Scope of Work

Appendix 2

Deeming/Katie Beckett Optional Eligibility Category and HCBS Waivers

2131 - COMMUNITY CARE SERVICES PROGRAM

POLICY STATEMENT

Community Care Services Program (CCSP) is a Class of Assistance (COA) designed to provide in home and community-based services to individuals. These individuals meet the criteria for nursing home placement but choose to remain in a residential home situation.

BASIC CONSIDERATIONS

To be eligible under the CCSP COA, an A/R must meet the following conditions:

- The A/R is admitted to CCSP and receiving a waivered service(s).
- The A/R resides in a residential home situation, such as his/her own home, another person's home or a personal care home.
- The A/R meets the Length of Stay (LOS) and Level of Care (LOC) eligibility criteria.
- The A/R meets all other basic and financial eligibility criteria.

NOTE: There is no age requirement for participation in CCSP. A client is not required to be homebound to receive CCSP services.

CCSP Medicaid recipients receive certain *waivered* services not normally covered by Medicaid, including the following:

- Adult Day Health
- Alternate Living Services (personal care home placement)
- Emergency Response System
- Home Health Services/Home Delivered Services
- Personal Support Services
- Respite Care

NOTE: To maintain continuous eligibility for CCSP Medicaid, a client must receive waivered services each calendar month.

Individuals who express an interest in Community Care services are to be referred to the Area Agency on Aging for assessment. The telephone screening specialist assesses the individual's suitability for community-based care in lieu of nursing home placement. If the individual meets the CCSP eligibility criteria, the A/R’s name is placed on the CCSP waiting list. When funds become available, the individual is referred to the Care Coordination Agency for a face-to-face assessment.

BASIC CONSIDERATIONS (cont.)

- If the individual is determined eligible at the face-to-face assessment, s/he is admitted to CCSP.
- The care coordinator arranges for the provision of the CCSP waivered services to the recipient.
- CCSP is a budgeted program, therefore, it is limited to a certain number of clients statewide.

NOTE: The date the first waivered service is provided to the CCSP recipient is the service date.

PROCEDURES

Follow the steps below to determine ABD Medicaid eligibility under the CCSP COA.

Step 1 Accept the A/R's Medicaid application.

Step 2 Conduct an interview.

Step 3 Verify that the A/R is under CCSP care coordinator and receiving waivered service(s) by receipt of the Community Care Communicator (CCC). The CCC should indicate the beginning date of care coordination and the service date.

Step 4 Determine basic eligibility, including Length of Stay (LOS) and Level of Care (LOC). Refer to the **Chapter 2200, Basic Eligibility Criteria**.

Step 5 Determine financial eligibility.

- See **Chapter 2500, ABD Financial Responsibility and Budgeting**, for procedures on whose resources to consider and the resource limit to use in determining resource eligibility.
- Complete a Medicaid CAP budget to determine income eligibility. Refer to the **Section 2510, Medicaid CAP Budgeting**.

Step 6 Determine the A/R's cost share for CCSP services. Refer to **Section 2559, Patient Liability/Cost Share and Section 2553, Protection of Income.**

PROCEDURES (cont.)

Step 7 Approve CCSP Medicaid if the A/R meets all the above eligibility criteria.

NOTE: DO NOT approve Medicaid under the CCSP class of assistance for any month earlier than the month of the service date.

Step 8 Notify the A/R of case disposition and cost share.

Step 9 Notify the care coordinator of the disposition and cost share on the CCC or by entering the care coordinator's name and address in the system as the Authorized Representative. This will enable the care coordinator to receive system generated notices giving dates of eligibility and cost share information.

Step 10 Complete a review of the case in the month in which the CCSP LOC expires as indicated in Field 41, L.O.S, of the LOC form.

- If a new LOC form extending the stay is received from the CCSP care coordinator, continue Medicaid eligibility under the CCSP COA.

- If the new LOC form stating that the LOC has **NOT** been extended is received from the care coordinator OR a new LOC form is not received from the CCSP care coordinator by the end of the month the LOC expires, complete a CMD. Refer to the **Section 2052, Continuing Medicaid Determination**. Notify the CCSP care coordinator of the outcome of the CMD and any change in cost share.

NOTE: If LOC form or CCC is not received within two weeks from the end of the approved CCSP stay, send a CCC to the care coordinator requesting information on whether the stay has been extended.

NOTE: If Medicaid eligibility is terminated as a result of the CMD and a new LOC form is subsequently received within 30 days of the termination date on the system, reopen the case as closed in error. If a new LOC form is received more than 30 days after the system termination date, process a new application. The month the new LOC form is signed is the **earliest** month for which the case can be reopened under the CCSP COA.

PROCEDURES (cont.)

CCSP Temporarily In a NH

If a CCSP A/R temporarily enters a NH (30 days or less), they may continue as CCSP if the NH is enrolled as a CCSP provider. The NH stay would be billed as respite care. The MES would not make any changes in the system based on the temporary NH stay. Change to NH COA if the A/R remains for more than 30 days.

Joint CCSP and Hospice Eligibility

A CCSP recipient may elect to receive Hospice services along with CCSP. Hospice is paid directly by DCH without any Hospice information entered into DFCS' computer system. A/R should remain in CCSP COA. If A/R was in Hospice COA, switch to CCSP. See Appendix I, SUCCESS Functions, for instructions.

Special Considerations

A disabled child may be eligible for a $30 SSI personal needs allowance from SSA if s/he meets the following criteria:

- Is disabled
- Received SSI benefits (limited to PNA) while in a medical treatment facility
- Is ineligible for SSI solely because of deemed income or resources of the parents
- Is currently eligible for Medicaid under one of the following COAs:
  - TEFRA/Katie Beckett (Section 2133)
  - CCSP (Section 2131)
  - Is receiving services under GAPP (Section 2933)

If the child meets the above criteria, refer the parent(s) to SSA to continue the SSI $30 PNA payment and Medicaid. Continue to maintain the child under the COA above unless the child no longer meets the criteria for that program.

2132 – New Options Waiver (NOW) and Comprehensive Supports Waiver Program (COMP)

POLICY STATEMENT

New Options Waiver (NOW)/ Comprehensive Supports Waiver Program (COMP) are classes of assistance (COA) designed to provide in-home and community based services to Medicaid eligible intellectually disabled and developmentally disabled individuals who do not receive Medicaid benefits under a cash assistance program.

