

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 DHS, Division of Long Term Care, Bureau of Long Term Support ~~or the Division of Mental Health and Substance Abuse Services, Bureau of Prevention, Treatment and Recovery (COR)~~. The waiver application should be submitted for approval prior to the start of any waiver funded services. This chapter addresses the content of the waiver application packet and the applicable requirements. There are differences in the application packet content requirements between the CIP II/COP-W and the CIP 1A, CIP 1B, ~~BIW~~, and CLTS ~~and COR~~ waiver programs. Where the required elements are the same it is noted. Where the requirements differ substantially, a separate description is included.

~~A. COR Pre-enrollment~~

~~The COR waiver program has a pre-enrollment, pre-application requirement. A Community Opportunities and Recovery (COR) Pre-Enrollment Information and Funding Estimate form (F-21070, 08/2008) must be submitted to the Division of Mental Health and Substance Abuse Services, Bureau of Prevention Treatment and Recovery for approval **prior to** the submission of the application packet. (The form is available from DMHSAS at [F-21070](#).)~~

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-W ~~and COR~~ waiver programs. For CIP 1A/1B and ~~BIW~~ waivers an application checklist is also required (See [Appendix Q](#).) For CLTS waivers a cover letter is not required, but the CLTS application packet must include a completed CLTS application checklist (See [F-21080](#) or [Appendix E](#).)

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 agency seeks approval;

3. A reference to any special Department initiative affecting the plan (e.g., ICF-MR Downsizing Initiative, Community Relocation Initiative, etc.);
4. The proposed waiver program start date;
5. The request for a No Active Treatment (NAT) rating, if required (applies only to CIP II/COP-W applicants only);
6. A description of any planned home modification;
7. A description 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 and COR**, 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). A copy of the completed LTC-FS must accompany the application.
 - b. CIP 1A/1B applicants older than 17 years 9 months are screened using the adult LTC-FS. A copy of the completed LTC-FS must accompany the application.
 - c. ~~For BIW level of care determinations, a completed [F 62256](#) and [F 62256A](#) (see also [Appendix A](#)) and other supporting physician and/or therapy reports are required and must accompany the application in order for the state to establish and annually recertify level of care. Please refer to [Appendix A-7](#) for additional information.~~
 - 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). A copy of the completed CLTS-FS must accompany the application if a narrative assessment is **not** submitted. If the narrative assessment is included with the application, only the CLTS-FS results page must be submitted.
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**. To be considered 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. A screen older than one 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 ~~and COR~~**, the Functional Screen must be completed by a qualified screener and must 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. A functional screen older than one 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 one year must be redone.
 - d. **Functional Screen Information:** For additional information about the various long term care functional screens, screener qualification requirements and the screening 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 ~~and COR~~
 - 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 younger than 65 years of age who are mentally retarded 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 considered. See [Chapter II](#), Section 2.04 for more information about NAT determinations and requirements.

- b. Medicaid Waiver Program Health Report Form (F-20810) or Assessment Supplement.

The COP-W and CIP II ~~and COR~~ waiver programs require documentation of the applicant's health status from a medical professional. (See [Chapter II](#), Section 2.02 C.) 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 (The [F-20810](#)) must be submitted with the application. 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.

- ~~e. **COR only:** The Pre-Admission Screening and Annual Resident Reviews (PASARR) Level II Screen~~

~~Applicants for the COR waiver must be eligible for and/or receiving Specialized Psychiatric Rehabilitative Services. The applicant packet must contain a copy of the most recent PASARR Level II Screen, including supporting documents.~~

- ~~d. **COR only:** A copy of the most recent annual Minimum Data Set (MDS).~~

C. Documentation of Financial Eligibility

1. Eligibility and Cost Sharing Worksheet (F-20919) or CARES Community Waivers Budget Screens.

The form F-20919 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 current, completed [F-20919](#) 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 by the IM agency using the Client Assistance for Reemployment and Economic Support (CARES) system. Current copies of the CARES Community Waivers Budget 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 outcome 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 see: [ltcare/outcomes.pdf](#) or [Appendix I](#).

