

## **SECTION V.6.                    Initiating Services Procedures**

### **A. Home-Based Setting**

1. The case manager shall arrange and coordinate the initiation of services.
2. If the case manager or provider(s) believe that the applicant meets Choices for Care (CFC), Long-Term Care Medicaid financial eligibility criteria, services may start immediately after the Department of Disabilities, Aging and Independent Living (DAIL) “Clinical Certification” is made, with a mutual agreement between the provider and the individual or legal representative concerning payment for services rendered prior to final Department for Children and Families (DCF) financial eligibility approval.
3. Individuals shall be informed by the case manager that, by starting services in advance of final CFC financial eligibility determination, the individual will be liable for payment of services provided if they are subsequently found financially ineligible for CFC services.
4. In the event that there is a question regarding the individual’s potential CFC financial eligibility, the provider may delay the initiation of CFC services until the DCF has determined CFC financial eligibility and DAIL has authorized the Service Plan.
5. The provider shall not bill the State for CFC services provided until DCF has approved financial eligibility and DAIL has authorized the CFC Service Plan.
6. If DCF determines the individual does not meet the financial eligibility criteria for CFC services, the provider may bill the individual for services provided, as long as the services provided are not reimbursable under other applicable insurance options (e.g. Medicare or private insurance).

### **AFC Home:**

1. If the Authorized Agency believes that the applicant meets Choices for Care (CFC), Long-Term Care Medicaid financial eligibility criteria, services may start immediately after the Department of Disabilities, Aging and Independent Living (DAIL) “Clinical Certification” is made, with a mutual agreement between the provider and the individual or legal representative concerning payment for services rendered prior to final Department for Children and Families (DCF), Economic Services Division (ESD) financial eligibility approval.
2. Individuals shall be informed by the AFC Coordinator that, by starting services in advance of final CFC financial eligibility determination, the individual will be liable for payment of services provided if they are subsequently found financially ineligible for CFC services.

3. In the event that there is a question regarding the individual's potential CFC financial eligibility, the provider may delay the initiation of CFC services until the DCF has determined CFC financial eligibility and DAIL has authorized the Service Plan.
4. The provider shall not bill the State for CFC services provided until DCF has approved financial eligibility and DAIL has authorized the CFC Service Plan.
5. If DCF determines the individual does not meet the financial eligibility criteria for CFC services, the provider may bill the individual for services provided, as long as the services provided are not reimbursable under other applicable insurance options (e.g. Medicare or private insurance).

## **B. ERC Setting**

1. The ERC Provider shall arrange and coordinate the initiation of services.
2. If the ERC provider believes that the applicant meets Choices for Care (CFC), Long-Term Care Medicaid financial eligibility criteria, and the Residential Care Home has been issued a Level of Care Variance by the Department of Licensing and Protection (DLP), services may start immediately after the Department of Disabilities, Aging and Independent Living (DAIL) "Clinical Certification" is made, with a mutual agreement between the provider and the individual or legal representative concerning payment for services rendered prior to final Department for Children and Families (DCF) financial eligibility approval.
3. Individuals shall be informed by the ERC provider that, by starting services in advance of final CFC financial eligibility determination, the individual will be liable for payment of services provided if they are subsequently found financially ineligible for CFC services.
4. In the event that there is a question regarding the individual's potential CFC financial eligibility, the provider may delay the initiation of CFC services until the DCF has determined CFC financial eligibility and DAIL has authorized the Service Plan.
5. The provider shall not bill the State for CFC services provided until DCF has approved financial eligibility, the Licensed Level III Residential Care Home Provider has obtained a Level of Care Variance from DLP (if applicable) and DAIL has authorized the CFC Service Plan.
6. If DCF determines the individual does not meet the financial eligibility criteria for CFC services, the provider may bill the individual for services provided, as long as the services provided are not reimbursable under other applicable insurance options (e.g. Medicare or private insurance).

