>
</tr>
<tr>
<td>Homestyle Direct LLC</td>
<td>113 Main Street N., Kimberly, ID 83341</td>
<td>Jim Griffith</td>
<td>(866) 735-0921</td>
<td>(208) 423-4615</td>
</tr>
</tbody>
</table>

I hereby certify that I have examined this list of available Service Providers, and have indicated my selection by placing my initials/mark next to the provider that I wish to perform the service indicated at the top of the page.

Signed: ________________________________________ Dated: __________
Printed Name of Signer: __________________________________________________________
Client Name (printed): __________________________________________________________

07/09/2015  Page: 1
# PLAN OF CARE / COST COMPARISON BUDGET

## FOR THE AGED AND DISABLED WAIVER

This state agency is requesting disclosure of your Social Security number in order to expedite processing of your Plan of Care. Disclosure is voluntary and you will not be penalized for failure to disclose SSN per IC -4-1-8.

- **Initial Plan of Care**
- **Re-Entry - Previous Termination Date**
- **Update Plan of Care**
- **Annual Plan of Care**

### Last name  First name  Middle initial

<table>
<thead>
<tr>
<th>Address (Number, street)</th>
<th>City, State, Zip code</th>
<th>Date of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Social Security number</th>
<th>Area agency on aging number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Level of care
- **(Please check one)**
- **Level of care - current approval date**
- **Level of care - previous approval date**

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>Date:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Diagnosis 1
- **From 450B**
- **Diagnosis 2**
- **From 450B**

### START DATE: From 450B  MEDICAID FACILITY DISCHARGE DATE: From 450B

### WAIVER EFFECTIVE DATE:

### Recommendation

#### Plan of care - effective from  to

### HOME AND COMMUNITY - BASED CARE COSTS

#### 1. Plan of care information:

<table>
<thead>
<tr>
<th>a.</th>
<th>Case management (1/4 hr.) Units auth. / mo. x Unit cost</th>
<th>Mo. cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>b.</td>
<td>Homemaker (1 hr.) Units auth. / mo. x Unit cost</td>
<td>Mo. cost</td>
</tr>
<tr>
<td>c.</td>
<td>Attendant Care / HHA / HSA - Other (1 hr.) Units auth. / mo. x Unit cost</td>
<td>Mo. cost</td>
</tr>
<tr>
<td></td>
<td>I/DDARS - ILS (1/2 hr.) Units auth. / mo. x Unit cost</td>
<td>Mo. cost</td>
</tr>
<tr>
<td>d.</td>
<td>Respite Care / Attendant (1 hr.) Units auth. / mo. x Unit cost</td>
<td>Mo. cost</td>
</tr>
<tr>
<td></td>
<td>Home Health Aide (1 hr.) Units auth. / mo. x Unit cost</td>
<td>Mo. cost</td>
</tr>
<tr>
<td></td>
<td>LPN (1 hr.) Units auth. / mo. x Unit cost</td>
<td>Mo. cost</td>
</tr>
<tr>
<td></td>
<td>RN (1 hr.) Units auth. / mo. x Unit cost</td>
<td>Mo. cost</td>
</tr>
<tr>
<td></td>
<td>I/DDARS - ILS (1/2 hr.) Units auth. / mo. x Unit cost</td>
<td>Mo. cost</td>
</tr>
<tr>
<td></td>
<td>Other (1 hr.) Units auth. / mo. x Unit cost</td>
<td>Mo. cost</td>
</tr>
<tr>
<td>e.</td>
<td>Adult Day Care (1 hr.) Units auth. / mo. x Unit cost</td>
<td>Mo. cost</td>
</tr>
<tr>
<td>f.</td>
<td>Meals - one (1) per day (meal) Units auth. / mo. x Unit cost</td>
<td>Mo. cost</td>
</tr>
<tr>
<td>g.</td>
<td>Home Mod. (describe) Unit cost</td>
<td>Mo. cost</td>
</tr>
<tr>
<td>h.</td>
<td>Adaptive Aides and Devices 1 (describe) Unit cost</td>
<td>Mo. cost</td>
</tr>
<tr>
<td></td>
<td>Adaptive Aides and Devices 2 (describe) Unit cost</td>
<td>Mo. cost</td>
</tr>
</tbody>
</table>

### Total A.1 - Waiver Service Costs

### Total A.2 - Other Medicaid Cost

### Total A.5 - Total HCBS Cost

### Total B.7 - Facility Cost Factor

---

Page 1 of 4
### OTHER MEDICAID SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>Payment History</th>
<th>Estimated Mo. Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Physician</td>
<td>$ _____</td>
<td>$ _____ / 3 = $ _____</td>
</tr>
<tr>
<td>b. Pharmacy</td>
<td>$ _____</td>
<td>$ _____ / 3 = $ _____</td>
</tr>
<tr>
<td>c. Therapy</td>
<td>$ _____</td>
<td>$ _____ / 3 = $ _____</td>
</tr>
<tr>
<td>d. Lab / X-ray</td>
<td>$ _____</td>
<td>$ _____ / 3 = $ _____</td>
</tr>
<tr>
<td>e. Supplies</td>
<td>$ _____</td>
<td>$ _____ / 3 = $ _____</td>
</tr>
<tr>
<td>f. Durable medical equipment</td>
<td>$ _____</td>
<td>$ _____ / 3 = $ _____</td>
</tr>
<tr>
<td>g. Transportation</td>
<td>$ _____</td>
<td>$ _____ / 3 = $ _____</td>
</tr>
<tr>
<td>h. Other:</td>
<td>$ _____</td>
<td>$ _____ / 3 = $ _____</td>
</tr>
<tr>
<td>i. Other:</td>
<td>$ _____</td>
<td>$ _____ / 3 = $ _____</td>
</tr>
<tr>
<td>j. Other:</td>
<td>$ _____</td>
<td>$ _____ / 3 = $ _____</td>
</tr>
</tbody>
</table>

