Section 7. Application and Case Processing

7.1 Request for Application

An individual or his/her guardian may apply for the Medicaid Waiver for Persons with Developmental Disabilities through either the local Bureau of Developmental Disabilities Services (BDDS) office or the local Area Agency on Aging office. Individuals (or their guardians) have the right to apply without question or delay.

To apply for the DD Waiver, the individual or guardian must complete, sign, and date an *Application for Long-Term Care Services - State Form 45943*. (The time of day must also be noted on the application.) Other individual or agency representatives may assist the individual or guardian in completing the application form and forwarding it to the BDDS or AAA office serving the county in which the individual currently resides. (The application may be submitted in person, by mail or FAX.)

After the State Form 45943 is completed, signed and dated, the BDDS or AAA office must enter the individual's application/demographic information into the DART or INsite database and transmit the record to the DDARS database.

NOTE:
If an individual or his/her guardian has applied for the ICF/MR Waiver, that ICF/MR application and the date of that application will transfer to the DD Waiver. Current ICF/MR Waiver applicants do not have to reapply for the DD Waiver. They will, however, have to apply for Targeted Case Management through the local BDDS or AAA office.

Within 14 days of receiving the Waiver application, the BDDS or AAA staff must have contact with the individual or his/her guardian and discuss the process for determining eligibility for the waiver (diagnosis/documentation of a developmental disability, Medicaid eligibility, and level of care) and will arrange with the client/guardian/advocate to obtain information necessary for the eligibility determination. Additionally, the BDDS or AAA staff will explain that prior to the determination of eligibility for the waiver, the individual's name will go on the waiver waiting list (explained in more

detail in 7.3 and 7.4). The individual's name will be removed from the waiting list if it is later determined that he/she is not eligible for the waiver program. If the applicant is not a Medicaid recipient, he/she will be

immediately referred to the local Division of Family and Children to apply for Medicaid.

7.2 Initial Level of Care Determination

An individual must meet the level of care required for placement in an Intermediate Care Facility for the Mentally Retarded (or Developmentally Disabled) (ICF/MR) to be eligible for community services through the DD Waiver. Applicants for the DD Waiver must be evaluated to determine if they meet the ICF/MR Level of Care (i.e. are at risk of institutionalization).

7.2.1 Level of Care "Packet"

To complete a level of care determination, the intake case manager or case manager designee must obtain **A Developmental Disabilities Profile (DDP)**.*

(For children age 5-11 years, the DDP assessment must also be completed. Additionally, an age-referenced assessment must be completed.)

Information necessary to complete the DDP must be obtained through:

1) **Psychological records including I.Q. score;**
2) **Social assessment records;**
3) **Medical records; and**
4) **Any additional records necessary to have a current and valid reflection of the individual.**

(#1-4 may be older than one year if the QMRP certified that they continue to be a valid reflection of the individual. If collateral records are not available or are not a valid reflection of the individual, additional assessments may be obtained through the local BDDS-contracted diagnostic evaluation (D&E) team.)

If the QMRP intake case manager determines that the individual does meet ICF/MR level of care, (based on a DDP score of 28, psychological, social, medical evidence, and for children under age 5, an age-referenced assessment), the individual's name will remain on the local DD

* The DDP must be done annually with the annual redetermination of Level of Care.

Waiver waiting list. If the individual does not have an on-going case manager, he/she will choose one at that time.

If the applicant meets level of care, the level of care determination date must be entered into the DART or INsite database and transmitted to the IDDARS database.

If the intake case manger, determines that the applicant does not meet ICF/MR level of care and therefore is ineligible for services under the DD Waiver, the intake case manager must complete a Notice of Action form (*HCBS Form 5*), and provide a copy of the form, its accompanying *Appeal Rights as an HCBS Waiver Services Recipient,* and an explanation of the decision to the individual or guardian. *A Data Entry Worksheet (HCBS DE T/D)* must be completed, entered into the database, and transmitted to DDARS. The effective date of the denial is the same date and time that the waiver application was signed by the applicant. The individual's name should be removed from the waiting list unless the individual/guardian files an appeal.

The intake case manager may discuss other service options with the individual and guardian. An individual who does not meet level of care criteria and consequently, is not eligible for the DD Waiver, may still be eligible for Targeted Case Management if he/she is a Medicaid recipient and developmentally disabled according to the State definition. If the individual is eligible for Targeted Case Management and does not already have an on-going case manager, he/she should choose one at this time.

