

Appendix B: Participant Access and Eligibility

Appendix B-1: Specification of the Waiver Target Group(s)

- a. Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

SELECT ONE WAIVER TARGET GROUP	TARGET GROUP/SUBGROUP	MINIMUM AGE	MAXIMUM AGE	
			MAXIMUM AGE LIMIT: THROUGH AGE –	NO MAXIMUM AGE LIMIT
<input type="radio"/>	Aged or Disabled, or Both (<i>select one</i>)			
<input checked="" type="radio"/>	Aged or Disabled or Both – General (<i>check each that applies</i>)			
<input checked="" type="checkbox"/>	Aged (age 65 and older)	65		<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>	Disabled (Physical) (under age 65)	21	64	<input checked="" type="checkbox"/>
<input type="checkbox"/>	Disabled (Other) (under age 65)			<input checked="" type="checkbox"/>
<input type="radio"/>	Specific Recognized Subgroups (<i>check each that applies</i>)			
<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input type="radio"/>	Mental Retardation or Developmental Disability, or Both (<i>check each that applies</i>)			
<input type="checkbox"/>	Autism			<input type="checkbox"/>
<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
<input type="checkbox"/>	Mental Retardation			<input type="checkbox"/>
<input type="radio"/>	Mental Illness (<i>check each that applies</i>)			
<input type="checkbox"/>	Mental Illness (age 18 and older)			<input type="checkbox"/>
<input type="checkbox"/>	Mental Illness (under age 18)			<input checked="" type="checkbox"/>

- b. Additional Criteria.** The State further specifies its target group(s) as follows:

Be a resident of Pennsylvania residing in a managed care county according to the following rollout schedule:

- January 1, 2017 implementation of CHC in the Southwestern zone (Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Somerset, Washington, and Westmoreland counties);
- January 1, 2018 implementation of CHC in the Southeast zone (Bucks, Chester, Delaware, Philadelphia and Montgomery counties);
- January 1, 2019 implementation of CHC in the remainder of the state.

Be 21 years of age or older.

Waiver services are limited to individuals with physical disabling conditions that are expected to last

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indefinitely, including individuals with acquired brain injury injuries, and who require a Nursing Facility level of care.

- c. **Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

<input checked="" type="radio"/>	Not applicable – There is no maximum age limit
<input type="radio"/>	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit (<i>specify</i>):

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Appendix B-2: Individual Cost Limit

- a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*) Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

●	No Cost Limit. The State does not apply an individual cost limit. <i>Do not complete Item B-2-b or Item B-2-c.</i>		
	Cost Limit in Excess of Institutional Costs. The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. <i>Complete Items B-2-b and B-2-c.</i> The limit specified by the State is (<i>select one</i>):		
			%, a level higher than 100% of the institutional average
		Other (<i>specify</i>):	
	Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. <i>Complete Items B-2-b and B-2-c.</i>		
	Cost Limit Lower Than Institutional Costs. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver. <i>Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.</i>		
	The cost limit specified by the State is (<i>select one</i>):		
			The following dollar amount: \$
		The dollar amount (<i>select one</i>):	
		Is adjusted each year that the waiver is in effect by applying the following formula:	
		May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.	
			The following percentage that is less than 100% of the institutional average: %
		Other – <i>Specify</i> :	

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- b. Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

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- c. Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

<input type="checkbox"/>	The participant is referred to another waiver that can accommodate the individual's needs.
	Additional services in excess of the individual cost limit may be authorized. Specify the procedures for authorizing additional services, including the amount that may be authorized:
	Other safeguard(s) (<i>specify</i>):

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Appendix B-3: Number of Individuals Served

- a. Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1 FY15-16	
Year 2 FY 16-17	
Year 3 FY 17-18	
Year 4 (renewal only) FY 18-19	
Year 5 (renewal only) FY 19-20	

- b. Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

<input type="radio"/>	The State does not limit the number of participants that it serves at any point in time during a waiver year.
<input checked="" type="radio"/>	The State limits the number of participants that it serves at any point in time during a waiver year. The limit that applies to each year of the waiver period is specified in the following table:

Table B-3-b	
Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4 (renewal only)	
Year 5 (renewal only)	

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- c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):

