CHAPTER 4

CONSUMER SERVICES
SECTION 4-6: PRESUMPTIVE MEDICAID ELIGIBILITY & PRESUMPTIVE ENROLLMENT

PURPOSE/SUMMARY:
Part I of this section sets forth requirements as to when an individual may be enrolled in State-funded PASSPORT or State-funded Assisted Living under the presumption that the applicant will be determined by the CDJFS to meet financial eligibility for the Medicaid-funded waiver program. Parts II & III address the Medicaid financial eligibility and it is not intent that PAA staff are rendering financial eligibility decisions on behalf of the County Department of Job & Family Services (CDJFS) staff, nor are they expected to apply every Medicaid financial eligibility criterion that the County Department of Job & Family Services (CDJFS) staff utilize. Rather, the intention is to provide guidelines and considerations regarding key components of Medicaid financial eligibility to be used in making a decision as to whether or not it can be reasonably presumed that the applicant will be determined by the CDJFS to meet financial eligibility. This will help ensure that every applicant can be treated in a fair and equitable manner. Part IV addresses requirements for treatment of individuals after they have been enrolled in the State-funded program and are waiting for the CDJFS financial eligibility determination, or enrolled in the State-funded program and receive a financial eligibility denial of their application, as well as enrollees who were approved but were subsequently determined by the CDJFS to no longer meet the financial eligibility criteria.

Except for the Choices program, the PAA may enroll individuals in the State-funded program pending the final determination of Medicaid financial eligibility from the if the PAA has determined that the individual meets all the non-financial eligibility criteria and appears to meet Medicaid financial eligibility requirements for the Medicaid-funded waiver program.

Although the CDJFS retains sole responsibility for determining Medicaid financial edibility, the PAAs are actively involved with the procurement of the determination for the applicant/consumer. Approval for the Medicaid-funded PASSPORT or Assisted Living Home Care waiver requires that applicants/ State-funded program enrollees must eventually meet Medicaid financial eligibility guidelines. This is especially important for those enrolled in the State-funded program because no individual may be enrolled in the State-funded program for more than three months. In particular, the PAA must dedicate itself to determining if specific income and resource tests are met. It is important that the PAA personnel be familiar with the eligibility limits of Medicaid. ODJFS forms can be found on the ODJFS Forms Central web page at http://www.odjfs.state.oh.us/forms/results1.asp. In the “Search/Sort by” field, click on the “Form Number” button. Next, enter the form number in the “Search For” field.

PAA staff who require access to CRIS-E or MITS must contact ODA’s Community Long Term Care Division (Mindy Sadler MSadler@age.state.oh.us).

Completion of ODJFS form 07078 Code of Responsibility will be necessary and requires the following information. Forms will be returned if submitted incompletely or incorrectly.

- Name entry still requires the user's middle initial. If no middle initial, note it on the form.
- The Agency reference is to indicate the Ohio Department of Aging
- County & Work Unit can be answered with an 'NA'.
- The agency type checkbox is to indicate 'Non-ODJFS State'.
- Access Requested is limited to CRISE and/or MITS. We do not have access to any other pieces of ODJFS' systems.

The MITS Access form is completed for individuals who would use MITSELIG to resolve MITS reimbursement issues. PAA user will place a check mark in option '9 - Recipient Eligibility File' within the Inquiry column. This is the only area where access will be granted for PAA staff. The form also requires a signature from the user's supervisor. This supplies the assurance of a legitimate need for the user to access this area. Send or fax the completed document(s) to ODA: attention Community LTC Division. ODA will submit these forms to ODJFS' Bureau of Community Long Term Care services along with a cover sheet.