7.3 Waiting List

Persons determined to be eligible for waiver services will remain on the local waiting list until a vacancy or "slot" becomes available on the waiver. Home and Community-Based Waiver programs limit the number of unduplicated recipients who may be served on the waiver each year. A slot represents an unduplicated recipient for the waiver year. Therefore, once that finite number of recipients is reached in the waiver year, a slot does not become available until the beginning of the next waiver year (even if someone vacates a slot in the middle of the waiver year).

Each local BDDS district office must maintain two waiting lists (one list for persons being diverted from institutional placement and one for persons being deinstitutionalized) that must contain the names of individuals who applied for the DD Waiver at the BDDS office or the local AAA office(s) serving the counties within that BDDS district. (More than one AAA office

may be located within a BDDS district.) Individuals who apply in one district and then move to another are placed on the district waiting list in the new district of residence. The original application and date of application are to be used in determining the individual's place on the waiting list with the new BDDS office.

At least 30-60 days prior to the start of the new waiver year (October 1), the BDDS District Manager will identify the number of slots available for the new waiver year, review the district's waiver waiting list, and "target" the next individuals on the waiting list to fill the available waiver slots. The individuals targeted to fill the available slots on the waiver are the individuals who have the oldest waiver application dates of all individuals on the BDDS district's waiting list (with the exception of priority slots - see Section 7.4).

7.3.1. Waiting List Special Considerations

If an individual is moving from a Medicaid funded facility and wants to "convert" his/her facility funding to community based waiver funding, the individual may be able to create his/her own slot and go into waiver program regardless of the start of a new waiver year. (This is possible if there are a number of "unfunded" slots available that are being held for purposes of "conversion".)* Further, if an individual who is moving from a facility due to closure or downsizing of the facility, chooses to move to another facility rather than take a waiver slot, another individual who is a resident of a facility may "cascade" and occupy that waiver slot.

If an individual who has applied for the waiver moves into or out of a facility while on the waiting list, the original application and date of application will continue to be used in determining his/her place on the waiting list.

7.4 Waiver Slot Assignment

DDARS will reserve a specific number of "priority slots" they may use for individuals who are not first on the waiting list but are in emergency situations that require them to be targeted immediately. The following are considered priority situations:

1) Death of a primary caregiver;
2) Long term institutionalization of the primary caregiver;

* This "conversion" must be linked to the permanent closure of an ICF/MR bed.

3) Aging out of the Department of Education residential funded program;
4) Aging out of Child in Need of Services residential funded program;
5) Aging out of children's ICF/MR group home;
6) Aging off the Medically Fragile Children Waiver;
7) Loss of Aged and Disabled or Traumatic Brain Injury Medicaid Waiver;
8) Omnibus Budget Reconciliation Act "must move";
9) Nursing home closure;
10) ICF/MR facility "must move": as determined by the Indiana Department of Health.

<u>The individual's loss of services date must be in the current waiver year to be considered as meeting one of these priority situations.</u>

Waiver slots are allocated according to the following procedures:

1) Slots assigned to individuals receiving waiver services are allocated to the BDDS district offices serving the counties in which the individuals reside.
2) When an individual terminates waiver services, his/her slot will continue to be allocated to the BDDS district office for the county in which the individual last resided while receiving waiver services.
3) As new slots become available as a result of new funding for the waiver, the slots will be allocated to the BDDS district offices based on the districts' percentages of the statewide population.
4) As new slots become available as a result of the conversion of an ICF/MR facility, the slots will be allocated to the BDDS district office in which the facility is located. As an individual moves from the facility, the slot will be managed by the BDDS district office servicing the county to which the individual moves.
5) As new slots become available as a result of leveraging existing funding from State line item or county funded services from persons with developmental disabilities to match federal (Medicaid) funding, the slots will be allocated to the BDDS district office in which the individuals receiving the State-line item or county funded services currently reside.

6) When individuals using conversion/cascade slots terminate waiver services, the slots will remain assigned to the BDDS district in which the person last resided while receiving waiver services. The BDDS District Manager will target another individual who meets one of the priority situations to re-fill the slot.

7.5 Processing "Targeted" Individuals

When a "diversion" waiver slot becomes available, the next individual on the "diversion" waiver waiting list will be "targeted" to fill the slot.

When a "deinstitutional" waiver slot becomes available, the next individual on the "deinstitutional" waiver waiting list will be targeted to fill the slot.