Not applicable. The state does not reserve capacity.		
The State reserves capacity for the following purpose(s). Purpose(s) the State reserves capacity for:		
Table B-3-c		
	Purpose (provide a title or short description to use for lookup):	Purpose (provide a title or short description to use for lookup):
	Nursing facility transitions and individuals with imminent risk of nursing facility admission	Active Protective Service Cases
	Purpose (describe):	Purpose (describe):
	OLTL reserves waiver capacity for individuals who are at imminent risk of nursing facility admission if not for the availability of waiver services, or an individual is transitioning from a nursing facility into the community. All participants enrolled in the CHC Waiver have comparable access to all services offered in the Waiver. This is evidenced by the Person-Centered Support Plan process that is required for all participants and requires that service options be promoted and fully explored with every individual.	OLTL reserves waiver capacity for individuals who are referred with active protective services cases and where services at home would be a safe and appropriate option. All participants enrolled in the CHC Waiver have comparable access to all services offered in the Waiver. This is evidenced by the Person-Centered Support Plan process that is required for all participants and requires that service options be promoted and fully explored with every individual.
	Describe how the amount of reserved capacity was determined:	Describe how the amount of reserved capacity was determined:
	Waiver Year	Capacity Reserved

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	Year 1		
	Year 2		
	Year 3		
	Year 4 (only if applicable based on Item 1-C)		
	Year 5 (only if applicable based on Item 1-C)		

d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

<input checked="" type="radio"/>	The waiver is not subject to a phase-in or a phase-out schedule.
<input type="radio"/>	The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an <i>intra-year</i> limitation on the number of participants who are served in the waiver.

e. **Allocation of Waiver Capacity.** *Select one:*

<input checked="" type="radio"/>	Waiver capacity is allocated/managed on a statewide basis.
<input type="radio"/>	Waiver capacity is allocated to local/regional non-state entities. Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. **Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

<p>All applicants for the CHC HCBS waiver must meet nursing facility level of care requirements as determined by a qualified professional using the Clinical Eligibility Determination. After this evaluation, OLTL requires that applicants receive information on all available home and community-based services, including the Living Independence for the Elderly (LIFE) program, as well as institutional services. Applicants then indicate the program of their choice and document the receipt of information regarding their options by electronically completing the OLTL Freedom of Choice form. This form must be signed and dated by the applicant (or his or her legal representative) seeking services and is to be maintained in the applicant's case record.</p> <p>Individuals that are eligible for the waiver will be served.</p> <p>In the event that the number of enrollees applying for services exceeds program capacity and a waiting list for waiver services becomes necessary, the following procedure will be implemented giving priority in descending order to the following groups for enrollment in the program:</p> <ol style="list-style-type: none"> 1. Qualified applicants diverted from an imminent nursing facility admission including any applicant with an active Adult Protective Services (APS) or Older Adult Protective Services case who qualifies for and could benefit from CHC services.
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2. Nursing facility residents who meet program requirements, express a desire to return to a home and community based setting, and need services to live successfully in the community.
3. All other qualified applicants in chronological order by date of inquiry.

Category 1 has the highest priority and is admitted first. Then, applicants in Category 2 followed by applicants in Category 3 are admitted. Within each category, applicants are admitted by date of application.

Attachment #1 to Appendix B-3

Waiver Phase-In/Phase Out Schedule

a. The waiver is being (*select one*):

<input type="radio"/>	Phased-in
<input type="radio"/>	Phased-out

b. **Waiver Years Subject to Phase-In/Phase-Out Schedule** (*check each that applies*):

Year One	Year Two	Year Three	Year Four	Your Five
			<input type="checkbox"/>	<input type="checkbox"/>

c. **Phase-In/Phase-Out Time Period.** *Complete the following table:*

	Month	Waiver Year
Waiver Year: First Calendar Month		
Phase-in/Phase out begins		
Phase-in/Phase out ends		

d. **Phase-In or Phase-Out Schedule.** *Complete the following table:*

Phase-In or Phase-Out Schedule			
Waiver Year:			
Month	Base Number of Participants	Change in Number of Participants	Participant Limit

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Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

a. a-1. State Classification. The State is a (*select one*):

<input checked="" type="radio"/>	§1634 State
<input type="radio"/>	SSI Criteria State
<input type="radio"/>	209(b) State

a-2. Miller Trust State.

