

ODMR/DD HCBS WAIVERS

Individual Options (IO) and Level One (LV1)

Instructions for Completion of Initial and Redetermination Applications

MEDICAID DEVELOPMENT AND ADMINISTRATION

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This document contains instructions for completion of the following forms:

- ❖ **Initial Level of Care Eligibility Determination**
- ❖ **Redetermination: Significant Change In Condition**
- ❖ **Redetermination: No Significant Change In Condition**
- ❖ **Freedom of Choice Documentation**
- ❖ **Functional Assessments**
- ❖ **Required Evaluations**
- ❖ **LOC Date Change Cover Sheet**

General Instructions

- Use the attached forms for initial and redetermination requests for the Individual Options and Level 1 Waivers.
- Do not use these forms for enrollment on the Ohio Home Care Waiver or the Transitions Waiver which is administered by the Department of Job & Family Services, or the PASSPORT Waiver, which is administered by the Department of Aging, or for ICFMR facility Level of Care, which has a separate process.
- Complete all fields as described in these instructions. Do not leave fields blank. If not applicable, select or enter N/A.
- It is strongly recommended that you use the fill-able forms from the ODMR/DD website or use black or blue ink to print neatly when completing the forms. Do not use correction fluid or correction tape to make corrections. Make corrections by drawing a single line through the mistake, add the correct information and initial the change. You may reproduce the forms in exact form for computer use. On request, MDA will provide a Word version of each of the forms.
- Send the application 90 – 60 days prior to waiver start date, along with a copy of all other required documents to the address below.

Ohio Department of MRDD
Medicaid Development and Administration
30 East Broad Street, 13th Floor
Columbus, OH 43215-2541

<http://mrdd.ohio.gov/medicaid/enrollment.htm>

- Maintain a copy of the entire packet in the county board's official waiver file, so that it is available for ODMR/DD review by the Division of Audits, Facility Licensure/Quality Assurance and/or Office of Accreditation, and by ODJFS Quality Assurance and Audits.
- All instructions and forms related to ODMR/DD waiver enrollment can be found at the website listed above.

APPLICANT INFORMATION - Instructions Apply to All Applications

Name	Enter the first name, middle initial and last name of the individual applying for waiver services. Use the individual's given name as it appears on legal documents, not a nickname.
County	Enter the county board that will be responsible for the delivery of HCBS waiver services, even if a council of government (COG) administers the waiver.
Client #	Enter the 7 digit ODMRDD Client number
Date of Birth	Enter the month, day and year of the applicant's date of birth, in mm/dd/yyyy format.
SSN	Enter the enrollee's 9-digit Social Security Number.
Address	Enter the street address, city and zip code where the individual will receive mail when enrolled on the waiver.
Guardian	Enter the name of the individual's guardian, if the individual has a court-appointed legal guardian. If not, write "N/A". If you place a guardian name on the application, you must have the same guardian signature on the Freedom of Choice form.
Guardian's Address	Enter the street address, city and zip code of the individual's legal guardian, if the individual has a guardian. Otherwise, write N/A.
Waiver Type	Check the box for the waiver which the individual is applying. Check only one box.

The following instructions apply to:

- **Initial Level of Care Eligibility Determination and**
- **Redetermination: Significant Change In Condition**

ICF/MR WAIVER LEVEL OF CARE DETERMINATION

1. Protective Level of Care OAC 5101:3-3-08 and 5101:3-3-07(C)(1)	Circle Yes or No to indicate whether the individual meets Protective Level of Care. The individual must meet the minimum criteria for Protective Level of Care as defined in rule.
2a. Diagnosed condition that establishes the individual's developmental disability, age 6 and above OAC 5101: 3-3-07(C)(2)	Enter the diagnosed condition that establishes the individual's developmental disability. Indicate all conditions that apply. <ul style="list-style-type: none"> ○ If "mental retardation" is indicated, the individual must have mild, moderate, severe or profound mental retardation. ○ Attach a medical evaluation completed by an Ohio licensed physician and a psychological evaluation signed by an Ohio licensed psychologist or a psychiatric evaluation signed by a licensed psychiatrist that verifies the individual's diagnosed condition. ○ The diagnosis and date of onset is critical to establish the developmental disability.
2b. Developmental delays assessed for individuals birth through age five	<ul style="list-style-type: none"> ○ Indicate all developmental delays that assessments have identified for this individual, only for individuals from birth through age five (5).
3. Manifested before 22? OAC 5101:3-3-07(C)(3)	<ul style="list-style-type: none"> ○ Circle Yes or No to indicate whether the disability was manifested before the age of 22.
4. Continue indefinitely? OAC 5101:3-3-07(C)(4)	<ul style="list-style-type: none"> ○ Circle Yes or No to indicate whether the disability is likely to continue indefinitely.
5. Substantial functional limitations OAC 5101:3-3-07(C)(5)	Circle 'yes' or 'no' for each of the seven questions in this section. Base these answers on a completed functional assessment. Use the correct functional assessment for the individual's age group. Keep the functional assessment on file. Do not submit the assessment form.
6-7. Skill acquisition OAC 5101:3-3-07(C)(6) and (C)(7)	Skill acquisition means the individual could benefit from services and supports specifically designed to promote the individual's acquisition of skills and decrease or prevent regression in the performance of those major life activities where substantial functional limitations have been identified. Circle yes or no to indicate whether the individual could benefit from services and supports to promote the acquisition of skills in each area of substantial functional limitation marked in item 5 above and is willing to participate in an individualized plan of services and supports.
8. Level of Care Recommendation	The Service Support Administrator must check a box to indicate which Level of Care is recommended for the individual. The Service and Support Administrator must print and sign name and date the recommendation indicating his/her title.
9. Proposed Date for Waiver Services to Begin	Indicate the month, day and year the county board wants waiver services to begin. MDA will attempt to honor this date, but there is no guarantee that it will be the actual date set. In no case will the level of care effective date be prior to the date that a completed Initial ICF/MR Waiver Level of Care application or a completed Redetermination application is received by the MDA office.

