

1115 Long-Term Care Waiver

Materials for the December 17, 2004 Interactive Television Session

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**1115 Long-Term Care Medicaid
DRAFT Program Summary 12/06/04**

I. ELIGIBILITY

A. General Eligibility

To be eligible for 1115 Long-Term Care (LTC) Medicaid program an individual must:

- Be a Vermont resident, and
- Be 65 years of age or older OR 18 years of age with a physical disability (as defined by Social Security Administration), and
- Meet the clinical criteria for the program, and
- Meet all financial and non-financial criteria for LTC Medicaid.

Individuals NOT eligible for the 1115 Long-Term Care Medicaid program are individuals who:

- Do not meet all of the above criteria, or
- Have a primary need for LTC services due to a mental health diagnosis or developmental disability, or
- Have a need for LTC services that can be effectively met with existing Medicare, Medicaid, or private insurance covered services. (e.g. Home Health Agency services, Day Health & Rehab, CRT, TBI waiver, DD waiver, ASP, etc.)

NOTE: Individuals choosing nursing home setting who have a mental health diagnosis must have a PASSAR screening completed by Division of Mental Health, per existing regulations.

B. Clinical Eligibility:

a. Highest Need Group (entitlement category)

- i. Extensive (code 3) or total assistance (code 4) with Toileting, Eating, Bed Mobility or Transfer (late-loss Activities of Daily Living (ADL)) **AND** at least limited assistance (code 2) with any other ADL (dressing, bathing, personal hygiene, mobility)
-OR-
- ii. Cognitive skills for daily decision-making assessed as severely impaired
-OR-
- iii. Cognitive skills for daily decision-making assessed and coded as moderately impaired **AND** behavior exhibited that is not easily altered (wandering, verbal/physical abuse, inappropriate behavior, resist care)
-OR-
- iv. A condition or treatment that requires daily skilled nursing such as IV meds, suctioning, ventilator/respirator
-OR-
- v. Unstable medical condition that requires daily skilled nursing care such as pneumonia, dehydration, gastric tube feeding, O2 therapy, dialysis, etc.

b. High Need Group (enrollment when funds available)

- i. Extensive (score 3) or total (score 4) assistance with Bathing, Dressing, Eating, Toileting, Personal Hygiene, Mobility
-OR-

- ii. Daily skilled teaching (nursing, physical therapy, occupational therapy or speech therapy) required to regain control or function of at least one of the following: gait training; speech; range of motion; bowel and/or bladder training
-OR-
- iii. Behavior present that requires a controlled environment for safety of self (wandering, verbal abuse, physical abuse, socially inappropriate)
-OR-
- iv. A condition or treatment that requires skilled nursing assessment, monitoring, and care on a less than daily basis such as severe pain management, suctioning, medication injections **AND** an aggregate of other services (personal care, nursing care, medical treatments/therapies) on a daily basis (example: LNA three days/week, P.T. two days/week and nursing two days/week= 7 days)

C. Financial eligibility

To be financially eligible, individuals must apply for and meet the existing LTC Medicaid criteria as determined by the Department for Children and Families (DCF), Economic Services Division (ESD). The 1115 LTC Medicaid Program is proposing an increase to the resource limit to \$5,000 for single individuals receiving home-based services who own their home.

Efforts are being made to explore ways to greatly decrease the time it takes to determine LTC Medicaid financial eligibility. This includes the possibility of electronic bank searches.

II. SERVICES

Services vary based on the setting chosen by the individual or their legal representative. The volume and type of services provided is determined by the individual's clinical needs. It is expected that the range of services will remain the same as they are with the existing Home-Based (HB) waiver, Enhanced Residential Care (ERC) waiver and nursing home.