Indicate whether the State is a Miller Trust State.

<input type="radio"/>	Yes
<input checked="" type="radio"/>	No

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

<i>Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)</i>	
<input type="checkbox"/>	Low income families with children as provided in §1931 of the Act
<input checked="" type="checkbox"/>	SSI recipients
<input type="checkbox"/>	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
<input checked="" type="checkbox"/>	Optional State supplement recipients
<input checked="" type="checkbox"/>	Optional categorically needy aged and/or disabled individuals who have income at: (<i>select one</i>)
<input checked="" type="radio"/>	100% of the Federal poverty level (FPL)
<input type="radio"/>	% of FPL, which is lower than 100% of FPL
<input type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
<input checked="" type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
<input checked="" type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
<input type="checkbox"/>	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
<input type="checkbox"/>	Medically needy in 209(b) States (42 CFR §435.330)
<input checked="" type="checkbox"/>	Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
<input checked="" type="checkbox"/>	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) <i>specify:</i>
All other mandatory and optional groups under the State Plan are included	
<i>Special home and community-based waiver group under 42 CFR §435.217) Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed</i>	

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<input type="radio"/>	No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.
<input checked="" type="radio"/>	Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. <i>Select one and complete Appendix B-5.</i>
<input type="radio"/>	All individuals in the special home and community-based waiver group under 42 CFR §435.217
<input checked="" type="radio"/>	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 (<i>check each that applies</i>):
<input checked="" type="checkbox"/>	A special income level equal to (select one):
<input checked="" type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)
<input type="radio"/>	% of FBR, which is lower than 300% (42 CFR §435.236)
<input type="radio"/>	\$ which is lower than 300%
<input type="checkbox"/>	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
<input type="checkbox"/>	Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
<input type="checkbox"/>	Medically needy without spend down in 209(b) States (42 CFR §435.330)
<input type="checkbox"/>	Aged and disabled individuals who have income at: (<i>select one</i>)
<input type="radio"/>	100% of FPL
<input type="radio"/>	% of FPL, which is lower than 100%
<input type="checkbox"/>	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) <i>specify</i> :

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Appendix B-5: Post-Eligibility Treatment of Income

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217):

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

<input type="checkbox"/>	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses <i>spousal</i> post-eligibility rules under §1924 of the Act. <i>Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.</i>
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Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).

<input checked="" type="radio"/>	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State elects to (<i>select one</i>):
<input checked="" type="radio"/>	Use <i>spousal</i> post-eligibility rules under §1924 of the Act. <i>Complete Items B-5-b-2 (SSI State and §1634) or B-5-c-2 (209b State) and Item B-5-d.</i>
<input type="radio"/>	Use <i>regular</i> post-eligibility rules under 42 CFR §435.726 (SSI State and §1634) (<i>Complete Item B-5-b-1</i>) or under §435.735 (209b State) (<i>Complete Item B-5-c-1</i>). <i>Do not complete Item B-5-d.</i>
<input type="radio"/>	Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. <i>Complete Item B-5-c-1 (SSI State and §1634) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.</i>

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules. However, for the five-year period beginning on January 1, 2014, post-eligibility treatment-of-income rules may not be determined in accordance with B-5-b-1 and B-5-c-1, because use of spousal eligibility and post-eligibility rules are mandatory during this time period.

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Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b-1. Regular Post-Eligibility Treatment of Income: SSI State and §1634 State. The State uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (select one):		
<input checked="" type="radio"/>	The following standard included under the State plan (select one)	
<input type="radio"/>	SSI standard	
<input type="radio"/>	Optional State supplement standard	
<input type="radio"/>	Medically needy income standard	
<input checked="" type="radio"/>	The special income level for institutionalized persons (select one):	
<input checked="" type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)	
<input type="radio"/>	%	of the FBR, which is less than 300%
<input type="radio"/>	\$	which is less than 300%.
<input type="radio"/>	%	of the Federal poverty level
<input type="radio"/>	Other standard included under the State Plan (specify):	
<input type="radio"/>	The following dollar amount: \$ If this amount changes, this item will be revised.	
<input type="radio"/>	The following formula is used to determine the needs allowance:	
<input type="radio"/>	Other (specify):	
ii. Allowance for the spouse only (select one):		
<input type="radio"/>	SSI standard	
<input type="radio"/>	Optional State supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount: \$ If this amount changes, this item will be revised.	
<input type="radio"/>	The amount is determined using the following formula: Specify	
<input checked="" type="radio"/>	Not applicable (see instructions)	
iii. Allowance for the family (select one):		
<input type="radio"/>	AFDC need standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount: \$ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.	