BASIC CONSIDERATIONS

To be eligible under the NOW/COMP COA, an A/R must meet the following conditions:

- The A/R is approved for waivered services by an MHDDAD Regional Office.
- The A/R is approved by an Intake and Evaluation Team (I & E) for the NOW/COMP, evidenced by a completed DMA-6 or DMA-7(only used for NOW/COMP).
- The A/R is placed in a NOW/COMP slot and is receiving NOW/COMP waivered services.
- The A/R meets the Length of Stay (LOS) and Level of Care (LOC) basic eligibility criteria.
- The A/R meets all other basic and financial eligibility criteria.

NOW/COMP Medicaid recipients receive certain *waivered* services, including the following:

- Support Coordination
- Community Access
- Community Residential Alternative
- Community Guide
- Specialized Medical Equipment and Supplies
- Environmental Accessibility Adaptation
- Vehicle Adaptation
- Community Living Support
- Behavioral Supports Consultation Services
- Financial Support Services
- Professional Therapeutic Services (in and out of home)
- Transportation
- Adult Dental Services

Respite services (including overnight), natural support training, and individual directed goods and services are applicable to the NOW Waiver only.

Community residential alternative services are applicable to the COMP Waiver only.

The individual determined suitable by the I and E Team for NOW/COMP is placed under support coordination (case management).

The Support Coordinator arranges for the provision of waivered services to the recipient.

BASIC CONSIDERATIONS (cont.)

NOTE: The beginning date of Support Coordination (case management) is the same as the **enrollment date** for an A/R leaving an institution, and the same as the **date services begin** for an A/R already residing in the community.

A/Rs who are coming out of an institution may receive Support Coordination for up to six months prior to placement in MRWP/CHSS and while they are still living in the facility.

PROCEDURES

Follow the steps below to determine ABD Medicaid eligibility under the NOW/COMP COA.

Step 1 Accept the A/R's application, the Form 1008, NOW/COMP Communicator, and approved LOC instrument.

NOTE: After April 1, 2003, DMA-6s will no longer be completed by GMCF but by private vendors contracting with Mental Health. Instead of an actual DMA-6, it will be a mailer containing pertinent information. A new LOC instrument is required upon entry into NOW/COMP

Step 2 If the A/Rs income includes SSI, STOP, deny application. SSI NOW A/Rs' claims are directly billed to DCH through the NOW agency.

Step 3 If the A/R is institutionalized or resides in the community, and is ABD Medicaid eligible, schedule a review when information is received from the Support Coordinator or provider. Proceed to Step 6.

Step 4 If the A/R is institutionalized or resides in the community, and is not currently eligible for Medicaid, schedule an initial interview when information is received from the Support Coordinator or provider.

Step 5 Determine basic eligibility. Refer to Chapter 2200, Basic Eligibility Criteria.

Step 6 Determine financial eligibility.

- Refer to Chapter 2500, ABD Financial Responsibility and Budgeting.
- Complete a Medicaid Cap Budget to determine income eligibility. Refer to Section 2510, Medicaid Cap Budgeting.

Step 7 Determine if the Length of Stay criteria is met. Refer to Section 2235, Length of Stay.

Step 8 The system will determine the A/R's Cost Share for NOW/COMP services. Refer to Chapter 2559, Patient Liability/Cost Share**. The PNA is the same amount as the Medicaid Cap.**

PROCEDURES (cont.)

Step 9

Approve if the A/R meets all eligibility criteria.

NOTE: Do not approve Medicaid under the NOW/COMP COA for any month prior to the month of either the NOW/COMP Enrollment Date or Date Services Begin listed on Form 1008, NOW/COMP Communicator, or prior to 2/1/94, the effective date of the NOW, or 10/1/97, the effective date of the COMP amendment.

Step 10

Complete Section III of Form 1008, NOW/COMP Communicator. Enter the Medicaid number at the top of the form. Send to the originating I & E Team with a copy to the Regional Office(as noted on Form 1008). A list of Regional Office addresses and the counties they serve is found at the end of Section 2132. The I & E Team will complete the return address for the I & E Team and the Regional Office. File a copy in the case record.

Step 11

Notify the A/R and any authorized representative of case disposition.

Annual Reviews and Specials

Effective March 1, 2002, all DMA-6 forms processed by the I & E Teams for continued LOC will be completed on or before the birth date of the recipient. It will be valid until the following birth date, but not for longer than 365 days.

A new LOC instrument will not be required at annual review unless the review month coincides with the recipient's birth month. Otherwise, a LOC instrument received in the birth month of a recipient is to be treated as a special review.

SPECIAL CONSIDERATIONS

The NOW/COMP COA requires one specifically designated form, a Form 1008, NOW/COMP Communicator. The Communicator must be reproduced locally. A copy of Form 1008 is found in Appendix F.

The NOW/COMP Communicator functions much like the Community Care Communicator (CCC). The form is initiated by the I & E Team completing the following sections:

- The top section, with all identifying information except the Medicaid number, unless the A/R is already a Medicaid recipient.
- Section I
- Section II
- Section IV
- Section V should include the I & E Team's address.

Division of Mental Health, Developmental Disabilities and Addictive Diseases
REGIONAL OFFICES, REGIONAL HOSPITALS and COMMUNITY SERVICE BOARDS
Revised August 3, 2005

<table>
<tr><th>Region</th><th>Regional Hospital</th><th>Community Service Board</th><th>Counties in Service Area</th></tr>
<tr><td colspan="4">REGION ONE (1 Page of 2)</td></tr>
<tr><td rowspan="3">Charles Fetner
Regional Coordinator

Vacant
Regional Services Administrator

1305 Redmond Circle
Building 401
Rome, Georgia 30165
Phone 706-802-5272
1-800-646-7721
FAX 706-802-5280

<u>Admin. Asst</u>: Chris Novak</td><td rowspan="3">Northwest Georgia Regional Hospital
1305 Redmond Circle
Rome, Georgia 30161
24 Hour (706) 295-6011

Karl H. Schwarzkopf, Ph.D.
Regional Hospital Administrator
Phone (706) 295-6246
Fax (706) 802-5454

Thomas W. Muller, M.D.
Clinical Director
Phone (706) 295-6285
Fax (706) 295-6320</td><td>Tom Ford, Ph.D., Director
Lookout Mountain Community Services
P.O. Box 1027
Lafayette, GA 30728
<u>Telephone</u>: (706) 638-5584
<u>FAX</u>: (706) 638-5585
S.P.O.E. ACCESS NUMBER:
1-800-882-1552</td><td>Catoosa
Chattooga
Dade
Walker</td></tr>
<tr><td>Klay Weaver, Director
Highland Rivers Community Service Board
1710 White House Drive, Suite 204
Dalton, Georgia 30720
<u>Telephone</u>: (706) 270-5000
<u>FAX</u>: (706) 270-5124
S.P.O.E. ACCESS NUMBER:
1-800-923-2305