A. Home-Based Setting

- a. Case management
- b. Personal care (consumer-directed, surrogate-directed and home health directed)
- c. Adult Day
- d. Respite care (consumer-directed, surrogate-directed and home health directed)
- e. Companion (consumer-directed, surrogate-directed and home health directed, Sr. Companion)
- f. Personal Emergency Response System (PERS)
- g. Assistive Devices/Home Modifications

B. Enhanced Residential Care Setting

- a. Case Management
- b. Nursing overview
- c. Personal care services
- d. Medication management
- e. Social and recreational activities
- f. Support for individuals with cognitive impairments
- g. 24-hour on-site supervision

- h. Laundry services
- i. Household services
- j. Meal Preparation
- k. Room and furnishings

C. Nursing Home Setting

- a. Care Management
- b. Rehabilitation therapies
- c. Nursing services
- d. Personal care services
- e. Medication management and pharmacy services
- f. Social and recreational activities
- g. Support for individuals with cognitive impairments
- h. 24-hour on-site supervision
- i. Laundry services
- j. Housekeeping
- k. Transportation
- l. Meals and nutritional/dietician services\
- m. Physician services
- n. Dental services
- o. Social worker services
- p. Room and furnishings

III. PROTOCOL

A. Referral Sources

DAIL will provide referral forms to all who request them and will include at least the following:

- Individuals
- Family
- Nursing Homes
- Hospitals
- Area Agencies on Aging
- AHS District Offices
- Home Health Agencies
- Residential Care and Assisted Living Residents
- Housing Authorities
- Adult Family Care
- Adult Day Centers
- Physician's Offices
- VCIL
- Advocacy Groups

B. Application Process

- a. Referral: Initial referral forms will be completed by any one of the above referral sources and submitted to the local Department of Aging and Independent Living (DAIL) staff. Information includes living arrangement, legal representatives,

choice of setting, choice of case management agency, current agency involvement, basic clinical and financial information.

- b. **Initial Screening:** DAIL staff will screen referral forms for missing/incomplete information. DAIL staff will contact the individual and/or referral source to gather additional information as needed.
 - c. **Clinical Assessment:** DAIL staff will complete a short clinical assessment (preferably face-to-face) to determine clinical eligibility and category (Highest, High, or Moderate Need group)
 - d. **Financial Assessment:** If the individual meets the Highest Need clinical criteria or High Need clinical criteria and funds are available, the DAIL staff will complete a brief financial assessment to determine “Conditional Authorization”. (*See page 2 Eligibility C. and page 4 Protocol E.*)
 - e. **LTC Medicaid Application:** All individuals who meet the Highest Need or High Need (with funds available) criteria must apply for LTC Medicaid financial eligibility through DCF. DAIL staff will provide an application form to the individual or legal representative if needed. The application must be completed as soon as possible.
 - f. **1115 LTC Options Choices:** DAIL staff will discuss choices as part of the application/assessment process.
 - g. **Priority Assessment:** If the individual meets the High Need criteria and funds are NOT available, DAIL staff will complete a priority assessment and refer to the local waiver team. The individual will be placed on a waiting list according to priority score. DAIL staff will inform the individual.
 - h. **Notifications:** If found clinically eligible for Highest or High with funds available, DAIL staff will send LTC Program Clinical Certification to DCF. Notice indicates clinical status, choice of setting, “Conditional Authorization” status, highest paid provider and who will be assisting the individual with their application for LTC Medicaid financial eligibility. DCF may then process LTC Medicaid application and providers may start services if appropriate.
 - i. **Transitional Service Plan:** In addition to the LTC Program Clinical Certification, DAIL staff will create a “Transitional Services Plan” identifying the LTC services and estimated volume of care (home-based). Providers may use this plan to start services pending LTC Medicaid approval. (*See Protocol E. and F.*)
 - j. **Final Authorization:** When LTC Medicaid financial eligibility is determined, DCF will notify the individual, the facility as appropriate and DAIL staff. If eligible for Home-Based or ERC setting, DAIL staff will then authorize services and send notification to individual and providers.
- C. Assessments:** Upon DAIL authorization, a full assessment must be completed and submitted for services to continue beyond the “Transitional Service Plan” end date. The process for assessments is as follows:
- a. **HB setting:** Case manager from the chosen case management agency will complete a full assessment (ILA) and plan of care within 14 calendar days. DAIL staff will complete Utilization Review on the proposed plan of care and authorize ongoing services accordingly.
 - b. **ERC setting:** Provider will complete and submit a full assessment within 14 calendar days (RCHRAT/POC). DAIL staff will complete Utilization Review on the proposed plan of care and authorize ongoing services accordingly.
 - c. **Nursing Home setting:** Provider will complete assessment (MDS) according to existing nursing home regulation.