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<input type="radio"/>	The amount is determined using the following formula: <i>Specify</i>
<input type="radio"/>	Other (specify):
<input checked="" type="radio"/>	Not applicable (<i>see instructions</i>)
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:	
a. Health insurance premiums, deductibles and co-insurance charges	
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>	
<input checked="" type="radio"/>	Not applicable (<i>see instructions</i>) <i>Note: If the State protects the maximum amount for the waiver participant, not applicable must be checked.</i>
<input type="radio"/>	The State does not establish reasonable limits.
<input type="radio"/>	The State establishes the following reasonable limits (<i>specify</i>):

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Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c-1. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant’s income:

i. Allowance for the needs of the waiver participant (select one):			
<input type="radio"/>	The following standard included under the State plan (select one)		
<input type="radio"/>	The following standard under 42 CFR §435.121:		
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The special income level for institutionalized persons (select one)		
<input type="radio"/>	<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)	
<input type="radio"/>	<input type="radio"/>	%	of the FBR, which is less than 300%
<input type="radio"/>	<input type="radio"/>	\$	which is less than 300% of the FBR
<input type="radio"/>	<input type="radio"/>	%	of the Federal poverty level
<input type="radio"/>	Other standard included under the State Plan (specify):		
<input type="radio"/>	The following dollar amount: \$		
			Specify dollar amount: If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance:		
<input type="radio"/>	Other (specify)		
ii. Allowance for the spouse only (select one):			
<input type="radio"/>	The following standard under 42 CFR §435.121		
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following dollar amount: \$		
			If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:		

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<input type="radio"/>	Not applicable (<i>see instructions</i>)
iii. Allowance for the family (<i>select one</i>)	
<input type="radio"/>	AFDC need standard
<input type="radio"/>	Medically needy income standard
<input type="radio"/>	The following dollar amount: \$ <input type="text"/> The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula: <input type="text"/>
<input type="radio"/>	Other (specify): <input type="text"/>
<input type="radio"/>	Not applicable (<i>see instructions</i>)
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:	
a. Health insurance premiums, deductibles and co-insurance charges	
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>	
<input type="radio"/>	Not applicable (<i>see instructions</i>) <i>Note: If the State protects the maximum amount for the waiver participant, not applicable must be checked.</i>
<input type="radio"/>	The State does not establish reasonable limits.
<input type="radio"/>	The State establishes the following reasonable limits (<i>specify</i>): <input type="text"/>

NOTE: Items B-5-b-2 and B-5-c-2 are for use by states that use spousal impoverishment eligibility rules and elect to apply the spousal post eligibility rules.

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Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b-2. Regular Post-Eligibility Treatment of Income: SSI State and §1634 state. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (select one):		
<input type="radio"/>	The following standard included under the State plan (select one)	
<input type="radio"/>	SSI standard	
<input type="radio"/>	Optional State supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The special income level for institutionalized persons (select one):	
<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)	
<input type="radio"/>	%	A percentage of the FBR, which is less than 300% Specify the percentage:
<input type="radio"/>	\$	A dollar amount which is less than 300%. Specify dollar amount:
<input type="radio"/>	%	A percentage of the Federal poverty level Specify percentage:
<input type="radio"/>	Other standard included under the State Plan (specify):	
<input type="radio"/>	The following dollar amount:	\$ If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance:	
<input type="radio"/>	Other (specify):	
ii. Allowance for the spouse only (select one):		
<input type="radio"/>	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:	
	Specify the amount of the allowance:	
<input type="radio"/>	SSI standard	
<input type="radio"/>	Optional State supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount:	\$ If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:	