*Haralson Behavioral Health
*Haralson County receives many MHDDAD services from Haralson Behavioral Health Services operated by the Board of Health.
S.P.O.E. ACCESS NUMBER:
770-836-9551 or
1-877-937-9911</td><td>Bartow
Cherokee
Fannin
Floyd
Gilmer
Gordon
Haralson*
Murray
Paulding
Pickens
Polk
Whitfield</td></tr>
<tr><td>Joan Turner, Director
Pathways Center for Behavbioral and Developmental Growth
120 Gordon Commercial Drive, Suite A
LaGrange, GA 30240-5740
<u>Telephone</u>: (706) 845-4045
<u>FAX</u>: (706) 845-4341
S.P.O.E. ACCESS NUMBER:
1-888-247-9048</td><td>Carrol
Coweta
Heard
Meriwether
Troup</td></tr>
</table>

Region	Regional Hospital	Community Service Board	Counties in Service Area
REGION ONE (Page 2 of 2)			
		Cathy Johnson, Director **McIntosh Trail Community Service Board** 1501-A Kalamazoo Drive Griffin, GA 30224 Telephone: (770) 358-8251 FAX: (770) 229-3223 **S.P.O.E. ACCESS NUMBER: 770-358-5252**	Butts Fayette Henry Lamar Pike Spaulding Upson

<table>
<tr><th>Region</th><th>Regional Hospital</th><th>Community Service Board</th><th>Counties in Service Area</th></tr>
<tr><td colspan="4">REGION TWO (Page 1 of 2)</td></tr>
<tr><td rowspan="3">Audrey Sumner
Regional Coordinator

Daniel McFerran
Regional Services Administrator
3405 Mike Padgett Highway, Bldg. 3
Augusta, GA 30906
Phone 706-792-7733
FAX 706-792-7740

Admin. Asst:
Vacant</td><td rowspan="3">East Central Regional Hospital
100 Myrtle Boulevard
Gracewood, GA 30812
24 Hour (706) 790-2011

East Central Regional Hospital (Augusta)
3405 Mike Padgett Highway
Augusta, GA 30906
24 Hour (706) 792-7006

Gail Jackson M.D.
Regional Hospital Administrator
100 Myrtle Boulevard
Gracewood, GA 30812
Phone (706) 790-2030
Fax (706) 790-2025

Lydia E. Weisser, D.O., M.B.A.
Clinical Director
3405 Mike Padgett Highway
Augusta, GA 30906
Phone (706) 792-7021 or (706) 790-2160
Fax (404) 212-4628</td><td>Laura Tyler, P.H.D., Director
Georgia Mountains Community Services
4331 Thurmond Tanner Road
Flowery Branch, GA 30542-2829
Telephone: (678) 513-5700 or 1-800-527-5827
Emergency and Night Number: 1-800-347-5827
FAX: (678) 513-5827
S.P.O.E. ACCESS NUMBER:
1-800-347-5827</td><td>Banks
Dawson
Forsyth
Franklin
Habersham
Hall
Hart
Lumpkin
Rabun
Stephens
Towns
Union
White</td></tr>
<tr><td>Charles D. Williamson, Director
Community Service Board of East Central Georgia
3421 Mike Padgett Highway
Augusta, GA 30906-3815
Telephone: (706) 432-7800
FAX: (706) 432-3791
S.P.O.E. ACCESS Number:
1-800-766-6041
Behavioral Health Link
961 Broad Street
Augusta, GA 30901</td><td>Columbia
Lincoln
McDuffie
Richmond
Taliaferro
Warren
Wilkes</td></tr>
<tr><td>J. Frank Brantley, Director
Ogeechee Behavioral Health Services
P.O. Box 1259
Swainsboro, GA 30401-1259
Telephone: (478) 298-2522
FAX: (478) 289-2544
(Secretary-Donna Almond)
S.P.O.E. ACCESS NUMBER:
1-800-766-6041
Behavioral Health Link
961 broad Street
Augusta, GA 30901</td><td>Burke
Emanuel
Glascock
Jefferson
Jenkins
Screven</td></tr>
</table>

Region	Regional Hospital	Community Service Board	Counties in Service Area
REGION TWO (Page 2 of 2)			
		Terry Tellefson, Director **Advantage Behavioral Health Systems** 250 North Avenue Athens, GA 30601-2244 Telephone: (706) 542-9739 FAX: (706) 542-9681 **S.P.O.E. ACCESS NUMBER: 1-800-357-9774**	Barrow Clarke Elbert Greene Jackson Madison Morgan Oconee Oglethorpe Walton
		Bobby Robbins, Director **GRN Community Service Board** P.O. Box 687 Lawrenceville, GA 30046-0687 Telephone: (770) 339-5019 FAX: (770) 339-5382 **S.P.O.E. ACCESS NUMBER: 770-962-5544 OR 1-800-241-3175**	Gwinnett Newton Rockdale
		Angela Hicks-Hill, Director **Oconee Community Service Board** P.O. Box 1827 Milledgeville, GA 31059-1827 Telephone: (478) 445-4817 FAX: (478) 445-4963 **S.P.O.E. ACCESS NUMBER: (478) 445-3201** **Crisis Line 1-877-229-5082**	Baldwin Hancock Jasper Putnam Washington Wilkinson

