

The Family Support Network Answers

Frequently Asked Questions

**Regarding the
Children's and Adult Home-Based Support Services
Programs**

**Created February 2008
Updated October 2009**

Greetings, Fellow Advocates!

Welcome to the Family Support Network's Frequently Asked Questions Document.

This is written in response to the many, many questions people with disabilities and families have asked us as they used the Children's or Adult's Home-Based Support Services Program.

We expect it to be an organic document, changing as we find out more information, or as we need to make changes. When that happens we will send out an e-mail to our lists.

The "Frequently Asked Questions Document" is based on the many questions we received during the "Dreaming New Dreams" Seminars" in the fall of 2007 and questions we've received since then. We even threw in a few that we thought you probably wanted to know the answer to and hadn't thought to ask. We invite you to e-mail us with new questions, clarifications, or even to tell us we're wrong! Our e-mail address is: fsn@familysupportnetwork.org.

Please note that there are many helpful documents on the homepage of the Family Support Network including the Waiver Provider Manual provided by the Division of Developmental Disabilities. <http://www.familysupportnetwork.org>.

What is a Waiver? Why is it important to us?	3
What are all the programs funded by Illinois State DD Waivers?	4
What about the Family Assistance Program?	4
Other DD Funded Community Services	5
The Application Process	5
Eligibility	8
How Much Funding is Available?	9
Transitioning from One Program to Another	9
Individual Service and Support Advocacy (ISSA)	10
Service Facilitation	11
The Service Plan	13
The Included Services	14
Questions from Service Facilitators	16
Hiring Personal Support Workers Directly	18
Asking an Agency to Provide Personal Support Workers	19
ACES\$	20
Developmental Training (DT)	25
Using Your Medicaid State Plan Card	26
Dental	29
Behavioral Intervention Services	31
Crisis Funding for Adults	32
The \$15,000 Over 5 Years Funding	32
(Not) Using Two Waiver Programs	34
Funding for Services such as Community College, Horse Back and Music Therapies, Camp and Park District Programs	35
Transportation	35
List of Independent Service Coordination Agencies	37
January 2008 Memos from DD Director Teninty	40

What is a Waiver? Why is it important to us?

The Children's and Adult Home-Based Support Services Programs (HBSS) for people with developmental disabilities are both part of "waiver" programs. They are funded with a mix of funding from the State of Illinois and the Federal Government. The State of Illinois pays the providers of supports and services. Then the Federal Government reimburses the State 50 cents for every dollar they have spent. In other words, they each pay half.

"Waiver Programs" are created when individual states design programs to support special populations. The states then apply to the United States Department of Health and Human Services to have rules for Medicaid Insurance "waived" so that they can receive reimbursement for part of the cost of the services.

The "waivers" allow states to create programs that provide much needed services in community settings.

This is done through Medicaid, the federal insurance program for people with low-income. Most adults with severe disabilities have low income, so they qualify. Illinois has also agreed to ignore income requirements for families of minor children in the Children's Home-Based Support Services program so all children who are enrolled in the program are eligible.

When Medicaid was passed into law in the 1960's it only paid for people to be in hospitals and nursing homes. Eventually Congress realized that hospitals and nursing homes were very expensive and many people with developmental disabilities didn't want or need to live in them. But, they were stuck using them, as there were no alternatives. Congress passed legislation allowing the Secretary of the U.S. Department of Health and Human Services to "waive" the rules in certain circumstances. States can design programs of services, make specific application, and get approval to waive the rules within those programs. States and participants have to live by the rules and guidelines the Feds require.

Of course, being able to "capture" these federal dollars is very important to the State of Illinois, especially as the State tries desperately to deal with a series of very bad budget years.

The Illinois Department of Human Services, through its Division of Developmental Disabilities, administers three "waiver" programs. They include a waiver for Adults with Developmental Disabilities which provides funding for Community Integrated Living Arrangements (CILA services), the Adult Home-Based Support Services Program, and Developmental Training. The Children's Support Services Waiver provides funding for the Children's Home-Based Support Services Program. The Division of Developmental Disabilities also administers a third waiver which provides funding for children living away from home in residential settings.

What are all the programs funded by Illinois State DD Waivers?

