

CHAPTER VI – THE WAIVER APPLICATION PACKET

6.01 Introduction: The Application

Every Medicaid waiver applicant must have a waiver application packet developed by the waiver agency and approved by the Department of Health and Family Services, Division of Disability and Elder Services, Bureau of Long Term Support. This chapter discusses the content of the waiver application packet and the requirements that must be met for the different parts of the packet. The expectation is that the application will be submitted for approval prior to the start of any waiver funded services. There are differences in the application packet content requirements between the CIP II/COP-W and the CIP 1A, CIP 1B, BIW and CLTS waivers. Where the required elements are the same it is noted as such. Where the requirements differ substantially, a separate description is included.

6.02 The Content of the Waiver Application Packet

A. The Cover Letter/Application Checklist

Service plan packets submitted for approval must be accompanied by a cover letter from the agency care manager/support and services coordinator. The cover letter is required for the CIP 1A/1B, BIW, CIP II and COP-Waiver programs. For CLTS waivers a cover letter is not required. Instead, the CLTS application packet must include a completed CLTS application checklist.

For the waiver programs that require a cover letter, there are a number of common elements that must be present to aid in the plan review and approval process. The required elements of the cover letter include:

1. The name of the applicant;
2. The specific waiver program (and slot type if applicable) for which the county seeks approval;
3. A reference to any special Department initiative affecting the plan (E.G ICF-MR Downsizing Initiative, Community Relocation Initiative);
4. The proposed waiver program start date;
5. The request for a No Active Treatment (NAT) rating (applies only to CIP II/COP-W applicants only);
6. A notation of any planned home modification;
7. A notation of any variance requested; and,
8. Identification of the care manager/ support and service coordinator or agency contact person in the event any additional information is needed.

B. Documentation of Level of Care – Functional Eligibility

1. The establishment of Level of Care (LOC) or functional eligibility is a required element of the Medicaid waiver eligibility process. Documentation of level of care/functional eligibility must accompany the waiver application and is also required as a part of the recertification process (see Chapter II for details concerning LOC).
 - a. For CIP 1A, CIP 1B, CIP-II and COP-W, both the initial LOC determinations and annual re-determinations of LOC are accomplished using the automated Wisconsin Adult Long Term Care Functional Screen (LTC-FS). See item “b” which follows below for special considerations.
 - b. The child who applies for CIP 1A/1B Waivers has his/her level of care/functional eligibility established using the Children’s Long Term Care Functional Screen. All CIP 1A/1B applicants older than 17 years 9 months are screened using the (adult LTC-FS).
 - c. For BIW level of care determinations, a completed DDE 2256 and 2256a (see **Appendix A**) and other supporting physician and/or therapy reports are required in order for the state to establish and also to recertify level of care. Please refer to Appendix A-7 http://dhfs.wisconsin.gov/bdds/waivermanual/app_a7.pdf for additional information on BIW level of care.
 - d. For CLTS Waivers both the initial LOC determinations and annual re-determinations of LOC are accomplished using the automated Wisconsin Children’s Long Term Care Functional Screen (CLTS- FS).
2. Functional Eligibility – Waiver Specific Requirements
 - a. **For CIP 1A and 1B**, the Functional Screen must be completed by a qualified screener and be **current**. The screen (screen completion date) may not be dated more than ninety calendar days prior to the waiver start date. If the initial screen was completed more than ninety calendar days prior to the waiver start date, the screen must be updated, and a screen older than 1 year must be redone. Please refer to the online functional screen instructions for guidance on completing the screen and also for screener qualification requirements.
 - b. **For CIP II/COP-W**, the Functional Screen must be completed by a qualified screener and be **current**. The screen (screen completion date) may not be dated more than ninety calendar days prior to the waiver start

date. If the initial screen was completed more than ninety calendar days prior to the waiver start date, the screen must be updated, and a screen older than 1 year must be redone.