Region	Regional Hospital	Community Service Board	Counties in Service Area
REGION THREE (Page 1 of 2)			
Earnestine Pittman Regional Coordinator **Lynn Copeland** Regional Services Administrator 100 Crescent Centre Parkway Suite 900 Tucker, GA 30084-7055 Phone 770-414-3052 FAX 770-414-3048 **Admin. Asst**: DeAnn Glover	**Georgia Regional Hospital at Atlanta** 3073 Panthersville Road Decatur, GA 30037 24 Hour (404) 243-2216 **Ron Hogan** Regional Hospital Administrator Phone (404) 243-2110 Fax (404) 212-4621 **J. Mark Rowles, M.D.** Clinical Director Phone (404) 243-2114 Fax (404) 212-4628	**Gary S. Richey, Director** **Dekalb Community Service Board** 445 Winn Way, Room 464 Decatur, GA 30030-1707 or P.O. Box 1648 Decatur, GA 30032 Telephone: (404) 294-3836 FAX: (404) 508-7795 Switchboard: (404) 294-3834 **S.P.O.E. ACCESS NUMBER: 404-892-4646**	Dekalb
		Bobby Robbins, Director **GRN Community Service Board** P.O. Box 687 Lawrenceville, GA 30046-0687 Telephone: (770) 339-5019 FAX: (770) 339-5382 **S.P.O.E. ACCESS NUMBER: 770-962-5544 or 1-800-241-3175**	Gwinnett Newton Rockdale
		Jade Benefield, Director **Clayton Community MH, AD Developmental Services** 112 Broad Street Jonesboro, GA 30236-1919 Telephone: (770) 478-2280 FAX: (770) 477-9772 **S.P.O.E. ACCESS NUMBER: 770-478-1099 or 1-888-740-9280** **Behavioral Health Services** **853 Battle Creek Road** **Jonesboro, GA 30236**	Clayton Clayton Fulton

Region	Regional Hospital	Community Service Board	Counties in Service Area
Region Three (Page 2 of 2)			
		Tod Citron, Director **Cobb County Community Service Board** 3830 South Cobb Drive, Suite 300 Smyrna, GA 30080 Telephone: (770) 429-5000 FAX: (770) 438-5136 **S.P.O.E. ACCESS NUMBER:** **770-422-0202**	Cobb Douglas
		Klay Weaver, Director **Highland Rivers Community Service Board** 1710 White House Drive, Suite 204 Dalton, Georgia 30720 Telephone: (706) 270-5000 FAX: (706) 270-5124 **S.P.O.E. ACCESS NUMBER:** **1-800-923-2305** ***Haralson Behavioral Health** *Haralson County receives many MHDDAD services from Haralson Behavioral Health Services operated by the Board of Health. **S.P.O.E. ACCESS NUMBER:** **770-836-9551 or** 1-877-937-9911	Bartow Cherokee Fannin Floyd Gilmer Gordon Haralson* Murray Paulding Pickens Polk Whitfield
		Cathy Johnson, Director **McIntosh Trail Community Service Board** 1501-A Kalamazoo Drive Griffin, GA 30224 Telephone: (770) 358-8251 FAX: (770) 229-3223 **S.P.O.E. ACCESS NUMBER:** **770-358-5252**	Butts Fayette Henry Lamar Pike Spaulding Upson

<table>
<tr><th>Region</th><th>Regional Hospital</th><th>Community Service Board</th><th>Counties in Service Area</th></tr>
<tr><td colspan="4">Region Four (Page 1 of 3)</td></tr>
<tr>
<td rowspan="3">David Sofferin
Regional Coordinator

Ken Brandon
Regional Services Administrator

P.O. Box 1378
Thomasville, Ga 31799
Phone 229-225-5099
FAX 229-227-2918
1-877-683-8557

Admin. Asst:
Marilyn Bryant</td>
<td rowspan="3">Southwestern State Hospital
400 South Pinetree Boulevard
Post Office Box 1378
Thomasville, Georgia 31799
24 Hour (229) 227-2915, 2700

Beverly Bajerski,
Regional Hospital Administrator
Phone (229) 227-3020
Fax (229) 227-2883

Joseph LeRoy, M.D.
Clinical Director
Phone (229) 227-2990
Fax (229) 227-2753

Central State Hospital
Powell Building
620 Broad Street
Milledgeville, GA 31062
24 Hour (478) 445-4169

Marvin Bailey,
Regional Hospital Administrator
Phone (478) 445-4128
Fax (478) 445-6034

Vacant
Clinical Director
Phone (478) 445-4515
Fax (478) 445-6034</td>
<td>Faye Holt, Acting, Director
Albany Area Community Service Board
P.O. Box 1988
Albany, GA 31702-1988
Telephone: (229) 430-4042
FAX: (229) 430-4047
S.P.O.E. ACCESS NUMBER: 1-866-582-7763
Behavioral Healthcare Consultants
First Contact
P.O. Box 819
Newton, Georgia 31770</td>
<td>Baker
Calhoun
Dougherty
Early
Lee
Miller
Terrell
Worth</td>
</tr>
<tr>
<td>Robert Jones, Director
The Georgia Pines Community MHDDAD Services
1102 Smith Avenue, Suite K
Thomasville, GA 31792-1659
Telephone: (229) 225-4370
FAX: (229) 225-4374
S.P.O.E. ACCESS NUMBER: 1-866-582-7763
Behavioral Healthcare Consultants
First Contact
P.O. Box 819
Newton, Georgia 31770</td>
<td>Colquitt
Decatur
Grady
Mitchell
Seminole
Thomas</td>
</tr>
<tr>
<td>Frank Fields, Director
River Edge Behavioral Health Center
175 Emery Highway
Macon, GA 31217-2692
Telephone: (478) 751-4515
FAX: (478) 752-1040
S.P.O.E. ACCESS NUMBER: 478-751-4519</td>
<td>Bibb
Jones
Monroe
Twiggs</td>
</tr>
</table>

Region	Regional Hospital	Community Service Board	Counties in Service Area
Region Four (Page 2 of 3)			
	West Central Georgia Regional Hospital **30000 Schatulga Road** **Columbus, GA 31907** **24 Hour (706) 568-5000** **James Jackson**, Regional Hospital Administrator Phone (706) 568-5203 Fax (706) 568-2257 **Anthony Dougherty, M.D.** Clinical Director, Interim Phone (706) 568-5209 Fax (706) 568-2257	**Don Blair, Director** **Phoenix Center Behavioral Health Center** P.O. Box 2866 Warner Robbins, GA 31099-2866 Telephone: (478) 322-4058 FAX: (478) 322-4085 Director's Phone: (478) 322-4059 **S.P.O.E. ACCESS NUMBER: 1-888-740-9280**	Crawford Houston Peach
		Perry Alexander, Director **New Horizons** P.O. Box 5328 Columbus, GA 31906-0328 Telephone: (706) 596-5583 FAX: (706) 596-5589 **S.P.O.E. ACCESS NUMBER: 706-596-5507 or 1-800-241-3659**	Chattahoochee Clay Harris Muscogee Quitman Randolph Stewart Talbot
		Pam Davis, Director **Middle Flint Behavioral HealthCare** P.O. Drawer 1348 Americus, GA 31709-1348 Telephone: (229) 931-2470 FAX: (229) 931-2474 **S.P.O.E. ACCESS NUMBER: 229-931-2404 or 1-800-342-7843**	Crisp Dooly Macon Marion Schley Sumter Taylor Webster