### **C. Flexible Choices (FC)**

1. Initiation of Services for new CFC applicants:
  - a. Clinical eligibility is determined by regional LTCCC
  - b. Referral is made to the Consultant Agency by the LTCCC sending a copy of the clinical certification form (CFC 803).
  - c. The consultant will send out a copy of the Welcome Letter, Self-Screening Form, Welcome to Flexible Choices booklet, Flexible Choices brochure, Rewarding Work brochure, Referral form (if not sent already).
  - d. The consultant sends information to contracted RN who completes the ILA and sends to the consultant within 10 days.
  - e. The consultant then goes to see participant. This meeting takes place in the participant's home and at a time that is convenient for the participant. It may involve several support people for the participant.
  - f. At that meeting:
    - i. The consultant and the participant review the current ILA and determine whether it needs to be updated. The Consultant will send the information to the contracted RN from the Consultant agency who will update or perform a new assessment as indicated by that review.
    - ii. The consultant establishes an allowance amount (see "The Allowance" below) based either on the current service plan or revised assessment.
    - iii. The participant and consultant start the budget development process (see "The Budget" below).
    - iv. The participant completes the Flexible Choices Informed Consent Form (CFC 832), allowance form (CFC 836), and budget form. The consultant and the participant sign an approved budget using the Budget Form (CFC 835). These forms are to be signed by the participant or legal guardian. A Power of Attorney may sign only if participant is unable to sign for him/herself.
  - g. The consultant sends a copy of the Informed Consent Form (CFC 832), the ILA, and the Allowance Approval Form (CFC836) to the regional Long Term Care Clinical Coordinator for utilization review and approval within 14 days of receiving the LTCCC Clinical Certification.
  - h. The Long Term Care Clinical Coordinator returns the approved allowance to the consultant and the participant once DCF has completed the financial eligibility.
  - i. The consultant forwards the completed budget and allowance form with a start date to Fiscal ISO, and the participant with a start date for services.
  - j. The consultant, working with the participant, sends the Notice of Start of Services through Flexible Choices Option (CFC 833) and the Notice of Stop of Services through Flexible Choices Option (CFC 834) to the necessary service providers.
  - k. There is no limit to how often a participant may access the services of their consultant.

2. Initiation of FC for current CFC participants: A participant begins receiving service in the Flexible Choices option through the following process:
  - a. The participant indicates his or her interest in Flexible Choices by completing a copy of the Flexible Choices Referral Form (CFC 831) and sending it to the Flexible Choices coordinator. The referral form includes consent for the consultant to talk to the case management agency, Adult Day provider, DAIL, and the Fiscal ISO. Participants may get a copy of this form either from the consultant agency, their case manager, the regional Long Term Care Clinical Coordinator (LTCCC), or online.
  - b. The consultant makes contact with the participant within two working days of the receipt of the referral form.
  - c. The consultant will send out a copy of the Welcome Letter, Self-Screening Form, Welcome to Flexible Choices booklet, Flexible Choices brochure, Rewarding Work brochure, Referral form (if not sent already).
  - d. The consultant contacts the participant's current case manager and confirms that the participant is a participant or surrogate directed participant in Choices for Care and requests a copy of the Independent Living Assessment (ILA), the personal care worksheet and the Service Plan including the Emergency Contacts and Back-up Plan.
  - e. The case manager sends this information within five working days of the request. The case management agency is also expected to share with the consultant participant information that will assist them in the completion of an appropriate budget for the participant.
  - f. The consultant contacts the participant to set up an initial care plan meeting with the participant within three working days of receipt of the material from the case management agency. This meeting takes place in the participant's home and at a time that is convenient for the participant. It may involve several support people for the participant.
  - g. At that meeting:
    - i. The consultant and the participant review the current ILA and determine whether it needs to be updated. The Consultant will send the information to the contracted RN who will update or perform a new assessment as indicated by that review.
    - ii. The consultant establishes an allowance amount (see "The Allowance" below) based either on the current service plan or revised assessment.
    - iii. The participant and consultant start the budget development process (see "The Budget" below).
    - iv. The participant completes the Flexible Choices Informed Consent Form (CFC 832), allowance form (CFC 836), and budget form. The consultant and the participant sign an approved budget using the Budget Form (CFC 835).
  - h. The consultant sends a copy of any revised or new assessment information, budget form (CFC 835), and the Allowance Approval Form (CFC836) to the regional LTCCC for utilization review and approval.

- i. The LTCCC returns the approved allowance to the consultant and the participant.
- j. The consultant forwards the completed budget and allowance form with a start date to Fiscal ISO, and the participant with a start date for services.
- k. The consultant, working with the participant, sends the Notice of Start of Services through Flexible Choices Option (CFC 833) and the Notice of Stop of Services through Flexible Choices Option (CFC 834) to the necessary service providers.

#### **D. Nursing Facility Setting**

1. If the nursing facility provider believes that the applicant may meet CFC, Long-Term Care Medicaid financial eligibility criteria, services may start immediately after the Department of Disabilities, Aging and Independent Living (DAIL) “Clinical Certification” is made, with a mutual agreement between the provider and the individual or legal representative.
2. The nursing facility provider shall inform individuals that, by starting services in advance of final CFC eligibility determination, the individual will be liable for payment of services provided if they are subsequently found financially ineligible for CFC services.
3. In the event that there is a question regarding the individual’s potential CFC financial eligibility, the nursing facility provider may delay the initiation of CFC services until the Department for Children and Families (DCF) has determined CFC financial eligibility and DAIL has authorized the Service Plan.
4. The nursing facility provider may not bill the State for CFC services provided until DCF has approved financial eligibility and DAIL has authorized the CFC Service Plan.
5. If DCF determines the individual does not meet the financial eligibility criteria for CFC services, the nursing facility provider may bill the individual for services provided as long as the services provided are not reimbursable under other applicable insurance options (e.g. Medicare or private insurance).