- c. **For CLTS**, the Children's Long Term Care Functional Screen must be completed by a qualified Screener and be current. The screen (screen begin date) may not be dated more than ninety calendar days prior to the waiver start date. A screen older than 1 year must be redone.
- d. **Functional Screen Information:** For additional information about the various long term care functional screens, screener qualification requirements and the screen process see:

The Wisconsin Adult LTC-FS instructions, available on line at:
<http://www.dhfs.state.wi.us/LTCare/FunctionalScreen/instructions.htm>

The instructions for Children's LTC-FS, available on line at:
<http://dhfs.wisconsin.gov/LTCare/FunctionalScreen/cltsfs/instructions.htm>

3. Additional Functional Eligibility Requirements: CIP II/COP-W

- a. **No Active Treatment**
Because COP-W and CIP II require nursing home level of care eligibility, a person with a developmental disability may only be served with COP-W or CIP II funds if a determination has been made that they do not need active treatment. When submitting a plan packet for a person with a developmental disability, the county agency must specifically request in writing that a "No Active Treatment (NAT) determination be made. No persons aged younger than 65 years who have the condition of mental retardation may receive a NAT rating.

The NAT determination will be made by the Community Options Section of the Bureau of Long Term Support or its designee at the time the Medicaid waiver application is approved. (See Chapter II, Section 2.04 for more information about NAT determinations and requirements at http://dhfs.wisconsin.gov/bdds/waivermanual/waiverch02_08.pdf)

- b. **Medicaid Waiver Program Health Report Form (DDE-810) or Assessment Supplement**
The COP-W and CIP II waiver programs require documentation of the applicant's health status from a medical professional. (See Chapter II, Section 2.02 C at

http://dhfs.wisconsin.gov/bdds/waivermanual/waiverch02_08.pdf) This documentation of health status requirement is met if the packet includes a completed LTC-FS Assessment/Supplement signed by a registered nurse. If the assessment/supplement is not signed by a nurse, a completed and signed Medicaid Waiver Program Health Report Form (DDE-810) must be submitted. The information on the health form should support the information provided in the level of care determination documentation (LTC-FS).

The health form must be **current**, dated **no more than 90 days before or after** the waiver program start date. The health report form must be signed by a physician, a registered nurse or a physician assistant.

C. Documentation of Financial Eligibility

1. Eligibility and Cost Sharing Worksheet (DDE-919) or CARES Screens

The form DDE-919 must be completed to determine Medicaid waiver program financial eligibility for Group A eligible persons who are SSI, SSI-E, or 1619 recipients and for participants in the Katie Beckett, Special Needs Adoption and Child Foster Care programs. The completed [DDE-919](#) form must be included in the waiver application packet as documentation of financial eligibility for these applicants.

For applicants other than those listed above, Medicaid waiver financial eligibility is determined using the Client Assistance for Reemployment and Economic Support (CARES) system. Copies of the CARES eligibility screens must be included in the waiver application packet as documentation of Medicaid waiver financial eligibility for the remainder of Group A participants (not listed above), as well as for all Group B and Group C eligible applicants (See Chapter III for more information about the financial eligibility determination process.)

D. The Assessment

1. Assessment Purpose

The purpose of the assessment is to gather current, comprehensive information about the applicant and his/her environment in order to determine which services, supports and environmental modifications are appropriate to enable the applicant to meet or maintain his/her desired outcomes, and to safely and independently participate in the life of their community. These statements provide a framework for learning about and understanding the individual's needs, values, preferences and priorities. For more detailed

information describing the twelve Long Term Care Outcomes Statements refer to [Appendix I](#):

2. Assessment Content

The content of the assessment should be person centered, focused on identifying not just the person's needs but also on learning about the applicant's individual outcomes. While they may be identified in the assessment process, these outcomes are defined by the participant. The outcomes identified should be person-specific, based on the applicant's lifestyle, his/her goals, ambitions, values, personal preferences and priorities.

In order to identify the person's individual outcomes, the assessor needs to gather information on their abilities, needs, goals and current supports in place. While discussing alternative choices available, the assessment should also explore the applicant's preferences in such areas as service delivery, living arrangement, medical care, and community participation. Based on what is learned about the person in the assessment, a service plan is developed that is tailored to meet the individual outcomes and the identified needs of the applicant.

In those situations where the applicant is unable to fully participate in this process, the assessor should involve people who know the person well (e.g., the guardian, family, friends, caregivers, etc.) in order to gain a clear understanding of the person's goals and preferences. The assessor should keep in mind that persons who have been adjudicated incompetent are often still capable of voicing their goals and preferences. Some persons are able to offer opinions and preferences through alternate forms of communication, and still others may communicate through their behavior.