Region	Regional Hospital	Community Service Board	Counties in Service Area
Region Four (Page 3 of 3)			
		Patsy Thomas, Director **Community Service Board of Middle Georgia** 2121 A Bellevue Road Dublin, GA 31021-2998 Telephone: (478) 272-1190 FAX: (478) 272-0102 **S.P.O.E. ACCESS NUMBER: 478 272-1190 or 1-800-868-5423 After Hours**	Bleckley Dodge Johnson Laurens Montgomery Pulaski Telfair Treutlen Wheeler Wilcox
		Angela Hicks-Hill, Director **Oconee Community Service Board** P.O. Box 1827 Milledgeville, GA 31059-1827 Telephone: (478) 445-4817 FAX: (478) 445-4963 **S.P.O.E. ACCESS NUMBER: (478) 445-3201** **Crisis Line 1-877-229-5082**	Baldwin Hancock Jasper Putnam Washington Wilkinson

Region	Regional Hospital	Community Service Board	Counties in Service Area
Region Five (Page 1 of 2)			
Charles Ringling Regional Coordinator **Lorr Elias** Regional Services Administrator 1915 Eisenhower Dr., Building 2 Savannah, GA 31406 Phone: 912-303-1670 FAX: 912-351-6309 1-800-348-3503 **Admin. Asst.: Sarah Dunbar**	**Georgia Regional Hospital at Savannah** **1915 Eisenhower Drive** **Savannah, GA 31406** **24 Hour (912) 356-2030** **Frank Drummond, M.D.** **Regional Hospital Administrator** **Phone: (912) 356-2045** **FAX: (912) 351-3550** **John Prather, M.D.** **Clinical Director, Interim** **Phone: (912) 356-2482** **FAX: (912) 351-3550**	**Frank Bonati, Dr. PH., Director** **Gateway Community Service Board** 1000 Commissioners Drive Darien, GA 31305 Telephone: (912) 437-9300 FAX: (912) 437-9483 **S.P.O.E. ACCESS NUMBER: 912-280-1405 or 1-866-713-7763 (for Brunswick)** **Savannah Area Behav. Health Collaborative (SABHC)** **Route 1, Box 280** **Bloomingdale, GA 31302** Telephone: (912) 966-3782 FAX: (912) 966-3775 **S.P.O.E ACCESS NUMBER 1-800-342-8168**	Bryan Camden Chatham Effingham Glynn Liberty Long McIntosh Chatham
		June Dipolito, Director **Pineland Area MHDDAD Community Service Board** P.O. Box 745 Statesboro, GA 30459-0745 Telephone: (912) 764-6906 FAX: (912) 489-3058 **S.P.O.E. ACCESS NUMBER: (912) 764-6129 or 1-800-746-3526**	Appling Bulloch Candler Evans Jeff Davis Tattnall Toombs Wayne
		J. Frank Brantley, Director **Ogeechee Behavioral Health Services** P.O. Box 1259 Swainsboro, GA 30401-1259 Telephone: (478) 298-2522 FAX: (478) 289-2544 (Secretary-Donna Almond) **S.P.O.E. ACCESS NUMBER: 1-800-766-6041** **Behavioral Health Link** **961 broad Street** **Augusta, GA 30901**	Burke Emanuel Glascock Jefferson Jenkins Screven

Region	Regional Hospital	Community Service Board	Counties in Service Area
Region Five (Page 2 of 2)			
		Dennis Wool, Ph.D., Director **Satilla Community Services** P.O. Box 1397 Waycross, GA 31502-1397 Telephone: (912) 284-2543 FAX: (912) 287-6660 S.P.O.E. Access Number 1-800-342-8168	Atkinson Bacon Brantley Charlton Clinch Coffee Pierce Ware
		Patsy Thomas, Director **Community Service Board of Middle Georgia** 2121 A Bellevue Road Dublin, GA 31021-2998 Telephone: (478) 272-1190 FAX: (478) 272-0102 **S.P.O.E. ACCESS NUMBER: 478 272-1190 or 1-800-868-5423 After Hours**	Bleckley Dodge Johnson Laurens Montgomery Pulaski Telfair Treutlen Wheeler Wilcox
		Sue Gupton, Interim Director **Behavioral Health Services of South GA** 3120 N. Oak Street Extension Suite C Valdosta, GA 31602-1007 Telephone: (229) 333-7095 FAX: (229) 333-7093 **S.P.O.E. ACCESS NUMBER: 229-247-4440 or 1-800-766-6041**	Burke Emanuel Glascock Jefferson Jenkins Screven

2133 – TEFRA/KATIE BECKETT

POLICY STATEMENT

Katie Beckett is a class of assistance (COA) available to children under age 18 who are financially ineligible for SSI.

These individuals are determined to be in need of institutionalized care but have chosen to remain at home because they can be cared for at a lower cost. Katie Beckett allows the deeming of the income and resources of the child's parents to be *waived* when determining ABD Medicaid eligibility.

BASIC CONSIDERATIONS

To be eligible under the Katie Beckett COA, an A/R must meet the following conditions:

- The A/R's age does not extend past the month s/he turns age 18.
- The A/R is chronically impaired to the extent of being a suitable candidate for institutionalized care (nursing facility, hospital or intermediate care facility for the intellectually disabled).
- The A/R is financially ineligible for SSI in a private living arrangement (LA-A, B or C) due to his/her own income and/or resources or income/resources deemed from his/her parent(s).
- The A/R meets the Level of Care (LOC) basic eligibility criteria.
- The A/R meets all other basic and financial eligibility criteria.

NOTE: Length of Stay (LOS) is **not** a requirement for this COA.

In some situations, a child may be eligible for either CCSP, NOW/COMP, or Katie Beckett. The benefits of each COA should be explained to the parent(s) or other personal representative. Also, the availability of CCSP and NOW/COMP services should be considered.

NOTE: Georgia Medical Care Foundation will determine disability on all Katie Beckett Level of Care determinations. No additional information or request needs to be completed, just complete the below steps for both LOC and Disability.

PROCEDURES

Follow the steps below to determine ABD Medicaid eligibility under the Katie Beckett COA.

Step 1 Accept the A/R's Medicaid application.