2. Assessment Content

The content of the assessment should be person-centered, focused on identifying the person's needs and his/her desired individual outcomes. While these outcomes may be identified in the assessment process, they 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 any supports currently 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 address the individual outcomes and meet the identified needs of the applicant.

While the assessment must always include a **face to face** meeting with the applicant, there are those situations where the applicant is unable to fully participate in this process. In those circumstances 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 often remain capable of voicing their goals and preferences. Others are able to offer their opinions and preferences through alternate forms of communication, and still others may communicate through their behavior. Regardless of their legal status or communication capability these applicant voice must be heard in the assessment and planning process.

Provided for 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. The medications the person is currently using, their purpose, and what is needed to ensure their safe and effective management and administration,
- d. Individual outcomes important to the person,
- e. Ability to perform/manage activities of daily living,
- f. Ability to perform/manage instrumental activities of daily living,
- g. Emotional and cognitive function,
- h. Behaviors that positively or negatively affect lifestyle or relationships,
- i. The current use of or need for restrictive measures, including associated risks, if any,
- j. Social participation, friendships, existing social supports,
- k. Cultural, ethnic and spiritual influences,
- l. Community participation and involvement,
- m. Personal preferences as to how, where and with whom the person wishes to live, their preferred environment, daily activities, and routines,
- n. Risks associated with choices made as to living arrangement, activities, relationships and behaviors,
- o. Risks associated with decisions made to accept/decline services, treatment or therapy and risks associated with choice of service providers,
- p. Economic resources available and how they are managed. In assessing this, waiver agencies should ensure that those resources are used for the person's benefit,
- q. Determine if there is any conflict of interest present in the management and use of the person's funds or in the selection or provision of services, including plans to resolve or address identified conflicts,
- r. Formal and informal support/services involved or available to the person,
- s. A discussion of participant rights and responsibilities including the individual's capability to understand and exercise them,
- t. A review of the applicant/participant's interest and ability to direct his/her own supports and services.

3. Medication Monitoring

As part of the initial and ongoing assessment processes the CM/SSC or IDT is responsible for determining the person's **capacity to safely and effectively manage and/or administer his/her medication** regimen. The inability to do so creates an ongoing or potential **risk** to the health and safety of the applicant/participant. Participants with chronic conditions are at risk for medication problems because in the course of treatment there may be relatively frequent hospitalizations, multiple physician/clinic contacts and more than one prescriber involved in the person's care. These circumstances can increase the

potential for problems like the over-medicating of a condition, duplicative prescriptions, adverse drug interaction or serious side effects.

The CM/SSC or IDT should assess the capability of the individual to manage his/her medication regimen and the presence of formal or informal supports (in place or available) to provide assistance, if indicated.

In the assessment process the CM/SSC or IDT should be alert to **indicators of real or potential medication management/administration risk**. These may include:

- a. Functional Screen results: Medication management/administration:
 - Under IADLs, item 1 or 2b is checked
 - On Health Related Services: the frequency of help needed is checked weekly or more often for either med management or administration.
- b. Reports or concerns expressed by the person, by caregivers or family,
- c. Documented history of medication mismanagement,
- d. A diagnosis of dementia or any other cognitive impairment,
- e. A guardian of the person appointed or activated POA-HC in place,
- f. An extensive list of prescription drugs.

The presence of one or more of these indicators indicates a need for a medication assessment. The CM/SSC or IDT should ensure that a qualified medical professional (e.g. RN or pharmacist) completes an assessment of the medication. This assessment should include a check for unnecessarily duplicative prescriptions and the presence or potential for adverse drug interactions or side effects.

4. Addressing the Medication Assessment Findings:

Any finding that actual or potential **risk** to the person is present should be documented and addressed with the prescriber(s) involved. The CM/SSC or IDT is responsible for informing prescribers of any concerns identified and ensuring that any changes to the medication regimen (e.g., meds discontinued or dosage changed, etc.) are implemented. Case notation must address whether the identified **risk** was resolved and if continued monitoring is necessary.