Appendix 4-6- a. ODA1115 Financial Information Worksheet
Appendix 4-6- b. ODA1115 Financial Information Worksheet Instructions

REQUIREMENTS & PROCEDURES:
The Medicaid-funded program eligibility criteria are based on several items of which one, Medicaid financial eligibility, is dependent upon the determination of the CDJFS. To apply for the Medicaid-funded program, an applicant may work initially with the PAA or with the CDJFS. It does not matter which agency begins the application process, but rather the effort is to simplify the process for the applicant. With the exception of Medicaid financial eligibility, the PAA is responsible for determining whether or not applicants meet the Medicaid-funded program eligibility criteria. Only the CDJFS can make the Medicaid financial eligibility determination. However, the PAA may enroll an individual in the State-funded program as follows:

I. DETERMINING WHETHER OR NOT AN APPLICANT MAY BE ENROLLED IN THE STATE-FUNDED PROGRAM.

A. The PAA may enroll the applicant **if** the PAA determines that the individual meets all the non-financial eligibility criteria specified in OAC rule173-51-02 for Assisted Living or OAC 173-40-02 for PASSPORT, **AND** the PAA has verified that the individual has applied to the CDJFS for Medicaid, **AND** the PAA has completed the ODA1115 Financial Information Worksheet [in PIMS].

1. Acceptable verification that the individual has applied to the CDJFS includes any of the following:
   a. A facsimile date stamp confirming successful transmission of the application;
   b. Receipt provided by the CDJFS;
   c. Verifying the CDJFS receipt of the application in either the ARAD – Address Registration screen, or the AEICI - Case Information screen in CRIS-E;
   d. The existence of an MAJ screen in CRIS-E;

e. Clear documentation verifying the receipt of the application in CLRC Running Record Comments in CRIS-E;
f. The individual is already on Medicaid and has an active case open in CRIS-E.

II. MEDICAID FINANCIAL ELIGIBILITY.

It is important to note that, this section is not intended to be used as a substitute for, or provide complete details regarding all applicable Medicaid financial eligibility requirements. Rather, it is intended to provide more general guidance and areas to consider to PAAs regarding some of the most common areas of Medicaid financial eligibility that are most likely to be encountered with those applying for the Medicaid waiver.

Medicaid is a need-based program which has several eligibility tests. It is funded through state and federal dollars. While the PAA is not expected to be Medicaid Eligibility Determiners, they are expected to understand the program well enough to make State-funded eligibility decisions so as to enable applicants to gain quicker access to services. This section will review key eligibility criteria for Medicaid. It will also review the computation rules for the determination of client liability. Additionally, the role of the Authorized Representative will be explained.

A. Residency & U.S. Citizenship:

An applicant for Medicaid must be an Ohio resident. However, county residency is not a requirement. Residency is established by physical presence within the state at - the time of application and where the individual is not receiving assistance from another state. The applicant must intend to remain in the state. Temporary absences from the state are permissible when the applicant plans to return to the state. Citizenship is also to be considered. All individuals, who are applying for Medicaid, stating they are U.S. citizens or nationals, must provide one-time documentation of their citizenship. However, the citizenship requirement does not apply to Individuals enrolled in Medicare, or to those receiving SSI, because they have already satisfied the citizenship requirement in order to receive those types of assistance. OAC 5101:1-38-02 provides more details http://codes.ohio.gov/oac/5101%3A1-38-02. For those who are not exempt from the requirement to document citizenship, some acceptable kinds of documentation include the following:

- A United States passport, unless it was issued with a limitation;
- A certificate of naturalization (DHS form N-550 or N-570);
- A certificate of United States citizenship (DHS form N-560 or N-561);
- A valid state-issued driver's license (So long as the state issuing the license requires proof of U.S. citizenship before issuance of such license, or verifies citizenship using a social security number from the applicant)
- Birth Certificate*

  * When none of the previous examples listed is available, a birth or nationality document or an identity document alone does not satisfy the citizenship documentation requirement, so the CDJFS will need to consider it in conjunction with at least one other document specified in rule. However, for

the purposes of presuming eligibility, unless the PAA has reason to believe otherwise, it is reasonable enough for the PAA to presume that the applicant will likely pass the test of citizenship. As a note: people from other U.S. territories, such as Puerto Rico, and legal refugees may be eligible for Medicaid, but may also be required to provide citizenship documentation.