Total A.2 - Other Medicaid Cost

3. Total of lines A.1 $ A.2 $ = $ A.3

4. Minus Recipient Spend-Down Amount - $ A.4

5. Total Home and Community Care Costs = $ A.5

### NURSING FACILITY INSTITUTIONAL COSTS

1. NF / I per diem $ $ x 30 days or NF /S per diem $ $ x 30 days = $ B.1

2. Other Medicaid services:

<table>
<thead>
<tr>
<th>Service</th>
<th>Payment History</th>
<th>Estimated Mo. Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Physician</td>
<td>$ _____</td>
<td>$ _____ / 3 = $ _____</td>
</tr>
<tr>
<td>b. Pharmacy</td>
<td>$ _____</td>
<td>$ _____ / 3 = $ _____</td>
</tr>
<tr>
<td>c. Lab / X-ray</td>
<td>$ _____</td>
<td>$ _____ / 3 = $ _____</td>
</tr>
<tr>
<td>d. Transportation</td>
<td>$ _____</td>
<td>$ _____ / 3 = $ _____</td>
</tr>
<tr>
<td>e. Other:</td>
<td>$ _____</td>
<td>$ _____ / 3 = $ _____</td>
</tr>
<tr>
<td>f. Other:</td>
<td>$ _____</td>
<td>$ _____ / 3 = $ _____</td>
</tr>
<tr>
<td>g. Other:</td>
<td>$ _____</td>
<td>$ _____ / 3 = $ _____</td>
</tr>
</tbody>
</table>

Total B.2 - Other Medicaid Cost

3. Total of lines B.1 $ B.2 $ = $ B.3

4. Minus Recipient Liability Reduction - $ B.4

5. Total Nursing Facility Costs = $ B.5

6. Waiver Program Factor X .90 B.6

7. Nursing Facility Cost Factor = $ B.7
Please document the Monthly Payment History / method used to determine costs in A.1 and B.2, (month and year).

**COST COMPARISON DETERMINATION**

1. Cost Comparison Data Indicates:
   a. If line A.5 $ ____________ is less than line B.7 $ ____________, then the recipient is eligible for Home and Community-Based Waiver Services and must be offered the choice of Nursing Facility Institutional Care or Home and Community Based Services.
      - **Recipient is eligible** for Home and Community-Based Waiver Services.
   b. If line A.5 $ ____________ is greater than line B.7 $ ____________, then the recipient is not eligible for Home and Community-Based Waiver Services.
      - **Recipient is not eligible** for Home and Community-Based Waiver Services.

**DESCRIPTION**

Please describe how the Plan of Care provides adequate coverage to ensure the health and welfare of the recipient. For Update Plan of Care, explain reasons(s) for the change(s).

**FREEDOM OF CHOICE**

A Medicaid Waiver Services case manager has explained the array of services available to meet my needs through the Medicaid Home and Community-Based Services Waiver. I have been fully informed of the services available to me in a Nursing Facility institutional setting. I understand the alternatives available and have been given the opportunity to choose between waiver services and institutional care. As long as I remain eligible for waiver services, I will continue to have the opportunity to choose between waiver services and institutional care.

1. Choice of Waiver Services:
   - [ ] At this time, I have chosen to receive waiver services in a home and community-based setting, rather than in an institutional setting.

   **Signature of Recipient / Guardian**
   **Date**

2. Choice of Institutional Services:
   - [ ] At this time, I have chosen to receive services in an institutional setting, rather than in a home and community-based setting.

   **Signature of Recipient / Guardian**
   **Date**

**CHOICE OF PROVIDERS**

If the recipient chooses to receive waiver services, they have the right to select any approved waiver service provider(s).

- [ ] I have been informed of my right to choose any certified waiver service provider when selecting waiver service providers.

   **Signature of Recipient / Guardian**
   **Date**

**EMERGENCY BACKUP PLANS**

Describe how medical needs, supervision, behavior issues, etc., will be covered during an emergency.
08/15/2015

To: Area 3 Aging & In-Home Services
   Tina Boneff
   2927 Lake Avenue
   Fort Wayne, IN 46805

From: Amy Rapp
   Waiver Specialist

Re: CCB for - Aged & Disabled Waiver - Slot - 10498
   CCB Serial Number =>> 201507080103AA03

Case Manager => BAUMAN, ANDREA
Plan of Care Dates =>> 06/30/2015 - 05/31/2016 (337 days)

This document contains Protected Health Information which is governed by the Health Insurance Portability and Accountability Act (HIPAA) and may only be disseminated to authorized individuals!

The referenced Cost Comparison Budget has been APPROVED by the Medicaid Waiver Specialist.

This approval for waiver services only ensures payment when, prior to the delivery of any service, the provider verifies that this individual has the correct type of open Medicaid (MA) and has not been placed into Risk-Based Managed Care. This does not include the Care Select Program. Risk-Based Managed Care members are not eligible for Home and Community Based Waiver Services, but those who receive care through the Care Select Program may be approved for waiver services.

The starting date of this Initial CCB must be confirmed by the case manager after it has been reviewed by the Waiver Specialist.

Medicaid "Aid Category" change
Medicaid Eligibility

This Initial CCB has been approved with the LOC noted below. The POC starting date can change when you confirm the Waiver starting date.
   Case Manager => BAUMAN, ANDREA
   CCB Type => Initial
   LOC => A00

Equal Opportunity/Affirmative Action Employer
The Cost Comparison Budget reviewed for this decision is noted below.