Within 7 days of the target date (the day a name has been identified for a slot), the BDDS Service Coordinator must:

a) Notify the individual and/or his/her guardian that the individual has been targeted for the waiver;
b) Notify the individual's case manger that the individual has been targeted for the waiver;
c) Submit the *"Request for Information "HCBS Form 6* to the local DFC office to obtain Medicaid eligibility information including "spend-down" (or "liability") amount. (The DFC office is to complete the request within 7 calendar days of receipt and return it to the BDDS Service Coordinator);
d) Notify the individual who will be responsible for gathering documents necessary to update the Level of Care packet if information from the initial Level of Care determination is no longer a valid reflection of the individual. At this time, the *450B Medical Form* must be completed (sections 1,2,3, and 6) and signed and dated by a physician within the past year. The individual updating the Level of Care packet will be either;
   - The individual's on-going case manager with the AAA; or
   - The individual's on-going independent case manager.
e) **For children under the age of five (5), the following information must be submitted to OMPP for the level of care determination**.

   - Transmittal Form for Medicaid Level of Care Eligibility (HCBS Form 7);
   - A completed Medicaid Form 450B (sections 1,2,3, and 6) signed and dated by a physician;

- A DDP and an age referenced comprehensive developmental assessment developed and utilized by the QMRP for the Level of Care decision.
- Additional psychological, social, and medical records as necessary to provide a current and valid reflection of the child. If collateral records are not available or are not a valid reflection of the individual, additional assessments may be obtained through the local BDDS-contracted D&E team.

f) In addition to children under 5, Level of Care packets for individuals who have been identified by the Indiana Department of Health as W198s or W199s, **must be submitted to OMPP** with a Transmittal Form for Medicaid Level of Care Eligibility (HCBS Form 7).

g) Enter the waiver target date information into the DART or INsite Database and transmit the record to the IDDARS database.

7.6 Initial Plan of Care and Cost Comparison Budget Development

7.6.1. Plan of Care

The BDDS, AAA, or independent case manager is responsible for facilitating the person-centered plan with the individual, guardian, and additional participants who the individual may request.

The case manager develops a POC based upon the Person Centered Planning/Support Plan process (Sections 12 and 13) that includes the full range of appropriate services, delivered in a planned, coordinated, efficient, and effective manner. The POC includes the proposed Medicaid waiver services, (targeted) case management, and other Medicaid State plan services, other publicly funded services, and informal supports that the individual receives/will receive. Additionally, unmet needs and emergency back-up plans must be addressed by the case manager on the POC.

The case manager is responsible for coordinating the proposed waiver funds with any other proposed sources of public funding. Medicaid funding (waiver or regular Medicaid services) should be utilized first to fund services whenever possible. For example, supported employment follow-along services should be funded through the DD Waiver rather than Title XX. Waiver funding should be utilized before State line item or CHOICE funding for comparable services.

The case manager must complete a *Service Planner Form* that indicates the proposed waiver services to be provided during a "typical" week for the individual.

7.6.2 Cost Comparison Budget

After the POC has been developed and the Service Plan completed, the case manager develops the proposed Cost Comparison Budget (CCB). The CCB must include a written explanation of the individual's need for the proposed services, the manner by which the services protect the individual's health and safety, the individual's needs that will not be met, and a description of emergency back-up plans.

If the cost of services on an individual's CCB exceeds $350 a day, the case manager must attach a letter of explanation detailing explicitly the following issues (at least):

a) Explain the reason for 24 hour supervision of the individual;
b) Identify what is needed by the individual to be healthy and safe in the community. (Strive to separate what is necessary to be healthy and safe, from what is desired by the individual, family, advocates, etc.)
c) Describe how the individual's needs drive the Service Planner and budget;
d) Identify from where the individual is being deinstitutionalized (or diverted);
e) Describe the reason for 1:1 staffing or other high levels of staff supervision;
f) Explain why the individual does not have housemate(s) and describe plans for the individual to have a housemate; and
g) List the <u>specific</u> steps being taken, including timeframes, to reduce the individual's behavioral, medical, or other issues that may be causing the need for high levels of services and funding.

The case manager must review the POC, Service Planner and CCB with the individual/guardian and the individual or guardian must sign indicating acceptance of the POC/CCB. The individual/guardian must also be informed (and sign to document that he/she has been informed of):

a) The right to choose any certified waiver service provider when selecting waiver service providers, including the targeted case manager.
b) The right to choose between institutional placement and Home and Community-Based Waiver Services.