B. Limiting Physical Factor:
An applicant for Medicaid must have a Limiting Physical Factor meaning the applicant must be 65 years of age or older, blind, or disabled. Disability can be established through the individual's receipt of Social Security Disability or Supplemental Security Income payments, or via ODJFS County Medical Services determination. Disability for traditional Medicaid may also be established by the need for nursing facility services as evidenced by the individual having an Intermediate Level of Care (ILOC) or Skilled Level of Care (SLOC). PASSPORT also requires an ILOC or SLOC and in this way, Limiting Physical Factor is met.

C. Income:
Medicaid utilizes many differing need standards by which to judge whether the applicant or consumer is needy. In the Medicaid waiver programs, the Special Income Level (SIL) is used. The SIL is also generally used for determining income eligibility for institutional Medicaid individuals, and is also referred to in our system as the Institutional Need Standard (INS). This level is indexed to the current SSI standard for a single person living independently. The INS is 300% of the SSI standard. As the SSI standard increases, so should the INS increase. If the applicant is ineligible for the program, yet is disabled, it may still be possible for him/her to meet Medicaid financial eligibility through the community need standard.

Current Medicaid eligibility standards can be viewed in CRIS-E by typing RFDI into the "Next.Tran" field and TMEP into the "Parameter" field.

When determining income for the INS, it is necessary to include all gross income of the applicant, regardless of the source. The individual's gross income, earned and unearned, will need to be compared to the INS.

If the applicant's gross income is in excess of the INS, then it should be considered unlikely that he will meet the criterion for Medicaid income eligibility, and should not be presumptively enrolled. However, even if ineligible for the Waiver program, it might still be possible for him to be determined by the CDJFS to be eligible for traditional Medicaid using the Spend Down process. This could occur regardless of whether the applicant is in his/her own home or in a nursing home.

If the applicant's gross income is equal to or less than the INS, then it can be reasonably presumed that the individual will meet the criterion for Medicaid income eligibility using the INS. The PAA will also need to identify the amount of patient liability that the consumer would be responsible for paying towards that cost of waiver services.

Income which can be reliably anticipated to be received during the month is counted in the eligibility determination. Income should not be mistaken for assets. Some common types of income would include the following:

- Social Security Benefits
- Railroad Retirement Benefits
- Veterans' Benefits
- Supplemental Security Income (SSI)
- Pensions
- State Retirement Plans
- Workman's Compensation - Workman's Compensation is generally paid out every 2 weeks. Determine the monthly income by taking the gross bi-weekly income and multiplying by 24 and then dividing by 12. (*Most individuals give the check amount, not the monthly amount, but the monthly amount is higher than the 2-check amount.)*

D. Resources:

1. A Medicaid applicant is entitled to have $1500.00 in resources. Usually, this would be in cash or in a form that could be easily convertible to cash; such as bank 08/09 Chapter 4 Section 4-6 Page 6 accounts, savings bonds, trusts, life insurance. There are exemptions that apply to the applicant. Also, if there is a spouse in the community, there may be additional Spousal Impoverishment provisions that would allow the legitimate transfer of resources from the PASSPORT consumer to his/her spouse. A "spouse" means a person who is considered legally married to another under Ohio law. The following resources are exempt from consideration with Medicaid:
   - The value of Household Goods and Personal Effects;
   - The personal residence of the applicant that is less than $500,000;
   - One vehicle used for transportation, regardless of its value:
     - It can include, in addition to cars and trucks: boats, snowmobiles, animal-drawn vehicles, and even animals.
     - One vehicle is excluded regardless of value if, for the individual or a member of the individual's household, it is: necessary for employment; necessary for the treatment of specific or regular medical problems; modified for operation by, or the transportation of, a handicapped person; or necessary, because of climate, terrain, distance or similar factors, for the performance of essential daily activities
     - Applicants may think of different types of vehicles in different ways. You may have to ask question from several different angles. For example, it may be a good idea not to only ask, "Do you have a car?" but rather, "Please tell me about any vehicles you have, such as, a car, truck, pick-up, RV, motorcycle, etc…"