The Illinois Department of Human Services (<http://www.dhs.state.il.us/>) administers three waiver programs specifically for people with developmental disabilities. Those three waivers provide funding for a total of six programs. They are:

- **CILA (or Residential CILA)** – Community Integrated Living Arrangements are the supports and services adults with disabilities receive from provider agencies when living in residential settings such as group homes.
- **In-Home CILA or Family CILA** – These terms are used interchangeably for the same supports and services as above. However, a provider agency usually delivers the supports and services in the family home. The amount of funding is typically much less than residential CILA.
- **Adult Home-Based Support Services Program** – In this flexible program, adults with disabilities develop an array of services and supports that can be delivered in a variety of ways. We will answer more questions regarding this program later in this document.
- **Adult Developmental Training (DT)** – Through this program, people with disabilities receive services during the day. DHS awards this to people with disabilities as a separate service. People can receive this service only, or it can be part of their CILA services, or they may select it as part of their Adult Home-Based Support Services Program. Sometimes people refer to this as “Day Training” or “Sheltered Workshop”.
- **Children’s Home-Based Support Services Program** – This is a new program which started July 1, 2007. Families who were receiving services through DHS program code “72D” were transitioned into this program. We will be answering questions regarding this program later in this document.
- **Children’s Residential Waiver** – This is also a new program which started July 1, 2007. Children who were already living in residential settings, with CHS program code “17D”, were transitioned into this program. The Division of Developmental Disabilities strives to keep children OUT of this program by using the Children’s Home-Based Support Services Program.

What about the Family Assistance Program?

The Family Assistance Program (FAP) is the original sister program to the Adult Home-Based Support Services Program. Together they were referred to as the “Family Support Programs”.

The Family Assistance Program is not a waiver program. It is funded entirely by Illinois tax dollars commonly referred to as General Revenue Funds or GRF. It provides a monthly check equal to one times SSI. Starting January 1, 2009, that amount is \$674.

To be eligible, families cannot have income over \$65,000 a year after deductions on the family’s IRS Tax form.

DHS has enrolled no new families into this program in six years. As of October, 2009, about 354 families are still enrolled. Six years ago that number was over 1,500. The decrease in enrollment is primarily related to the transition of children to the Adult Home-Based Support Services Program and the lack of new enrollment. Participants in the program can transition directly into the Adult Home-Based Support Services Program assuming they apply and continue to meet eligibility criteria.

Other DD Funded Community Services?

DHS funds many agencies through grants and purchase of service contracts to run programs they have designed. Your local Independent Service Coordination (ISC) agency can help you identify other funded services in your area or you may contact the Illinois LifeSpan Project at www.illinoislifespan.org or 800-588-7002.

The Application Process

How do I apply for the Adult or Children's Home-Based Support Services Programs?

DHS selects adults and children for new enrollment from the PUNS (Prioritization of Urgency of Need for Services) database. The selection criterion includes urgency of need, length of time on the database, statewide geographic distribution, current living arrangements, caregiver situations, randomness, etc.

DHS enters the criterion into the computer which randomly generates the names of people with disabilities who meet the criteria.

After names are selected, DHS notifies the individual and/or his family, and the Independent Service Coordination (ISC) Agency that serves the geographic area where the individual lives. The ISC works with the individual and his or her family to **complete the appropriate Pre-Admission Screening (PAS) and submits the necessary "application packet"**.

A number of capacities (**approximately 10 as of January 2008**) are held open each month for immediately urgent situations such as **abuse, neglect, and homelessness**.

More details are available on the Family Support Network website at:

<http://www.familysupportnetwork.org/800%20New%20Enrollment%20Announcement.pdf> and <http://www.familysupportnetwork.org/PUNS%20FLOWCHART.pdf>.

What is "PUNS"?

"PUNS" is an acronym which stands for the "Prioritization of Urgency of Need for Services" database. We say that the name is an unfortunate acronym because, for us, **PUNS is no joke**. It represented a real victory for disability advocates when it was finally passed into law and implemented in 2004.

Even if an individual is not in need of services right now, you should be sure that you or your family member has enrolled in the database. The PUNS allows us to have accurate information to use as advocates as we talk to our policymakers. The PUNS is one of the tools the State uses as it decides who will receive services on an individual basis. The PUNS is the tool the State uses as new programs and services are being developed.

Inclusion in the database does not assume eligibility for services or guarantee the receipt of services. You can read more about the PUNS database and how to access it on page three of the September 2005 Family Support Network Newsletter at:

<http://www.familysupportnetwork.org/Newsletter2005September.pdf> .

or on the State of Illinois Developmental Disabilities website at:

<http://www.dd.illinois.gov/SignUp.cfm>

How do I get on PUNS?

To be included on the PUNS database, contact the local ISC (Independent Service Coordination) agency in your geographic area. These agencies are the "front door" to Illinois' state-funded service system for people with developmental disabilities. They will talk with you about the service system and discuss your needs. They will fill out the PUNS form with your input and submit it to the State.

The PUNS must be filled out in person.

Identify your local Independent Service Coordination agency online at <http://www.dd.illinois.gov/LocalAgency.cfm>. There is also a list at the end of this document.

Independent Service Coordination Agencies are often referred to as "PAS" agencies because they are also contracted by the State to provide Pre-Admission Screening (PAS) – the process of certifying that the individual needing services meets the criteria to qualify for services funded by Medicaid reimbursement.

From time to time, people report that their ISC has refused to fill out a PUNS for them or that it was not done in a timely fashion. The first step is to contact the agency director and ask for their assistance.