Initial Level of Care Eligibility Determination

Use this forms when completing a Level of Care packet for an individual who is not already receiving ODMR/DD HCBS Waiver services for the waiver type requested. If the individual has been receiving Home Care Waiver services or Passport Waiver services, treat the application as an initial eligibility determination.

Redetermination: Significant change in condition

Use this form when completing a Level of Care packet for an individual who is already receiving ODMR/DD HCBS Waiver services and when the individual’s physical or mental condition, or functional abilities change to an extent that there is some question about whether the individual’s Level of Care may have changed. This form should also be submitted when the individual turns 6 or 16 years of age.

Redetermination: No significant change in condition

Use this form when completing a Level of Care packet for an individual who is already receiving ODMR/DD HCBS Waiver services and whose condition has not changed to the extent that a different Level of Care could be warranted.

Freedom of Choice Documentation

Complete this form and send a copy with ALL Initial and Redetermination waiver applications.

If an individual does not choose HCBS Waiver Services, do not send the form to the Department, as there will not be a waiver application submitted. Place the form in the applicant’s file at the county board.

A. Selection of HCBS Waiver	Check the appropriate box.
B. Applicant Responsibilities	Review each item with the applicant.
C. Signature boxes	Obtain the signature and date for the applicant and/or legal guardian and the Service and Support Administrator. The authorized representative cannot sign in lieu of the applicant.

Functional Assessments

The Functional Assessments contained available on our website reflect the ICF/MR Level of Care criteria for waiver services, found in OAC 5101: 3-3-07. This rule specifies that each individual must have three limitations of the possible seven major areas of life activity (six for children) to qualify for ICF/MR Level of Care. Each Functional Assessment lists the areas of life activity and gives the criteria for determining whether an individual has a functional limitation in the life area. Because the criteria are specific to the individual’s age group, a different Functional Assessment applies to each age group. Functional Assessments for all age groups can be found on the ODMR/DD website.

Required Evaluations

The process for determining ICF/MR Level of Care is found in OAC 5101:3-3-155. Specifically, the rule states evaluations must include:

- (a) Diagnosis, including medical, psychiatric and developmental diagnoses, including dates of onset, if the date of onset is significant in determining whether the individual has a developmental disability; and
- (b) Review of current functional capacity.

Evaluation of the individual’s current functional capacity and any other pertinent evaluations should be maintained in the individual’s file by the county. Documentation of diagnosis must be submitted with both the Initial ICF/MR Waiver Level of Care and the Redetermination : Significant Change packets.

Incomplete Applications

In the event additional information is required in order to determine ICF/MR Level of Care, a 20-letter will be issued to the county board and a copy sent to the client and/or guardian. If the requested information is not received within the specified time period, the initial or redetermination application can be denied. In no case will the level of care effective date be prior to the date that a **completed** Initial ICF/MR Waiver Level of Care application or a **completed** Redetermination application is received by the MDA office.

LOC Date Change Cover Sheet

Complete the redetermination process and send the LOC Date Change Cover Sheet along with the Redetermination Application and Freedom of Choice form to the Waiver Unit.

The LOC date change may occur any time during the waiver span. However, the new LOC start date must be prior to the end date of the current LOC. In no case can the span dates extend beyond 365 days.

		EXAMPLE		
Changing dates may Prior	<u>LOC Dates:</u>		<u>Required PAWS:</u>	the LOC affect a
	Current LOC	7/1/05 to 6/30/06	7/1/05 to 9/14/05 – Revision	
	New LOC	9/15/05 to 9/14/06	9/15/05 to 9/14/06 - Redet	

Authorization request previously submitted to the department. Submission of a new Prior Authorization request may be necessary.

Submit a PAWS document to fiscal to end date the current LOC and a second PAWS to cover the new requested span dates.