2. One burial plot for the applicant and members of his/her immediate family, depending on whether it is irrevocable, and its value (An individual's immediate family includes his parents, including adoptive parents, minor or

adult children, including adoptive and stepchildren, siblings, including adoptive and stepsiblings and the spouses of the immediate family members. In order for the burial space exclusion to apply to spouses of the immediate family members, the marriage must be in effect. For example, a burial space held for a sister-in-law is no longer excludable if she and the individual's brother divorce);

3. Life Insurance: Term Insurance is Exempt. Whole Life Policy (ies) with an aggregate face value equal to or less than $1500.00 is exempt. When the value of the policy (ies) is greater than $1500.00, then the total cash surrender value is counted toward the resource limit;

4. Prepaid, IRREVOCABLE, burial contract regardless of the amount placed into the contract; 08/09 Chapter 4 Section 4-6 Page 7;

5. Income-producing property presents complicated calculations. It is recommended that individuals with such holdings not be presumed eligible;

6. Assets for which there is no real market;

7. Cash held temporarily by the applicant for the replacement of an exempt resource that has been lost, damaged, or stolen. This exemption is good for nine months, but may be renewed for a second nine month period.

8. Assets which are jointly held by a husband and wife may be partially exempt from the countable assets determination. Institutionalizations which began on or after January 1, 1990 are subject to the Spousal Impoverishment Provisions. This provision requires that there be a spouse who is non-institutionalized and living in the consumer's residence. The purpose is to assist the community spouse from being impoverished by the medical expenses of the institutionalized or waiver-eligible spouse. Individuals newly approved for Medicaid Waiver would meet the institutionalization criteria. Continuity of institutionalization is broken by any absences from the institution for 30 consecutive days or non-receipt of home and community-based waiver services for 30 consecutive days. Therefore, if continuity is broken and then 30 days later there is a new application for the Waiver, there would have to be a new resource assessment completed.

   First, all assets held by a husband and wife are added together regardless of whose name is identified as the owner of record. Pre-nuptial agreements are not counted as valid for the purpose of establishing Medicaid eligibility.

   Second, the spouse is entitled to one half of these resources subject to a minimum floor and a maximum ceiling. The spouse would be entitled to the couple's resources up to this amount. The ceiling is the maximum amount that the community spouse can retain from the couple's resources. A higher level

of assets could be awarded to the community spouse by a court or possibly through the ODJFS State Hearings Procedure. This would be allowed if the higher amount is needed to assure the continued protection of the community spouse. Assets that are in the name of the consumer but that the community spouse is entitled to keep must be transferred to the spouse before the first regularly scheduled reapplication of Medicaid eligibility. This reapplication usually occurs at annual intervals. The consumer should be advised to complete this transfer as quickly as possible. This transfer procedure is distinct from the transfer of assets rules reviewed below.

Finally, it is possible that an individual may still be in the midst of an institutionalization when an application is made for waiver services because of hospitalization or nursing home placement. In these situations, the CDJFS would review assets according to the initial date of institutionalization.

IF THE APPLICANT IS UNABLE TO CONFIRM OR REPORT JOINT COUNTABLE ASSETS, ENROLLMENT IN THE STATE FUNDED PROGRAM WILL NOT BE OFFERED.

9. Transfer of Assets Rules OAC 5101:1-39-07 (Medicaid: Transfer of Resources) http://codes.ohio.gov/oac/5101%3A1-39-07.

   Because Medicaid is a program based on financial need, the CDJFS is required to assess transfers of an applicant/consumer's assets, resources, real and/or personal property. Medicaid presupposes that a transfer of an asset for less than fair market value being received is by definition an inappropriate transfer. The CDJFS will review the inappropriate transfer according to the date on which the transfer occurred. Ineligibility for Medicaid due to an improper transfer continues until either: the property is returned to the applicant/consumer; or, until a period of time has elapsed with reference to the cost of the applicant's/consumer's care which would result in resources being below the allowable limit (Restricted Medicaid Coverage Period). There is no limit to the amount of time a period of restricted coverage may run.