If you believe that you have incorrectly been refused an opportunity to fill out the PUNS, please contact the Division of Developmental Disabilities at 1-888-DD-PLANS, the Family Support Network (309-693-8981), and/or the Illinois LifeSpan Project (800-588-7002).

What goes in the "Application Packet"?

The application packet will include a wide variety of information. Your Independent Service Coordination Agency is responsible for making sure it is complete and will ask you to help them.

It will include (but may not be limited to) information about the person's disability, probably from their doctor and/or school, their ability to qualify financially, an evaluation by a psychiatrist or psychologist, and a cover letter explaining in more detail the reasons this person needs services.

The cover letter is very important and needs to provide clear and detailed information about the needs and challenges of the person with a disability and how it is impacting his or her family. A savvy applicant will ask to review the letter before the packet is submitted; making sure it reflects the reality of their lives.

When will services actually begin?

It is **REALLY IMPORTANT to understand that services will not begin** until the individual or family receives the "award letter" and "a service plan" is in place.

After the award letter is received, the individual and/or his family can begin choosing and working with providers of services to begin services. In the Home-Based Support Services Programs, the first provider to choose will be the Service Facilitator. If the family chooses to self-direct Personal Support Workers, they will also want to start the process of working with ACES\$ (See page 20).

Who performs the psychological evaluation? Who pays for it?

Independent Service Coordination agencies receive funding specifically earmarked to pay for psychological evaluations as part of the application process. The Division of Developmental Disabilities has a list of qualified psychologists who can do the evaluations. The Federal Government regulates what the requirements are to be qualified. Unfortunately, school psychologists do not meet those criteria.

Is there a limit on the number of participants in either program?

Yes. As of the end of July 2008, eleven hundred (1100) children was the federally approved maximum capacity for the Children's Home-Based Support Services Program. The federally approved maximum capacity for the adult programs is now fifteen thousand, two hundred twenty five (15,225) which includes Community Integrated Living Arrangements (CILA), the Adult Home-Based Support Services program (HBSSP), and Developmental Training (DT). In 2007, the adult waiver served over 8,000 people in CILA, almost 2,000 people in the HBSSP, and over 3,600 people in DT.

Illinois files to amend the maximum capacity higher whenever new funding becomes available through legislation passed by the Illinois General Assembly (your state legislators). The Feds have always easily and quickly approved this change.

Realistically, the State decides capacity by dividing the amount of dollars available by the average cost per participant and then applying to the Feds to amend the waiver. Capacity has always been increased, never decreased.

How many people are waiting to be served by the Home-Based Support Services Programs? Is it hard to get into the program?

As of September 2009, PUNS indicated that over 25,000 people are enrolled in the PUNS. Over 18,000 of those have currently identified themselves as in need of services. We suspect that a larger number of people exist that are not even on the PUNS list. The State of Illinois provides updated, detailed information about PUNS on the web at <http://www.dhs.state.il.us/page.aspx?item=31193>.

Eligibility

Who is eligible for the Children's and Adult Home-Based Support Services Programs?

It is important to understand that eligibility for waiver programs does NOT CREATE AN ENTITLEMENT to services. This is a BIG shock to many families who have enjoyed the entitlement of a free and appropriate public education through the Individuals with Disabilities Education Act (IDEA).

The general clinical criteria are that: a child or adult must be or become Medicaid eligible (parents income can be waived for determining the child's eligibility for the Waiver program), have a DD and need "active treatment" which means their needs are such that they could qualify for institutional setting level of care. This does not mean you have to say that if you don't get services you will institutionalize your child. It only means that their level of disability is such that they would qualify for institutional care.

You may read the complete eligibility criteria on pages 10 through 12 of the Provider Manual at: http://www.dhs.state.il.us/OneNetLibrary/27896/documents/By_Division/Division%20of%20DD/Waiver%20Provider%20Manual.pdf

At what ages do children qualify for the Home-Based Support Services Program? What about adults?

The minimum age for children is 3 years old and the maximum age is up to their 22nd birthday. Adults can enroll in the Home-Based Support Services Program starting at 18 and stay in across their lifetime.

Yes, there is a four year overlap. Individuals and adults can choose which program to be in during the years between 19 and 22, and at what point they want to transition to the adult program.

Would/could a child with Asperger's Syndrome whose IQ exceeds 70 qualify for the Children's Waiver?

Perhaps. It depends on how the condition impacts the individual's ability to function in life. A comprehensive assessment of the individuals needs must be completed to know for sure.

A person must be diagnosed with Autism by a Psychiatrist or Developmental Pediatrician. A psychological evaluation with adaptive skills must be done. The SIB or Vineland are the most common tools used.

Then that information along with other evaluations are used by the Independent Service Coordination Agency doing pre-admission screening to determine if the individual has deficits in three of six activities of daily living (AOL's) and that those deficits are significant enough to make them eligible for active treatment (that they need support) and services. Activities of daily living include self care, language, learning, mobility, self direction, and capacity for independent living.