D. Denials

- a. Clinical: At any time, if the individual does not meet the clinical criteria for the Highest or High Need group, DAIL staff will send a notice to the individual and/or legal representative, case manager, and DCF with appeal rights.
- b. Financial: At any time, if the individual does not meet the LTC Medicaid financial eligibility criteria, DCF staff will send a notice to DAIL, the individual and/or legal representative, and the case manager with appeal rights.
- c. Other: At any time, if the individual does not meet any one of the other eligibility criteria (see I. Eligibility, A.), DAIL will send a notice of decision with appeal rights. For example, if the individual moves out of state or their needs can be met with other services.

E. Conditional Authorization

During the initial application process, DAIL will determine which individuals meet the financial criteria that will allow us to grant “Conditional Authorization”. Individuals granted this status may start services prior to LTC Medicaid financial determination. If LTC Medicaid is denied and the provider is unable to collect payment from the individual, after exerting all due diligence, DAIL will cover the cost through State General Funds for up to 60 days.

F. Starting Services

For those individuals who are determined “Conditionally Authorized”, providers are to begin services as soon as possible. For individuals not “Conditionally Authorized” services may start in mutual agreement between the provider(s) and the individual. Final authorization for ongoing services will not occur until LTC Medicaid financial eligibility is approved.

G. Billing for Services

Providers may not bill Medicaid for any 1115 LTC services until the individual has been found financially eligible for LTC Medicaid.

H. Waiting List

If an individual meets the High Need clinical criteria and funds are not available to serve them, DAIL staff will complete a priority score sheet. (*See Priority Score Sheet*) The individual will be placed on a waiting list according to their priority score. The Waiver Team, including DAIL staff, will manage the waiting list.

I. Annual & Interim Reassessments

- a. HB setting: Case managers must complete an annual reassessment (ILA) and send it to local DAIL staff for utilization and clinical review.
- b. ERC: Provider coordinates annual reassessment (RCHRAT) with the case manager, completes and sends it to local DAIL staff for utilization and clinical review.
- c. Nursing Homes: Providers must complete reassessments (MDS) according to current nursing home regulations. Local DAIL staff will complete utilization review when triggered by DLP.

J. Service Changes

- a. HB setting: To request a change in type or volume of services, the case manager must submit a plan of care change request with supporting documentation. DAIL

staff will complete utilization review. Local DAIL will send a copy of approved/denied plan of care to the individual and/or legal representative and providers.

- b. ERC: To request a change in reimbursement for ERC, the provider must submit a revised RCHRAT to the case manager. The case manager must complete the tier reimbursement form and submit with the RCHRAT and plan of care change request to local DAIL staff. DAIL staff will complete utilization review. DAIL staff will send a copy of the approved/denied plan of care to the individual and/or legal representative and providers.
- c. Nursing Home: No change in nursing home process.

K. Setting Changes

Any individual may request a transfer by submitting a Setting Change Request form.

- a. HB setting → Nursing Home: Case manager will complete a “Setting Change Request” form and send to DAIL staff. DAIL staff will authorize services at the nursing home identified and notify DCF and nursing home provider. The nursing home must complete an MDS according to existing regulations. DCF will recalculate the patient share and send notice to the individual, DAIL, and nursing home provider.
- b. HB setting → ERC: Residential care homes must first send a request to DLP for a level of care variance for all individuals who are clinically eligible for nursing home care. (Not required for Assisted Living Residences) Case manager will then complete a “Setting Change Request” form and send to local DAIL staff. When a variance is approved by DLP, local DAIL staff will authorize services at the ERC selected and notify DCF and the ERC provider. The provider must complete a RCHRAT and submit to local DAIL staff after admission. DCF will recalculate the patient share and send notice to the individual, DAIL, and ERC provider.
- c. ERC → HB setting: Case manager will complete a “Setting Change Request” form, current assessment (ILA) and Plan of Care and send to local DAIL staff. DAIL staff complete utilization review and authorize home-based services on the plan of care and notify DCF and the providers. DCF will recalculate the patient share and send notice to the individual, DAIL, and highest paid provider.
- d. ERC → Nursing Home: Case manager will complete a “Setting Change Request” form, and send to local DAIL staff. DAIL staff will authorize nursing home services and notify DCF and the nursing home provider. The nursing home must complete an MDS per existing nursing home regulations. DCF will recalculate the patient share and send notice to the individual, DAIL, and nursing home provider.
- e. Nursing Home → HB setting: Nursing home will complete a “Setting Change Request” form and send to DAIL staff. DAIL staff will refer to case management agency identified on the form. Case manager will complete an assessment (ILA) and POC and send to DAIL staff. DAIL staff will complete utilization review and authorize home-based services. DAIL staff will notify DCF and providers. DCF will recalculate the patient share and send notice to the individual, DAIL, and highest paid provider.
- f. Nursing Home → ERC: Residential care homes must first send a request to DLP for a level of care variance for all individuals who are clinically eligible for nursing home care. (Not required for Assisted Living Residences) Nursing home will then complete a “Setting Change Request” form and send to local DAIL staff. (Level III residential care homes must send a request to DLP for a variance to section 5.1.A of the licensing regulations.) DAIL staff will refer to case