   Unlimited transfers of real and personal property are allowed between spouses since the rules don't differentiate which spouse actually owns the property. Transfers may also be made to a disabled child, regardless of the child's age. The individual may transfer the home that is still considered the principal place of residence to any of the following individuals:

   - The individual's spouse (with some stipulations);
   - His or her child under the age of twenty-one;
   - His or her child age twenty-one or over who is blind or permanently and totally disabled;

- His or her sibling who has an equity interest in the home and if the sibling has resided in the home for at least one year immediately before the individual became institutionalized;

- His or her adult child who was residing in the home for at least two years immediately before the date the individual becomes institutionalized, and who provided care to the individual which permitted the individual to reside at home, rather than in an institution or facility. However, part of the documentation the CDJFS will need to consider in determining whether or not this Homestead exemption will be allowed, a Level of Care (LOC) determination must be established to determine if the individual would have required institutionalization.

IF THE APPLICANT OR SPOUSE (IF ANY) HAS TRANSFERRED RESOURCES WITHIN THE LAST 60 MONTHS, ENROLLMENT IN THE STATE FUNDED PROGRAM WILL NOT BE OFFERED

IF THE APPLICANT OR SPOUSE (IF ANY) HAS REPORTED A TRUST, OF ANY TYPE, HAS BEEN ESTABLISHED, ENROLLMENT IN THE STATE FUNDED PROGRAM WILL NOT BE OFFERED.

Medicaid Eligibility Asset/Income Summary Sheet

RESOURCE	COUNTABLE	EXEMPT
Burial Account	Value of revocable agreements	Irrevocable contracts regardless of value
Burial Plot		One space per immediate family member
Homestead	If no longer principle place of residence	Principle place of residence, including temporary absence
Automobile		One vehicle
Whole Life Insurance	Count cash value when aggregate face value exceeds $1500	Aggregate face value = to or less than $1500; or irrevocably assigned ownership
Term Life Insurance		Exempt
Liquid Assets: e.g. cash, bank accounts	Count total value	Cash held temporarily (9-18 month maximum) for replacement of an exempt resource that has been lost, stolen, or destroyed
Non-Marketable Assets		Applicant/consumer must establish that resources cannot be sold

E. Patient Liability (OAC 5101:1-39-24) http://codes.ohio.gov/oac/5101%3A1-39-24. The Medicaid determination of patient liability comes after Medicaid financial eligibility has been established. Once it is clear that the financial tests of Medicaid have been met, the patient liability calculation is completed to determine if the individual has a financial obligation to share in the costs of care for State-funded program liability and/or an estimated amount prior to CDJFS' determination. As in the assets section, there is a means by which the individual's monies can be allocated to a community spouse (CS). There are deductions which are allowed in the patient liability calculation. The deductions are listed in the order in which they would be calculated and subtracted in the liability budget. These deductions are:

1. Individual Maintenance Needs Allowance.

2. Community Spouse's Monthly Income Allowance. The community spouse is entitled to an allowance that is determined by comparing the CS's income to a Minimum Monthly Maintenance Needs Allowance (MMMNA) standard. Additional calculations are completed to establish if the CS is eligible for an Excess Shelter Allowance (ESA). The ESA is an amount of shelter expenses which is in excess of a specified dollar amount per month and including a specified utility allowance per month. The maximum Minimum Monthly Maintenance Needs Allowance is a specified dollar amount unless increased by a court order or ODHS Hearing Decision. Reasons for increasing the MMMNA could include catastrophic medical expenses of the community spouse; home repairs; and debts of the CS or debts of another which are the responsibility of the CS.

3. Family Allowance. If the applicant has a community spouse and other dependent children, parents, or siblings living in the home, then an additional Family Allowance could be calculated and subtracted from the applicant's income for the needs of the dependents. The standard is determined by multiplying the standard by the number of dependents (other than the community spouse), subtracting the dependents' gross income from the product and then dividing the remainder by three.