Provided for quick reference, the following list includes the major topical areas that should be explored and documented in a thorough assessment:

- a. Background and social history,
- b. Physical and medical health history,
- c. Individual outcomes important to the person,
- d. Ability to perform physical activities of daily living,
- e. Ability to perform instrumental activities of daily living,
- f. Emotional and cognitive function,
- g. Behaviors that positively or negatively affect lifestyle or relationships,
- h. Social participation, friendships, existing formal and informal social supports,
- i. Cultural, ethnic and spiritual influences,
- j. Community participation and involvement

- k. Personal preferences as to how and where to live, preferred daily activities/routines and their environment,
- l. Risks associated with choices made in living arrangement, activities and relationships and behaviors,
- m. Economic resources available and how they are managed,
- n. Formal and informal supports available to the person,
- o. A discussion of participant rights and responsibilities including the individual's capability to understand and exercise them,
- p. A review of the applicant/ participant's interest and ability to direct his/her own supports.

3. Assessment Documentation Requirements

Important: For all programs, the assessment document (e.g., the LTC-FS Assessment/ Supplement or Person Centered Assessment) must be completed and must give a full picture of the applicant. An assessment that is incomplete is not acceptable and may delay the plan approval process.

- a. For CIP 1A/1B and BIW, the assessment requirement is met with the completion of the Supplement (assessment) to the Adult Long Term Care Functional Screen or another suitable person-centered assessment tool.
- b. For the CIP II/COP-W programs, the assessment requirement is met upon completion of the LTC-FS and the Assessment Supplement.
- c. For the CLTS program, the assessment requirement may be met upon completion of the note section of the CLTS-FS including all assessment content identified previously or a suitable person centered assessment.

E. The Individual Service Plan

A completed Individual Service Plan (ISP), the [DDE-445](#), or a Bureau approved, locally developed substitute ISP is required for every Medicaid waiver application (see DDE Memo 2006-13). The ISP is a summary of the applicant's proposed package of formal and informal supports and services. It includes information about what services will be provided, who will provide those services, service costs, frequency, and funding sources. The service plan literally follows the assessment, identifying the applicant's individual outcomes and utilizing the most cost-effective waiver and non-waiver funded resources available to both meet the needs identified in the assessment and address the individual outcomes sought by the person.

The planned services and service providers listed on the ISP should reflect the participant's individual outcomes and preferences, and be chosen in the course

of an informed decision making process. The completed service plan will identify the supports and services put in place to help the participant address the outcomes listed on the [DDE-445A](#) .

1. Individual Service Plan Content

The completed DDE-445 form individualizes the waiver program for the person and establishes the protocol for provision of supports and services. The service plan contains individual demographic information as well as a listing of the services designed to address the person's identified individual outcomes. The plan establishes the program and service start dates and lists all service providers, service frequency, service costs and their respective funding source.

The individual service plan form includes supports and/or services which are not funded by the waiver. For example, funding sources may include COP, Medicare, Medicaid Card, Family Support local funding and in the case of room and board, participant resources. Other services and/or supports may be provided informally such as in the case of the neighbor who voluntarily assists, or the local church. **These services are not waiver services.** Refer to the department memo [DSL Numbered memo 2007-14](#) for more detailed instruction on this topic.

Beginning January 1, 2007, every program-funded service or support listed on the service plan must be directed toward addressing, meeting or maintaining an identified individual outcome described on the DDE 445A.

The ISP must be signed by the waiver participant and the care manager/support and service coordinator. Line by line instructions for completion of the Individual Service Plan form and the DDE- 445-A are located with the form in the DHFS forms library as well as in Appendix I of this Manual.

Note: The ISP may also be signed by the applicant/participant's guardian (of the Person) or by the activated Power of Attorney for Health Care or by his/her authorized representative. When an authorized representative signs the ISP on the participant's behalf a completed ISP Authorized Representative Form [DDE-987](#) must be maintained in the agency file. Participants with an authorized representative or other legal decision maker retain the right to be fully informed about the service plan content and any changes made to the plan.

Important: The applicant must be informed in writing of his or her right to accept or reject the proposed service plan and his/her freedom to choose between the community-based services offered or institutional care. In addition, the participant must be informed of his/her program rights and responsibilities verbally and in writing. If a participant has a guardian that refuses to sign the

ISP, the service plan cannot be approved unless it is part of a protective service order under Chapter 55 Wis. Statutes. In these circumstances a copy of the protective services order must accompany the plan.