- a. If the individual lives in a regulated substitute care setting the CM/SSC or IDT should ensure the facility has a written medication management plan in place and that the plan is in compliance with DHS rule.
- b. If the individual lives independently or in a setting where the responsibility for medication management/administration is not governed by state law or

department rules, the CM/SSC or IDT must ensure there is **documentation*** in the record indicating:

- 1) Current medication(s) prescribed and the prescribers;
- 2) The person responsible for their management/administration (including the individual if s/he is independent);
- 3) The person responsible for supervising the medication management/administration if it is clear that the participant needs assistance; and
- 4) The agency staff to be contacted in the event a medication administration/management incident occurs
 - Reportable incidents include suspected overdose, missed doses, adverse drug reactions, lost or stolen prescriptions, etc.

* While this documentation is not required as part of the application, the requirements are met if the completed assessment includes the list of prescribed medications (item 1 above) and case notation in the file addresses items 2, 3 and 4 above.

5. Assessment Documentation Requirements

Important: For all programs, the assessment document (e.g., the LTC-FS Assessment/Supplement or Person Centered Assessment) must be completed in its entirety, rendering 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 the completion of another person-centered assessment tool (subject to DHS approval).
- b. For the CIP II/COP-W ~~and COR~~ programs, the assessment requirement is met upon completion of the LTC-FS and the Assessment Supplement. (See the [F-20980](#).)
- 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 [F-20445](#), or a Bureau approved, locally developed substitute ISP is required for every Medicaid waiver application. (See [DLTC 2006-13](#).) The ISP is a summary of the applicant's package of formal and

informal supports and services and reflects decisions made by waiver participants about the service providers they choose. It includes information about what services will be provided, which providers will deliver those services; the service rates, 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.

1. Individual Service Plan Content

The completed F-20445 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 needs and individual outcomes. The plan establishes the program and service start dates and lists all service providers, service amount and frequency, service costs and their respective funding source(s).

The individual service plan form also identifies supports and/or services which are **not funded** by the waiver. For example, additional 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 listed may be provided informally, such as in the case of the neighbor who voluntarily assists, or the local church. While they must be listed in the service plan, **these services are not waiver services**. Including a service in the person's Individualized Service Plan (ISP) does not necessarily mean that the service must be paid for with public funds. If the service qualifies for funding under the waiver and the service is needed by the waiver participant, waiver funds must be used. Alternatively, the use of public funds is not required for services not covered by the particular waiver program solely because the services are included in the person's Individual Service Plan (ISP).

Waiver funding includes the dollars that make up both the federal and nonfederal share of Medicaid funds and includes all of the local funds that may be used as the nonfederal share for locally matched slots and for costs above state per diem rates. Waiver laws and policies apply to the expenditure of local public funds only when those funds are used as the nonfederal share of the cost of waiver-funded services. The department cannot subject services that not funded by or allowable under the waivers to the same rules that apply to waiver-funded services.

~~**COR Waiver Only:** The COR waiver also requires a separate written Crisis Back-up Plan for periods of intense supervision and supports to keep the person in the community.~~

2. Completing the ISP: Rights, Choice, Signatures

The completed 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 F-20445-A are located with the form in the DHS forms library at [F-20445i](#).

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 [F-20987](#) must be maintained in the agency file. Participants with an authorized representative or any other legal decision maker retain the right to be fully informed about the service plan content and any changes made to the plan.

Applicant/Participant Rights

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. The participant must be informed of his/her program rights and responsibilities verbally and in writing as specified in [Appendix M](#). In addition, the participant's rights under [DHS 94](#) must also be addressed, when applicable. 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 court order for protective services must accompany the service plan.

Applicant/Participant Choice

The selection of service providers, the requirement that waiver participants be given choice of provider and the documentation that this information has been given to the participant or their guardian are important requirements of the individualized service plan and the planning process. There are three important requirements that apply:

- a. Federal rules require that waiver participants be given a choice of any willing provider, so long as:
 - Prior to providing service that provider is qualified or becomes qualified under the standards for that service; **and**
 - The provider is willing to accept the rate for that service for the area in which the participant resides.

