Appendix B: Participant Access and Eligibility

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 one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☒ **Intellectual Disability or Developmental Disability, or Both**					
	☒	**Autism**	21		☒
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

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

Waiver eligibility is limited to people who:

Meet Medical Assistance Program clinical and financial eligibility for Intermediate Care Facility for Persons with Other Related Conditions (ICF/ORC) or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID) services, and

Have a diagnosis of Autism Spectrum Disorder (ASD) manifested before the age of 22 as determined by a licensed psychologist, certified school psychologist, psychiatrist, developmental pediatrician, licensed physician, licensed physician assistant, or certified registered nurse practitioner using the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) applicable at the time of the diagnosis, and

Have substantial functional limitations in three or more major life activities as a result of ASD and/or other developmental disabilities that are likely to continue indefinitely: self-care, receptive and expressive language, learning, mobility, self-direction and/or capacity for independent living, and

Are 21 years of age or older, and

Are residents of Pennsylvania.

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):*

- (●) **Not applicable. There is no maximum age limit**
- ( ) **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

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. *Do not complete Item B-2-b or item B-2-c.*
- ( ) **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. *Complete Items B-2-b and B-2-c.*

  The limit specified by the state is *(select one)*

  - ( ) **A level higher than 100% of the institutional average.**

    Specify the percentage:

  - ( ) **Other**

    Specify:

- ( ) **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. *Complete Items B-2-b and B-2-c.*
- ( ) **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.

  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.

The cost limit specified by the state is *(select one)*:

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the 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:**

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

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:

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)*:

☐ **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)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

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	754
Year 2	754
Year 3	754
Year 4	754
Year 5	754

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)* :

- ○ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**
- ◉ **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	718
Year 2	718
Year 3	718
Year 4	718
Year 5	718

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

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:

Purposes	
People transferring from the Adult Community Autism Program	
People discharged from hospital/rehabilitation care	
People released from incarceration	
People discharged from a state hospital or state center	
People identified in Adult Protective Services investigations	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

People transferring from the Adult Community Autism Program

Purpose *(describe):*

Capacity is reserved to enable adults with ASD who are have been enrolled in the Adult Community Autism Program (ACAP) to transfer to the Adult Autism Waiver. Individuals transferring to the waiver must meet the eligibility requirements for the Adult Autism Waiver as specified in Appendix B-1, B-4, B-5, and B-6.

All participants enrolled in the waiver have comparable access to all services offered in the waiver regardless of whether he or she is enrolled due to meeting reserved capacity criteria or the Selection of Entrants to the Waiver criteria in Appendix B-3-f. All participants must go through the service plan process, including the full exploration of all service options.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity is based on the number of adults with ASD in ACAP that have requested to transfer to the AAW in 2019.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	3
Year 2	3
Year 3	3
Year 4	3
Year 5	3

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

People discharged from hospital/rehabilitation care

Purpose *(describe):*

ODP reserves waiver capacity for participants requiring hospital/rehabilitation care beyond 30 consecutive days and up to 6 consecutive months from the first date of leave. Settings which are considered hospital/rehabilitation care include medical and psychiatric hospital settings, rehabilitation care programs and nursing homes. Settings which are not considered hospital/rehabilitation care include residential treatment facilities, state mental health hospitals, approved private schools and private and state ICFs/ID.

All participants enrolled in the waiver have comparable access to all services offered in the waiver regardless of whether he or she is enrolled due to meeting reserved capacity criteria or the Selection of Entrants to the Waiver criteria in Appendix B-3-f. All participants must go through the service plan process, including the full exploration of all service options.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity is determined by the historical average number of participants who have been on hospital/rehabilitation leave for more than 30 consecutive days and up to 6 consecutive months.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	0
Year 2	0
Year 3	0
Year 4	15
Year 5	15

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

People released from incarceration

Purpose *(describe):*

For participants that are incarcerated for 6 months or more, capacity may be reserved up to 180 days prior to the expected release date from a correctional facility.