The case manager must enter the proposed POC, Service Planner, and CCB into the INsite database and electronically transmit the information to the BDDS office serving the county in which the individual currently resides.

Note: The POC, Service Planner, and CCB may be developed during the level of care process if the level of care is being updated due to the length of time the individual was on the waiting list and there is a good indication that the individual will continue to meet level of care. Otherwise, the information is to be developed and submitted to the local BDDS office within 50 calendar days of the individual's waiver "target" date.

7.7 State Authorization of the Plan of Care and Cost Comparison Budget

The local BDDS Service Coordinator will review the POC and Cost Comparison Budget within 5 days of receiving it electronically and will confirm that:

a) The individual has been appropriately targeted for an available slot;
b) The identified needs of the individual will be met;
c) The health and safety of the individual will be assured; and
d) BDDS funds to supplement the CCB are available if required.

The Service Coordinator may request additional information from the case manager to assist in reviewing the packet.

If the Service Coordinator denies the POC and CCB, a denial letter must be transmitted to the case manager. Within 5 days of the receipt of this denial, the case manager must provide to the individual/guardian, a completed *Notice of Action HCBS Form 5*, denial letter, the *Appeal Rights as an HCBS Waiver Services Recipient*, and must give an explanation to the individual or guardian of the decision to deny.

If the Service Coordinator approved the POC, Service Planner, and CCB, they are electronically transmitted to the DD Waiver Specialist in IDDARS.

Within 7 calendar days of receipt of an approval from the Service Coordinator, the DD Waiver Specialist will review the POC, Service Planner and CCB and confirm the following:

a) The individual is a current Medicaid recipient within the category of "Aged, Blind, Disabled" or low-income:
b) The individual has a current ICF/MR level of care approval for the waiver;
c) The individual has been targeted for an available waiver slot;
d) The individual's identified needs will be met and health and safety will be assured;
e) The costs are consistent with identified needs of the individual and the services to be provided;
f) That if the total cost of Medicaid waiver and regular Medicaid State plan services for the individual, exceeds the total costs of serving an individual with similar needs in an ICF/MR facility, the programmatic cost-effectiveness will be maintained;
g) The individual or guardian has signed, indicating acceptance of, the POC and CCB; signed that he/she has been offered choice of certified waiver service providers; and signed that he/she has chosen waiver services over services in an institution.

The DD Waiver Specialist at IDDARS may request additional information from the case manager and BDDS to assist in reviewing the packet.

If the DD Waiver Specialist denies the POC and CCB, a denial letter must be transmitted to the case manager and BDDS. Within 5 calendar days of receipt of the denial, the case manager must complete and provide a copy of a *Notice of Action HCBS Form 5,* the *Appeal Rights as an HCBS Waiver Services Recipient*, and an explanation of the decision to deny to the individual or guardian. The case manager should discuss other service options with the individual and guardian and the individual's name should be removed from the waiting list <u>unless the individual or guardian files an appeal.</u>

If the DD Waiver Specialist approves the POC and CCB, the approval letter is to be transmitted to the case manager and BDDS. The case manager must notify the individual or guardian within 5 calendar days of receipt of the approval and provide a copy of the approval letter.

If the DD Waiver Specialist approves the POC and CCB pending Medicaid eligibility, disenrollment of a child from Hoosier Healthwise, level of care approval, facility discharge, or other reasons, the pending approval letter is to be transmitted to the case manager and BDDS. The case manger

must notify the individual or guardian within 5 calendar days of receipt of the approval and provide a copy of the approval letter. The case manger must notify the DD Waiver Specialist when the pending issues have been resolved and the DD Waiver Specialist will issue an approval decision letter.

The Office of Medicaid Policy and Planning (OMPP) will review all Plans of Care and CCBs that contain costs of more than $350 per day for 30 days in one calendar year, in order to assure adequacy and appropriateness of the plan.

7.8 Initial Plan of Care Implementation

An individual cannot begin waiver services prior to the approval of the initial POC and CCB by the DD Waiver Specialist. If the DD Waiver Specialist issues an approval letter, pending certain conditions being met, those conditions must be resolved prior to the start of the individual's waiver services.

