
CERTIFICATION OF ELIGIBILITY

CERTIFYING THE SERVICE PLAN PACKET

The service plan packet is the collection of forms and documents used to certify that the individual is eligible for waiver program participation.

ASSEMBLING THE PACKET

The care manager is responsible for assembling the packet and assuring the forms are completed and signed and dated by the proper individuals. It should be identified as a new application packet. The packet must be sent for review and verification before services can be funded by the waiver program.

The initial service plan packet should include the following items:

- Cover letter
- Automated Long Term Care Functional Screen (LTC FS), completed by a certified screener, including the eligibility results page (the last page of the LTC FS). The screen completion date should be within 90 days prior to the waiver start date.
- COP-W/CIP II Assessment/Supplement Form – 6.0 Version to the LTC FS (completed and sign/dated by a qualified care manager, certified social worker, and/or RN). The Assessment/Supplement should be current – i.e. best practice would be within 90 days prior to the waiver start date.
- Health Form* (*if an RN did NOT sign/date the Supplement Form*), signed by a registered nurse, physician, or physician's assistant.) If the Supplement is signed/dated by a RN, no Health Form needs to be completed for the initial service plan. If a Health Form needs to be completed, the signature date should be within 90 days before or after the waiver start date.
- Medicaid Waiver Eligibility and Cost Sharing Worksheet or CWB screen printouts
- ISP (signed and dated by the participant, guardian (if applicable), or authorized representative (if applicable) and the care manager)
- ISP – Individual Outcomes filled out completely
- Formula to Determine Amount of Income Available to pay for Room and Board in Substitute Care Form (DDE-920) completed for participants who reside in a substitute care facility (if applicable)
- Variance Request for Institutional Respite (if applicable)
- Variance Request for an Adult Day Care located in or on the grounds of a nursing home (if applicable)
- Variance Request for an individual who is elderly who will reside in a CBRF 21 beds or above (if applicable)
- Information about a Ramp - Home Modification (if applicable)
- Information about a Home Modification if over \$2,000 (if applicable)
- Request for a No Active Treatment (NAT) and required documentation (if applicable)

CERTIFICATION PROCESS

The packet is first reviewed for technical compliance:

- Are all the components of the packet included and completed correctly?
- Are the documents signed and dated by the appropriate persons?
- Is the LTC FS dated within 90 days prior to the expected effective waiver eligibility date?
- Is the Assessment/Supplement filled out completely?
- Is the Assessment/Supplement signed and dated by the appropriate person(s)?
- Does the information in the Assessment/Supplement coincide with the information entered on the LTC FS?
- Are medical and remedial expenses listed? If they exceed \$100, is there an explanation of expenses?
- Does the applicant/participant have a cost share? Is it listed in box 10 on the ISP or in the text of the ISP? Is it clearly identified? Is it clear that the applicant/participant is the funding source?
- Are the SPC Codes on the ISP correct?
- Does the information on the forms support each other? (No contradictions)
- Has the ISP – Individual Outcome page been filled out completely?
- Do the waiver services that are listed on the ISP have an identified and corresponding outcome?