All participants enrolled in the waiver have comparable access to all services offered in the waiver regardless of whether he or she is enrolled due to meeting reserved capacity criteria or the Selection of Entrants to the Waiver criteria in Appendix B-3-f. All participants must go through the service plan process, including the full exploration of all service options.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity is determined by the historical average number of participants who have been incarcerated per year.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	5
Year 2	5
Year 3	5
Year 4	5
Year 5	5

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

People discharged from a state hospital or state center

Purpose *(describe):*

To enable adults with ASD who have been discharged from a state hospital or state center to receive necessary supports to transition to the community, capacity is reserved for adults with ASD who resided in a state hospital or state center for at least 90 consecutive days, are determined ready for discharge and whose discharge plan specifies a need for long-term support. Discharged individuals must still meet the eligibility requirements for the Adult Autism Waiver specified in Appendix B-1, B-4, B-5, and B-6.

All participants enrolled in the waiver have comparable access to all services offered in the waiver regardless of whether he or she is enrolled due to meeting reserved capacity criteria or the Selection of Entrants to the Waiver criteria in Appendix B-3-f. All participants must go through the service plan process, including the full exploration of all service options.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity is based on the historical number of adults with ASD ready for discharge from a state hospital or state center with discharge plans that indicate a need for long-term support.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	10
Year 2	10
Year 3	10
Year 4	10
Year 5	10

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

People identified in Adult Protective Services investigations

Purpose *(describe):*

To enable adults with ASD who have experienced abuse, exploitation, abandonment, and/or neglect to receive waiver services to help prevent future abuse, exploitation, abandonment, or neglect. Capacity is reserved for adults with ASD who have a protective services plan developed pursuant to the Adult Protective Services Act that specifies a need for long-term support. Individuals must be eligible for the Adult Autism Waiver as specified in Appendix B-1, B-4, B-5, and B-6. In addition, capacity is reserved only for individuals who were not receiving a Pennsylvania home and community-based services waiver at the time the protective services plan was developed.

All participants enrolled in the waiver have comparable access to all services offered in the waiver regardless of whether he or she is enrolled due to meeting reserved capacity criteria or the Selection of Entrants to the Waiver criteria in Appendix B-3-f. All participants must go through the service plan process, including the full exploration of all service options.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity is based on the historical number of adults with ASD with protective services plans indicating a need for long-term support.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	5
Year 2	5
Year 3	5
Year 4	5
Year 5	5

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

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)*:

- ◉ **The waiver is not subject to a phase-in or a phase-out schedule.**
- ○ **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 intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- ◉ **Waiver capacity is allocated/managed on a statewide basis.**
- ○ **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:

Individuals who meet reserved capacity criteria are eligible for waiver enrollment as long as the yearls reserved capacity is still available.

For individuals who do not meet reserved capacity criteria, enrollment priority is given to individuals who meet all of the following criteria:

- Requested service prior to January 1, 2020;
- Placed on the AAW priority 1 interest list prior to January 1, 2020;
- Not receiving ongoing state funded or state and Federally funded long-term support services (e.g., Medicaid HCBS Waiver supports; ICF/ID; nursing facility; services in a state hospital; Community Residential Rehabilitation Services; services in a Long-Term Structured Residence; Residential Treatment Facility; and extended acute care for people with serious mental illness);
- Aged 18 or older; and
- Meet LOC requirements.

If waiver capacity is not available, individuals that meet the above criteria will be placed on a waiting list until capacity is available. When waiver capacity becomes available, based on date of initial date of placement on the interest list, they will be offered the choice to enroll in the waiver by receiving an application based on two prioritization criteria: geographic distribution and date and time of requests for service.