Willing providers include those that may already be providing waiver-covered services to waiver participants or those who aspire to do so. Providers that are not yet qualified by the waiver agency or the state regulatory agency, if applicable, must be given the opportunity to become qualified. This requirement applies to adults and children in all waivers.

- b. Waiver agencies are required to inform waiver participants and their guardians that they have the right to choose any qualified provider for any waiver covered service at any time. Giving participants the information on their right to choose and offering them the list of all willing providers for the service or services that are called for in the person's proposed plan must be done early in the planning process so that providers have a fair and equal opportunity to be chosen. Listings of available, willing providers may be obtained from the current [Medicaid Waivers Provider Registry](#) as described in Chapter IV. (See also the DLTC numbered memo at [DLTC N Memo2009 12.](#))
- c. The provision of the information described in **sections a.** and **b.** above to the participant and their guardian, if any, must be documented.

Provider Requirements

To become a waiver program service provider, the individual or entity must:

- 1) Be qualified to meet the standards for providers of the service they intend to provide;
- 2) Be chosen or accepted by the waiver participant or their guardian, if any;
- 3) Be willing to accept the rate for the service (If a rate has been established by the waiver agency for providers of that service or for the specific individual, if an individualized rate was established by the waiver agency that is coordinating services.);
- 4) Have executed a Medicaid Waiver Provider Agreement and comply with the terms and conditions of that agreement and this Manual; and
- 5) Be capable of assuring the health, safety and welfare of the waiver participants in the provision of those services.

F. Individual Service Plan – Individual Outcomes – The F-20445A:

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 [F-20445A](#)) 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. The outcome statements listed should be unique to the individual consumer and reflect his/her voice or perspective.

The F-20445A 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. Because assessment is an ongoing process, 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 F-20445A (or a Bureau approved local version) applies to all waiver programs and became effective January 1, 2007. Additional implementation instructions are available at [DLTC 2006-13](#).

G. Individual Service Plan - Narrative (Applies to CIP 1A/1B and, ~~BIW~~)

The Individual Service Plan Narrative is a required component of the CIP 1A/1B, ~~BIW~~ application packet. 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 about 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 needs and describe how the person's desired individual outcomes will be achieved.

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.

Challenging/ Dangerous Behaviors and Restrictive Measures

When the applicant's behavior is known to be challenging or dangerous, 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. In some instances, there may be a need to use restrictive measures of some kind.

If restrictive measures are used by compensated providers, separate, distinct Department and County approvals of the use of a restraint or other restrictive measure are required before the provider may use such measures. The only exception is an emergency, and then only as defined in the Guidelines. To obtain approval, the provider must make application for approval of restraint or use for other restrictive measures and include this with the plan packet. The proposed use must also be referenced in the individual service plan narrative.

Separate county and Departmental approval must be obtained before the use of any restraint or restrictive measure. Detailed guidance on the Department's application process for the use of a restrictive measure can be found in both Chapters VIII and IX and in Appendix R of this Manual. (See the [Guidelines App R](#).) If the restrictive measure is used by family or an uncompensated/informal provider, Department approval is not required. However, when such use is identified the waiver agency should determine whether the application of the measure is appropriate, whether its application puts with the health and safety of the applicant or participant **at risk**

and whether the measure(s) identified may be a reportable violation of Wisconsin Elder/Adult at Risk laws (s. 46.90).

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 in the assessment it is learned 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.

H. The HSRS L1 Screen – Applies to CIP 1A/B, ~~BIW~~ and CLTS

For CIP1A/1B, ~~BIW~~ and CLTS, the printed HSRS L1 Screen must be included in the application packet. The screen verifies that the applicant has been registered on HSRS and permits the Bureau to assign a waiver slot to the person so that funding will be available. 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.

1. CIP 1A, and 1B, ~~BIW~~

A variance is necessary if the plan includes services such as Institutional Respite, Day Services or provision of any other service in or on the grounds of an ICF-MR, nursing home, hospital or another institution. If the person's plan includes services that are provided in or 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 being requested and necessary. Advance discussion with the Bureau's assigned waiver follow along staff is strongly encouraged. When a situation requires a variance and no variance

approval is obtained it may be grounds for terminating waiver funding for the participant. All requests for variances should be sent to the Bureau's assigned waiver follow along staff (Area Quality Specialist) ¹.