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<input type="radio"/>	Not applicable (<i>see instructions</i>)	
iii. Allowance for the family (<i>select one</i>):		
<input type="radio"/>	AFDC need standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount: \$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:	
<input type="radio"/>	Other (<i>specify</i>):	
<input type="radio"/>	Not applicable (<i>see instructions</i>)	
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:		
a. Health insurance premiums, deductibles and co-insurance charges		
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>		
<input type="radio"/>	Not applicable (<i>see instructions</i>) <i>Note: If the State protects the maximum amount for the waiver participant, not applicable must be checked.</i>	
<input type="radio"/>	The State does not establish reasonable limits.	
<input type="radio"/>	The State establishes the following reasonable limits (<i>specify</i>):	

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Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c-2. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (select one):			
<input type="radio"/>	The following standard included under the State plan (select one)		
<input type="radio"/>	The following standard under 42 CFR §435.121:		
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The special income level for institutionalized persons (select one)		
<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)		
<input type="radio"/>	%	A percentage of the FBR, which is less than 300% Specify the percentage:	
<input type="radio"/>	\$	A dollar amount which is less than 300%. Specify dollar amount:	
<input type="radio"/>	%	A percentage of the Federal poverty level Specify percentage:	
<input type="radio"/>	Other standard included under the State Plan (specify):		
<input type="radio"/>	The following dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance:		
<input type="radio"/>	Other (specify):		
ii. Allowance for the spouse only (select one):			
<input type="radio"/>	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:		
Specify the amount of the allowance:			
<input type="radio"/>	The following standard under 42 CFR §435.121:		
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		

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<input type="radio"/>	The following dollar amount: <input type="text"/>	If this amount changes, this item will be revised.
	The amount is determined using the following formula: <input type="text"/>	
	Not applicable (<i>see instructions</i>)	
iii. Allowance for the family (<i>select one</i>)		
	AFDC need standard	
	Medically needy income standard	
	The following dollar amount: <input type="text"/> The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.	
	The amount is determined using the following formula: <input type="text"/>	
	Other (specify): <input type="text"/>	
	Not applicable (<i>see instructions</i>)	
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.735:		
a. Health insurance premiums, deductibles and co-insurance charges		
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>		
	Not applicable (<i>see instructions</i>) <i>Note: If the State protects the maximum amount for the waiver participant, not applicable must be checked.</i>	
	The State does not establish reasonable limits.	
	The State establishes the following reasonable limits (<i>specify</i>): <input type="text"/>	

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Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant (select one):		
<input type="checkbox"/>	SSI Standard	
<input type="checkbox"/>	Optional State Supplement standard	
<input type="checkbox"/>	Medically Needy Income Standard	
<input type="checkbox"/>	The special income level for institutionalized persons	
<input type="checkbox"/>	Specify percentage:	
<input type="checkbox"/>	The following dollar amount: <input type="text"/>	If this amount changes, this item will be revised
<input type="checkbox"/>	The following formula is used to determine the needs allowance:	
<input type="checkbox"/>	<input type="text"/>	
<input type="checkbox"/>	Other (specify):	
<input type="checkbox"/>	<input type="text"/>	
ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community. Select one:		
<input type="checkbox"/>	Allowance is the same	
<input type="checkbox"/>	Allowance is different. Explanation of difference:	
<input type="checkbox"/>	<input type="text"/>	
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified section 1902(r)(1) of the Act:		
a. Health insurance premiums, deductibles and co-insurance charges.		
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. Select one:		
<input type="checkbox"/>	Not applicable (see instructions) Note: If the State protects the maximum amount for the waiver participant, not applicable must be checked.	
<input type="checkbox"/>	The State does not establish reasonable limits.	
<input type="checkbox"/>	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.	

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NOTE: Items B-5-e, B-5-f and B-5-g only apply for the five-year period beginning January 1, 2014. If the waiver is effective during the five-year period beginning January 1, 2014, and if the state indicated in B-5-a that it uses spousal post-eligibility rules under §1924 of the Act before January 1, 2014 or after December 31, 2018, then Items B-5-e, B-5-f and/or B-5-g are not necessary. The state's entries in B-5-b-2, B-5-c-2, and B-5-d, respectively, will apply.