-Geographic Distribution
ODP allocates waiver capacity on a regional basis to ensure access across the Commonwealth. Four regions are defined as follows:

West: Allegheny, Armstrong, Beaver, Butler, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Venango, Warren, Washington, and Westmoreland Counties

Central: Adams, Bedford, Blair, Cambria, Centre, Clinton, Columbia, Cumberland, Dauphin, Franklin, Fulton, Huntington, Juniata, Lancaster, Lebanon, Lycoming, Mifflin, Montour, Northumberland, Perry, Snyder, Somerset, Union, and York Counties

Southeast: Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties

Northeast: Berks, Bradford, Carbon, Lackawanna, Lehigh, Luzerne, Monroe, Northampton, Pike, Schuylkill, Sullivan, Susquehanna, Tioga, Wayne, and Wyoming Counties

When ODP adds new capacity, it will add capacity to each region so that the total waiver capacity is allocated in proportion to Pennsylvania’s population age 21 or older in each region, according to the most recent version of the U.S. Census Bureau’s Current Population Estimates. Once enrolled, participants may move anywhere in the Commonwealth and continue to be enrolled in the waiver.

Persons ages 18-20:
When waiver capacity is available based on the above prioritization criteria and the person is age 21 or older, ODP will offer the individual a choice to enroll in the waiver by sending the person and representative (if applicable) an application. If waiver capacity is available and the person’s age is 18 through 20, ODP will offer enrollment to the next person on the waiting list using the prioritization criteria. If a person is not offered enrollment due to their age, ODP will give that person a choice to enroll in the waiver by sending the person and representative (if applicable) an application once they reach the age of 21 and waiver capacity is again available.

Individuals who do not meet reserved capacity criteria and request services on or after January 1, 2020, will be added to the waiting list for the other waivers administered by ODP using the eligibility and prioritization criteria described in those waivers. When no more individuals remain on the AAW priority 1 interest list described above, ODP will expand the waiting list for the other waivers to include the AAW. The AAW will be amended to state that individuals on the waiting list for a waiver administered by ODP who meet the eligibility criteria for AAW and who meet prioritization criteria as determined by the Prioritization of Urgency of Need for Services (PUNS) will be offered the opportunity to enroll in the AAW.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

- (●) **§1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

2. Miller Trust State.

Indicate whether the state is a Miller Trust State *(select one)*:

- (●) **No**
- ( ) **Yes**

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*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- [ ] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [x] **Optional state supplement recipients**
- [x] **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

  - (●) **100% of the Federal poverty level (FPL)**
  - ( ) **% of FPL, which is lower than 100% of FPL.**

    Specify percentage: [ ]

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [x] **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)**
- [ ] **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)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [x] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [x] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

  Specify:

All other mandatory and optional groups under the State Plan are included.

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*

○ **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.*

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

☒ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

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. 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 period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), 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.

☒ **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 *spousal* post-eligibility rules under §1924 of the Act.**
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 September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

◉ **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 (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **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.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

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

b. Regular Post-Eligibility Treatment of Income: SSI 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*):

◉ **The following standard included under the state plan**

Select one:

○ **SSI standard**
○ **Optional state supplement standard**
○ **Medically needy income standard**
◉ **The special income level for institutionalized persons**

(*select one*):

- (●) **300% of the SSI Federal Benefit Rate (FBR)**
- ( ) **A percentage of the FBR, which is less than 300%**

  Specify the percentage: [ ]
- ( ) **A dollar amount which is less than 300%.**

  Specify dollar amount: [ ]

( ) **A percentage of the Federal poverty level**

Specify percentage: [ ]

( ) **Other standard included under the state Plan**

Specify:

( ) **The following dollar amount**

Specify dollar amount: [ ] If this amount changes, this item will be revised.

( ) **The following formula is used to determine the needs allowance:**

Specify:

( ) **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

- (●) **Not Applicable**
- ( ) **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:

  Specify the amount of the allowance (*select one*):

  - ( ) **SSI standard**
  - ( ) **Optional state supplement standard**
  - ( ) **Medically needy income standard**
  - ( ) **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

◉ **Not Applicable (see instructions)**

○ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify 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.

○ **The amount is determined using the following formula:**

Specify:

○ **Other**

Specify:

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.