How Much Funding is Available?

How much funding does a participant in the Children's Home-Based Support Services Program have available per month?

All children enrolled in the Home-Based Support Services program have access to the same amount of funding per month. That amount is equal to two times whatever SSI is that year. Every year that amount changes to keep up with inflation. Starting January 1, 2009, SSI is \$674 so the amount available is \$1,348 per month.

How much funding does a participant in the Adult Home-Based Support Services Program have available per month?

If the participant is still in school, he or she has access to supports and services with a cost of up to two times SSI. As of January 1, 2009, that amount is \$1,348 per month, the same as the Children's program.

If the participant has left their school system, the amount increases to up to three times SSI. In 2009, that amount is \$2,022 per month.

Where can we get the information about increases in the monthly allotment for the Children's or Adult Home-Based Support Services Programs?

Changes always happen at the first of the calendar year when federal SSI reimbursement changes. Usually there is publicity around those changes. Your Independent Case Coordination Agency or your Service Facilitator is a good source of information. However, a great place to check is online at <http://www.socialsecurity.gov/OACT/COLA/SSI.html>. You will be interested in the dollar figure listed for the "eligible individual" monthly amounts.

Transitioning from One Program to Another

Do participants in the Children's Home-Based Support Services Program transition automatically into the Adult Home-Based Support Services Program?

Yes, assuming they complete the necessary paperwork and continue to qualify.

Between the ages of 18 and 22, can participants choose which program to be in? What age is considered child and what is adult to get into program?

The waivers were written to deliberately provide a 4 year overlap between the children's and adult programs. The children's program starts at 3 and goes up to their 22nd birthday. Some individuals leave school at 18 – others continue to 22. The needs of the individual and their family may better be addressed in one program or the other. Though the programs are very similar, there are some differences. You should compare and contrast and choose for yourself. The programs were deliberately designed to provide flexibility to cover what is needed by a variety of people.

I understand that you cannot receive Division of Rehabilitative Services (DRS) Home Services at the same time you receive the Adult or Children’s Home-Based Support Services. Can a participant or family request services then discontinue DRS if found eligible for more services?

Yes, you can continue to receive DRS Home Services until you receive an award letter for either the Adult or Children’s Home-Based Support Services programs. The award letter will be contingent upon discontinuing the DRS Home Services Waiver.

Individual Service and Support Advocacy (ISSA)

What is ISSA?

ISSA stands for Individual Service and Support Advocacy. The purpose of ISSA is to make sure participants are getting the services they need and that their rights and safety are assured. The Feds feel there is a conflict of interest for participants to receive ISSA and Service Facilitation from the same organization. A good ISSA advocate also provides support to the Service Facilitator, the participant, and the family.

What agencies provide ISSA?

Independent Service Coordination Agencies provide Individual Service and Support Advocacy. ISSA is one of four important services that the State of Illinois contracts with Independent Service Coordination Agencies to provide. In total they are responsible for:

- Interviewing individuals and families for the “**Prioritization of Urgency of Need for Services**” (**PUNS**) database.
- Doing **Pre-Admission Screening (PAS)** for individuals and families to begin to receive services. In other words, they are the ones who put together and submit the “packets” of information needed for application for services.
- Performing **Individual Service and Support Advocacy (ISSA)** services described above.
- And providing **Case Coordination** by helping participants identify and access services once they have been “awarded” funding by the Division of Developmental Disabilities.

How do I link with an agency providing ISSA services?

Current participants in both the Adult and Children’s Home-Based Support Services Programs should already have an active relationship with the Independent Case Coordination Agency that is providing ISSA services in their area.

New participants in the program will already have a relationship with their Independent Case Coordination Agency as this is the same agency that helped them fill out their PUNS survey and apply for the Home-Based Support Services Program.

How often will I have contact with my ISSA agency?

ISSA agencies are supposed to make face-to-face contact with the participant four times a year. He or she is required to visit you at least once a year in your home. If the individual attends a day program, one visit must be at the day program location. The other visits may be in other settings. For instance, you may choose to get together where you work or have a Coke at McDonalds!

Is the ISSA role for children the same as adults?

Yes, the required quarterly visits and participation in the annual service plan are the major areas of responsibility.

Does the cost of ISSA come from the participant's monthly allotment as service facilitation does?

No. Agencies providing ISSA services get separate funding to do that.

Service Facilitation

What are Service Facilitators supposed to do?

Service Facilitators are the people who help participants and their families think about their dreams, strengths, challenges, and needs. They put together the service plan with the assistance of the family and the individual. They also assist participants and families in gaining access to needed services (medical, social, educational, and others). They oversee the day to day implementation of the service plan to ensure the participant's health, safety, and welfare.

Does the Service Facilitator have to be a Medicaid provider or is the agency he or she works for billed?