F. Individual Service Plan --Individual Outcomes - DDE-445A:

A primary goal of waiver service provision is to provide an array of supports and services designed to help the person achieve his/her individual outcomes. The Individual Service Plan- Individual Outcomes page (the DDE-445A) was developed to provide a means to document the person's desired individual outcomes, as identified in the assessment, and link those outcomes with the services and supports described on the ISP. Outcome statements should not be generic statements; rather, these outcome statements must be unique to the individual consumer and reflect his/her voice or perspective.

The DDE-445A also contains a field to document the status of and/or progress toward achieving the person's desired outcomes and also to list those persons/agencies with a role or responsibility in helping attain the desired individual outcome.

The completed DDE-445A should contain a list of the person's desired individual outcomes, each described with a clear statement that reflects the individual's voice/perspective. Assessment is an ongoing process, and the form should reflect that fluidity. It should be updated as needs change, and when new desired individual outcomes are identified, they should be added.

The requirement to use the DDE-445A (or a Bureau approved local substitute version) form applies to all waiver programs and is effective January 1, 2007. Additional implementation instructions are available in the **DDE Memo 2006-13** distributed in August, 2006.

G. Individual Service Plan - Narrative (applies to CIP 1A/1B, BIW and CLTS only)

The Individual Service Plan Narrative is a required component of the CIP 1A/1B, BIW application packet. The CIP II/COP-W and CLTS programs no longer require a narrative summary.

The individual service plan narrative is a distinct section of the service application packet. The narrative is written based on the content of the participant's Individual Service Plan. The purpose of the narrative is to clearly communicate detailed information surrounding the applicant's proposed service delivery. The narrative provides a detailed explanation of how the services included on the Individual Service Plan will meet all of the applicant's assessed need(s) and also

includes a description of how the person's desired individual outcomes will be achieved.

When the applicant has challenging behavior, the individual service plan narrative must include an explanation of the approaches that will be used to support the person. This may include copies of specific service or behavior support plans that are proposed to be followed.

Restraint or other restrictive measure usage Important: Separate distinct Department approval of the use of a restraint or other restrictive measure, the application for approval of restraint or use of a restrictive measure must be included with the plan packet and should be referenced in the individual service plan narrative. Separate Departmental approval must be obtained before the use of any restraint or restrictive measure. Guidance on the Department's application process for the use of a restraint or a restrictive measure can be found in both Chapters VIII and IX of this Manual.

When the applicant's assessment identifies the need for which a service, support or intervention is to be provided, the individual service plan narrative should describe how that service addresses the need. For example, when the assessment identifies that the person tends to wander from home, the narrative should identify the planned strategies the provider will use to assure that the person will be kept safe from the consequences of this behavior.

If the assessment identifies a behavior that places the person at risk of harm to his/her self or to others, the narrative together with a behavioral treatment/support plan will provide a detailed explanation of how the behavior will be addressed to reduce the risk of harm.

The narrative provides an outline of the proposed service plan that was designed to meet the person's desired individual outcomes. The Medicaid waiver programs require community integration for participants, both in where they live and where they spend their time during the day. The service plan narrative focuses on the ways the person will utilize planned services and formal and informal community resources to meet his/her desired individual outcomes and maintain and enhance community integration.

H. The HSRS L1 Screen

For CIP1A/1B, BIW and CLTS, the printed L1 Screen must be included in the application packet (The L1 screen is not required for CIP II/COP-W). The screen verifies that the applicant has been registered on HSRS and permits the Bureau to assign a waiver funding slot. An application for participation in these waiver programs will not be approved until registration on HSRS has been verified.

I. Variance Requests

Additional documentation required for some waiver application packets may include a variance request. In CIP II and COP-W only, a variance requested may be related to providing Medicaid waiver services to persons residing in a CBRF that is larger than twenty beds and also for the CBRF connected to a nursing home. The variance request requirement for persons who are developmentally disabled to reside in a CBRF up to eight beds has been eliminated (Please see Chapter V).

1. CIP 1A, 1B, BIW

A variance is necessary if the plan includes services such as Institutional Respite or providing any other service in a nursing home or on the grounds of an institution.

If the person's plan includes services with a provider that provides services on the grounds of an institution, the care manager/support and service coordinator must submit the variance request for approval. In order for continued funding to be assured the variance must be submitted prior to the start of the service that necessitates the need for a variance. When the need for the variance is sudden and unanticipated, BLTS may approve the variance on a retroactive basis. Such situations require written documentation explaining the reason(s) retroactive approval is necessary. Advance discussion with the Bureau's assigned waiver follow along staff is strongly encouraged. When a situation that requires a variance has no approved variance it is grounds for terminating waiver funding for the participant. All requests for variances should be sent to the Bureau's assigned waiver follow along staff.