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Appendix B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

- a. Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for waiver services:

i.	Minimum number of services. The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is <i>(insert number)</i> : <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	Frequency of services. The State requires <i>(select one)</i> :
	<input type="checkbox"/> The provision of waiver services at least monthly
	<input type="checkbox"/> Monthly monitoring of the individual when services are furnished on a less than monthly basis. If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency: <div style="border: 1px solid black; width: 100%; height: 30px; margin-top: 5px;"></div>

- b. Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed *(select one)*:

<input type="radio"/>	Directly by the Medicaid agency
<input type="radio"/>	By the operating agency specified in Appendix A
<input checked="" type="radio"/>	By an entity under contract with the Medicaid agency. <i>Specify the entity</i> : <div style="border: 1px solid black; padding: 5px; margin-top: 5px;">OLTL is contracting with a conflict-free, non-governmental, non-state agency, to conduct the initial and annual level of care determinations and redeterminations, hereafter referred to as Clinical Eligibility Determinations/Redeterminations. The selected entity will have subcontracts with local organizations to perform the initial Clinical Eligibility Determinations and annual Redeterminations, and will be responsible for monitoring these local organizations to ensure Initial that initial Clinical Eligibility Determinations are completed 15 days after the participant referral from the Independent Enrollment Entity. The selected entity will also be responsible for validating the results of the documentation collected by the CHC-MCOs and officially making the annual level of care redetermination. Lastly, the selected entity will be responsible for ensuring that evaluations and assessments are completed within the required timeframes as set forth in policy.</div>
<input type="radio"/>	Other <i>(specify)</i> : <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>

- c. Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

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Assessors must meet the following qualifications:

1. One year experience in public or private social work and a Bachelor's Degree which includes or is supplemented by 12 semester hours credit in sociology, social welfare, psychology, gerontology, or other related social sciences; or a bachelor's degree with a social welfare major; or any equivalent combination of experience and training including successful completion of 12 semester hours credit in sociology, social welfare, psychology, gerontology, or other related social sciences **OR**
2. Two years of case work experience including one year of experience performing assessments of client's functional ability to determine the need for institutional or community based services and a bachelor's degree which include or is supplemented by 12 semester hours credit in sociology, social welfare, psychology, gerontology or other related social sciences **OR**
3. One year assessment experience and a bachelor's degree with social welfare major **OR**
4. Any equivalent combination of experience or training including successful completion of 12 semester credit hours of college level courses in sociology, social welfare, psychology, gerontology or other related social sciences. One year experience in the AAA system may be substituted for one year assessment experience.

The equivalency statement in the items noted above means that related advanced education may be substituted for a segment of the experience requirement and related experience may be substituted for required education except for the required 12 semester hours in the above majors.

Physicians must be licensed through the Pennsylvania Department of State under Chapter 17 of Title 49 PA Code.

- d. Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

An individual is NFCE if he or she needs the level of care provided in a nursing facility.

Under Federal and State law and regulations, which identify the level of care provided in a nursing facility, an individual is considered NFCE if:

1. The individual has an illness, injury, disability or medical condition diagnosed by a physician; and
2. As a result of that diagnosed illness, injury, disability or medical condition, the individual requires care and services above the level of room and board; and
3. A physician certifies that the individual is NFCE; and
4. The care and services are either
 - a) skilled nursing or rehabilitation services as specified by the Medicare Program in 42 CFR §§ 409.31(a), 409.31(b)(1) and (3), and 409.32 through 409.35; or
 - b) health-related care and services that may not be as inherently complex as skilled nursing

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or rehabilitation services but which are needed and provided on a regular basis in the context of a planned program of health care and management and were previously available only through institutional facilities.

The Clinical Eligibility Determination is made using a standardized clinical eligibility tool and physician certification form which indicates the physician's diagnosis and clinical eligibility recommendation.