The individual Service Facilitator does not have to be enrolled as a Medicaid provider. The organization the Service Facilitator works for MUST be enrolled as a Medicaid waiver provider. Remember that Service Facilitators must be qualified as QMRPs (Qualified Mental Retardation Professionals).

Can the Service Facilitator bill for two hours of service each month even if they do not do two hours of work?

The Office of Developmental Disabilities says that you must reserve funding for two hours a month of service facilitation. Service Facilitators are not required to bill for two hours of service. In fact, if they do not perform two hours of work they cannot bill for it.

If you believe you are being billed for hours of service facilitation you are not receiving, you should talk to your facilitator about it. You may also share your concerns with your ISSA agency or Office of DD staff.

REMEMBER THAT SERVICE FACILITATORS DO A LOT OF WORK THAT IS INVISIBLE TO YOU. Paperwork is not fun or quick and is considered billable time.

Individual Service Plans (ISPs) take a lot more hours to prepare or update than the two hour minimum allowance.

The two hours are only a MINIMUM. If more hours are needed, they can be billed. But, they must first be approved by the individual/family in writing and a new service agreement must be developed.

If I am unhappy with my Service Facilitator, can I choose a different one?

Yes! A complete list of Service Facilitators is available on the FSN homepage at <http://www.familysupportnetwork.org/Service%20Facilitators%20by%20County.htm>.

Your ISSA advocate can help you make the change. **Make sure you notify all parties about the switch and be clear about the effective date.**

What is the Division of Developmental Disabilities doing to encourage more service facilitation in underserved areas? This is especially difficult in some rural areas.

The State of Illinois must assure the Feds that all services (including service facilitation) are available everywhere. If there is a problem identifying a Service Facilitator in your area, you should communicate that need clearly through your ISSA advocate, through your DHS Network Facilitator, at the DHS DD Statewide Advisory Council, and/or in writing to Lilia Teninty, the Director of the Division of Developmental Disabilities.

The first practical step is to contact your ISSA advocate who will be able to help you think about which Service Facilitators in your area will be a good fit for you and your family. Remember that we are in a moment of extraordinary growth. It is our (the FSN's) hope and belief that more service facilitation will be developing all over the state as the programs grow.

If Service Facilitation could be done outside of an agency, how would that work?

Service Facilitation cannot be done outside an agency. Service Facilitators must work for an agency that has a contract with the Illinois Department of Human Services. They must also meet the requirements of a QMRP (Qualified Mental Retardation Professional).

It is possible, of course, to create an agency made up of only Service Facilitators. That has not happened yet. But it could be an exciting development and could be researched with DHS staff.

The Division of Developmental Disabilities dropped the accreditation requirements as of July 1, 2007.

Can a Service Facilitator also be a Personal Support Worker?

If a Service Facilitator wants outside employment, and is willing to accept the rate of pay the individual or family is offering, it is possible. However, they must find out what the policy is of the agency where they are employed before they begin any outside employment.

Can the Independent Case Coordinator providing ISSA services also be the Service Facilitator?

No. One of the roles of an ISSA advocate is to provide oversight to the participant's program (read more under the ISSA heading). ISSA is designed to provide a "check and balance" in the system.

The Service Plan

Who is responsible for writing service plans?

Creating a service plan is collaboration between the Service Facilitator, the person receiving services, family members as applicable, and other services providers as needed. The ISSA representative should also attend the annual service planning meeting.

The Service Facilitator is responsible for actually writing up and keeping the plan. He or she must "sign off" on it.

What has to be in the service plan?

The service plan should be as simple as possible and include what the individual and family believes are important. The service plan is important because it directs services.

It does not need to be a medical model and does not need to have measurable goals and objectives that families or participants need to count and track. However, some goals for the person's future must be included.

If our needs change each month, do we need to rewrite our service plan each time?

Try to write the service plan as flexibly as possible, anticipating as many needs as possible. However, the service plan must be consistent with the needs of the individual. The plan can be re-written or updated as often as you desire, or as needs change.

How often does the service plan need to be updated?

The service plan needs to be reviewed at least once a year. It can be revised as often as the family wants.

The Included Services

The following is a very brief overview. Remember to check the Provider Manual (www.familysupportnetwork.org or www.dd.illinois.gov) or with your Service Facilitator for more in-depth information

Individual Service and Support Advocacy (ISSA)

- Both Children's and Adults
- Provided by Independent Service Coordination Agency
- Covered OUTSIDE the monthly allotment
- Advocacy Assistance
- First level of quality assurance
- Participates in ISP development
- 4 visits a year either in home or day training or another natural setting – all face to face
- If an adult attends a day program, one visit must be at the day program location.
- 25 hours per fiscal year is state maximum
- Additional hours with prior approval

Service Facilitation

- Both Children's and Adults
- Helps create and coordinate the Individual Service Plan (ISP)
- Participants must reserve 2 hours a month
- Individual or family can agree to more hours
- 6 visits a year – all must be face to face
- For adults, 2 visits may be in a day program. The other visits are at the home.
- For children, all visits are in the home.

