BENEFICIARY REQUIREMENTS

To qualify for the Supports Waiver (SW), a person must be 18 years of age or older, be offered a waiver opportunity slot and adhere to all of the following eligibility criteria:

1. Meet the Developmental Disability Law criteria as defined in Appendix A;

2. Have his/her name on the Developmental Disabilities Request for Services Registry (RFSR);

3. Meet the financial and non-financial Medicaid eligibility criteria for Medicaid services;

4. Meet the medical requirements;

5. Meet the requirements for an intermediate care facility for individuals with an intellectual disability (ICF/IID) level of care which requires active treatment of a developmental disability under the supervision of a qualified intellectual disabilities professional;

6. Meet the determination that the SW is the Office for Citizens with Developmental Disabilities (OCDD) waiver, based on person centered planning and a needs based assessment, that will meet the needs of the individual;

7. Meet the health and welfare assurance requirements for home and community based waiver services; and

8. Be a resident of Louisiana.

To remain eligible for waiver services, a beneficiary must receive one or more waiver services every thirty days.

Request for Services Registry

Enrollment in the waiver is dependent upon the number of approved and available funded waiver slots. Individuals who request waiver services are placed on a statewide RFSR and are selected for an OCDD waiver opportunity based on the urgency of need and earliest registry date.

Requests for waiver services must be made from the applicant or his/her authorized representative by contacting the applicant's local governing entity (LGE).

When the LGE determines that the applicant's condition meets the definition of a developmental disability as defined by the Louisiana Developmental Disability Law (see Appendix A), the applicant's name will be placed on the RFSR and the applicant/authorized representative will be sent a letter stating the individual's name has been secured on the RFSR along with the original request (protected) date. The individual will then undergo a screening for urgency of need. Entry into an OCDD waiver will be offered to applicants from the RFSR by urgency of need and the earliest request for services date. If, through the needs assessment and person centered planning process, it is determined that the SW is the OCDD waiver that will meet the needs of the individual, the individual will be given a SW slot.

Verifying Screening for Urgency of Need (SUN) and Request Date

Applicants, or their authorized representatives, may verify their screening for urgency of need (SUN) score and request date by calling their local LGE (see Appendix C).

Level of Care

The SW program is an alternative to institutional care. All waiver applicants must meet the definition of a person with developmental intellectual disability (ID) as defined in Appendix A.

The LGE will issue either a Statement of Approval (SOA) or a Statement of Denial (SOD).

The Bureau of Health Services Financing (BHSF) "Request for Medical Eligibility Determination" 90-L Form is the instrument used to determine if an applicant meets the level of care of an ICF/IID. The 90-L Form must be completed, signed, and dated by the individual's Louisiana licensed primary care physician. A licensed advanced nurse practitioner, or a licensed physician's assistant may sign the 90-L, but the supervising or collaborating physician's name and address must be listed. The 90-L Form must be submitted with the individual's initial or annual plan of care (POC) to the LGE. The LGE is responsible for determining that the required level of care is met for each beneficiary.

The applicants/authorized representatives are ultimately responsible for obtaining the completed 90-L Form from the applicant's primary care physician. This form must be obtained prior to linkage to a support coordination agency for an initial POC and no more than 90 days before the annual POC start date.

Beneficiary Discharge Criteria

Beneficiaries will be discharged from the SW if one of the following criteria is met:

1. Loss of Medicaid eligibility as determined by the parish Medicaid Office;

2. Loss of eligibility for an ICF/IID level of care as determined by the LGE;

3. Incarceration or placement under the jurisdiction of penal authorities, courts or state juvenile authorities;

4. Change of residence to another state with the intent of becoming a resident of that state;

5. Admission to an ICF/IID or nursing facility, without the intent to return to waiver services. The waiver beneficiary may return to waiver services when documentation is received from the treating physician that the admission is temporary and shall not exceed 90 days. The beneficiary will be discharged from the waiver on the 91st day if the beneficiary is still in the ICF/IID facility. Payment for SW services will not be authorized while the beneficiary is in an ICF/IID facility or nursing facility;

6. Determination by the LGE that the beneficiary's health and welfare cannot be assured in the community through the provision of reasonable amounts of waiver services, i.e. the beneficiary presents a danger to him/herself or others;

7. Failure to cooperate in any eligibility determination process, the initial or annual implementation of the approved POC, or the responsibilities of the SW beneficiary; or

8. Continuity of stay is interrupted as a result of the beneficiary not receiving SW services during a period of 30 or more consecutive days. Continuity of stay will not apply to interruptions in waiver services because of hospitalization or institutionalization (such as admission to an ICF/IID or nursing facility) as long as there is documented expectation from the treating licensed physician that the beneficiary will return to waiver services no later than 90 days from admission to the hospital or institution.

In the case of an event or effect that cannot be reasonably anticipated or controlled (Force Majeure), support coordination agencies, service providers, and beneficiaries, whenever possible, will be informed in writing, and/or by phone, and/or via the Medicaid website, of interim guidelines and timelines for retention of waiver opportunities and/or temporary suspension of continuity of stay.

The service provider is required to notify the support coordination agency within 24 hours if the beneficiary has met any of the above stated discharge criteria.