Select one:

◉ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

○ **The state does not establish reasonable limits.**

○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

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

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

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*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ◉ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:
- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised
- ○ **The following formula is used to determine the needs allowance:**

  Specify formula:
- ○ **Other**

  Specify:

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:

◉ **Allowance is the same**

○ **Allowance is different.**

Explanation of difference:

iii. 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.

Select one:

◉ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

○ **The state does not establish reasonable limits.**

○ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

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. 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).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

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 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: 1

ii. Frequency of services. The state requires (select one):

- (●) **The provision of waiver services at least monthly**
- ( ) **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:

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

- ( ) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- ( ) **By a government agency under contract with the Medicaid agency.**

Specify the entity:

- (●) **Other**

Specify:

Individuals added to the waiver waiting list as of January 1, 2020 will have their initial level of care assessed by Qualified Developmental Disabilities Professionals through their Administrative Entity, a county government agency which is delegated authority for some waiver administration functions through an Administrative Entity Operating Agreement. Once enrolled in the waiver, reevaluations of level of care are determined by the state Medicaid agency.

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:

The AE is responsible to have Qualified Developmental Disability Professional (QDDP) performing level of care evaluations.

QDDPs must meet one of the following three criteria:

1. A Master's degree or higher level of education from an accredited college or university and one year of work experience working directly with persons with developmental disabilities;
2. A Bachelor's degree from an accredited college or university and two year's work experience working directly with persons with developmental disabilities; or
3. An Associate's degree or 60 credit hours from an accredited college or university and four year's work experience working directly with persons with developmental disabilities.

The AE is responsible to ensure that no conflict of interest exists in the level of care evaluation process.

AEs may contract with another agency or independent QDDP who meets the criteria above to obtain a QDDP certification of need for an ICF/ID or ICF/ORC level of care in order to ensure a conflict-free determination.

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.

The AEs are responsible for the completion of an initial evaluation of need for level of care. The initial evaluation will be performed by a QDDP.

1. ICF/ID
i. There are four fundamental criteria that must be met prior to an individual being determined eligible for an ICF/ID level of care:

1. Have a diagnosis of intellectual disability;

2. Intellectual disability manifested prior to age 22;

3. Adaptive skill deficits in three or more areas of major life activity based on a standardized adaptive functioning test; and

4. Be recommended for an ICF/ID level of care based on a medical evaluation.

2. Autism Spectrum Disorder ICF/ORC
i. There are four fundamental criteria that must be met prior to an individual with autism spectrum disorder being determined eligible for an ICF/ORC level of care:

1. Have a diagnosis of autism spectrum disorder;

2. Autism spectrum disorder manifested prior to age 22;

3. Adaptive skill deficits in three or more areas of major life activity based on a standardized adaptive functioning test; and

4. Be recommended for an ICF/ORC level of care based on a medical evaluation.

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)*:

◉ **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**

○ **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 Evaluation
The fundamental criteria identified in Appendix B-6-d of this waiver must be met prior to an individual being determined eligible for enrollment in the waiver. The AE is responsible to certify need for an ICF/ID or ICF/ORC level of care based on the evaluation and certification of the QDDP. The following level of care criteria must be met prior to enrollment in the waiver:

The following four criteria must be met to document a diagnosis of autism spectrum disorder and ICF/ORC level of care and determine eligibility upon initial certification:

1. A licensed psychologist, certified school psychologist, psychiatrist, developmental pediatrician, licensed physician, licensed physician's assistant or certified registered nurse practitioner certifies that the individual has autism spectrum disorder as documented in a diagnostic tool.

2. A QDDP certifies that the individual has impairments in adaptive functioning based on the results of a standardized assessment of adaptive functioning which shows the individual has significant limitation in meeting the standards of maturation, learning, personal independence, or social responsibility of his or her age and cultural group. The results of the assessment must also show that the individual has substantial adaptive skill deficits in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction and/or capacity for independent living.

3. Documentation substantiates that the individual's autism spectrum disorder and substantial adaptive skill deficits manifested during the developmental period which is from birth up to the individual's 22nd birthday.