<table>
<thead>
<tr>
<th>Service</th>
<th>Rate</th>
<th>Total Cost</th>
<th>Service Dates</th>
<th>Authorization #</th>
<th>Description</th>
<th>Type of Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily Waiver Cost</td>
<td>$78.36</td>
<td>$45.84</td>
<td>$0.00</td>
<td>Daily HCBC</td>
<td>$124.20</td>
<td>Provider</td>
</tr>
<tr>
<td>Facility per diem</td>
<td>$107.32</td>
<td>$21.42</td>
<td>$0.00</td>
<td>Daily Facility</td>
<td>$128.74</td>
<td>Provider</td>
</tr>
</tbody>
</table>

Please call the waiver specialist at - - or e-mail amy.rapp@fssa.in.gov if you have any questions.

Signature of Medicaid Waiver Representative

Amy Rapp
TO: Providers of Assisted Living and Case Management under the Aged and Disabled and Traumatic Brain Injury Medicaid Waivers and Money Follows the Person (MFP) programs

FROM: Yonda Snyder, Director

SUBJECT: Allowable Room and Board Rates

DATE: April 1, 2015

The purpose of this memorandum is to clarify the allowable room and board rates an assisted living facility may charge individuals who participate in the Indiana Medicaid Waiver and Money Follows the Person Aged and Disabled and Traumatic Brain Injury programs. This memorandum supersedes all previous communications regarding allowable room and board rates.

Under 455 IAC 3-1-12, participants living in assisted living facilities are entitled to retain at least their personal needs allowance (PNA) as established by the State of Indiana.

A provider, after assuring that the participants retain their PNA, may bill participants up to the current maximum Federal Supplemental Security Income (SSI). Providers may not charge Medicaid waiver participants a room and board rate that exceeds the maximum SSI rate.

Please see the three illustrations below for further clarification. The amounts included in the examples below are for illustrative purposes only. Providers are responsible for determining the current maximum SSI and the State PNA when calculating room and board rates. The current SSI may be found at: http://www.ssa.gov/oact/cola/SSI.html. Per Ind. Code §12-15-7-2, the State PNA is $52.

**Example 1: Medicaid Waiver Participant Receiving only SSI Income**

<table>
<thead>
<tr>
<th>Medicaid Waiver Participant Monthly Income</th>
<th>SSI for an Eligible Individual</th>
<th>PNA</th>
<th>Allowable Room and Board Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>$733.00</td>
<td>$733.00</td>
<td>$52.00</td>
<td>$681.00</td>
</tr>
</tbody>
</table>

www.IN.gov/fssa
Equal Opportunity/Affirmative Action Employer
**Example 2: Medicaid Waiver Participant with Income in Excess of the SSI Rate**

<table>
<thead>
<tr>
<th>Medicaid Waiver Participant Monthly Income</th>
<th>$745.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSI for Eligible Individual</td>
<td>$733.00</td>
</tr>
<tr>
<td>PNA</td>
<td>$52.00</td>
</tr>
<tr>
<td>Allowable Room and Board Rate</td>
<td>$693.00</td>
</tr>
</tbody>
</table>

**Example 3: Medicaid Waiver Participant with Income in Excess of the SSI Rate**

<table>
<thead>
<tr>
<th>Medicaid Waiver Participant Monthly Income</th>
<th>$1,000.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSI for Eligible Individual</td>
<td>$733.00</td>
</tr>
<tr>
<td>PNA</td>
<td>$52.00</td>
</tr>
<tr>
<td>Allowable Room and Board Rate</td>
<td>$733.00</td>
</tr>
</tbody>
</table>

In all these examples, the participant retains his or her PNA and the room and board rate is no greater than the maximum SSI.

Please contact Steve Bordenkecher at (317) 234-6466 or via email at stephen.bordenkecher@fssa.in.gov.
NOTICE OF HEARING DECISION

APPELLANT: [Redacted]  DATE OF NOTICE OF ACTION: September 6, 2013
CASE NUMBER: [Redacted]  DATE OF APPEAL: September 10, 2013

HEARING DATE: October 18, 2013
PLACE: Huntington County DFR

JURISDICTION

This matter is being adjudicated under the provisions of 42 CFR 431.200 et seq. and 405 IAC 1.1-1 et seq.

ISSUE

The sole issue before the Administrative Law Judge is a denial of Medical Assistance due to excess resources.

The Administrative Law Judge has carefully reviewed all evidence, Federal/State regulations, and policy transmittals in regard to this matter. The Decision, which follows, outlines the facts and conclusions therefrom that are the basis for the final determination by the Administrative Law Judge.

THIS DECISION IS FAVORABLE TO THE APPELLANT. THE STATE AGENCY IS INSTRUCTED TO TAKE FURTHER ACTION.
FINDINGS OF FACT

1. The appellant and her spouse share an assisted living room at Heritage Pointe. On December 21, 2012, the appellant’s slot for an Aged and Disabled Waiver was targeted (the "snapshot date"). The appellant’s spouse resides in the community.

2. An application for Medical Assistance to the Aged for the appellant was filed with the State agency on July 31, 2013. The three retro-active months are April 2013, May 2013, and June 2013. Assistance is being sought effective April 1, 2013.

3. On September 6, 2013, the State agency notified the appellant that this application for medical assistance was being denied for the reasons: Value of resources owned by the community spouse and institutionalized spouse exceeds program eligibility standards; and Because you do not meet the requirements of the Supplemental Security Income (SSI) program, your excess resources cannot be applied against your medical expenses.

4. A request for a hearing was received at Hearing and Appeals, Family and Social Services Administration, on September 10, 2013 from the appellant.

5. Attorneys Keith Huffman and Jeslynn Ruble presented the appellant’s position at a hearing scheduled and held on October 18, 2013, under the provision of 405 IAC 1.1-1 et seq. and 42 CFR 431.200 et seq.