- e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

<input checked="" type="radio"/>	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
<input type="radio"/>	A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan. Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

- f. **Process for Level of Care Evaluation/Reevaluation.** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Initial Level of Care Evaluation – OLTL uses the following process to determine an individual's initial level of care:

- The applicant first applies for CHC Waiver services through the statewide Independent Enrollment Entity (IEE).
- The IEE makes a referral to the conflict-free entity for a clinical eligibility determination and assists the applicant with obtaining a completed physician certification form from the applicant's physician (M.D. or D.O.).
- The conflict-free entity assessor visits the applicant within 15 days of receiving the referral from the IEE, and uses the standardized Clinical Eligibility Determination tool to identify information regarding the applicant's medical status, recent hospitalizations, and functional ability (ADLs and IADLs). The Clinical Eligibility Determination tool is used in all 67 counties for all individuals entering a home and community-based waiver, LIFE and to determine institutional level of care.
- The physician completes the physician certification form indicating the applicant's diagnosis and the physician's clinical eligibility recommendation. Once complete, the IEE forwards the physician's certification form along with a request for a clinical eligibility determination to the conflict-free entity.
- The IEE follows the status of the clinical eligibility determination process and assists with any required communication between the applicant, the applicant's physician, and the conflict-free entity.
- The conflict free entity is responsible for making the final clinical eligibility decision subject to OLTL oversight. In instances where the applicant's physician and the assessor differ on the final clinical eligibility determination, OLTL's Medical Director will review the collected

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documentation and make the final determination.

Annual Redetermination – OLTL uses the following process for the annual redetermination of waiver participants:

- Using the standardized Clinical Eligibility Determination tool, the participant’s CHC-MCO is responsible for collecting the necessary information and documentation to complete the clinical eligibility determination. This information is then forwarded to the conflict-free entity for the annual redetermination of clinical eligibility.
- The conflict-free entity is responsible for validating the results of the documentation collected by the CHC-MCOs making the final clinical eligibility determinations, subject to OLTL oversight.

As stated above, in instances where the applicant’s physician and the assessor differ on the final clinical eligibility determination, OLTL’s Medical Director will review the collected documentation and make the final determination.

A contract manager, who is an employee of the Office of Long Term Living, will be assigned to oversee this contract and will require quarterly reports on timeliness of the determinations and the agencies agency’s adherence to the contract requirements. A yearly report on all program requirements will also be required and reviewed for compliance.

OLTL maintains Administrative Authority over the evaluation and reevaluation processes by monitoring the timeliness and appropriateness of LOC evaluations and reevaluations referenced in the Quality Improvement section below.

- g. Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

<input type="radio"/>	Every three months
<input type="radio"/>	Every six months
<input type="radio"/>	Every twelve months
<input checked="" type="radio"/>	Other schedule (<i>specify</i>): A redetermination is required every 365 days or sooner if there is a significant change in condition.

- h. Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):

<input checked="" type="radio"/>	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
<input type="radio"/>	The qualifications are different. The qualifications of individuals who perform reevaluations are (<i>specify</i>):

- i. Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care (*specify*):

The CHC-MCO will ensure that a meeting with the participant in the participant’s home takes place to collect the information/documentation required to reassess the participant’s need for waiver services. Each CHC-MCO will be required to maintain its own tickler system to complete timely reevaluations

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and maintain consistency in service. CHC-MCO's are required to collect the information necessary for redeterminations every 365 days or more frequently as needed.

The information/documentation gathered will then be forwarded to the conflict-free entity before 365 days of the prior evaluation/re-evaluation for determination of on-going eligibility of the participant.

The reevaluation information is maintained in the participant's file at both the CHC-MCO and the conflict-free entity, and is subject for review during OLTL biennial monitoring visits. Additionally, OLTL will receive regular reports from both the CHC-MCO and the conflict-free entity detailing the timeliness and accuracy of the re-evaluations. This information will be reviewed by the Bureau of Quality within OLTL and corrective action will be taken if either party fails to meet identified standards.

- j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR § 92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Data will be stored in the Commonwealth's Enterprise Data Warehouse where all participant information is stored and maintained. This includes enrollment data, eligibility information, incident management, and billing and claims management.

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Appendix B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State’s procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

PARTICIPANT FREEDOM OF CHOICE

The Commonwealth of Pennsylvania assures CMS that when a Nursing Facility (NF) or community resident applies for CHC waiver services and the participant is determined to likely require Nursing Facility level of care, the individual will be:

- Informed by the IEE of all available home and community-based services, including the Living Independence for the Elderly (LIFE) program for individuals aged 55 and over; and,
- Given the choice of receiving Nursing Facility institutional services, waiver services, LIFE program services as appropriate, or no services

Participant Freedom of Choice of Care Alternatives

All individuals who are determined to be eligible to receive community services in the waiver will be informed in writing, initially by the IEE of their right to choose between receiving community services in the waiver, LIFE, NF services, or choose not to receive services. All eligible participants will execute his/her choice during the initial enrollment process and annually during the development of the person-centered service plan. Documentation is made in the participant’s file that the form was completed; completed forms are maintained in the participant’s file.