Personal Support Workers

- Both Children's and Adults
- Workers must be 18 or Older
- Paid directly by ACES\$
- Called "Personal Support Workers"
- Spouses of adults may not be workers
- Family members of adults may be workers
- Parents, stepparents, and spouses or other "legally responsible relatives" may not be paid workers for participants in the Children's Home-Based Support Services Program

Or You Can Hire an Agency to

- Provide direct support workers for you
- Find and hire the worker for you
- Train and supervise the worker for you
- AND pay the worker directly – No ACES\$!
- Your cost per hour may be higher

Behavior Intervention and Treatment

- Both Children's and Adults
- New rates – same for both
- 2 levels – based on qualifications
- Adult – 66 hours per year
- Children – no limit
- Therapists are enrolling with DHS now
- Therapist must become a Medicaid provider
- They can contact DHS at 217-557-6260 for more information

Unpaid Caregiver Counseling

- Both Children's and Adults
- Individual and group
- Accept Medicaid rate
- Go through DHS to be qualified – must show state license
- There are caps

Unpaid Caregiver Training

- Both Children's and Adults
- Tuition and Fees
- Does not include transportation, food, lodging
- Prior approval by Network Facilitator
- Provider has to accept Medicaid reimbursement

Temporary Assistance

- Adults Only
- Formerly known as Crisis Services
- Outside the monthly maximum
- Requires written prior approval
- For emergencies due to the absence or incapacity of the primary unpaid caregiver
- Up to \$2,000 a month for up to 2 months for additional personal support
- Unlimited reoccurrences per year

Special Recreation Associations – NEW!

- Has to accept Medicaid reimbursement
- Staff has to be trained
- Have to bill in hourly increments
- Can provide personal supports
- Can also choose to provide developmental training – big certification process
- No approved providers yet (Oct. 2009)
- <http://www.il-ipra.org/forms/2006ITRServicesDivision.pdf>

Developmental Training

- Adults Only
- 1,100 hours is the limit per year
- 92 hours per month is average over 12 months
- 115 hours is limit per month
- \$10.39 per hour is rate
- Transportation is included and cannot be billed outside this rate

Non-Medical Transportation

- Adults Only
- Cannot be used for developmental training which includes transportation
- Cannot be used for transportation covered by medical card (Dr's, therapies, x-ray, etc)
- .37/mile – capped at \$500/month
- Service Facilitator has to sign off

Nursing for Adults

- Adults Only
- Within monthly maximum
- Services:
- Skilled Nursing – RN
- Skilled Nursing – LN

Fiscal year maximums apply (see manual)

Emergency Home Response

- Adults Only
- Electronic device to call for help
- For folks who can live independently
- Monthly fee which is paid through your service plan
- One time installation fee monthly fee
- Division of DD matches the Dept. on Aging rates and uses their certified providers.

\$15,000 over Five Years Funding

- Both Children's and Adults
- Outside the Monthly Allotment
 - Assistive Technology
 - Adaptive Equipment
 - Vehicle Modifications
 - Home Accessibility Modifications
- Must have prior approval
- Work with your Service Facilitator

Out of Home Respite

- Both children and adults
- Outside the monthly maximum (89D)
- Effective immediately, Home-Based participants may receive Out-of-Home Respite

Also for Adults only!

- Regular Work/Sheltered Employment
- Supported Employment –SEP *
- Adult Day Care *
- Temporary Intensive Staffing *
- * These require prior approval

Therapies for Adults

- Adults only
- Within monthly maximum
 - Occupational Therapy
 - Physical Therapy
 - Speech Therapy
- Written prior approval
- Fiscal year maximums apply

Questions from Service Facilitators

What does the Service Facilitator need to document on behalf of the individual and his service plan, including his goals, objectives, needs, and dreams?

The provider manual provides guidance on the role of the Service Facilitator. There is not a specific rule about how service facilitation is done.

Service Facilitation is really similar to how all QMRPs oversee the services being provided in other waiver programs (such as DT and CILA) funded by the DD waivers. The process and documentation requirements are all similar. The service plan outlines the services being provided to the individual and the need for those services as well as individual preferences.

Periodic visits are designed to monitor/ensure the services are being delivered and that they continue to meet the needs. Progress notes are the best way to document visits and other important events over time. Progress notes should reflect progress made (on the goals in the ISP) or lack of progress and any revisions made. The service plan is updated as needed but at least annually.

What does the Service Facilitator need to document in order to bill for the time he or she spends working for the participant?

The Service Facilitator needs to document their activity in a way that ties their work to the specific time it was performed. If the Service Facilitator agency bills one hour on the 12th of the month, there should be some record of what case activity took place that day. This could be a phone log, a home visit, working on the service plan, its update or renewal, or collateral contacts on behalf of the individual (like locating potential new providers, mailing information, etc.). It could even be the monthly review of bills being submitted by the Service Facilitator on behalf of other providers.