Step 2 Screen for SSI financial eligibility in one of the following ways:

- Complete a SSI trial budget, deeming the income and/or resources of the child's parent(s). Refer to Section 2508, Deeming. Allow a one third deduction to the child's own income if it is Child Support from a non-custodial parent.

- Obtain a current SSI denial letter, if available. However, do NOT require the family to apply for SSI if completion of a SSI trial budget indicates ineligibility for SSI.

If the child is financially eligible for SSI, deny the ABD Medicaid application and refer the child to SSA for a SSI determination.

If the child is financially ineligible for SSI, proceed with the Katie Beckett application.

NOTE: Review any reduction in the income or resources that might make the child eligible for SSI. Schedule interim reviews if changes are anticipated, and terminate Katie Beckett Medicaid if the child becomes eligible for SSI.

Step 3 Give the family (or foster care worker if A/R is foster child) a packet of information regarding Katie Beckett COA. Go over forms/instructions with them so that they thoroughly understand how to complete. This packet should include:

- Katie Beckett Cover Letter
- Pediatric DMA-6(A) and instructions for completion
- TEFRA/Katie Beckett Medical Necessity/Level of Care Statement (DMA-706)
- Cost-Effectiveness Form (DMA-704)

The A/R's family (or foster care worker), the attending physician and Medicaid Eligibility Specialist (MES) have roles in completing a DMA-6(A) on the A/R. Refer to Appendix F – Forms for instructions in completing DMA-6(A).

The A/R's physician completes the Medical Necessity/Level of Care Statement that outlines how the child's needs are met and the desired outcomes. The caregiver (parent or guardian) must

PROCEDURES (cont)

sign and date. Foster Care members must have the signature of the DFCS representative. Refer to Appendix F – Forms for instructions on completing the Medical Necessity/Level of Care Statement.

The A/R's physician completes the Cost-Effectiveness Form.

Step 4

When the family (foster care worker) returns the DMA-6(A), the Cost-Effectiveness Form and the Medical Necessity/Level of Care Statement, check the forms to make sure that EVERY question has been addressed, even if completed with N/A (not applicable). The forms must be signed with original signatures by the physician, parent(s), foster care worker as indicated. Stamped signatures are not acceptable. The doctor's signature date on the DMA-6(A) is valid for 90 days. Return to the family for completion if lacking any of the requirements. Give them a reasonable time frame in which to return information

Step 5

Have the family (foster care worker) obtain a signed psychological evaluation if any of the following is indicated on the DMA-6(A):

- Section B, item number 13, has a diagnosis of either mental illness, intellectually disabled, autism, or Asperger's syndrome

OR

- Section C, item number 33, Behavioral Status has ANY of the boxes checked OTHER THAN "Cooperative" and/or "Alert".

A psychological evaluation may be completed by a Ph.D., M.Ed., Child Development Specialist (Babies Can't Wait), Developmental Pediatrician or School Psychologist to accompany the other forms which are sent to GMCF. At initial application, this evaluation must have been completed within the last 3 years of the date received at GMCF.

Give the family a reasonable time in which to return the psychological evaluation.

Step 6

When the Medical Necessity/Level of Care Statement, Form DMA-706, is received from the family (foster care worker), make sure copies of therapy notes are attached if indicated. The signature date on the Medical Necessity/Level of Care Statement is valid for 90 days.

PROCEDURES (cont.)

Step 7

When the Medical Necessity/Level of Care Statement, Form DMA-706, is received from the family (foster care worker), make sure copies of Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP) are attached if indicated.

Step 8

Once the MES has received all the necessary information/forms, the MES becomes the "gatekeeper" of the material. As such, copies should be made of any data sent to GMCF.

Step 9

The LOC and disability determinations are obtained by **mailing** the following completed items to the Georgia Medical Care Foundation (GMCF).

- Level-of-Care determination routing form/checklist (DMA-705)
- DMA-6(A)
- Medical Necessity/Level of Care Statement (DMA-706)
- Psychological (if indicated)
- Therapy Notes (if indicated)
- IFSP (if indicated)
- IEP (if indicated)

Send ALL items together at one time. Please check all forms and make sure they are complete. Mail packet to :

Georgia Medical Care Foundation
Attention: TEFRA/Katie Beckett
P.O. Box105406
Atlanta, GA 30348

NOTE: If at any time the mailing address of the parents of a KB child changes during the LOC determination process please notify GMCF via the TEFRA/Katie Beckett routing form/checklist (DMA 705).

Step 10

GMCF reviews the information submitted and does the following:

- If packet is incomplete, GMCF will issue an initial technical denial, which includes what items are missing. Letter is sent to DFCS and the family. The Family will have 30 days to return the missing information to GMCF. The address for the family to mail information to is printed on the letter. If the family mistakenly sends the

PROCEDURES (cont.)

information to DFCS, forward immediately to GMCF to the address on the letter.

If additional information is not received by the 30th day then GMCF will issue a final technical denial.

- If packet is complete, GMCF makes the LOC determination.

  - If LOC approval letter is received from GMCF, continue with eligibility determination process, Step 14.
  - If LOC is initially denied by GMCF, the family and DFCS will receive an "Initial Denial of Admission" letter. Proceed to Step 11.

Step 11

The "Initial Denial of Admission" letter will identify the specific reason for the LOC denial. The family will have only 30 days from the date on the letter to appeal the decision by providing additional clinical information directly to GMCF for a reconsideration of the LOC determination. When counting days, day one is the first day following the date on the letter, regardless of whether that day is a weekend or a holiday. However, if the 30th day falls on a weekend or a holiday, the next full business day is the 30th day. The address for the family to respond to is printed on the letter.

If the family mistakenly sends the information to DFCS, forward immediately to GMCF to the address on the letter.

GMCF will make a LOC determination, and the MES will proceed as follows:

- If approval letter is subsequently received, continue with eligibility determination process, Step 14.

If GMCF denies LOC or family fails to appeal and/or provide additional clinical information within the 30 days after the LOC denial, DFCS and family will receive a "Final Determination Denial of Admission". The letter will cite the specific criteria not met. The family will have an additional 30 days in which to appeal and/or provide medical information. For applications, MES will deny the case for no LOC. DO NOT WAIVE notice. For reviews, see REVIEW in this section.

PROCEDURES (cont.)

If the family challenges the LOC denial, the family will send the appeal directly to DCH's Legal Services at:

Georgia Department of Community Health
Legal Services Section
2 Peachtree Street – 40th Floor
Atlanta, Georgia 30303

The appeal to DCH must be made within 30 days of the date of the LOC denial letter. When counting days, day one is the first day after the date on the letter, regardless of whether that day is a weekend or holiday. However, if the thirtieth falls on a weekend or holiday, the next full business day is the thirtieth day.

