



Achieve with us!

**FACTS ABOUT
THE FIVE
HOME
&
COMMUNITY BASED
WAIVER PROGRAMS**



For people with intellectual and developmental disabilities

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FREQUENTLY ASKED QUESTIONS

How can I appeal if I am denied services or eligibility?

You may request an administrative hearing **if you have been denied:**

- ▶ The opportunity to have your request documented in a statewide database;
- ▶ Your request to receive ICF/IID services instead of waiver services;
- ▶ A requested waiver service;
- ▶ The provider of your choice.



Your request for a hearing must be submitted within 90 days of the denial.

You may also request an administrative hearing if there has been:

- ▶ A reduction or termination of service; or
- ▶ An unreasonable delay in acting on an application for eligibility or service.

To request an administrative hearing, you can call your case manager or write to:

OFFICE OF ADMINISTRATIVE HEARINGS
PO Box 42489
OLYMPIA, WA 98504-2489

Phone: 800.583.8271 or
360.407.2700

FAX: 360.586.6563

ABOUT THIS BOOKLET...

The information provided in this booklet comes from the Centers for Medicare and Medicaid Services (CMS), in response to questions asked about ***Medicaid Title XIX Home and Community-Based Services (HCBS) Waivers.***

In Washington State, more than two fifths or 40% of individuals eligible to receive services from the Department of Social and Health Services (DSHS) Developmental Disabilities Administration (DDA) are on a Medicaid waiver.



Waiver services are funded in part by federal Medicaid dollars, and the federal government has specific rules that states must follow in order to receive federal funding. Centers for Medicare and Medicaid Services (CMS) is the federal funding agency that enforces compliance with Medicaid rules.

If you have a need for services available on the waiver program, ask your case manager if you are eligible. If so, you have a right to be placed on a waiver enrollment database if there is no waiver opening available.

WHAT ARE THE WAIVERS?

For individuals with a developmental disability who are clients of the DSHS Developmental Disabilities Administration and require the level of support provided in an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID), the state offers the option of Home and Community-Based Services.

Funding for these services comes through a federal program under Title XIX of the Social Security Act called Medicaid **Home and Community-Based Services (HCBS) Waivers**. All HCBS waiver programs and services are voluntary.



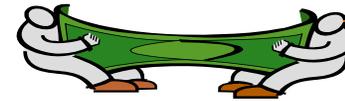
The HCBS waivers allow the state to use Medicaid funding while “waiving” Medicaid rules that require services to be provided in an institutional setting.

The purpose of the waivers is to provide integrated, community-based services to individuals with developmental disabilities.

may receive. “Duration” is “how long” you may receive it. The frequency, amount and duration are documented in your PCSP for each service.

Can DDA deny a waiver service based on funding?

DDA cannot deny a service available to you on your waiver and identified in your Person-Centered Service Plan due to a lack of funding.

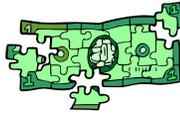


If my needs change and a reassessment shows that I need a higher level of services, can DDA deny the increase due to inadequate funding?

If a reassessment indicates that you need a higher level of service, DDA is obligated to ensure that you receive those services that are available on your current waiver or on another available waiver or are offered an institutional setting.

Moving to an institutional setting would only be done in situations where an individual requested this option, a qualified provider could not be found, the person’s health and safety would be seriously compromised if he or she continued to live in the community or your needs cannot be met on the current waiver or on another available waiver and there is capacity at an institution.

FREQUENTLY ASKED QUESTIONS



Will the state pay for all the Medicaid waiver services identified in the Person-Centered Service Plan (PCSP)?

Yes; when developing a plan case resource managers will help you identify how your service needs are going to be paid. Waiver services identified in your plan will be paid for by the state.

Services not available through the waiver may be funded through another source. Non-waiver services are often funded through the Medicaid State Plan or state supported programs.

What is in my PCSP?

The Person-Centered Service Plan (PCSP) should describe all of the waiver and non-waiver services you need to meet your health and welfare needs to live successfully in the community. The descriptions should include the frequency, amount and duration of the services to be provided as well as identify the providers.

What does "frequency", "amount" and "duration" mean?



The "frequency" is how often you will receive the service. The "amount" is "how much" service you

CHILDREN'S INTENSIVE IN-HOME BEHAVIORAL SUPPORT (CIIBS) WAIVER



The Children's Intensive In-home Behavioral Support (CIIBS) Waiver combines wraparound planning with positive behavior supports to empower families to remain together. This is done by addressing your child's needs to reduce or extinguish challenging behaviors. You and your child will partner with service providers to create positive supports focusing on behavioral change, relationships and skill building. For initial enrollment, you must be between the ages of 8 and 18, but remain eligible for CIIBS until age 21. The CIIBS program design relies on the shared responsibility of the individual's parents and offer services to effectively support the individual to prevent out of home placement.

Services Covered: Determined by the Person-Centered Service Plan. Average cost of service, including respite is \$4,000 per month per client for any combination of Nurse Delegation*; Positive Behavior Support and Consultation*; Environmental Adaptations; Assistive Technology*; Therapeutic Equipment and Supplies*; Specialized Medical Equipment and Supplies*; Specialized Clothing; Vehicle Modifications; Staff/Family Consultation and Training; Transportation*; and Respite. Behavioral Health Stabilization Services* and Risk Assessment are available services but not included in the \$4,000 per month average cost of service.