For variances involving services on the grounds of institutions to be granted, the prospective service must be determined to be "less restrictive" than another comparable service available in the community or be sufficiently unique that an individual's needs do not appear to be able to be met by any other provider in reasonable proximity to the person.

Under no circumstances may a waiver participant reside on the grounds of an institution. Any variance approved is always specific to the person for whom the variance is sought and applies only to the specific provider and setting that was the subject of the request. Time limits will be applied to all variances. Other conditions of approval may also be placed on the approval if granted.

The CIP1A/1B and BIW variance request must include the following elements:

- a. The specific reason for the request

- b. A description of all community-based services of a similar nature that are available and the barriers to using them in this instance
- c. A description of the proposed services
- d. A description of the plans to address the limitations associated with institutional settings (refer to Chapter IV for definition of institution).

2. CIP II and COP-W

A variance is necessary if the plan includes services such as Institutional Respite or the provision of Adult Day Care services in a nursing home or on the grounds of an institution. A variance will also be necessary if the plan includes providing CIP II/COP-W funding for the applicant/participant to reside in a CBRF larger than twenty beds or a facility connected to a nursing home or other institution.

More complete information about the variance requirements for use of waiver funds for Respite Care or Adult Day Care services provided in a nursing home or on the grounds of an institution is located in Chapter IV under the requirements for the specific SPC requested.

Information on the type and content of the variance request for the use of CIP-II /COP-W funds in a CBRF larger than twenty beds and for facilities that are connected to a nursing home or other institution is located in Chapter V, Section 5.05 of this manual.

3. CLTS Waivers

A variance is necessary if the plan includes institutional respite. The CLTS variance request must include the following elements:

- a. The specific reason for the request
- b. A description of all community-based services of a similar nature that are available and the barriers to using them in this instance
- c. A description of the proposed services,
- d. A description of the plans to address the limitations associated with institutional settings.

J. Home Modification Request

Home modification requests are reviewed as part of the overall plan review process. Proposed home modification services for new applicants must be described in the initial service plan packet. The home modification should be described in the cover letter. The request must be accompanied by supporting

documents (plans, estimates, material and labor breakdowns, etc.) **and** must be listed on the service plan.

Important: While all home modifications must be listed on the service plan, **all ramps, fences,** and any other proposed modifications costing in excess of \$2000 must be submitted for plan approval as part of the initial service plan packet or as an ISP Update and are subject to Department approval. Further information on the Home Modification approval process may be found in Chapter IV, pages IV-78-80.

K. Documentation of Room and Board Costs

For all new applications for the waivers CIP 1, BIW, CIP II and COP-W where the participant will live in a substitute care facility, a completed form DDE -920) must be included in the application packet.

6.03 Waiver Program Start Date

The applicant's waiver program eligibility and Medicaid eligibility should be developed simultaneously. Just as with the regular Wisconsin Medicaid program, waiver program applicants who meet all programmatic and financial eligibility requirements may be eligible for three months retroactive Medicaid state plan (Medicaid card) benefits. For further information, see [Chapter III](#) of this Manual—Financial Eligibility.

A. The earliest possible start date for participation in a Medicaid Waiver Program is the date on which all of the following criteria are met.

- 1. The date the person met all Medicaid financial and non-financial eligibility requirements.** For applicants who become financially eligible as a result of their waiver application, the date of financial eligibility for Medicaid card services may be retroactive to the first of the month up to three months prior to their waiver program application date.

This may occur if the person had Medicaid reimbursable expenses at any time during the three-month period and if s/he would have been eligible during that period and all of the requirements below were met during the period.

- 2. The date the applicant's initial service plan was developed; defined as the date qualified care planning staff develops the initial service plan with the participation of the applicant.** The date on which the applicant signs the ISP may be later than the ISP development date without affecting the waiver program start date. However, documentation must exist that indicates the

waiver program applicant was involved in the development of the initial service plan.