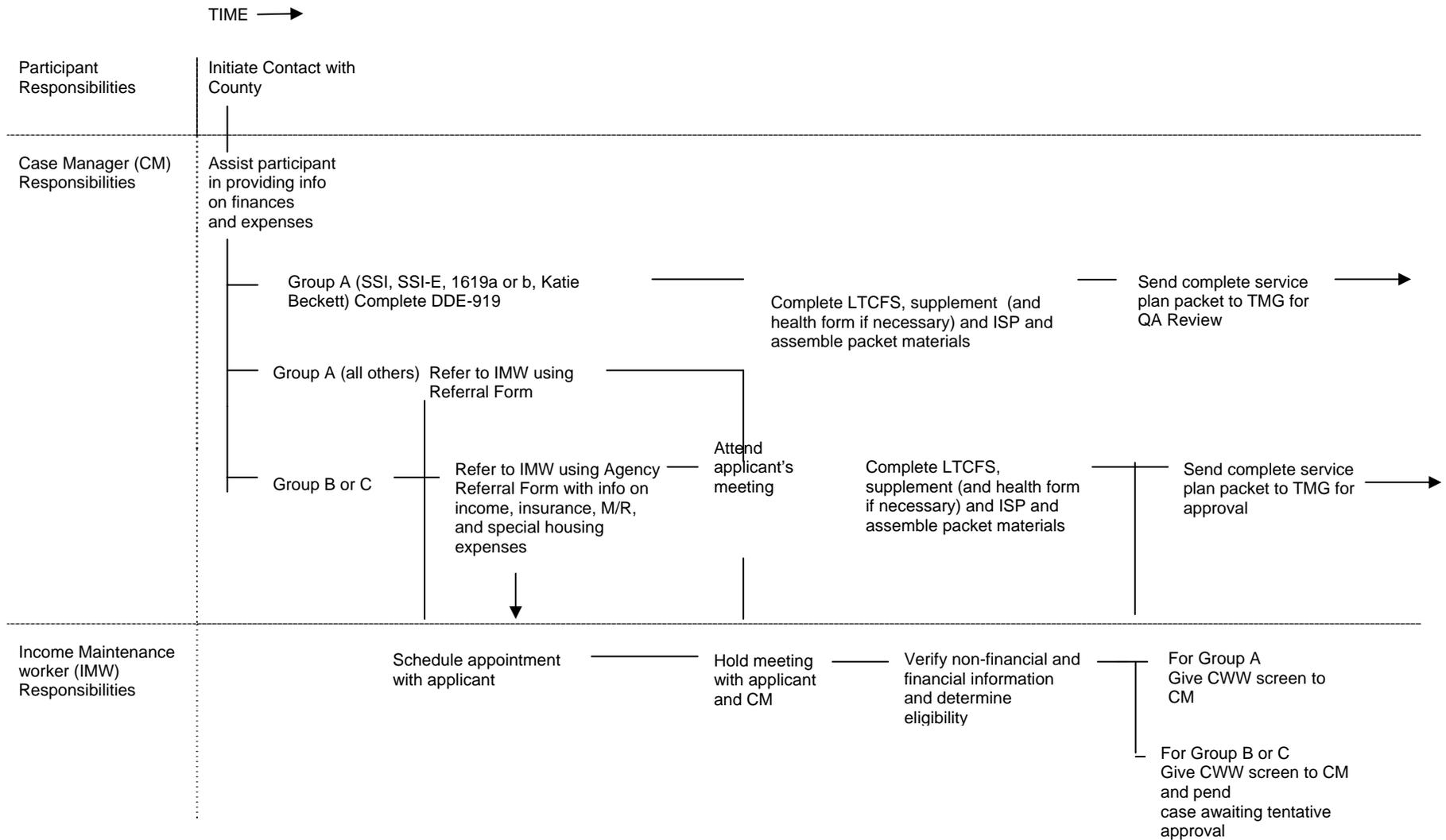
The packet is then reviewed for quality issues:

- Are all concerns identified in the LTC FS addressed in the Assessment/Supplement?
- Are all concerns raised in the Assessment/Supplement addressed in the plan?
- Do there appear to be any unmet safety needs?
- Do the Assessment/Supplement and ISP appear to give a complete picture of the applicant's/participant's needs, wants, and interests?
- Does it appear the applicant's/participant's preferences have been indicated?