4. Documentation on a medical form as a result of a current medical evaluation performed by a licensed physician, physician's assistant, or certified registered nurse practitioner that states the individual is recommended for ICF/ORC level of care or documentation on a Medical Assistance Evaluation form (MA51) as a result of a current medical evaluation completed by a licensed physician, physician's assistant, or certified registered nurse practitioner that indicates the individual is recommended for an ICF/ORC level of care.

The following four criteria must be met to document a diagnosis of intellectual disability and ICF/ID level of care and determine eligibility upon initial certification:

1. A licensed psychologist, certified school psychologist, psychiatrist, developmental pediatrician, or licensed physician who practices psychiatry certifies that the individual has significantly sub-average intellectual functioning based on a standardized general intelligence test which is documented by either:
a. Performance that is more than two standard deviations below the mean of a standardized general intelligence test, which reflects a Full Scale IQ score of 70 or below; or
b. Performance that is slightly above two standard deviations below the mean of a standardized general intelligence test during a period when the individual manifests serious impairments of adaptive functioning.

2. A QDDP certifies that the individual has impairments in adaptive functioning based on the results of a standardized assessment of adaptive functioning which shows the individual has significant limitation in meeting the standards of maturation, learning, personal independence, or social responsibility of his or her age and cultural group. The results of the assessment must also show that the individual has substantial adaptive skill deficits in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction and/or capacity for independent living.

3. Documentation substantiates that the individual's intellectual and substantial adaptive skill deficits manifested during the developmental period which is from birth up to the individual's 22nd birthday.

4. Documentation on a medical form as a result of a current medical evaluation performed by a licensed physician, physician's assistant, or certified registered nurse practitioner that states the individual is recommended for ICF/ID level of care or documentation on a Medical Assistance Evaluation form (MA51) as a result of a current medical evaluation completed by a licensed physician, physician's assistant, or certified registered nurse practitioner that indicates the individual is recommended for an ICF/ID level of care.

Reevaluation Process
Applicants who have been determined by the AE to meet program eligibility requirements specified in Appendix B-1, upon enrollment and then annually thereafter are evaluated by a physician, physician's assistant, or nurse practitioner licensed in the United States, using the MA51 to determine level of care.

The MA51 is used to determine annual reevaluation of level of care for participants enrolled in AAW and must be completed within 365 days of the previous MA51.

If the MA51 indicates an applicant meets ICF/ID level of care criteria, ODP will assign a QDDP to assess whether the applicant requires ICF/ID level of care using the criteria in B-6-d.

For reevaluations, Supports Coordinators assist physicians, physician's assistants, or certified registered nurse practitioners, licensed in the United States with completing the MA51 when necessary.

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)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**
  Specify the other schedule:

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

- ○ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ◉ **The qualifications are different.**
  Specify the qualifications:

Once enrolled in the waiver, level of care reevaluations are determined by the state Medicaid agency by persons who have at least three years of professional experience developing, implementing, or evaluating a human service program, and a bachelor's degree; or an equivalent combination of experience and training. Reevaluations are based on Supports Coordinators performing assessments and gathering information that is necessary to make an LOC determination as well as diagnoses and LOC recommendation made by a physician, physician's assistant, or certified registered nurse practitioner licensed in the United States.

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):*

ODP is responsible to complete the reevaluation of need for an ICF/ID or ICF/ORC level of care within 365 days of the participant's initial evaluation and subsequent anniversary dates of reevaluations. Reevaluations are completed in conjunction with the annual review of the service plan. After the level of care reevaluation is completed, ODP staff indicate in the Home and Community Services Information System (HCSIS) that level of care was reevaluated, and the result of that reevaluation. HCSIS generates an alert to ODP staff prior to the annual reevaluation coming due. Alerts are monitored regularly by ODP staff to ensure timely completion of annual level of care reevaluation.

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:

Records of all initial level of care evaluations are maintained at the AE office where the participant is registered, per the AE Operating Agreement.