6. The appellant was not present for this hearing.

7. The 62 pages of additional documentation presented by the appellant’s attorneys at this hearing were labeled as Appellant’s Exhibits 1 through 11.

8. The State agency determined the appellant’s eligibility for Medical Assistance under the provisions of Public Law 100-360, the Medicare Catastrophic Coverage Act (MCCA) of 1988, which mandates the use of special resource criteria which require the calculation of a married couple’s combined countable resources as of a snapshot date.

9. That except for the home-based services the appellant receives through the Aged and Disabled Waiver, she would require full-time care in a long-term care facility.

10. The appellant is appealing the State’s decision in order to be determined eligible for Medicaid effective April 1, 2013. The approval of the appellant for the Medicaid
Aged and Disabled Waiver would reduce the couple’s monthly living expenses by $3000.00 each month.

11. The appellant is also appealing for a spousal allocation to her husband of all of her income of $636.90 to therefore increase his monthly spousal income standard to $4,159.87, and that the State agency increase their resource standard to $1,200,000.00.

12. The Special Income Level (SIL) for the Aged and Disabled Waiver is 300% of the SSI Maximum Benefit Rate. Effective 01-01-13, the SIL is $2130. The appellant receives gross monthly Social Security benefits of $636.90. She passes the SIL test.

13. The Community Spouse Income Standard is $1892.00 for the months of April 2013 through June 2013. Effective July 1, 2013, the standard is $1939.00.

14. The Maximum Spousal Maintenance Standard is $2898.00, effective January 1, 2013.

15. The community spouse’s total monthly income, other than interest and investment income, consists of gross Social Security benefits of $1307.90 plus a pension of $1240.63 = $2548.53.

16. The Community Spouse’s Shelter Standard is $568.00 effective April 1, 2013, and $582.00 effective July 1, 2013.

17. The Community Spouse’s average monthly rent is $3,832.92 ($126/day x 30.42 days in a month).

18. The Community Spouse’s rent of $3,832.92 – the Shelter Standard of $568.00 = the Excess Shelter Allowance as $3264.92 for April 2013 through June 2013; and $3,832.92 - $582.00 = the Excess Shelter Allowance as $3,250.92 effective July 1, 2013. This is all correct.

19. The Community Spouse’s medication and medical expenses for the month of April 2013 were: $424.56; May 2013 $289.89; June 2013 $298.93; and July 2013 $294.41. The average of these four months is $326.95.

20. The allocation of all of the appellant’s income to the Community Spouse would raise his income to $3,185.43 ($2548.53 + $636.90).

21. The appellant’s monthly rent is $3,832.92 ($126/day x 30.42 days in a month).

22. Her total monthly medical costs are $168.65.
23. The combined countable resources of the appellant and the community spouse on the snapshot date were $77,474.03.

24. The appellant and her spouse had the following countable resources as determined by the State agency:
   - April 1, 2013 $75,478.35
   - May 1, 2013 $69,664.45
   - June 1, 2013 $66,737.77
   - July 1, 2013 $61,379.94

25. A "reasonable rate of return" on the community spouse's available investment assets is 1% per annum. Investing $61,379.64 at 1% interest will produce monthly income of $51.15 for the community spouse.

26. The couple's combined resource standards were determined by the State agency to be $40,237.00, and the State agency denied the appellant's application because the couple's resources exceeded that amount.

**LEGAL BASIS**

Pursuant to Public Law 100-360, the Medicare Catastrophic Coverage Act (MCCA) of 1988, Section 1924 was added to the Social Security Act which mandates the use of special income and resource criteria in determining eligibility for certain institutionalized individuals. The special resource criteria pertain to individuals who are legally married to community spouses and who begin continuous periods of institutionalization in a hospital or health facility on or after September 30, 1989.

According to Section 3300.00.00 of the ICES Program Policy Manual, "Indiana's home and community based services waivers, approved under Section 1915(c) of the Social Security Act are designed to provide home care for persons who otherwise would need institutional care."

According to Section 3315.00.00 of the ICES Program Policy Manual, the Special Income Level (SIL) test is a specific financial eligibility determination that applies only to the Aged, Blind, and Disabled categories. The SIL eligibility test applies to all of the waivers, except the PRTF waiver. Refer to Section 3325.05.00 for SIL budgeting procedures.

When the SIL test is applicable, there are other specific eligibility provisions that apply as follows:
For the A&D waiver, TBI waiver, and MFP program for A/D and TBI, if the applicant/recipient passes the SIL test, then the spousal impoverishment protection resource provisions explained in Sections 2635.10.10 through 2635.10.10.15 are used. Spousal impoverishment protection is not used for any of the other waivers.

If the individual passes the SIL test, which is an eligibility step, then post-eligibility is the next step to determine the amount, if any, of the spend-down.

Parental income is exempt in the SIL test and if the child passes the SIL test, parental resources are exempt. If Medicaid coverage is needed prior to the start date of waiver services, retroactive coverage can be approved using regular eligibility rules for those months, including parental deeming as appropriate for the child’s category. If the parents request Medicaid coverage to coincide with the waiver start date, the parents are not required to provide any information regarding their income or resources.

According to Section 3010.20.15 of the ICES Program Policy Manual, The Special Income Level (SIL) used in determining eligibility under certain HCBS waivers is 300% of the SSI Maximum Benefit Rate. Effective 01-01-13, the SIL is $2130; (effective 1-1-12, $2094; 1-1-09 through 12-31-11, the SIL was $2022).