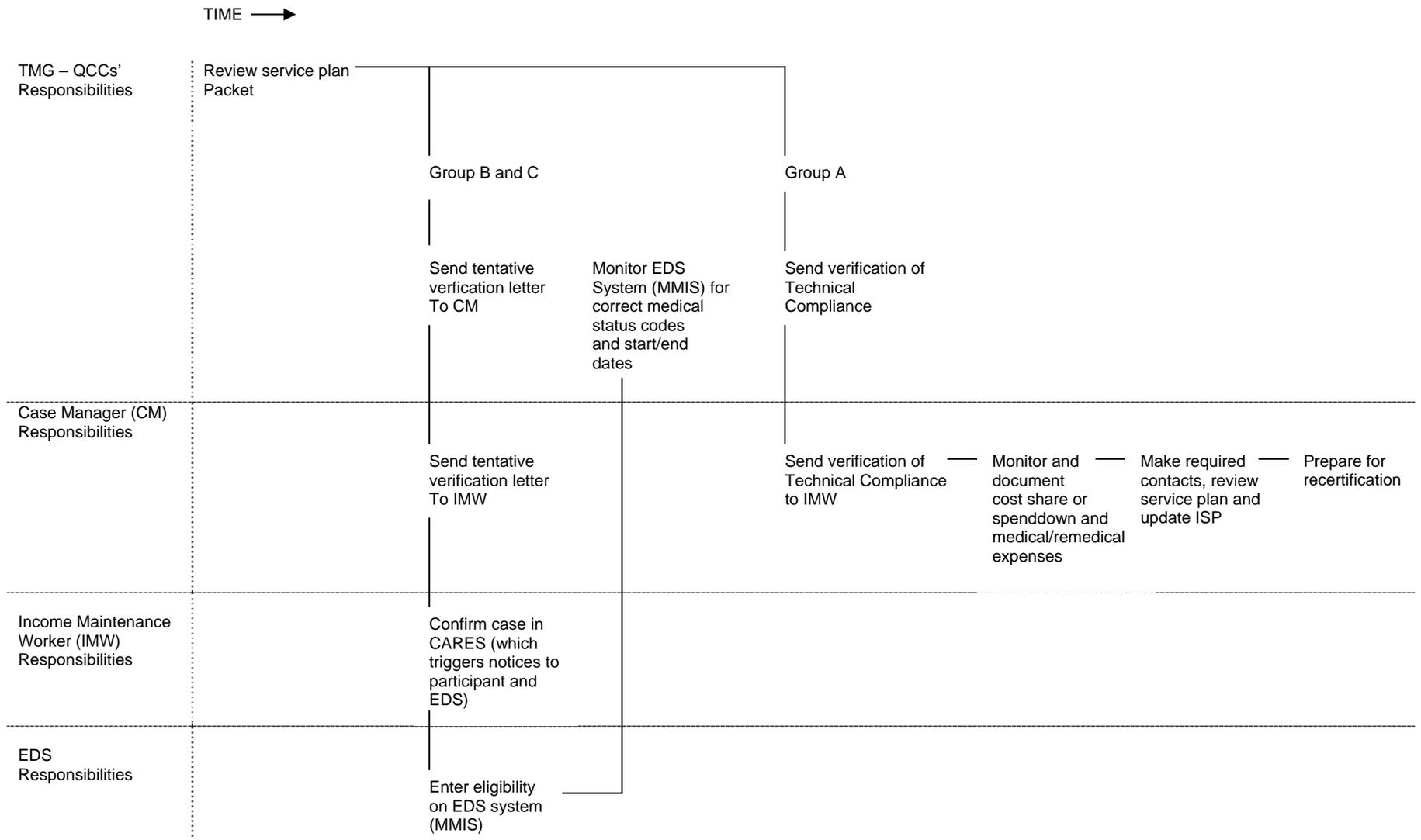
When the review is completed and the packet is certified, the effective date of eligibility for the applicant will be determined.

A New Plan Certification Process Flowchart, Service Plan Packet Checklist, and At-a-Glance Reference Guide follow on the next five pages.

New Plan Certification Process Flowchart



New Plan Certification Process Flowchart



Initial Service Plan Checklist

COVER LETTER

- Identifies the participant and the waiver program
- Identifies the case manager, contact person, and phone numbers
- Defines special actions needed and related deadlines
- Provides additional information (e.g. change in living arrangements)
- Makes notes of missing or incomplete information and provides date when information can be expected
- Indicates a No Active Treatment rating is requested
- May indicate a preferred start date
- If CRI or Diversion application, all necessary forms requesting this funding are complete

ASSESSMENT/SUPPLEMENT

- Is completed fully
- Is signed and dated by the care manager
- Is signed and dated by a Registered Nurse (If supplement is not signed/dated by RN, must complete Health Form)
- Identifies current needs and preferences
- Information coincides with the Long Term Care Functional Screen

LONG TERM CARE FUNCTIONAL SCREEN

- Completed and dated on or within 90 days prior to effective date of eligibility
- Completed by a certified screener
- Includes all applicable pages
- Is appropriately completed
- Identifies an eligible Nursing Home level of care

ISP

- Identifies the specific waiver program
- Identifies the participant (name, address, telephone)
- Cites an accurate service plan development date (date the plan was first discussed with the participant)
- Indicates the living arrangement
- Lists all long term care services (formal and informal) regardless of funding
- Services meet all needs identified in the assessment/supplement
- Is properly signed and dated by the participant and case manager (durable power of attorney, guardian, authorized representative, or witness signature's must be properly identified)
- Describes the type of services
- Identifies all service providers
- Identifies service delivery start dates
- Lists unit of service (e.g. hours/day, day/month)
- Lists cost per unit of service (e.g. dollars/hr)
- Lists and estimates of the actual daily costs for each waiver or COP service (e.g. annual cost divided by 365 days)
- Identifies all funding sources (e.g. SS, SSI, COP, CIPII, COP-W, Medicaid, Medicare, cost share, DVR, VA, personal, pensions, private insurance, etc.)
- Lists the total cost share amount, if applicable and identifies waiver-allowable services toward which cost share will be applied (if cost share is being applied to vendor)
- All SPC's listed in ISP are correct
- Signature date is not earlier than the ISP development date
- All columns in ISP Outcomes are complete
- All waiver services listed on ISP have an identified outcome listed