4. Medical expenses not subject to third party payment, including:

   - Medicaid, Medicare, or other health insurance premiums;
   - Insurance deductibles, coinsurance, or copayments;
   - Necessary medical or remedial care, recognized under Ohio law, but not covered by Medicaid and not subject to third party payment;
   - Unpaid past medical expenses.

III. PROCESS

1. FINANCIAL:

b.As part of the assessment, PAA certified staff will complete the financial assessment worksheet (ODA1115) to determine if the individual's financial situation is likely to result in the CDJFS issuing the final Medicaid financial eligibility for Medicaid waiver enrollment and to be utilized to determine the individual's liability for enrollment to the State-funded program. It will be concentrating on the income and asset tests described above and document the information in PIMS. In the event that PIMS is unavailable, a copy of the worksheet and instructions for its completion are found in the Appendices 4-6-a and 4-6-b. When enrollment in the state-funded program cannot be offered due to the outcome of the financial assessment worksheet, the PAA shall inform the applicant of this fact, confirm services cannot be initiated until the CDJFS makes a final determination that approves him/her for Medicaid financial eligibility, and inform the individual of hearing rights (ODA1117).

c.There will be no retroactive change to the estimated liability during the State-funded enrollment period once CDJFS has issued the individual's final liability going forward on a Medicaid waiver program.

d.PAA shall outline to the individual the Medicaid special income level guidelines for income and assets, and explain as simply as possible, the Medicaid concepts of spousal impoverishment and client liability, if applicable. PAA staff shall review the documents required by the CDJFS to verify Medicaid eligibility (A copy of the Application/ Reapplication Verification Request JFS07104 can be found on the ODJFS Forms Central web site for review of Medicaid's documentation requirements).

e.PAA must determine if the individual is capable of completing and submitting a JFS 07200 application and a JFS02399 (application for HCBS waiver). It is appropriate to determine if another family member or friend could assist the individual. Should neither of these options be available, the PAA should review the role of Authorized Representative with the individual. It is the individual's choice to have an Authorized Representative. Any person may file an application for an individual as long as that person has the individual's permission. The JFS 07200 and JFS 02399 application is to be filed with the CDJFS in the individual's county of residence. The CDJFS is expected to conduct a face-to-face interview no later than ten business days after the receipt of a signed and dated application. The advantages of the PAA acting as Authorized Representative is two-fold:

i. The representative will receive copies of all significant correspondence from the CDJFS to the applicant. This will assist the representative in determining the current status of the Medicaid application.

ii. Should the CDJFS deny, reduce, or terminate Medicaid assistance, the Authorized Representative may represent the individual through the ODJFS State Hearing process.

2. **ENROLLMENT**

There are two important and distinct components that apply to individuals who have been enrolled in the State-funded program.

a. The first "State-funded Enrollment" is the time while the applicant is waiting for the CDJFS to make a financial eligibility determination.

b. The second "State-funded Enrollment" is applicable ONLY to PASSPORT enrollees when there is receipt of an adverse determination from the CDJFS ("Loss-of-Medicaid-Eligibility"). **This is NOT available to Assisted Living waiver enrollees. This component is ONLY available for 30 days**. Loss-of-Medicaid-eligibility status is a non-waiver-funded PASSPORT waiver program component available to temporarily protect the consumer, the PAA, and PASSPORT providers from Medicaid financial eligibility outcomes that may either produce dangerous absences of consumer care or the denial of provider reimbursement when services have been provided in good faith.

i. This provision is not intended to be an automatic extension of PASSPORT for anyone who receives an adverse determination; rather it is the continuation of services necessary to protect the health and safety of the consumer, then s/he may be temporarily transferred to loss-of-Medicaid eligibility status in accordance with OAC 174-40-04 (http://codes.ohio.gov/oac/173-40-04) until alternative services can be arranged. Such alternatives include community-based long-term care services; or, assist the consumer in nursing home placement.

ii. A PASSPORT waiver enrollee can be enrolled on the State-funded program for 3 months only (and this must include any days previous to waiver program enrollment in which the enrollee was enrolled on the State-funded program).