ODP maintains copies of all level of care reevaluations.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Performance Measure LOC1: Number and percent of new enrollees who have a level of care (LOC) completed prior to entry into the waiver. Numerator = Number of new enrollees who have an LOC completed prior to entry into the waiver. Denominator = Number of new enrollees.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Home and Community Services Information System (HCSIS)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Performance Measure LOC2: Number and percent of initial LOC determinations where the instrument and process described in Appendix B-6 of the waiver are used. Numerator = Number of initial LOC determinations where the instrument and process described in Appendix B-6 of the waiver are used. Denominator = Number of initial LOC determinations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant record review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

For Performance Measure LOC1, a 100% review of data from HCSIS is conducted quarterly by ODP staff to assess compliance.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

LOC2. ODP evaluates whether initial level of care determinations are completed accurately according to ODP policies and procedures. The AE must complete level of care evaluations using ODP's forms and processes. The AE is required to document remediation actions and submit the documentation to ODP within 30 days. When documentation is located or completed and eligibility in any one of the criteria is not met, disenrollment procedures will be initiated as per ODP policies and procedures. If a determination is made that an AE is incorrectly applying the criteria and making determinations that are incorrect, targeted technical assistance is provided to the AE in order to ensure the AE fully understands the process and applies it correctly. ODP will initiate actions as needed to resolve any outstanding issues with AE performance using the methodology outlined in the AE Operating Agreement.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

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).

ODP sends notification of freedom of choice between the AAW, institutional services, or no services with the application for the waiver.

If an applicant is determined to meet the criteria in Appendix B-1-b, ODP will send the applicant a list of SCOs when he or she receives an application for the AAW. The participant will choose their SCO with assistance from ODP staff if necessary. The Supports Coordinator will then work with the participant and individuals he or she chooses to develop a service plan as specified in Appendix D. This process includes providing a statewide provider directory to the participant, so he or she is aware of all available providers.

The Supports Coordinator will notify the participant or his or her legal representative in writing that the participant has freedom of choice among feasible service delivery alternatives.

To document that the participant has been notified of his or her freedom of choice, ODP developed three forms. A Waiver Service Supports Coordinator Choice Form documents the participant was notified of his or her right to choose an SCO. A Service Delivery Preference Form documents the participants choice between waiver, institutional services, or no services. A Waiver Service Provider Choice Form documents that the participant received a list of available providers and has been informed of his or her freedom to choose willing and qualified providers.

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.

Supports Coordinators will maintain copies of forms documenting freedom of choice in the participants record located at the SCO.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency 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):

Materials will include a statement in five languages - Spanish, Chinese, Cambodian, Vietnamese and Russian - to inform individuals with Limited English Proficiency (LEP) that they may have the document translated free of charge by calling a toll-free number established by DHS that will connect them to an interpreter service. The DHS Office of Administration, Bureau of Equal Opportunity, coordinates LEP issues for DHS and has identified the specific languages to include based upon analysis of the non-English speaking population in accordance with state and Federal policy for access to services for people with LEP. DHS contracts with a telephone interpreter service that staffs the toll-free number and has translators for many languages spoken in the Commonwealth, including less common languages that will not be included in the written materials. Additionally, the Commonwealth has a statewide language interpretation contract that provides access to over thirty contractors who can provide translation and interpretation services via phone, writing or face-to-face.

If a person leaves a message in a language other than English on the toll-free number for requesting services described in Appendix B-3-f, ODP contacts the DHS telephone interpreter service, which will translate the message and translate ODP's return of the phone call.

The telephone interpreter service will translate for ODP staff in other phone calls to people with LEP. DHS will arrange for in-person translation services to translate in-person interviews by ODP staff or contractors, including initial functional eligibility assessments and interviews for quality monitoring.

Arrangements for accommodating individuals who are deaf or hearing impaired will be made as needed.

Waiver participants with LEP are identified during the enrollment process. ODP ensures that the Supports Coordinator is aware of the LEP and will use translation services. The Supports Coordinator must notify other providers of the need for translation services. Upon annual monitoring, ODP will monitor for the use of translation services by that participant’s providers.