HEALTH FORM

Initial Service Plan Checklist

- Must be completed for participants if the Supplement is not signed /dated by an RN
- Must be signed by an MD, RN, or PA and dated

FINANCIAL ELIGIBILITY

- DDE-919 or the CWB for expanded GROUP A participants (Group A)
- CWB screens are included for Group B and Group C
- Cost share coincides with information listed on the ISP
- If M/R expenses exceed \$100, is there information that conveys what the expenses are?
- DDE-920 for persons who will be residing in a substitute care facility

VARIANCE REQUESTS FOR INSTITUTIONAL RESPITE

For a participant to receive services in a Medicaid certified nursing home, hospital or ICF-MR, a variance request addressing the following must be sent with the packet:

- Reason(s) for the request and identify the caregiver in need of respite
- Anticipated length of placement
- Description of other community-based services of a similar nature available and specific barriers to using them.
- Description of proposed services
- Description of specific plans to address the limitations associated with institutional settings

VARIANCE REQUESTS FOR CBRF (OF ANY SIZE) STRUCTURALLY CONNECTED TO A NH FOR ELDERLY

For an elderly participant to receive services in a CBRF that is structurally connected to a NH, a variance request addressing the following must be sent with the packet:

- Must be person specific
- Must be non-institutional & enhance dignity & independence
- Must be the preferred residence of the person

HOME MODIFICATIONS – over \$2,000

For a participant to receive a home modification, a request for prior approval addressing the following must be sent with the packet:

- Complete breakdown of all material and labor costs
- Picture or diagram for the home modification, if possible

HOME MODIFICATIONS – all ramps

For a participant to receive a home modification (a ramp), a request for prior approval addressing the following must be sent with the packet:

- Complete breakdown of all material and labor costs
- Picture or diagram for the home modification, if possible

VARIANCE REQUESTS FOR ADULT DAY CARE IN OR ON GROUNDS OF A NURSING HOME

For a participant to receive services in an ADC in or on grounds of a nursing home, a variance request addressing the following must be sent with the packet:

- Must be person and provider specific
- Must explain why a provider outside of an institution is not available
- Must explain why a provider outside of an institution cannot be utilized by the person

VARIANCE REQUESTS FOR CBRF OVER 21 BEDS for ELDERLY

For a participant to receive services in a CBRF over 21 beds connected or not connected to a nursing home, a variance request addressing the following must be sent with the packet:

- Must be person specific
- Must be non-institutional & enhance dignity & independence
- Must be the preferred residence of the person

**At-A-Glance
Packet Contents for New Applications and Recertifications**

New Plans

New plan approval requirements:

- Assessments/Supplement Version 6.0
- Long Term Care Functional Screen
- Health Form (only needed if Assessment/Supplement is not signed by RN)
- ISP & ISP - Outcomes
- Financial Eligibility
- No Active Treatment (NAT) requested (if applicable)
- Formula to Determine Amount of Income Available for Room/Board in Substitute Care DDE-920 (if applicable)
- Variance Requests (if applicable)

**Recertifications – Group A
(Approved internally within county)**

Recertification requirements:

- Long Term Care Functional Screen
- Health Form
- ISP & ISP - Outcomes
- Financial Eligibility
- No Active Treatment (NAT) reviewed and approved (if applicable)

**Recertifications – Group B and Group C
(Mailed to TMG or approved internally within county)**

Recertification requirements:

- Long Term Care Functional Screen
- Health Form
- ISP & ISP – Outcomes
- Financial Eligibility
- No Active Treatment (NAT) reviewed and approved (if applicable)

NOTES

EFFECTIVE DATE OF ELIGIBILITY

☞ PURPOSE OF THE EFFECTIVE DATE OF ELIGIBILITY

The effective date of eligibility is the date a new applicant becomes eligible for COP-W or CIP II funding. It is the first day services may be billed to the waiver program.

Understanding the process can help care managers obtain the earliest possible effective date for a waiver applicant.

If the care manager would like a specific date as the effective date of eligibility, he or she should note the date and the reason for the request in the cover letter that accompanies the service plan packet.