Should the family send the appeal to DFCS, forward the appeal to DCH's Legal Services. The state office Medicaid Unit will notify the county if an appeal has been filed. There are no benefits to continue with a denied application.

An Administrative Law Judge (ALJ) conducts the hearings for both LOC hearings and hearings for other reasons. However, requests for LOC hearings are routed through DCH Legal Services, not through OSAH. Follow the OSAH procedures (Appendix B – Hearings) for any hearing requests other than LOC.

Step 12

The MES will do the following based on the outcome of the final LOC hearing:

- If the ALJ upholds the LOC denial, the case remains closed. No further action is required. However, if the family wants to appeal the ALJ decision, see Step 13.
- If the ALJ overturns the LOC denial and provides a letter to that affect, the MES will register the Katie Beckett case again using the original application date and complete the eligibility determination process. It is not necessary to have the family sign a new application. Proceed to Step 14 or any other step not completed.

Step 13

To appeal the ALJ decision, the family should file a written request for an agency review within 30 days of receipt of the decision to:

Department of Community Health
Commissioner Clyde Reese
Office of the General Counsel
2 Peachtree St, NW, 40th floor
Atlanta, Georgia 30303

PROCEDURES (cont.)

A copy must also be sent to DCH Legal at the same address in Step 11 , or they may fax copy to 404-657-5766.

Step 14

Determine the child's suitability for care under a home care plan in lieu of institutionalized placement using the Cost-Effectiveness Form and the Katie Beckett Worksheet. Refer to Appendix F – Forms for the Worksheet.

Complete a Katie Beckett Worksheet as follows:

- Based on the approved LOC as determined by GMCF, select the Medicaid cost of the appropriate institution using DCH's provided amounts. Refer to Appendix A1 for amounts. Base the type of institution chosen by the LOC reflected on the LOC approval letter.

NOTE: If the LOC is hospital, submit the Cost-Effectiveness Form and Katie Beckett Worksheet to DCH until such time as the amount to use in determining cost-effectiveness for hospitals has been provided. Mail/fax copy of forms DMA-704 and the KB Worksheet to your area Medicaid Program Specialist, who will forward to DCH for completion.

- Subtract the physician's estimated monthly cost of home care on the Cost-Effectiveness Form from the monthly Medicaid billing rate of the institution.
- If in-home care is **more** costly, **deny** the Katie Beckett application.
- If in-home care is **less** costly or **equal** to, proceed with the Katie Beckett application.

NOTE: Take into consideration in the cost comparison process any health or LTC insurance coverage. Do not use GAPP services/costs in the cost effectiveness determination. This includes skilled nursing care.

NOTE: The MES should never complete the Cost-Effectiveness Form for the family. If the doctor leaves blanks on the form, it is up to the family to get it completed. Other medical entities may complete and initial the parts of the form that pertain to services they render to the A/R.

Step 15

Proceed with the eligibility determination process, completing financial and other Basic Eligibility Criteria, if not already completed.

PROCEDURES (cont.)

NOTE: Medicaid eligibility under the Katie Beckett COA is not held to the pay date shown on the LOC approval letter for new applications or LOC expirations. For new applications the three months prior may be approved even if those months pre-date the pay date on the LOC letter. For LOC expirations the LOC is approved from the end date of the previous LOC approval even if those dates pre-date the pay date on the LOC approval letter. The end date of the LOC is one year from the date that the LOC determination was completed by GMCF, unless the LOC letter indicates otherwise.

Step 16

If the A/R meets all eligibility criteria, approve Medicaid on the system by entering all pertinent data including any retroactive months. The system will determine financial eligibility using the Medicaid Cap and issue notification letter(s). There is no patient liability for this COA.

REVIEWS

Complete a review of eligibility annually and document any anticipated change in resources, income or potential SSI eligibility.

Complete Steps 3, 4, 8 – 10, and 13 - 16. If the DMA-6(A) indicates that a psychological evaluation is required, see Step 6 for procedures. Submit a new psychological to GMCF every third year of receipt of Medicaid under this COA. However, in the intervening years, provide GMCF with a copy of the still current psychological. If the Care Plan indicates the A/R receives therapy, follow procedures in Step 6. If the Care Plan indicates IFSP and/or IEP, follow procedures in Step 7.

Complete the following if the LOC is denied:

- If the family receives a letter of “Initial Denial of Admission” and submits additional clinical information timely to GMCF, leave case open pending “Final Determination Denial of Admission” or LOC approval.
- If family receives the “Final Determination Denial of Admission” from DCH, the family has 30 days in which to appeal. The MES should close the case effective the end of the month in which the 30 day appeal time falls. DO NOT waive notice.
- The state office Medicaid Unit will notify the county if the family has requested an appeal of the LOC. If the family

Reviews (cont)

appeals and requests that the case remains open pending the appeal or provides additional medical information to GMCF, the MES should reinstate the case. Add the following text to the reinstatement notice: "Case is reopened pending the outcome of the appeal or reconsideration based on additional medical information."

- If the family appeals the denial and the LOC denial is overturned, reinstate the case, if not already reinstated.
- If the family appeals the denial and the hearing upholds the LOC denial, close the case, if reinstated, and waive the notice. If the family wishes to appeal the upheld LOC denial, they should make this appeal in writing to the DCH Commissioner. See Step 13.
- If the family does not appeal, the case remains closed

NOTE: The end date of the LOC is one year from the date that the LOC determination was completed by GMCF, unless the LOC letter indicates otherwise. As much as possible align the expiration of the LOC with the annual review. However, never allow the LOC to expire before a new one is obtained. Best practice is to send the Katie Beckett packet with the DMA-6(A) to the family at least a month prior to the expiration of the LOC. Anytime the A/R becomes ineligible for Katie Beckett Medicaid, terminate the case and complete a CMD. Refer to Section 2052, Continuing Medicaid Determination.

PROCEDURES FOR CHILD TURNING EIGHTEEN

In the month the A/R turns 18 years of age, allow the Katie Beckett COA to close for the ongoing or following month. Then register and approve the A/R under SSI Medicaid (S10) beginning the first month the Katie Beckett COA is closed. Send a verification checklist to the A/R or AREP requesting verification of application for SSI benefits. If the A/R fails to apply for SSI, close the existing case for failure to make application for other benefits. If the A/R provides verification of application for SSI, allow the SSI Medicaid (S10) COA to remain open until the month after the month the child turns 19 years of age or until the SSI application is approved. If SSA makes a determination of **not** disabled, close the SSI Medicaid (S10) COA providing timely notice.