According to Section 3320.05.00 of the ICES Program Policy Manual, If the waiver applicant/recipient passes the SIL financial test, the resource eligibility rules for married couples explained in Sections 2635.10.10 through 2635.10.10.15 apply for the following waivers:

Aged and Disabled (A/D);
Traumatic Brain Injury (TBI)
MFP Program for A/D and TBI
If the waiver spouse fails the SIL test, regular resource rules and limits apply. The spousal impoverishment protection rules do not apply to any of the other waivers.

In determining whether spousal impoverishment protection applies in a given circumstance, waiver services are considered in the same manner as institutionalization. For example, a married couple both of whom are institutionalized are not subject to the special spousal rules; similarly, a married couple both of whom receive (or will receive if Medicaid eligible) waiver services are not subject to the special spousal rules. If the spouse of the waiver applicant/recipient is institutionalized, the special spousal rules do not apply regardless of the waiver type.
The resource assessment (RA) date (or snapshot, as it is sometimes called) is determined as explained in Section 2635.10.10 if the waiver spouse has a prior continuous period of institutionalization or receipt of A&D, TBI, or MFP services.

If the waiver spouse has never had a prior continuous period of institutionalization nor received waiver services, the snapshot date is determined as follows:

1. The date of the Medicaid application is the RA date if it is later than any of the dates below:
   - The date the waiver slot is obligated for the individual;
   - The date on which level of care is approved (not effective date);
   - The date on which the waiver Cost Comparison Budget (CCB) is approved.

2. If the date of the Medicaid application is earlier than all of the dates in #1, the RA date is the earliest of the 3 dates in #1.

The Community Spouse Resource Allowance used in the resource eligibility determination is the same as that used for institutionalized situations and is specified in Chapter 3000.

According to Section 3325.05.00 of the ICES Program Policy Manual, the SIL test is an eligibility test used in the MA A, MA B and MA D categories. If the individual passes the SIL test, it is followed by a post-eligibility calculation to determine the amount, if any, of the spend-down.

The Special Income Level (SIL) standard is 300% of the maximum benefit payable under the SSI program. The SIL increases annually when SSI increases in January. Refer to Chapter 3000 for the SIL amount. There is no couple SIL for a married applicant/recipient.

The income of the applicant/recipient is included in the SIL test. Income of parents and income of spouses is not included.

Countable income in the SIL test is as follows:

- Gross earnings (no exemptions, and no employment disregard)
- Net rental income (Sections 3420.05, 3420.05.05, 3415.10)
- Net self-employment income (Section 3410.15)
- All gross unearned income except SSI.

The amount of any income placed into an approved Miller trust as defined in Section 3320.10.00, is exempt in the SIL test. The amount of income placed into the trust could be the entire amount or a portion. The terms of the trust must specify the income source and amount in order for it to be exempt in the SIL test. Income placed into the Miller trust counts in the post-eligibility calculation.
If countable income is equal to or less than the SIL, the person passes the SIL test.

According to Section 2635.10.10.10 of the ICES Program Policy Manual, the community spouse's share of these resources is one-half of the married couple's combined countable resources, not to exceed the maximum community spouse resource allowance.

According to Section 3005.15.00 of the ICES Program Policy Manual, "...When an institutionalized individual has a spouse, the community spouse resource limit is the greatest of the following amounts effective January 1, 2013.

- the state standard of $23,184.00;
- the spousal share, up to a maximum of $115,920.00;
- any amount of resources ordered by a court against the institutionalized spouse for the support of the community spouse; or
- the amount established by an Administrative Law Judge as the result of an appeal."

According to Section 2635.10.10.10 of the ICES Program Policy Manual, the special resource provisions of the Medicare Catastrophic Coverage Act are applicable beginning with the first month of institutionalization included in the possible Medicaid covered period. The first of the month resource eligibility rule (refer to Section 2605.20.10) is applicable to resource eligibility determinations made under the special resource provisions for an institutionalized spouse with a community spouse. Beginning with this first month, the total value of the couple's non-exempt resources, including real property owned by the institutionalized spouse, is compared to their combined resource limit (the community spouse limit plus the standard for a single individual). If countable resources are equal to or less than the combined resource limit, the institutionalized spouse is eligible for assistance for that month, which is the initial month of special resource eligibility for the institutionalized spouse. For subsequent months during the continuous period of institutionalization, resources owned solely by the community spouse are exempt. If the countable resources exceed the standard, and ownership of real property is not involved, the institutionalized spouse is ineligible for that month. The process is repeated for subsequent months. If a month of eligibility does not occur, the application is to be denied. If the countable resources, including non-exempt real property, are greater than the standard, the next step is to subtract the equity value of the real property. If there still are excess resources in personal property, the applicant is ineligible. If not, the applicant must agree to offer the real property for sale or rent as a condition of eligibility.

Pursuant to 42 USC 1396r-5(e)(2)(c), "If either such spouse establishes that the community spouse resource allowance (in relation to the amount of income generated by such an allowance) is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance, there shall be substituted, for the
community spouse resource allowance under subsection (f)(2), an amount adequate to provide such a minimum monthly maintenance needs allowance."

Section 1924(d) of the Social Security Act [42 USC 1396r-5(d)(6)] was amended for all individuals institutionalized after February 7, 2006. Application of 'Income First' Rule to Revision of Community Spouse Resource Allowance.—for purpose of this subsection and subsections (c) and (e), a State must consider that all income of the institutionalized spouse that could be made available to a community spouse, in accordance with the calculation of the community spouse monthly income allowance under this subsection, has been made available before the State allocates to the community spouse an amount of resources adequate to provide the difference between the minimum monthly maintenance needs allowance and all income available to the community spouse.

According to Section 3010.20.10 of ICES Program Policy Manual, the Spousal Income Standard is $1892.00 (effective 07/01/12) and $1939.00 (effective 07/01/13), the Shelter Standard is $568.00 (effective 07/01/12) and $582.00 (effective 07/01/13), and the Maximum Spousal Maintenance Standard is $2898.00 (effective 01/1/13).