management agency identified on the form. Case manager will send assessment and POC to DAIL staff. When a variance is approved by DLP (not needed for ALR), DAIL staff will authorize services and notify DCF and the provider. After admission, the provider must complete a RCHRAT and submit to DAIL staff. DCF will recalculate the patient share and send notice to the individual, DAIL, and ERC provider.

L. Terminations

Individuals may voluntarily withdraw from 1115 LTC Medicaid Program at any time.

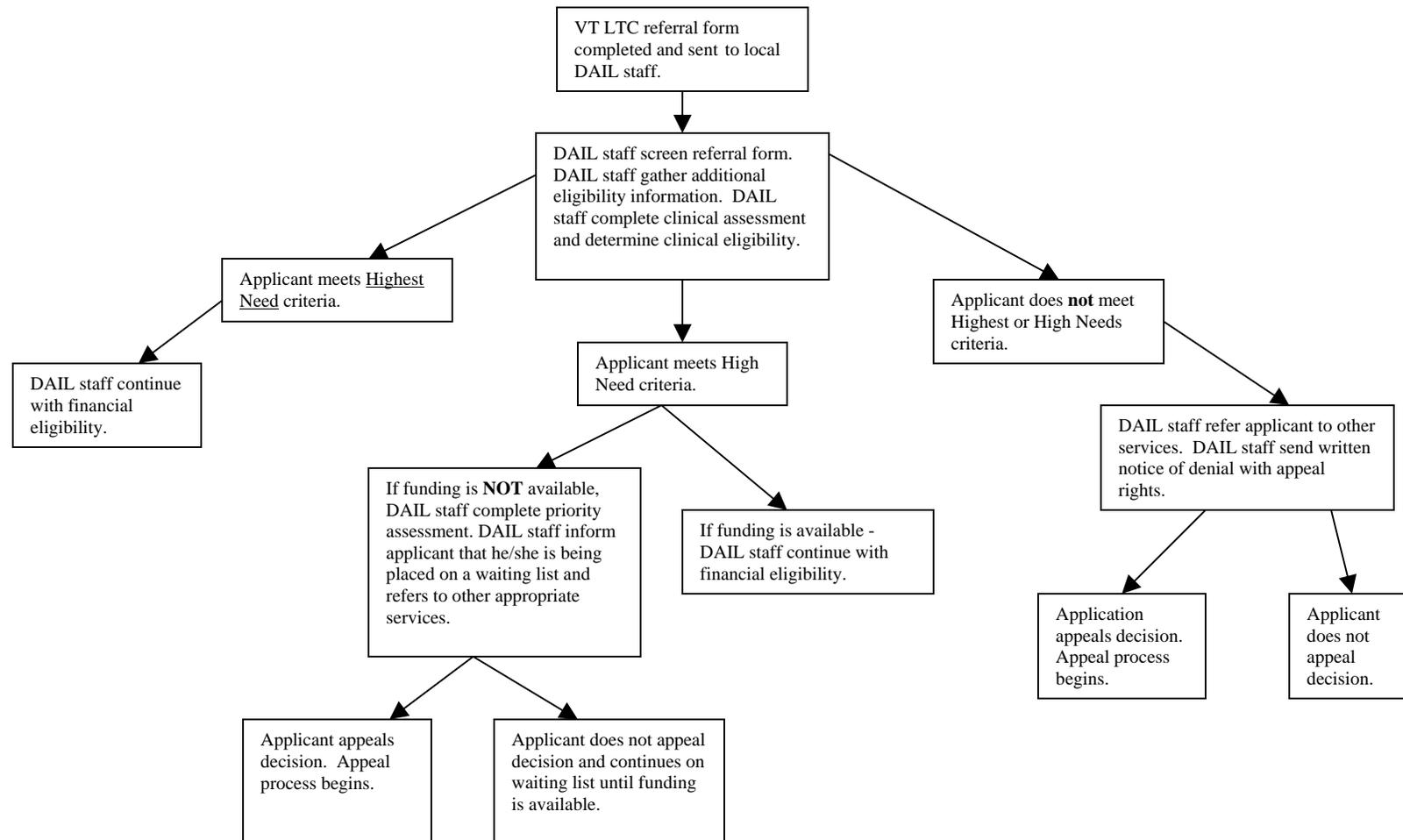
Individuals will be terminated from the 1115 Medicaid Program for the following reasons:

- Clinically ineligible
- Financially ineligible
- Needs can be met with other services
- Moved out of state
- Death
- Safety factors that effect the welfare of service providers
- Not utilizing services for 30 days

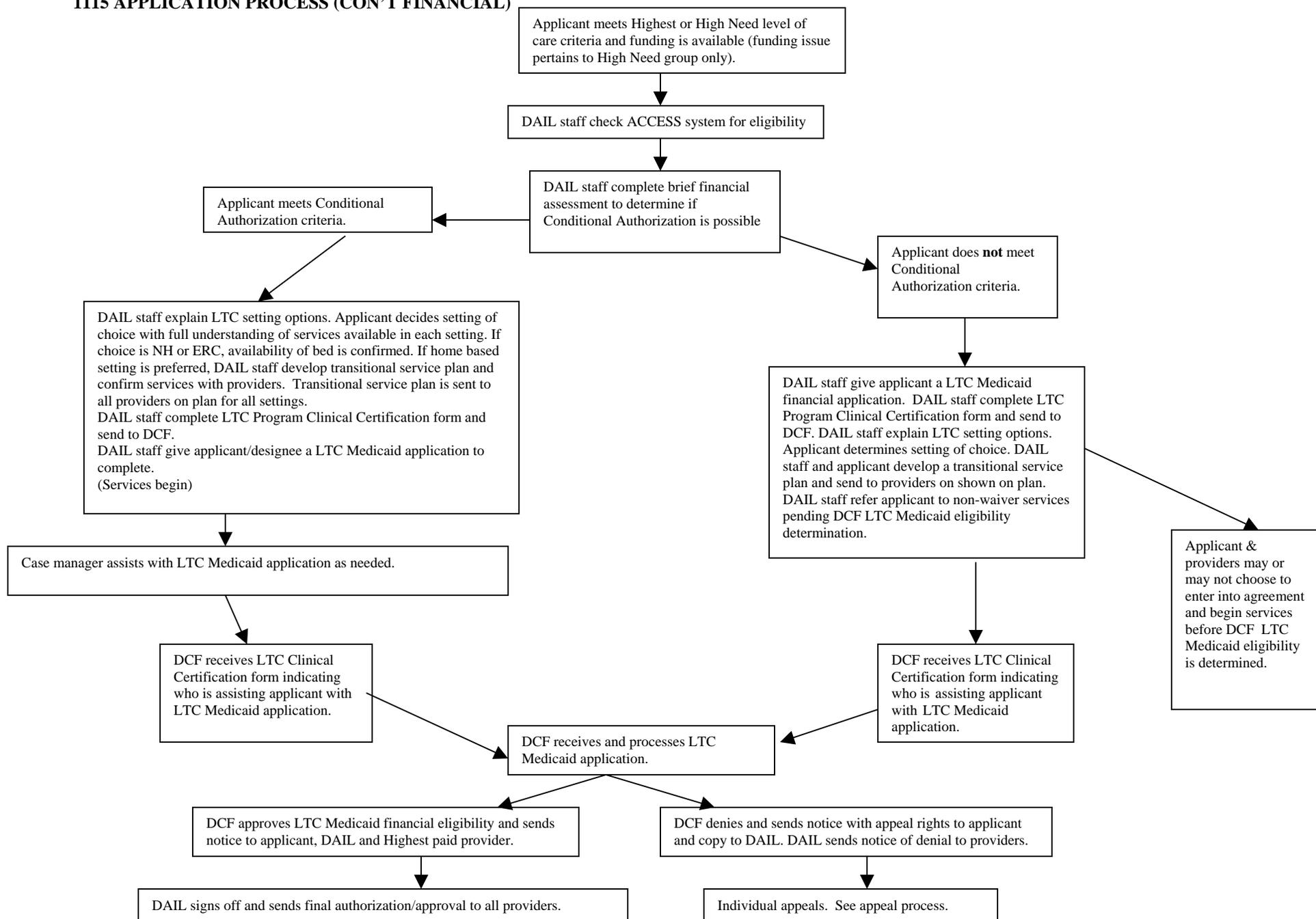
M. Out-of-State

The current out-of-state policies will continue.

1115 APPLICATION PROCESS (THROUGH CLINICAL DETERMINATION)



1115 APPLICATION PROCESS (CON'T FINANCIAL)



**1115 LTC Medicaid “Conditional Authorization”
DRAFT Proposal 12/1/04**

- I. **Summary:** The purpose of “Conditional Authorization” is to identify limited situations in which 1115 LTC Medicaid services may be started immediately with a “guarantee” of payment by the State. Once an individual has been deemed “Conditionally Authorized” for 1115 LTC Medicaid, providers may start services immediately while the individual continues the LTC Medicaid financial application process. If DCF determines the individual is ineligible for LTC Medicaid, the individual will be responsible for payment of services provided. If the provider is unable to obtain payment from the individual, the State will reimburse from General Funds for services provided within the identified 60-day “Conditional Authorization” period.
- II. **Criteria:** Once the DAIL staff has verified clinical eligibility for Highest or High (with funds available), they take the following steps to determine “Conditional Authorization”.
- 1. Transfers**
DAIL staff will refer to the transfer of assets question on the 1115 LTC Medicaid referral form. If the individual has transferred any asset or resources within the past 60 months (five years), then the process will **STOP**. The individual will not be deemed “conditionally authorized”. If no transfers have occurred, then DAIL staff will **PROCEED** with the process.
- 2. ACCESS**