NOTE: Eligibility must be reviewed under all Medicaid COA's (Waivers, etc.) before closing the (S10) COA.

SPECIAL CONSIDERATIONS

A disabled child may be eligible for a $30 SSI personal needs allowance from SSA if s/he meets the following criteria:

- Is disabled
- Received SSI benefits (limited to PNA) while in a medical treatment facility
- Is ineligible for SSI solely because of deemed income or resources of the parents
- Is currently eligible for Medicaid under one of the following COAs:
  - Katie Beckett (Section 2133)
  - CCSP (Section 2131)
  - Services under GAPP (Section 2933)

If the child meets the above criteria, refer the parent(s) to SSA to continue the SSI $30 PNA payment and Medicaid. Continue to maintain the child under the COA above unless the child no longer meets the criteria for that program.

2139 – INDEPENDENT CARE WAIVER PROGRAM

POLICY STATEMENT

The Independent Care Waiver Program (ICWP) is a class of assistance (COA) that provides in home care to individuals who are Severely Physically Disabled (SPD) or who have Traumatic Brain Injuries (TBI). SPD individuals are those who cannot physically care for themselves and require assistance from another for daily functioning. These individuals need more care than can be provided by CCSP. ICWP A/Rs must meet the criteria for nursing home placement although they remain at home.

BASIC CONSIDERATIONS

To be eligible under this COA, an A/R must meet the following conditions:

- The A/R is between 21 through 64 years of age. Applicants approved prior to age 65 may continue to be eligible after attaining age 65 if they continue to meet all other eligibility criteria.
- The A/R is receiving case management services through a DMA approved ICWP case management provider.
- The A/R is residing in a residential home situation, such as his/her own home.
- The A/R meets the length of stay (LOS) and the level of care (LOC) basic eligibility criteria.
- The A/R meets all other basic and financial eligibility criteria.

ICWP Medicaid recipients receive certain *waivered* services not normally covered by Medicaid, including the following:

- case management
- companion services
- counseling
- emergency response system (ERS)
- environmental modification
- homemaker services
- occupational therapy
- personal care services
- skilled nursing
- specialized medical equipment and supplies
- transportation.

Refer any individuals interested in receiving services under ICWP to Georgia Health Partnership (GHP) at 678/527-3632, 3619 or 3633. The toll free number is (800) 982-0411, extension 3619.

BASIC CONSIDERATIONS (cont.)

The case management provider (case manager) submits the LOC information to GMCF and initiates the ICWP services approval process.

- The case manager obtains the LOC instrument and sends to DFCS. Receipt of the LOC instrument verifies the LOC for ICWP. A DMA-6 is still a valid LOC instrument for some of the older cases.
- The case manager submits an Individual Plan of Care and a Recipient Application form to the DMA Waivered Services Unit for approval of ICWP services. The Waivered Services Unit notifies the case manager of approval or denial of the A/R for ICWP services.
- If DMA approves the A/R, the case manager submits an Independent Care Waiver Communicator to DFCS, specifying the date case management began, which is used for LOS, and the date of the first waivered service, which serves as the slot date for eligibility purposes in the same manner as it is used under CCSP.

NOTE: The beginning date of case management and the slot date should be the same in most cases, since case management is a waivered service under ICWP.

If ICWP services are approved by DMA, the case manager and the A/R decide on service providers.

The A/R may apply for ICWP Medicaid while residing at home, in a hospital or in a nursing home.

PROCEDURES

Follow the steps below to determine ABD Medicaid eligibility under the ICWP class of assistance.

Step 1 Accept the A/R's ABD Medicaid application.

Step 2 Obtain information necessary to process application.

Step 3 Verify that the A/R is receiving ICWP services through receipt of an ICWP Communicator from the case manager. The ICWP Communicator should indicate the beginning date of case management and the slot date.

PROCEDURES (cont.)

Step 4 Determine basic eligibility, including Length of Stay (LOS) and Level of Care (LOC). Refer to Chapter 2200, Basic Eligibility Criteria.

NOTE: If DFCS has not received the LOC instrument within 30 days of the application date, contact the case manager to obtain it.

Step 5 Determine financial eligibility. Consider the A/R to be in LA-D.

- See Chapter 2500, ABD Financial Responsibility and Budgeting, for procedures on whose resources to consider and the resource limit used in determining resource eligibility.
- Complete a Medicaid Cap budget to determine income eligibility. See Medicaid CAP Budgeting in Chapter 2510.

Step 6 Determine the A/R's cost share using the Community Spouse Maintenance Need Standard (CSMNS) as the personal needs allowance (PNA) and all other policies applicable to patient liability/cost share budgeting.

NOTE: If AR is over the Medicaid CAP and has a QIT please remember that there is the potential of a cost share with these cases. Case will be completed in success with a zero cost share. EW will compute cost share manually and notify via the ICWP Communicator.

Step 7 Notify the A/R of eligibility/cost share.

NOTE: Do not approve Medicaid under the ICWP class of assistance for any month prior to the month of the slot date. Do not approve Medicaid under the ICWP COA if the A/R is under age 21 or age 65 or older.

Step 8 Notify the ICWP Case manager by:

- Entering the Case Manager's name and address in the system as an Authorized Representative. The Case Manager will then receive information concerning dates of eligibility and cost share.

OR

- Completing Section II of the ICWP Communicator. Enter the Medicaid number on the top of the form. Send one copy to the Case Manager and retain the other in the case record.

SPECIAL CONSIDERATIONS

ICW Communicator (ICWC)

The ICWP class of assistance requires the Independent Care Waiver Communicator (ICWC) form as a means for the ICWP Case Manager to communicate with the DFCS Eligibility Worker. The Eligibility Worker may use this form or the system as a means of relaying ICWP approval, denial or termination information to the Case Manager. Make copies of this form, found at the end of this section, as needed.

The ICWC functions much like the Community Care Communicator (CCC). The form is initiated by the case manager and forwarded to DFCS after the A/R is approved for ICWP services. The case manager completes the following sections of the ICWC:

- The top section, with all identifying information except the Medicaid number unless the A/R is already a Medicaid recipient.

- Section I, giving the date case management began, the slot date, and a request for a determination of Medicaid eligibility (if needed) and cost share amount.