According to Section 3455.15.10.10 of the ICES Program Policy Manual, the excess shelter allowance is "...the amount by which the sum of the community spouse's expenses for shelter and utilities exceeds the shelter standard...The spousal income standard and the excess shelter allowance are added, thus arriving at the spousal maintenance standard. The spousal maintenance standard cannot exceed the maximum...."

According to Section 2635.10.10.15 of the ICES Program Policy Manual, once initial resource eligibility has been established, any amount of the community spouse resource standard which is not already solely in the community spouse's name, can be transferred to him by the institutionalized spouse and not be counted in determining the institutionalized spouse's continuing resource eligibility. The community spouse will have a period of 90 days in which to complete this transfer.

**CONCLUSIONS OF LAW**

The appellant and her spouse reside in assisted living together. On December 21, 2012, the appellant was approved for an Aged and Disabled Waiver therefore; this is her snapshot date. The appellant has not been institutionalized for 30 continuous days.

Inasmuch as the income available to the appellant in April 2013 does not exceed 300% of the SSI standard effective 1/1/2013 ($2130.00), she passes the SIL test and she is eligible to receive the benefits of income and resource calculations pursuant to the Medicaid Catastrophic Care Act.
The spousal income standard was $1892.00 for April 2013 through June 2013; and $1939.00 effective for July 2013, at the time of the effective date of potential eligibility.

The spousal income standard was $1,892.00 at the time of the effective date of potential eligibility or April 1, 2013. The community spouse has excess shelter costs of $3264.92 for April – June 2013, this amount plus the spousal income standard increases the community spouse’s the minimum monthly maintenance allowance to the maximum of $2898. The appellant is requesting an increase in this amount in order to meet the excess expenses of the community spouse. It has been demonstrated that the community spouse does have excesses, which result in extreme financial duress, if the spousal maintenance allowance is not increased.

The community spouse has extreme expenses of $4159.87, which exceed the maximum of $2898 by $1260.87. The community spouse is entitled to have the minimum monthly maintenance allowance increased to $4159.87. The appellant only has $636.90 in income; therefore this amount is to be allocated to the community spouse to bring him to the minimum monthly maintenance allowance now set.

The community spouse now has income of $3185.43 ($2548.53 + $636.90).

Since the appellant became institutionalized after February 7, 2006, the amendment to the Social Security Act [42 USC 1396r-5(d)(6)] applies in this case. This amendment requires the application of ‘Income First’ Rule prior to allocating to the community spouse additional resources adequate to provide the difference between the minimum monthly maintenance needs allowance and all income available to the community spouse.

The community spouse’s monthly maintenance allowance of $4159.87 minus his monthly income of $3185.43 leaves a monthly income shortfall of $974.44.

By considering the interest income of $77.90 from the couple’s total assets ($77,474.03 total resources x 1% interest = $774.74 annual interest income ÷ 12 months = $64.56 per month interest income), there remains a deficit.

Even with allocating all of the couple’s resources of $77,474.03 to the community spouse, the total interest generated by all resources still leaves the community spouse with a deficit per month in order to meet his community spouse monthly maintenance allowance.

The Administrative Law Judge establishes the community spouse’s resource standard to be $77,474.03.
The couple's resources are now less than the community spouse resource standard of $77,474.03 and the appellant's resource standard of $1500, therefore the appellant is resource eligible effective April 1, 2013.

DECISION

The Administrative Law Judge does not sustain the denial of Medical Assistance to the Aged to [redacted] effective April 1, 2013.

The Administrative Law Judge establishes the community spouse’s resource standard to be $77,474.03. The community spouse’s monthly maintenance allowance is set at 4159.87.

The agency is directed to complete the budgeting process with regard to the allocation of income.

A new notice shall be issued and the appellant shall retain all rights of hearing and appeal.

The appellant’s community spouse shall have 90 days to transfer all assets to his name only.

Kelli J. Kensill
Administrative Law Judge
(Signature electronically affixed by Kelli J. Kensill, Administrative Law Judge)

DATE: The Hearing Decision date is listed on the cover page: “NOTICE OF ADMINISTRATIVE HEARING DECISION IS ENCLOSED”
APPLICANT: [NAME]
CASE NO.: [CASE NUMBER]

FACTS: [NAME] was over 65 years of age when she entered the assisted living section of Heritage Pointe in November 2011. [NAME] is seeking eligibility for waiver services, so the spousal allocation rules of the Medicare Catastrophic Coverage Act apply. [NAME] has not been institutionalized for more than thirty (30) consecutive days after September 30, 1989. On December 20, 2012, an application for Medicaid was filed with FSSA on behalf of [NAME]. [NAME] was notified on December 21, 2012, her slot for waiver services was targeted. The snapshot date in this case is the date her waiver slot was targeted, December 21, 2012.

[NAME] is the Community Spouse of [NAME]. Indiana Family and Social Services Administration ("FSSA") and [NAME] entered into a Stipulation of Fact (Exhibit 8) documenting the total countable resources of [NAME] were $77,474.03 on the snapshot date December 21, 2012.

[NAME] sold their home in July 2013. The net proceeds of $82,825.50 were deposited into their account on July 16, 2013.