3. **The date level of care eligibility is established.** Functional eligibility is established using the automated Long Term Care Functional Screen completed by a **qualified screener** who is a social worker, registered nurse or care manager/support and service coordinator. Because requirements differ, the date recognized as establishing level of care eligibility differs by waiver program:
 - a. **For CIP II/COPW** the screen completion date on the LTC-FS is the date level of care is established.
 - b. **For CIP 1A/1B**, the screen completion date on the LTC-FS is the date level of care is established.
 - c. **For BIW**, the BLTS central office review establishes the level of care.
 - d. **For CLTS**, the screen begin date on the Children's LTC-FS is the date level of care is established.
4. **The date the person first resided in a waiver allowable setting.**

B. Waiver Specific Start Date Considerations

1. **For CIP 1A/1B** the waiver agency may request a Waiver start date for an otherwise eligible applicant that is no more than ninety (90) days before or after the Screen Completion Date.
2. **For BIW** the waiver agency may request a Waiver start date for an otherwise eligible applicant that is no more than ninety (90) days before or after the signature date on the form OQA - [2256/2256-a](#).
3. **For CIP II and COP-W**, in order for services to be reimbursed by a Medicaid waiver program, the applicant/participant must meet all of the above criteria. The date on which all four criteria have been met is the earliest possible waiver program start date.
4. **For CLTS**, in order for services to be reimbursed by a Medicaid waiver program, the applicant/participant must meet all of the above criteria except for the CLTS waiver applicant who uses the Intensive In-Home Treatment Service. In these situations the Children's Services Section must also assign the waiver start date.

Note: The waiver participant's start date will not be affected if the county agency does not meet the annual February 28 deadline for submission of a

service plan packet. However, the county will not be reimbursed for any prior year service costs for that participant.

6.04 Medicaid Waiver Plan Submission and Approval Process

Incomplete documentation in the waiver application packet will delay the approval process. The care manager/support and service coordinator is responsible for providing sufficient application information to the Bureau or their quality assurance designee to make the waiver eligibility determination

A. CIP 1A/1B & BIW

Each applicant for Medicaid Waiver services must have a service application packet developed by the county agency and approved by a Community Integration Specialist (CIS) from the Bureau of Long Term Support (BLTS) Developmental Disabilities Services Section. To allow sufficient time for review and approval, county staff should submit the packets at least two weeks prior to the requested service start date. It is important that county agencies submit service packets that contain all required components and also to assure that each component is accurate and complete. A plan approval checklist will be used by CIS to verify the completeness of all submissions. This checklist form can be found in Appendix. County agencies may use it as a cover sheet for each plan packet.

Unless instructed otherwise, two copies of each Service Application Packet are submitted directly to the CIS assigned to the respective county. To obtain a list of the Community Integration Specialist Staff and their county assignments contact the Bureau of Long Term Support Developmental Disabilities Services Section, or visit the website address: www.dhfs.state.wi.us/bdds/cip/cipcodir.htm

1. CIP 1A Specific Requirements

Joint plan approval occurs when the applicant is a current long-term care resident of one of the State Centers for the Developmentally Disabled and is being funded by CIP 1A. In this situation the county must submit an additional copy of the service packet to the appropriate State Center staff for their review and approval. Plans are not approved unless both the CIS and Center staff approve.

When the plan has been approved, the CIS sends a letter stating such to the appropriate county representative. The participant/guardian receives a copy of the same letter. Approval may be conditional, so it is wise for the recipient of the letter to carefully review each letter. The support and service coordinator should forward a copy of the approval letter to the IM staff/ESS as formal notification of waiver program eligibility.

For all CIP 1A approval letters involving relocations from State Centers for DD, approval is contingent on the county agreeing to an enhanced, in person review schedule. This schedule has been revised as of January 1, 2008 and is effective for all relocations made from state Centers on or after that date. The enhanced review process includes the following:

- **30 Day Review:** Within approximately 30 days of the person's relocation date, Center Staff will work with the County Waiver agency's designated support and service coordinator to set up a person-centered status review to determine if the person's individualized service plan and placement in the community is working as intended and is aiming toward achieving the person's individualized outcomes expressed in the plan. Guardians and other family members as appropriate will be informed and will be welcome to attend these reviews.
- **90 Day Review:** On or about 31-90 days, but not later than the 110th day from the person's start or relocation date, the person's assigned CIS will work with the County Waiver agency's designated support and service coordinator to set up an in- person, person-centered status review. However, because this time period for a relocation plan can be critical to the success of the plan, a review may be scheduled at any time during this time if specific circumstances indicate a need to do so. This review will cover the same subjects as the 30 day review. Center staff may attend this review. Guardians and other family members as appropriate will be informed and will be welcome to attend these reviews.
- **Annual Review:** For each of the first three years after the person's relocation to the community, an annual person-centered review will be conducted to review the person's plan to determine whether or not it is working as intended, achieving the person's individualized outcomes expressed in the plan and whether it needs to be updated. This review must involve the County Waiver agency's designated support and service coordinator, the CIS and all others who typically attend the County annual plan review session. Center staff will generally not attend this review unless requested by the county, guardian or CIS and they are able to attend.