If the individual has had no transfers in the past 60 months, DAIL staff will then use the ACCESS system to look up the individual’s Medicaid eligibility status. If the individual is in the ACCESS system on Vermont Community Medicaid without a spend-down for the last 36 months (3 years), then the individual will be deemed “**Conditionally Authorized**”.
- III. **NOT Conditionally Authorized:** Individuals who do not meet the above criteria for “Conditional Authorization” will continue through the LTC Medicaid application process. Providers may chose to start services through a private arrangement with the individual pending LTC Medicaid approval. However, providers will not be reimbursed by the State for services provided if the individual is found ineligible for LTC Medicaid.
- IV. **Billing:** Providers may not bill for 1115 LTC Medicaid services provided until final LTC Medicaid financial eligibility has been approved (regardless of “Conditional Authorization”).

1115 WAIVER HIGH NEEDS GROUP PRIORITY SCORE SHEET

Applicant Name: _____ Date: _____

This priority tool is to be used when there is a wait list for 1115 Waiver applicants who meet the High Needs Group clinical criteria. Use the Eligibility Assessment tool to score each category. Insert the score for each category into the table below. Add the column for a total score. Individuals that score between 50-78 meet the criteria for priority category one (#1). Individuals with a total score of 26-50 meet the criteria for priority category two (#2). Individuals with a score of 0-25 meet the criteria for category three (#3). Funding shall be awarded in order of priority category. For example, applicants in Category #1 always have highest priority

	SCORE
1. Medical Conditions/Treatments (score 0-27)	
2. ADL's (score 0-8)	
3. Cognition (score 0-8)	
4. Behavior (score 0-9)	
5. Risk Factors (score 0-26)	
(0-78) Priority Score:	

Comments (optional):

Check the appropriate priority category and fill in the total score.