A new application for Medicaid benefits was filed for [NAME] on July 31, 2013. Their application was denied on September 6, 2013. A timely appeal requesting all of their countable resources be set aside for the Community Spouse and asks for an increase in the monthly maximum maintenance allowance to allow [NAME] to continue to share an assisted living room. Their current monthly living expenses are approximately
$7,500 each month. The approval of Medicaid Waiver slot will reduce these expenses by approximately $3,000 each month.

receives gross monthly Social Security income of $1,307.90 and gross monthly pension income of $1,240.63, without consideration of income allocated from IS entitled to a monthly income of $1,892.00 for April, May, and June 2013, under the provisions of The Medicare Catastrophic Coverage Act of 1988 ("MCCA"). This amount increased to $1,939.00 effective July 1, 2013.

had the following countable resources as determined by Family and Social Services Administration ("FSSA"):

<table>
<thead>
<tr>
<th>Date</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 1, 2013</td>
<td>$75,478.35</td>
</tr>
<tr>
<td>May 1, 2013</td>
<td>$69,664.45</td>
</tr>
<tr>
<td>June 1, 2013</td>
<td>$66,737.77</td>
</tr>
<tr>
<td>July 1, 2013</td>
<td>$61,379.94</td>
</tr>
</tbody>
</table>

countable resources were reduced by $14,098.41 over a four month period of time.

is entitled to an excess shelter allowance since his monthly shelter expenses exceed $568 for April 1, 2013, through June 30, 2013, and exceed $582 for July 1, 2013, forward. pays average monthly rent of $3,832.92 ($126/day x 30.42) for his assisted living care, which is medically necessary. is entitled to an allocation of $349.47 from to bring his income to the Maximum Community Spouse Income Share of $2,898.00.

has medication and medical expenses for his health care in addition to the average rent of $3,832.92 per month. These expenses vary from month to month. These expenses for April 1, 2013, through July 31, 2013, were:
April  $ 43.00  AARP Medicare Rx premium
    $125.65  United Health Care
    $255.91  Neighborcare Pharmacy
    $424.56

May    $ 43.00  AARP Medicare Rx premium
    $125.65  United Health Care
    $121.24  Neighborcare Pharmacy
    $289.89

June   $ 43.00  AARP Medicare Rx premium
    $125.65  United Health Care
    $130.28  Neighborcare Pharmacy
    $298.93

July   $ 43.00  AARP Medicare Rx premium
    $125.65  United Health Care
    $125.76  Neighborcare Pharmacy
    $294.41

These medical expenses average $326.95 per month from April 1, 2013 through July 31, 2013.

... has living expenses above and beyond these monthly expenses. ... expenses are more than his monthly spousal standard. ... requests the Administrative Law Judge to establish a higher monthly standard due to exceptional circumstances resulting in significant financial duress to allow him to remain in assisted living.

... with the allocation from ... has monthly income of $2,898. He has average medical expenses of $4,159.87 ($3,832.92 + $326.95).

... received gross monthly Social Security income of $636.90. The allocation of all of her income to the Community Spouse would raise his income to
$3,185.43. This amount is not sufficient to meet his average expenses of $4,159.87 per month.

pays monthly rent of $3,832.92 ($126 per day x 30.42). She has monthly medical costs of $125.65 for United Healthcare and $43.00 for AARP Medicare Rx.

**LEGAL BASIS:** Under the provisions of the MCCA, FSSA must make a determination of the spousal allocation from the institutionalized spouse to the community spouse to meet the monthly spousal standard subject to a maximum.

Under 42 USC 1396r-5(e)(2)(c), “If either such spouse establishes that the community spouse resource allowance (in relation to the amount of income generated by such an allowance) is inadequate to raise the community spouse’s income to the minimum monthly maintenance needs allowance, there shall be substituted, for the community spouse resource allowance under subsection (f)(2), an amount adequate to provide such a minimum monthly maintenance needs allowance.”

Also under 42 USC 1396r-(5)(d)(6), “For purposes of this subsection and subsections (c) and (e), a State must consider that all income of the institutionalized spouse that could be made available to a community spouse, in accordance with the calculation of the community spouse monthly income allowance under this subsection, has been made available before the State allocates to the community spouse an amount of resources adequate to provide the difference between the minimum monthly maintenance needs allowance and all income available to the community spouse.”

Under 42 U.S.C. §1396r-5(e)(2)(A)(i), the institutionalized spouse or the community spouse may request an increase in the community spouse monthly income allowance if the
community spouse needs additional income. Furthermore, under 42 U.S.C. §1396r-5(e)(2)(B), if the institutionalized spouse or the community spouse can show the community spouse needs income above the monthly spousal standard, due to exceptional circumstances resulting in significant financial duress, an additional amount may be provided.

This section is codified in IC 12-15-2-25(c) as follows: if either spouse establishes that a higher allowance is needed due to exceptional circumstances resulting in significant financial duress, the minimum monthly needs allowance may be increased after an administrative hearing or by a court order. FSSA has also established under ICES Manual Section 4205.10.05 that if the couple can appeal the income allocation and if they can show "the community spouse needs a higher allocation due to exceptional circumstances resulting in extreme financial duress."

According to §3005.15.00 of the Integrated Policy Manual for Public Assistance Programs, "The community spousal resource limit is the greatest of the following amounts effective April 1, 2013:

a. the state standard of $23,184;
b. the spousal share, up to a maximum of $115,920;
c. any amount of resources ordered by a court against the institutionalized spouse for the support of the community spouse; or
d. the amount established by an Administrative Law Judge as the result of an appeal.