If the individual's Medicaid eligibility is approved pending waiver approval, the case manager is to notify the DFC caseworker when the waiver has been approved. The caseworker and case manager are to coordinate the Medicaid eligibility date and waiver start date. (If Medicaid eligibility depends on eligibility for the waiver, the Medicaid start date is usually the first day of the month following approval of the POC and CCB.) The case manager must verify the waiver effective date/start date with the DD Waiver Specialist prior to completing the *Notice of Action Form.*

If an individual is a Hoosier Healthwise or other Medicaid managed care program participant, the case manager must contact the Managed Care Benefit Advocate to coordinate the managed care program stop date and waiver start date. (Individuals receiving the Indiana Health Care Hospice benefit do not have to disenroll from this benefit to receive waiver services that are not related to the terminal condition and are not duplicative of hospice care.) The case manager and Managed Care Benefit Advocate must inform the individual's parent or guardian of his/her options to assure he/she makes an informed choice.

When the POC and CCB are approved by the DD Waiver Specialist, pending facility discharge, the case manager must notify the DD Waiver Specialist the day after the individual is discharged form the facility and within 5 days the case manager must;

a) Complete and mail the *Notice of Action HCBS Form 5* and copies of the POC, Service Planner and CCB to the individual or guardian;
b) Mail copies of the *Notice of Action*, POC, Service Planner, and CCB to the waiver service providers;
c) Mail copies of the *Notice of Action* to the local county DFC office; and
d) If necessary, update POC information in the INsite database and electronically transmit the information to the DDARS database.

Within 5 calendar days after the individual begins waiver services, the DD Waiver Specialist must generate a report from the INsite database to notify OMPP to enter the following information in the Indiana AIM database;

a) Waiver start date;
b) Waiver level of care code; and
c) If applicable, facility discharge date.

7.9 Maintenance of Records

Records of evaluations (and re-evaluations) of level of care will be maintained at the local Area Agency on Aging, the local Bureau of Developmental Disabilities Services office, or with the Independent Case Manager/agency who evaluated or re-evaluated the individual. Records must be maintained for a minimum of three (3) years following the determination.

7.10 Authorization of Environmental Modifications, PERS, Medical Equipment and Supplies

Environmental modifications, specialized medical equipment/supplies and personal emergency response systems (PERS), as specified in the Waiver, may be authorized when necessary to enable the individual to increase his or her ability to function in a home and community-based setting with independence and physical safety.

These services must be necessary to prevent or delay institutionalization as defined in the individual's POC.
Environmental modifications may be made only to an individual's permanent home or long-term leased residence and require permission of the landlord when applicable.

Reimbursement is not available for services that:

a. Are not allowable under current Medicaid Waiver guidelines;
b. Are available under the Medicaid State Plan as prior authorized services;
c. Are available under the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act, as amended;
d. Are not included in the individual's POC; or
e. Have not been authorized via a *Request for Approval to Authorize Services - Form BAIS 0014).*

The case manager must obtain a physician's order for environmental modifications, specialized medical equipment or supplies, or PERS prior to including the service in the individual's POC.

The case manager must obtain a Medicaid prior authorization review and denial of specialized medical equipment and supplies before including them in the individual's POC.

Medicaid prior authorization review is not required for environmental modifications or PERS.

For an individual who will be moving from a facility, the case manager must indicate that the specialized medical equipment and supplies will be used by the individual following discharge from the facility.

Before including environmental modifications or specialized medical equipment and supplies in the individual's POC, the case manager must obtain an evaluation by an OT, PT, ST, audiologist, or rehabilitation engineer as appropriate to determine the specific needs of the individual. Specifications are utilized to obtain three bids from service providers.

Note:

a. If three bids cannot be obtained, due solely to a lack of qualified service providers in geographic proximity to the individual, the case manager must provide a written explanation as to why the three bids were not obtained.
b. Service bids must be in writing, itemize parts and materials and their costs, itemize labor items and their costs, and specify warranties on parts, materials and workmanship. Bids for environmental modifications must include drawings in sufficient detail to describe the modifications to the current home or environment of the individual.
c. The price to be authorized is the lowest price quotation, unless justified, such as when the higher price quotation costs less for maintenance, repair or replacement, more nearly meets the needs

of the individual, or provides greater safety, and is recommended for approval by the case manager.

Bids are not required for PERS; however, the rate may not exceed the cap rate established under Medicaid Waiver guidelines.
The case manager must complete, sign and date a *Request for Approval to Authorize Services Form BAIS 0014)* and must enter the information into the INsite database.

The case manager must submit the following to the BDDS district office serving the county in which the individual resides:

a. Physician's order;
b. Medicaid prior authorization denial, when required;
c. Evaluation;
d. Service bids, including written explanation when less than three bids are available;
e. Request for Approval to Authorize Service form; and
f. The individual's POC.