- Category #1: Score is 51-78. Score:** _____
- Category #2: Score is 26-50. Score:** _____
- Category #3: Score is 0-25. Score:** _____

1. **Medical Conditions/Treatments:** Check **all** conditions/treatments that require skilled nursing and total. From Eligibility Assessment page 1, Clinical Information #1.

- 3 – Severe Daily Pain Management
- 3 – End Stage Disease – less than daily
- 3 – Parenteral Feedings – less than daily
- 3 – Naso-gastric Tube Feeding – less than daily
- 3 – Wound Care – less than daily
- 3 – Medication Injections – less than daily
- 3 – Suctioning – less than daily
- 3 – Skilled Rehabilitation (PT/OT/ST)- daily
- 3 – Bladder or Bowel Retraining -daily

Medical Conditions/Treatments Score: _____

2. **Activity of Daily Living (ADL):** (non-late loss)

Check level of need for each activity and total all. From Eligibility Assessment, page 2, #3.

- a. Bed Mobility: 0- Independent 1- Supervision 2- Limited Assist
- b. Toilet Use: 0- Independent 1- Supervision 2- Limited Assist
- c. Transferring: 0- Independent 1- Supervision 2- Limited Assist
- d. Eating: 0- Independent 1- Supervision 2- Limited Assist

ADL Score: _____

3. **Cognition:** Select the **one** answer that best fits the applicant’s current cognitive skills for daily decision-making. From Eligibility Assessment, page 2, #4.

- 0 – Independent – decisions consistent/reasonable
- 4 – Modified independence – some difficulty in new situations only
- 8 – Moderately impaired – decision poor/cues/supervision required

Cognition Score: _____

4. **Behavior:** Score each behavior frequency and alterability then total all scores. From Eligibility Assessment, page 2, #5. Frequency: Never= 0, Less than Daily=1, Daily=2 Easily Altered: Yes=0, No=1

Behavior	Frequency	Easily Altered?
a. Wandering		
b. Physically Abusive to others		
c. Resisting Care		
Totals:		

Behavior Score: _____ (frequency score + easily altered score)

5. **Risk Factors:** Select **all** that apply and total all. From Eligibility Assessment page 3, E.

- 3 – Person has had multiple hospital admissions (3 or more) in last 6 months
- 3 – Person has had multiple Emergency Room visits (3 or more) in last 6 months.
- 3 – Person has fallen more than once in the last month. *Number of falls:* _____
- 3 – Person takes 5-7 prescription medications. *Number of medications:* _____
- 5 – Person takes 8 or more prescription medications. *Number of medications:* _____
- 3 – Primary caregiver is expressing burnout or is at risk of imminent harm, ill health, or loss of job
- 3 – Recent loss (past 3 months) of primary caregiver
- 3 – No informal caregivers

Risk Factors Score: _____ (combine all)

DAIL Staff Signature: _____

REGION: _____ Date Funding allocated: _____

VERMONT LONG TERM CARE CLINICAL ELIGIBILITY CRITERIA

DRAFT HIGHEST and HIGH NEED GROUPS (1-14-05)

Step 1

- A. If nursing facility care is the individual's choice, use PASARR screen. If the PASARR screen results in a determination that the individual may need active mental health treatment, **stop** and contact the Division of Mental Health for a STEP II PASARR Screen. **If no, continue to Step 2.**
- B. If home and community-based care is the individual's choice, use the HCB screen on the back of this document. If the answer to any question leads to 'STOP', the individual is not eligible for the HIGHEST NEED GROUP. **If the individual passes all screening questions, proceed to Step 2.**

Step 2

Does the individual require extensive or total assistance with at least one of the following Activities of Daily Living (ADL): Toileting; Eating; Bed Mobility; and Transfer, and *at least* limited assistance with any other ADL?

If yes, individual is eligible for the Highest Need Group. If no, proceed to Step 3.