** Services available under private insurance, Medicare, the Medicaid state plan (including EPSDT) and the community mental health system must be accessed first prior to using waiver funding.*

INDIVIDUAL & FAMILY SERVICES (IFS) WAIVER



The Individual and Family Services (IFS) Waiver, which became effective June 1, 2015, offers support to clients living with a family member in the community. The intent of this program is to provide support and services to the client and family members, centered on the needs of the client and the family.

Clients are eligible for the IFS Waiver if they are age 3 or older, live with a family member, and meet the waiver eligibility criteria listed on page 9 of this booklet.

Services Covered:

- ▶ IFS funding levels range from \$1,200 to \$3,600 per year, depending on assessed need (determined by assessment).
- ▶ IFS services include Respite; Positive Behavior Support and Consultation*; Community Engagement; Home and Vehicle Modifications; Peer Mentoring*; Assistive Technology and Speech; Occupational, and Physical Therapies*; Person Centered Plan Facilitation; Risk Assessment; Specialized Clothing; Specialized Equipment and Supplies*; Skilled Nursing*; Staff/Family Consultation and Training; Supported Parenting; Wellness Education; and Transportation to a waiver service*. Risk Assessment and Behavioral Health Stabilization Services are available and do not count against a client's annual allocation.



**Services available under private insurance, Medicare, the Medicaid state plan (including EPSDT) and the community mental health system must be accessed first prior to using waiver funding.*

FREEDOM OF CHOICE

The law requires that each individual eligible for the waivers will be given freedom of choice in selecting qualified providers of each service written in the plan.

You may appeal if:

- ▶ You are denied the qualified service provider of your choice.



If you are denied freedom of choice
in provider(s) and services(s)...
be sure to get the denial in writing.
You can appeal the denial.

HOW DO THE WAIVERS WORK?

An assessment is conducted and a Person-Centered Service Plan is developed to include:

- ▶ Addressing your health and welfare needs (waiver and non-waiver);
- ▶ Amount and duration of service(s) to be provided (regardless of funding source); and
- ▶ Your choice of qualified service provider(s)

The federal government will not reimburse for waiver services that are not included in this Person-Centered Service Plan.

Be sure that all of your service needs are written in the plan before you sign it.

The state is required, under the Medicaid HCBS Waivers, to fund all Medicaid waiver services written in the Person-Centered Service Plan and to update your plan annually.



BASIC PLUS WAIVER

The Basic Plus Waiver is intended for people who live with their families, on their own, in an adult family home, in another setting with assistance or an Adult Residential Care Assisted Living Facility (ARC) and are at high risk of out of home placement.



Services Covered:

- ▶ Hours per month available for Supported Employment or Community Inclusion, based on DDA assessment and employment status.
- ▶ Up to \$6,192 is available for any combination of Skilled Nursing (Nursing Delegation)*; Positive Behavior Support and Consultation*; Community Guide; Environmental Adaptations; Specialized Medical Equipment and Supplies*; Occupational, Physical and Speech Therapies*; Specialized Psychiatric Services*; Staff/Family Consultation and Training; ; Chemical Extermination of Bedbugs; Wellness Education and Transportation to a Waiver Service*. Risk Assessment and Behavioral Health Stabilization Services* are available without impact on the client's \$6,192 budget.
- ▶ Respite is based on assessed need.
- ▶ \$6,000 per year available for Emergency Assistance.

*Services available under private insurance, Medicare, the Medicaid state plan (including EPSDT) and the community mental health system must be accessed first prior to using waiver funding.

CORE WAIVER

The Core Waiver is intended for people who are at immediate risk of out of home placement and need up to 24-hour residential services.



Services Covered:

- ▶ Residential Services, Behavior Support, Therapies, Environmental Adaptations, Skilled Nursing, Employment services, Specialized Medical Equipment and Supplies and more.

COMMUNITY PROTECTION WAIVER

The Community Protection Waiver is intended for people who need 24-hour on-site awake staff supervision and therapies to maintain their own and community safety.

Services Covered:

- ▶ Residential Services, Positive Behavior Support, Therapies, Environmental Adaptations, Skilled Nursing, Employment services, Specialized Medical Equipment and Supplies, Risk Assessments and more.



WHO IS ELIGIBLE?



Eligibility for waiver services includes people with developmental disabilities who are:

- A client of DSHS Developmental Disabilities Administration (DDA)
- Must meet disability criteria established by the Social Security Administration (SSA).
- Eligible for Medicaid services in an institution;
- Determined to need home and community-based services in order to live in the community; and
- The individual's gross income does not exceed 300 percent of the SSI benefit amount and the individual's resources do not exceed \$2,000. (Parental income is not considered for children.)

The DSHS Developmental Disabilities Administration (DDA) has a set number of openings available under each of the waivers.

**Contact your case manager
if you are in need of services
on one of the HCBS waivers.**

Once you are determined eligible for the waiver program you must be informed of any feasible alternatives and given the choice of either institutional care or the Home and Community-Based Services Waiver.