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 it is clear that the individual's needs cannot be met by any other provider within reasonable proximity to the person. Under no circumstances may a CIP 1A; or CIP 1B ~~or BIW~~ 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, and
- d. A description of the plans to address the limitations associated with institutional settings.

2. CIP II and COP-W

A variance is necessary if the service plan includes Institutional Respite or the provision of Adult Day Care services in a nursing home or on the grounds of an institution. An approved 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. Optional variance request forms are available from the DHS forms library at [F-21056](#) or [F-21059](#).

Detailed 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 5.06 of this manual.

¹ The Area Quality Specialist (AQS) is the new title referring to the state staff formerly called Community Integration Specialists (CIS).

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 service plan review process. Proposals for home modifications for new applicants must be contained in the initial waiver application packet and the specific home modification proposed should be described in the cover letter. The request must be accompanied by supporting documents (plans, estimates, material and labor cost 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 application packet or as part of an ISP Update. Further information on the Home Modification approval process may be found in [Chapter IV](#). (See also the optional ramp home modification request form available at [F-21055](#).)

K. Documentation of Room and Board Costs

For **all new applications** for the CIP 1A/1B, ~~BIW~~, CIP II, and COP-W ~~and COR~~ waiver programs, when the applicant will reside in a substitute care facility, a completed [F-20920](#) form 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. As with the Wisconsin Medicaid State Plan programs, Medicaid 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 four 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. Determined by the IM unit, retroactive eligibility may occur if the person would have met financial and non-financial eligibility requirements, had Medicaid reimbursable expenses at any time during the three-month period and would have been eligible during that period had he or she applied.
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.** For CIP 1A/1B, CIP II/COP-W, and CLTS ~~and COR~~, functional eligibility is determined using the automated Adult or Children's Long Term Care Functional Screen. The screen must be completed by a **qualified screener** who is a qualified 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 ~~and COR~~** 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 eligibility date.~~
- 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 [F-62256](#) or the [F-62256a](#).~~
3. **For CIP II and COP-W and COR**, in order for services to be reimbursed by a Medicaid waiver program, the applicant/participant must meet all of the criteria in Section A above. 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.

C. Waiver Services Start Date:

The start date for waiver services may not be earlier than the waiver program start date. However, agencies should ensure the planned services begin as soon as possible on/after the approved program start date. **Agencies are responsible for assuring participant health and safety, and the services designed to meet this responsibility may not be delayed at agency discretion or for any reason other than the absence of funding or a lack of service provider availability.**

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 Application and Approval Process

The care manager/support and service coordinator is responsible for providing complete and accurate application information to the Bureau or its quality assurance designee. Incomplete documentation in the waiver application packet will delay the approval process.

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 the Area Quality Specialist (AQS) from the Bureau of Long Term Support (BLTS). To allow sufficient time for review and approval, waiver agency staff should submit the packets not less than two weeks prior to the requested service start date. It is important that waiver agencies submit service packets that contain all required components and also to assure that each component is accurate and complete. An **Application Checklist** will be used to document and verify the completeness of all submissions. This checklist form completed by state staff can be found in [Appendix Q](#) . Waiver agencies may at their option use the checklist as a cover sheet for each plan packet to verify the submitted application is complete. Application packets lacking all required documents or containing documentation that is incomplete may not be approved and will be returned for resubmission. Failure to submit a complete application could result in loss or delay of reimbursement.

Unless instructed otherwise, two copies of each Service Application Packet are submitted directly to the AQS assigned to the respective county. To obtain a list of the Community Integration Specialist 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 .

When the plan has been approved, the AQS sends an approval letter 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 county IM staff as formal notification of waiver program eligibility.

If the application for CIP 1 ~~or BIW~~ waiver services is ultimately denied by either the waiver agency or the DHS, this action must be documented by the waiver agency and the department and appropriate notification sent to the applicant.

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. CIP 1A plans are not approved unless both AQS and Center staff approve.