Step 3

Does the individual have a severe impairment with decision-making skills **or** a moderate impairment with decision-making skills **and** one of the following behavioral symptoms/conditions, which occurs frequently and is not easily altered?

Wandering
Verbal Abuse

Physical abuse
Inappropriate Behavior

Resists Care

If yes, individual is eligible for the highest need LTC Group. If no, proceed to Step 4.

Step 4

Does the individual have at least one of the following conditions or treatments that require skilled nursing assessment, monitoring, and care on a daily basis?

Stage 3 or 4 Skin Ulcers
IV Medications
End Stage Disease

2nd or 3rd Degree Burns
Parenteral Feedings
Suctioning

Ventilator/ Respirator
Naso-gastric Tube Feeding

If yes, individual is eligible for the highest need LTC Group. If no, proceed to Step 5.

Step 5

Does the individual have an unstable medical condition that requires skilled nursing assessment, monitoring and care on a daily basis related to, but not limited to at least one of the following?

Dehydration
Internal Bleeding
Aphasia
Transfusions
Vomiting
Wound Care

Aspirations
Chemotherapy
Oxygen
Septicemia
Pneumonia
Cerebral Palsy

Respiratory Therapy
Multiple Sclerosis
Open Lesions
Tracheostomy
Radiation Therapy
Gastric Tube Feeding

Quadriplegia

Dialysis

If yes, individual is eligible for the Highest Need Group.

If no, the individual is not eligible for the Highest Need Group.

Step 6

Does the individual require extensive to total assistance on a daily basis with at least one of the following ADLs: bathing, dressing, eating, toileting and/or physical assistance to walk?

If yes, individual is eligible for the HIGH NEED GROUP. If no, proceed to Step 7.

Step 7

Does the individual require skilled teaching (on a daily basis) to regain control of, or function with at least one of the following: gait training; speech; range of motion; and bowel and/or bladder training?

If yes, individual is eligible for the HIGH NEED GROUP. If no, proceed to Step 8.

Step 8

Does the individual have impaired judgment or impaired decision-making skills that require constant or frequent direction to perform at least one of the following ADLs: bathing; dressing; eating; toileting; transferring; and personal hygiene?

If yes, individual is eligible for the HIGH NEED GROUP. If no, proceed to Step 9

Step 9

Does the individual exhibit at least one of the following behaviors requiring a controlled environment to maintain safety for self: constant or frequent wandering; inappropriate behavior; or physically or verbally abusive behavior?

If yes, individual is eligible for the HIGH NEED GROUP. If no, proceed to Step 10

Step 10

Does the individual have a condition or treatment that requires skilled nursing assessment, monitoring, and care on a less than daily basis such as, but not limited to:

Wound Care	Suctioning
Medication Injections	End Stage Disease
Parenteral Feedings	Severe Pain Management
Tube Feedings	

AND

An aggregate of other services(personal care, nursing care, medical treatments or therapies) on a daily basis

If YES, the individual is eligible for either the HIGHEST OR THE HIGH NEED GROUP.

If NO to all of the above, the individual is not eligible for the HIGHEST OR HIGH NEED GROUP.

Home- and Community-Based Pre-Eligibility Screen

1. Is the applicant a Vermont resident and age 18 or over?

Yes No ***IF NO, STOP.***

2. Is the applicant at least 65 years of age, or does he/she have a physical disability?

Yes No ***IF NO, STOP.***

3. Does the applicant demonstrate a primary need for services due to a mental illness or developmental disability?

Yes No ***IF YES, STOP.***

4. Can the needs of the applicant be met with services other than 1115 Waiver services? If the answer is *YES* to any item, *STOP*.

- Medicare or Medicaid services Yes No
- Hospice Yes No
- Day Health Rehabilitation Services Yes No
- 1915(c) Waivers (TBI or DS) Yes No
- Attendant Services Program Yes No
- Other third party insurance Yes No

5. If the applicant is currently living in an institution, is there a reasonable expectation that housing can be found?

CONTINUE WITH CLINICAL ELIGIBILITY SCREENING on PAGE 1.

NOTE: If any of the above answers led to a “STOP”, then the applicant does not meet the “pre-screening” eligibility criteria for Long-Term Care 1115 waiver services.