iii. The need to continue services under this provision must be supported by documentation in PIMS (e.g., the reason why more time is needed to find alternative services and the need to protect the health and safety of the individual while doing so).

iv. During the time a person is on loss-of-Medicaid-eligibility status and enrolled in the State-funded program, the PAA is expected to continually work to arrange alternative services. For any person being served under this provision, the PAA shall do the following:

- Assist the consumer in order to responsibly transfer the consumer to traditional community-based long-term care services; or
- Assist the consumer in nursing home placement. When the alternative is arranged, the PAA shall disenroll the individual.

c. The 3 month State-funded Enrollment clock stops and restarts when an individual is in hospital and/or nursing home and returns back to community. [Note: the state-funded program clock is NOT 90 days—it is 3 months.]

d. However, the total enrollment in the State-funded program **CANNOT be more than 3 months**, whether accumulative or consecutive when applying the first and/or second component.

3. Upon enrolling an individual, the PAA must notify the individual (and his/her authorized representative) in writing, of the last date that State-funded home care services will be provided if the CDJFS has not made a determination and when applicable, the amount of liability determined for State-funded enrollment.

4. For State-funded enrolled individuals, other medical insurance such as Medicare and/or private insurance and other community resources are to be utilized first to pay for services.

5. Individuals must be disenrolled from the State-funded program no later than three months after enrollment who have not received a Medicaid financial eligibility determination (either approval or denial).

6. **Under NO circumstances may State-funded program services exceed 3 months from enrollment.** There are **NO** exceptions.

7. For any individual disenrolled from the State-funded program, the loss-of-Medicaid-eligibility provision (see (g.) does not apply since it is only applicable to individuals enrolled in the PASSPORT Medicaid-funded program who have received an adverse determination of Medicaid financial eligibility.

8. Upon receipt of a Medicaid financial eligibility determination (either approved or denied), the PAA must make the appropriate entries in the PIMS enrollment and eligibility windows to either convert the person to the waiver or to disenroll from the State-funded program.

9. Individuals denied enrollment into the State-funded program or who are disenrolled from the State-funded program shall be afforded appeal rights (ODA 1117), except for those who receive Medicaid financial eligibility approval and are therefore being disenrolled from State-funded in order to be enrolled in the Medicaid-funded waiver.

CONSUMER SERVICES
SECTION 4-7: CASE MANAGEMENT

INTRODUCTION:

Individuals enrolled in any ODA administered waiver program and the RSS program will be provided case management services. The goal of case management is to enable chronically impaired consumers to remain in the least restrictive environment while maintaining the greatest amount of independence and human dignity.

These goals are accomplished in a cost effective and service efficient manner with sensitivity to the consumer's own personal preferences and choice and are based upon the strengths present in the consumer and/or caregiver. Waiver and RSS case management is consumer-focused and promotes/supports the consumer's preferences, values, and right to self-determination. Waiver and RSS case management provides the following core functions:

1) Ongoing assessment, coordination and monitoring of a consumer's needs, strengths, circumstances and services to assure that services/interventions continue to be appropriate;

2) Development of an individualized, culturally competent, written care plan for each consumer in order to maximize the individual consumer's quality of life based on his/her capacity and preferences;

3) Coordinate and collaborate with all available funding sources in order to use available resources efficiently and effectively;

4) Modification of the care plan, as needed, to reflect current needs, goals, and interventions;

5) Consumer education in order to promote informed choice, understanding of risk, benefits of care options and decisions; and

6) Consumer advocacy, as needed, on behalf of the consumer and/or caregiver.

CLINICAL PRACTICE STANDARDS:

A. The PAA shall provide case management services to every enrolled waiver or RSS consumer.

B. The PAA shall assure case management is provided by a Licensed Social Worker or a Registered Nurse who is certified by ODA and meets the requirements set forth in the current three-party agreement between the ODJFS, ODA and the PAA.

C. The PAA's case management practice shall be consumer focused and support/promote the consumer's right to self-determination and independence.

D. The PAA's case management practice shall address all and any type of assistance to meet identified consumer needs.