For all CIP 1A approval letters involving relocations from State Centers for DD, approval is contingent on the waiver agency agreeing to an enhanced, in person review schedule. This schedule applies to all relocations made from state Centers on or after January 1 2008. The enhanced review process includes the following:

- **30 Day Review:** Within approximately 30 days of the person's relocation date, State 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 AQS 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 as well.
- **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 AQS 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 AQS and they are able to attend.

2. CIP 1B Specific Requirements

CIP 1B Waiver participants 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 AQS will work with the local 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 AQS 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 medical/health related documents, as well as for timely documentation of functional and financial eligibility. The waiver application review also focuses on whether the individual outcomes identified in the assessment are addressed in the service plan and whether any unmet needs, health and safety issues or other risks are apparent.

If there are errors or omissions in the packet, approval cannot be given until they are resolved and the submitting agency will be contacted. If the review process determines the applicant is not eligible for the program the agency will receive a letter explaining why approval was not granted. If the initial waiver application is approved, a letter is sent by the Bureau notifying the agency care manager/support and service coordinator of the approval decision and the waiver program start date. The care manager should then forward a copy of the approval letter to the county IM staff as formal notification of waiver program eligibility.

C. CLTS

The completed waiver application packet with CLTS Application Checklist (available from the DHS Forms Library at [F-21080.doc](#)) must be submitted to the Bureau of Long Term Support, 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.

D. COR

~~The completed waiver application packet must be submitted to the Bureau of Prevention Treatment and Recovery in the Division of Mental Health and Substance Abuse Services. 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 needs identified in the assessment are addressed in the service plan and if 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 as formal notification of waiver program eligibility.~~

6.05 The Waiver Application Packet – Reference Guide

The chart on the following two pages provides a reference guide to the required content of the application packet for each Medicaid waiver program.

Waiver Application Reference Guide:

	Level of Care Eligibility	Financial Eligibility	Assessment	Individual Service Plan	Narrative	General ²
BIW	F-62256 or F-62256a (See also Appendix J-7)	F-20919 or CARES Screens	Person-Centered Assessment	F-20445 & F-20445A Or an approved substitute ISP	Service Plan Narrative	Cover Letter, HSRS L1; Request for a Variance or a Home Modification An F-20920 (Substitute Care)
CIP 1A CIP 1B	A copy of the completed LTC-FS	F-20919 or CARES Screens	LTC-FS Assessment/ Supplement or another Person - Centered Assessment	F-20445 & F-20445A Or an approved substitute ISP	Service Plan Narrative	Cover Letter, HSRS L1; Request for a Variance or a Home Modification An F-20920 (Substitute Care)
CIP II/ COP-W	A copy of the completed LTC-FS & Health Form (If needed)	F-20919 or CARES Screens	LTC-FS Assessment/ Supplement	F-20445 & F-20445A Or an approved substitute ISP	Optional	Cover Letter, NAT Request; Request for a Variance or a Home Modification An F-20920 (Substitute Care)
COR	A completed LTC-FS & Health Form (If needed)	F-20919 or CARES Screens	LTC-FS Assessment/ Supplement, PASARR Level II Screen, MDS	F-20445 & F-20445A or approved substitute; Crisis Back-up Plan	Optional	Cover Letter, Crisis Back-up Plan Request for Variance or Home Modification, F-20920

² **REMINDER:** The waiver application packet may require additional documentation for any special initiatives (e.g., ICF-MR downsizing, Community Relocation Initiative, etc.).

Application Packet Reference Guide (continued):

	Level of Care Eligibility	Financial Eligibility	Assessment	Individual Service Plan	Narrative	General
CLTS	A printed copy of the current Children’s LTC-FS - when the LTC-FS is used in place of a narrative assessment. OR The current C-LTC-FS results page if a separate assessment is submitted. AND Disability Determination (If required)	F-20919 or CARES Screens	Enhanced CLTS-FS or Person - Centered Assessment	F-20445 & F-20445A Or an approved substitute ISP	Optional	Application Checklist, HSRS L1, Request for a Variance or a Home Modification