3. CIP 1B Specific Requirements

Waiver participant relocated from an ICF/MR under the relocation initiative will be subject to an enhanced review schedule as follows:

- **30 Day Review:** Within approximately 30 days of the person's relocation date, the CIS will work with the County Waiver agency's designated support and service coordinator to set up a person-centered status review to determine if the person's individualized service plan and placement in the community is working as intended and is aiming toward achieving the person's individualized outcomes expressed in the plan. Guardians and other family members as appropriate will be informed and will be welcome to attend these reviews.
- **Annual Review:** After approximately twelve months from the person's relocation date to the community, a person-centered review will be conducted to review the person's plan to determine whether or not it is working as intended, achieving the person's individualized outcomes expressed in the plan and whether it needs to be updated. This review must involve the County Waiver agency's designated support and service coordinator, the CIS and all others who typically attend the County annual plan review session.

B. CIP II/COP-W

The completed waiver application packet must be submitted to the Bureau of Long Term Support Community Options Section or its quality assurance designee. Waiver application packets are reviewed for completeness; consistency across the health related documents, as well as functional and financial eligibility. The waiver application review also looks at whether the individual outcomes identified in the assessment are addressed in the service plan and whether any unmet needs or health and safety issues are apparent.

When an initial waiver application is approved, a letter is sent notifying the agency care manager/support and service coordinator of the approval decision and the waiver program start date.

The care manager should forward a copy of the approval letter to the IM staff/ESS as formal notification of waiver program eligibility.

C. CLTS

The completed waiver application packet with CLTS Waiver application checklist must be submitted to the Bureau of Long Term Support's Children's Services Section. Waiver applications are reviewed for completeness as well as functional and financial eligibility. The Waiver application review also includes a thorough look at the family centered assessment, identified desired individual outcomes, any concerns regarding the child's health and safety, and the services and

supports included in the service plan to meet the assessed needs and outcomes of the child and family.

When an initial waiver application is approved, a letter is e-mailed notifying the agency support and service coordinator of the approval decision, the waiver program start date, the waiver program slot number, and the recertification month. If needed, the support and service coordinator should forward a copy of the approval letter to the income maintenance staff as formal notification of waiver program eligibility.

6.05 The Waiver Application Packet – Summary

The chart on the following page gives a quick reference summary of the required application packet contents.

By waiver program, the application packet must contain the following documentation:

	Level of Care Eligibility	Financial Eligibility	Assessment	Individual Service Plan	Narrative	General¹
BIW	DDE-2256 /2256a (See also Appendix J-7)	DDE-919 or CARES Screens	Person - Centered Assessment	DDE-445 , DDE-445A or Approved substitute ISP	Service Plan Narrative	Cover Letter, HSRS L1; Request for a Variance or a Home Modification A DDE – 920 (Substitute Care Only)
CIP 1A, CIP 1B	LTC-FS Report	DDE-919 or CARES Screens	LTC-FS Assessment/ Supplement and/or other Person - Centered Assessment	DDE-445 , DDE-445A or Approved substitute ISP	Service Plan Narrative	Cover Letter, HSRS L1; Request for a Variance or a Home Modification A DDE – 920 (Substitute Care only)
CIP II/ COP-W	LTC-FS Report & Health Form (If needed)	DDE-919 or CARES Screens	LTC-FS Assessment/ Supplement	DDE-445 , DDE-445A or Approved substitute ISP	Optional	Cover Letter, NAT Request; Request for a Variance or a Home Modification A DDE – 920 (Substitute Care only)
CLTS	Children’s LTC-FS and Disability Determination (If required)	DDE-919 or CARES Screens	Enhanced CLTS-FS or Person - Centered Assessment,	DDE-445, DDE-445A or Approved substitute ISP	Optional	Application Checklist, HSRS L1, Request for a Variance or a Home Modification

¹ The application packet may require additional documentation for any special initiatives (e.g., ICF-MR downsizing, Community Relocation Initiative, etc.)