A previous federal audit identified a lack of documentation for some service facilitation hours billed. DHS/DDD is concerned. Service Facilitators need to keep a daily log of their activities. For example, there shouldn't be any billing on a date that the Service Facilitator is absent from work or on vacation. Obviously no billable activity could have occurred on those dates.

Likewise it would be unusual to bill for more than 8 hours in a work day per worker, unless they made an evening visit and have documentation to support that. The hours billed must be accountable.

How much documentation is necessary for Personal Support Workers? There seems to be many variations.

DHS/DD tries not to dictate exactly how information is documented. For example, there is no form that is used for the ISP or for progress notes. They don't have an electronic case record (although some agencies might). For now there is a lot of room for individual variation in how information is documented. Some think that is a good thing.

There is no cookie cutter approach. Some Service Facilitators are using a detailed checklist every time they work with a participant and an end of the month summary. Others are only providing progress notes as discussed between participant, their family, and Service Facilitator.

One agency reports that it requires the PSW to complete a timesheet, and record progress towards goals in the service plan. This form is submitted monthly to the Service Facilitator who then records it in the agency's database.

Regarding Medicaid Spend Down and Form 2653, should we (Service Facilitators) be checking the box for the Home-Based Support Services Program?

Yes, this form is #9 in the attachments to the new Waiver Provider Manual. The instructions for the form are also provided. The form is old (1998) and confusing on the surface. It is technically not "our" form (DD).

For the Home-Based Support Services or Developmental Training services, Service Facilitators should check the second box, "Com Hab Services" (non-residential).

They can also check the third box, "In-Home", then "Waiver" and it won't matter. Both will have the same affect of putting the person in "spend down met" status.

What is the Service Facilitation rate? Does it ever change? How do we know? Do other rates go up at the same time?

While the total monthly allotment available for participants in the program changes every year with SSI, rates for most individual services billed against the monthly allotment increase as the Illinois General Assembly (the Illinois State Legislature) provides new funding for this and other programming.

A 2.5% increase for Service Facilitation and other services (such as DT) was effective Oct. 1, 2007. The information was sent to all agency Executive Directors. The rate increases were also published as legal notices in 28 newspapers statewide as required by law.

The rate sheet has also been posted on the FSN website at www.familysupportnetwork.org.

This may seem a little confusing. It will make more sense if you understand that the Home-Based Support Services programs are the only ones that have a monthly cap. Other programs such as CILA and DT don't. Individuals are approved for specific services and providers are reimbursed for those at the rate approved by the legislature.

Hiring Personal Support Workers Directly

Who can be a Personal Support Worker?

- Spouses of adults may not be workers
- Family members of adults may be workers
- Parents (biological or adoptive) or guardians of children may not be workers
- Workers for both children and adults must be 18 or older.

Why can't a parent/guardian of a child be a Personal Support Worker?

Payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant.

Can a niece who is 22 years old and a college student in social work be a Personal Support Worker?

Yes, however, she must pass the criminal background and abuse/neglect registry checks.

Do Personal Support Workers need to be enrolled as Medicaid Providers?

Yes. This is part of the process of enrolling with ACES\$, the fiscal/employer agency (FEA).

How do I find good Personal Support Workers?

There are many strategies. Some provider agencies keep lists. Your Service Facilitator can help you find one. Also your Independent Service Coordination Agency may be able to help.

Often "Centers for Independent Living" can provide lists. They usually refer to these workers as "personal assistants" or "PA's". You can identify your closest Center for Independent Living on-line at <http://www.incil.org/locations.asp>.

A great reference and support tool is the "Direct Support Worker Manual" developed in 2006 by University of Illinois "Institute on Disability" with funding from Illinois Council on Developmental Disabilities. You can view it online on the homepage of the Family Support Network website at www.familysupportnetwork.org.

You can buy a copy (\$30) by contacting Katie Keiling at 312-996-1002 or kkeiling@uic.edu. The hard copy comes with a CD containing many forms and other materials that you will find very helpful.

Many participants and families have enjoyed great success exploring their connections in their own communities. Working with local colleges and universities has provided many families with great workers, especially if you reach out to students interested in pursuing degrees in the world of DD, such as speech, physical, or occupational therapies, social work, or special education.

How long does it take to get a new Personal Support Worker enrolled with ACES\$?

For a Personal Support Worker to begin employment there must be proof of no criminal background before ACES\$ can allow payment. This is a challenge for some people as background checks can take up to 2 weeks and if they need a PA to start working, they will not be able to pay them through their waiver funds until the background clears. ACES\$ cannot allow any back pay so someone would have to choose to wait up to 2 weeks to hire a PA or pay the PA out of their own pocket (which as we all know is usually not a viable option.) There are also many forms that must be completed and filed with ACES\$. If the enrollment packet is incomplete, there can be extra delays.