☞ SETTING THE EFFECTIVE DATE

The service plan packet is reviewed for four conditions to determine the effective date. The effective date is the first date upon which all four conditions are met. These conditions include:

- The date the individual meets all the criteria to be eligible for full benefit **Medicaid**.
- The date the initial **service plan** is developed with the participant. This can be the date the care manager first started to discuss a plan of care with the participant, which may be earlier than the date the ISP was typed or signed.
- The date listed as the Screen Completion Date on the Wisconsin Long Term Care Functional Screen, (completed by a certified screener).
- The date the individual first resides in a **waiver-allowable setting**.

EXAMPLE 1 – Group A Applicant

Step 1 - The reviewer first looks at the service plan development date, the LTC FS completion date, and the date the individual first resided in a waiver-allowable setting. The first date all three conditions are met is the tentative effective date.

Example- Group A

Service Plan Development.....	10/14/09
Functional Screen	10/14/09
Resides in Allowable Setting.....	10/20/09

Step 2 - Next, the reviewer considers the date the applicant became eligible for Medicaid. Because Group A applicants are already eligible for Medicaid, the reviewer just confirms the applicant had Medicaid at the time of the waiver start date.

Example - Group A

Service Plan Development.....	10/14/09
Functional Screen	10/14/09
Resides in Allowable Setting.....	10/20/09
Eligible for Medicaid as of	11/15/95
Effective Date of Eligibility	10/20/09

EXAMPLE 2 – Group B or C Applicant

Step 1 - Medicaid eligibility must be determined for Group B and C applicants by an Income Maintenance worker. To finalize Medicaid eligibility, the care manager must give the tentative letter to the income maintenance worker so the applicant's name and Social Security number can be placed on the Electronic Data Systems (EDS) system. When the applicant's name appears on the Wisconsin Recipient Segment Screen (WRES) with the correct medical status codes and date of Medicaid eligibility, the care manager will receive a final letter citing the effective date of eligibility for the waiver program.

Group B or C

Service Plan Development.....	09/14/09
Functional Screen	09/14/09
Resides in Allowable Setting.....	10/05/09
Tentative Effective Date (per letter)	10/05/09
Eligible for Medicaid as of	09/14/08
Effective Date of Eligibility	10/05/09

Sometimes the Medicaid eligibility date is later than the effective date cited in the tentative letter, as illustrated in Example 2. When this happens, the care manager will receive a phone call from a Quality Assurance Consultant (QAC) and be asked to explain the discrepancy and review the options:

- Does the care manager mind the change in dates?
- If the date cited in the tentative letter is preferred, the care manager must contact the IM worker and see if the IM worker can resubmit the information to EDS with the date that was originally requested. This is accomplished by the IM worker manually entering the desired start date on a 3070 form.
- If the income maintenance worker identified a Medicaid eligibility problem, which necessitated a different Medicaid eligibility date, the Medicaid eligibility date will become the effective date of eligibility for the waiver program.

NOTES

- The effective waiver start date and HSRS start date may not necessarily be the same date. The effective waiver start date is the first date waiver services can be billed. The HSRS start date is the first day the waiver program actually funded services. This may be the same or later than the effective date. However, it would be to the county's advantage to bill for waiver services effective the waiver start date. **Important note: Required care management contacts begin effective the waiver start date even if actual waiver services are not funded until a later date.**
- COP funds can be used up to 90 days for waiver applicants as long as the following steps are taken within 10 days of using COP dollars: the completion of the LTC FS; completion of an ISP; and a referral has been made to and received by the county IM worker for a Medicaid application. COP dollars should be reimbursed retroactive for all waiver allowable services that were utilized once waiver funding is approved.
- Good practice is to complete the LTC FS and develop the service plan on the date of the Assessment/Supplement whenever possible. When the waiver mandate applies, the effective date must be within ten days of when COP-funded services are started.
- The IM worker can go back 90 days before the first meeting with the participant and establish Medicaid eligibility retroactively as of the first of that month. For example: if the meeting with the participant was on June 15, Medicaid eligibility for the waiver program could be established as early as March 1 **IF** the care manager completed a LTC FS, and developed a service plan on March 1st, and the applicant/participant resided in a waiver allowable setting all on March 1st.
- Please note, medical status codes for the waivers are not the same as nursing home codes. It is important for a waiver participant to have a medical status code that is reflective of community Medicaid. This will ensure that Medicaid providers, for example, a Medicaid Personal Care agency, is able to bill Medicaid for the services they provide to the person in his/her own home.
- Recertification is required annually during the anniversary month of the effective date of waiver eligibility, regardless of when services actually began.