For services with costs of less than $5,000.00, the BDDS District Manager must review all requests for environmental modifications, specialized medical equipment and supplies to assure the following:

a. The modifications or specialized medical equipment and supplies are allowable under current Medicaid Waiver guidelines;
b. Necessary and properly completed documentation accompanies the request; and
c. The request does not exceed the individual's lifetime caps for the service allowable under Medicaid Waiver guidelines.

For services with costs of $5,000.00 or greater, the BDDS District Manager must submit the information received from the case manager to the Waiver Specialist.

The BDDS District Manager for services with a cost of less than $5,000.00, or the Waiver Specialist for services with costs of $5,000.00 or greater must:

a. Indicate if the request is approved, approved with modifications, or denied on the *Request for Approval to Authorize Services* form;
b. Sign and date the *Request for Approval to Authorize Services* form as the authorized DDARS representative;
c. Return the signed *Request for Approval to Authorize Services* form to the individual's case manager;
d. Maintain copies of documentation associated with the request and determination;

e. Enter the decision rendered information from the Request for Approval to Authorize Services form into the INsite database; and

For services of less than $5,000.00, BDDS must electronically transmit the information from the Request for Approval to Authorize Services form to the Waiver Specialist. (NOTE: Edits are in place to prevent

f. the electronic transmission of Request for Approval to Authorize Services information unless all required information has been entered.)

The case manager must complete a *Notice of Action HCBS Form 5* and provide it to the individual or guardian and service provider. If the request is denied, the case manager must notify the individual of his or her appeal rights.

The case manager must oversee and inspect the timely completion of the service, consistent with the evaluation and approved bid.

Upon completion of the service consistent with the approved bid, the case manager must sign and date the *Request for Approval to Authorize Services Form BAIS 0014* and provide a copy of the form to the provider to submit with billing for the service and enter the completion information into the INsite database.

After the completion information is entered into the INsite database, the case manager may print out a completed *HCFA 1500 Form* for the provider to sign and submit along with the completed *Request for Approval to Authorize Services Form BAIS 0014* when billing for the service.

If the individual resides in a Medicaid-funded facility, the case manager may authorize the service provider to complete the service in advance of the individual's move if all of the following criteria are met:

a. The service must be necessary to enable the individual to move from the facility to home and community-based services;
b. The individual has been targeted for a Waiver slot and has a current level of care approval for the Waiver;
c. The *Request for Approval to Authorize Services Form BAIS 0014* has been approved by the appropriate BDDS District Manager or Waiver Specialist;
d. The service has been included in the individual's approved POC and CCB; and
e. The case manager shall not sign and date the Request for Approval to Authorize Services (form BAIS 0014) indicating completion of the

service prior to the individual's move from the facility and starting Medicaid Waiver-funded services.

On a monthly basis, DDARS staff will run a report developed within the INsite database to identify any plans of care requiring a *Request for Approval to Authorize Services* form for which there is no electronic transmission of the form. DDARS staff will work with the BDDS district office and case manager to resolve the disparities.

On at least a quarterly basis, DDARS staff will run a report generated within the INsite database that randomly selects a number of services requiring a *Request for Approval to Authorize Services* form and complete thorough reviews of those services.

7.11 Senate Bill 30 Children

Senate Bill 30 is a provision which allows parental income and resources to be disregarded when determining Medicaid eligibility for children under age 18 who are otherwise eligible for the Waiver for Persons with Developmental Disabilities.

Identification of the children involved will be made by the Intake or Ongoing Targeted Case Manager. A *Request for Information (HCBS Form 6*) will be sent to the child's local County DFC eligibility worker as an alert that the child is undergoing the evaluation process for approval of waiver services. Upon receipt of this form, the DFC is to process the Medicaid case to the furthest extent possible without consideration of parents' income and resources pending receipt of verification of the waiver, and then notify the case manager that the child is eligible pending approval of the waiver.

For children who do not already have an active Medicaid case, the effective date of Medicaid and the effective date of the waiver must be coordinated between the DFC eligibility worker and case manager. Similarly, the effective date of a new or changed spend down under this provision must coincide with the effective date of the HCBS Waiver.

The exclusion of parental resources and income applies only as long as the child is approved for the HCBS Waiver. Parental deeming resumes beginning the month following the month in which the HCBS Waiver was discontinued for the child who continues to live with his or her parents, in accordance with timely notice requirements.