CONCLUSION: [redacted] had countable resources of $61,379.64 as of July 1, 2013. The Stipulation of Fact entered into by FSSA and [redacted] states that 1% is a fair rate of return for their investments. The investing of $61,379.64 at 1% interest will produce income of $51.15 per month for [redacted] request that the sum of $1,200,000 be established as the resource standard.
has average shelter and medical expenses of $4,159.87 per month and would receive income of only $2,898 per month under the standard Medicaid provisions. Has shown he has exceptional circumstances which result in significant financial distress. Respectfully request a determination that is eligible for Medicaid as of April 1, 2013; a determination that the community spouse’s expenses are exceptional circumstances resulting in significant financial distress and increase the monthly spousal standard for the community spouse at $4,159.87 per month; and a determination that all of the couple’s non-exempt assets be allocated to

Respectfully Submitted,

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Bluffton, IN 46714
(260) 824-5566
To: All Providers

Subject: Hospice, Home and Community-Based Services, and Medicaid Home Health Services

The purpose of this document is to clarify when home health, hospice, and home and community-based services (HCBS), delivered via either the Medicaid Waiver program, BDSS State Line Services, or the CHOICE program, can be utilized in the delivery of services to our mutual clients.

Additionally, this document announces the policy change, effective September 1, 2009, to allow individuals who have elected the hospice benefit to also apply for and possibly receive HCBS. Therefore, a client electing the hospice benefits can request home and community-based services which may supplement the hospice services without duplication.

Note:

• Reminder: home and community-based services are the funding of last resort.

• The terms client, participant, individual, and consumer are used interchangeably within the Office of Medicaid Policy and Planning and the Divisions. Each term refers to the person actually receiving hospice, Medicaid State Plan, CHOICE, state funded, and/or waiver services.

Listed below are examples that will identify what is allowed through each funding source.

1. Clients currently receiving HCBS may also elect hospice services.

Example #1
A client receiving home and community-based services may elect the Medicare or Medicaid hospice benefit as deemed eligible. The HCBS case manager may request additional home and community-based services as long as those home and community-based services are not duplicative of hospice services. Within the Division of Disability and Rehabilitative Services, additional home and community-based services may only be requested when reflected within the client/participant’s individualized support plan and at the agreement of the participant’s support team. The hospice provider must provide all required services to meet the needs of the client in relation to the terminal diagnosis.

2. A client receiving hospice may supplement services by adding HCBS, effective September 1, 2009.

Example #2
A client who is currently receiving the Medicare or Medicaid hospice benefit may supplement services by applying for HCBS through the appropriate Division as long as those HCBS are not duplicative of hospice services and are available through the applicable source. Although no waiting list exists for the Aged and Disabled Medicaid waiver within the Division of Aging, within the Division of Disability
and Rehabilitative Services, the otherwise eligible client/applicant may be placed on a waiting list for Indiana Medicaid HCBS waiver services unless specific priority criteria is met, enabling the participant to enter into waiver services at the time of application. The hospice provider must provide all required services to meet the needs of the client in relation to the terminal diagnosis.

3. A client who is eligible to receive Medicaid state plan services may elect hospice benefits.

Example #3
A client who is currently receiving Medicaid state plan services may elect Medicare or Medicaid hospice benefits for his/her terminal illness. The client may receive unduplicated services through both programs.

4. A client who is currently receiving hospice benefits may elect to discontinue those hospice benefits and seek alternate means of meeting his/her health care needs.

Example #4
A client who is currently receiving Medicare or Medicaid hospice benefits may withdraw from the hospice program at any time. The client may choose to seek alternate means of meeting his/her health care needs at any time.

It is very important that each client’s medical condition is thoroughly reviewed and all viable options are discussed with the client so that an informed choice can be made. It is our hope that the above information is helpful as you discuss options with your clients.

Please feel free to contact the Division of Aging with any question or concerns:

- Jade Luchauer at (317) 234-1913 – CHOICE program
- Michelle Stein-Ordonez at (317) 233-1956 – home health and hospice
- Susan Waschevski at (317) 232-7148 – nursing facility level of care waivers

Please feel free to contact the Division of Disability and Rehabilitative Services with any questions or concerns:

- Juman Bruce at (317) 232-7820 – BDDS State Line Services
- Lynn Jump at (317) 234-2764 – MR/DD level of care waivers

Thank you for your continued hard work and dedication to the delivery of services to those in need.

If you need additional copies of this bulletin, please download them from the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/bulletin_results.asp. To receive e-mail notifications of future IHCP publications, subscribe to the IHCP E-mail Notifications at http://www.indianamedicaid.com/ihcp/mailing_list/default.asp.
Waiver Budgeting

Jane and Roy live at home. Roy meets nursing home level of care. The CCB was approved on July 17, 2015. His Medicaid application was filed on July 23, 2015, making it the snapshot date. He was eligible for Medicaid August 1, 2015.

Monthly Income:

<table>
<thead>
<tr>
<th></th>
<th>Roy:</th>
<th>Jane:</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSD</td>
<td>$2,439.90</td>
<td>Wages $2,279.00</td>
</tr>
<tr>
<td></td>
<td>104.90 Part B</td>
<td></td>
</tr>
<tr>
<td></td>
<td>127.07 Ins.</td>
<td></td>
</tr>
<tr>
<td>SIL</td>
<td>2,199.00</td>
<td></td>
</tr>
<tr>
<td>Initial Liability</td>
<td>$8.00 before spousal allocation</td>
<td></td>
</tr>
</tbody>
</table>

Shelter Expenses:

- Mortgage 541.00
- Insurance 48.57
- Taxes 64.15
- St. Util. Ded. 415.00

Shelter Ex. $1,068.72
Ex. Shelter Ded. -598.00
Ex. Shelter Alloc. $470.00

He established a QIT so the SIL was met. The QIT deposit is $240.90.

$240.90 Liability
- 104.90 Part B
- 127.07 Supplemental Health Insurance
- 183.00 Spousal Allocation
$0.00 Liability

Spousal Allocation:

- Minimum Maintenance Allowance $1,992.00
- Excess Shelter Expense 470.00
- Comm. Spouse income share $2,462.00
- Spouse’s Salary -$2,279.00
- Spousal Allocation $183.00