Participant Freedom of Choice of Providers

The IEE is responsible for ensuring that all individuals who are determined eligible for waiver services are given a choice of CHC-MCOs, and electronically documenting the participant's choice of CHC-MCO. After the participant selects a CHC-MCO, the IEE will process the enrollment and refer the participant to the selected managed care plan for services.

The CHC-MCO must offer the Participant the choice of at least two Service Coordinators. If a Participant does not select a Service Coordinator within fourteen (14) business days of Enrollment for a comprehensive needs assessment, the CHC-MCO must make an automatic assignment of Service Coordinator. The CHC-MCO must consider such factors (to the extent they are known), as current Provider relationships, the person assigned to the Participant for care management in the CHC-MCO's aligned D-SNP, specific medical needs, physical disabilities of the Participant, language needs, area of residence and access to transportation. The CHC-MCO must then notify the Participant by telephone or in writing of his/her Service Coordinator’s name, location and office telephone number. The CHC-MCO must make every effort to determine Service Coordination choice and confirm this with the Participant prior to the commencement of the CHC-MCO coverage in accordance with Participant

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Enrollment and Disenrollment, so that new Participants do not go without a Service Coordinator for a period of time after Enrollment begins or after assessment of needs for LTSS.

The participant also has the freedom to choose any qualified provider in the CHC-MCO's network to receive waiver services. The Service Coordinator is responsible for ensuring participants are fully informed of their right to choose willing and qualified service providers within the network at the time of development of the initial Person-Centered Service Plan, at each reevaluation, and at any time during the year when a participant requests a change of providers. The Service Coordinator is responsible for documenting the participant's choice of provider electronically as part of the participant's Person-Centered Service Plan.

- b. Maintenance of Forms.** Per 45 CFR § 92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The Independent Enrollment Entity (IEE) will collect for each waiver applicant their Freedom of Choice regarding where they receive services and Service Provider Choice of MCO, via an electronic record as part of the enrollment process. The IEE will submit this information to the chosen MCO upon each individual's enrollment in the CHC-MCO. The CHC-MCO will maintain these records in participant files.

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Appendix B-8: Access to Services by Limited English Proficient Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services “Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons” (68 FR 47311 - August 8, 2003):

During the Enrollment Process, the Independent Enrollment Entity will identify applicants who speak or read a language other than English as their first language. This information will be communicated to the chosen CHC-MCO when the participant transfer to the CHC-MCO occurs. The CHC-MCO must identify spoken and written language preferences identified by the IEE and CHC-MCO during its first contact(s) with the Participant.

The CHC-MCO must provide, at no cost to Participants, oral interpretation services in the requested language or sign language interpreter services to meet the needs of Participants. The CHC-MCO must also provide specialized interpretive services to ensure access to services for Participants who are deaf and blind. These services must also include all services dictated by federal requirements for translation services designated to the CHC-MCO Providers if the Provider is unable or unwilling to provide these services.

The CHC-MCO must make all vital documents disseminated to English speaking Participants available in the prevalent languages designated by the Department. Documents may be deemed vital if related to the access to programs and services and include informational material. Vital documents include Provider Directories, Participant handbooks, appeal and grievance notices, and other notices that are critical to obtaining services. The CHC-MCO must include appropriate instructions in all materials about how to access or receive assistance to access materials in an alternate language.

Vital documents must be posted on the CHC-MCO’s website.

The CHC-MCO must also provide alternative methods of communication for Participants who are visually or hearing impaired or both, including Braille, audio tapes, large print, compact disc, DVD, computer diskette, special support services, and/or electronic communication. The CHC-MCO must, upon request from the Participant, make all written materials disseminated to Participants accessible to visually impaired Participants. The CHC-MCO must provide TTY and/or Pennsylvania Telecommunication Relay Service for communicating with Participants who are deaf or hearing impaired, upon request.

The CHC-MCO must include appropriate instructions in all materials about how to access or receive assistance to access materials in an alternate format.

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