With the new “employer/employee” relationship, what type of additional liability is added to the “employer” when payments are late due to DHS/ACES\$/Comptroller issues?

Ultimately the liability does fall on the employer. However, since ACES\$ is under contract as a financial intermediary they do hold some responsibility. Unless the payroll is extremely late the employer is not required to pay the employee as long as an effort is being made to meet the pay date.

Asking an Agency to Provide Personal Support Workers

Can I ask my local DD Service Provider (or other organization) to hire and supervise my Personal Support Worker?

Of course! Many of you are doing that now. For many participants and their families that is a huge boon because the service provider will locate, supervise, and train the worker for you. You don't have to use ACES\$. The agency is responsible for background checks and paying your worker. Remember, however, they cannot provide all of these services for free and that will add to your cost per hour for that worker and use up your monthly allotment more quickly.

If an employee of an agency (respite worker, etc.) provides services, who gets the check; the person or the agency? Who is responsible for taxes on it?

The organization employing the worker receives reimbursement for the services provided by the agency. That organization is then responsible for paying the employee as well as their taxes, etc.

ACES\$

Who or What is ACES\$?

ACES\$ (Avenues to Consumer Employer Services & Support) is a “fiscal intermediary”. Fiscal Intermediaries are organizations that take on the responsibility of paying Personal Support Workers when a person with a disability or a family hires their Personal Support Workers directly.

The Feds demanded that Illinois use fiscal intermediary services for Personal Support Workers hired directly by the program participant or their families. They did it for a number of reasons including that Personal Support Workers need to pay taxes just like everybody else and that they have certain rights like Social Security, just like everybody else. The Fiscal Intermediary is also responsible for doing other work such as criminal background checks.

Illinois has hired ACES\$, an organization from Pennsylvania, to be the fiscal intermediary in Illinois. They are responsible for making sure all the appropriate paperwork is completed and writing the bi-monthly paychecks to workers based on their timesheets and Service Authorizations.

When do I have to use them?

The ONLY time that you will use ACES\$ is if you have hired Personal Support Workers DIRECTLY. That means that you found the worker, you negotiated their wages, you trained them, and you supervise them.

ACES\$ does not reimburse for any other services you may choose to use in the Home-Based Support Services Programs. The State reimburses directly for all other services.

Does ACES\$ have a website where I can learn more about them?

Yes! It is <http://www.acesfea.org>. Included on their website is their OWN Frequently Asked Questions document which is available for anyone to review without restrictions or prior registration. To access it, scroll down the NAVIGATION MENU on the left and click on the ACES\$ FAQ page. Or if you are reading this document electronically you can click on this link: [ACES\\$ FEA Frequently Asked Questions \(FAQ's\)](#)

How is ACES\$ reimbursed for their time, effort, and expenses? Is this cost taken out of our monthly allotment? They are a business, after all.

ACES\$ is paid a monthly fee per participant. That fee is paid separately by the Division of Developmental Disabilities and does not count against the individual's monthly allocation.

Can I hire Personal Support Workers directly and also have an agency provide workers?

Yes, participants can contract with an agency to hire, supervise, and pay workers and at the same time hire Personal Support Workers that they supervise directly and pay through ACES\$.

How can I contact them?

<http://www.acessefa.org/>

Springfield Office

830 South Spring Street
Springfield, IL 62704

Toll Free Phone: 877-223-7781

Toll Free Fax: 877-808-7014

Local Phone: 217-528-7046

Local Fax Line: 217-528-9849

Craig Morrison

Project Director

Cell: 217-381-9010

Ext. 3005

cmorrison@acessefa.org

Brad Robinson

Enrollment Agent

Ext. 3000

brobinson@acessefa.org

Stacey Cory

Customer Service Supervisor

Ext. 3002

scory@acessefa.org

Haydee Padilla

Customer Service Representative

Ext. 3007

hpadilla@acessefa.org

Kneoca Roberson

Operator/Customer Svc. Rep.

Ext. 3008

kroberson@acessefa.org

Tinley Park Office

16750 South Oak Park Ave
Tinley Park, IL 60477

Toll Free Phone: 877-223-7781

Local Phone: 708-532-3319

Local Fax Line: 708-532-3631

Quintin Bradley

Associate Project Director

Cell: 312-513-3001

Ext. 4005

qbradley@acessefa.org

Tamara Moore

Office Manager

Ext. 4000

tmoore@acessefa.org

Zach Blakemon

Operator/C.S.

Ext. 3001

zblakemon@acessefa.org

SCANNED timesheets with original

SIGNATURES can be e-mailed

[timesheets@ACES\\$fe.org](mailto:timesheets@ACES$fe.org)

This contact information is accurate as of
September 2009.

How do I get started? How is ACES\$ made aware that a family needs a home visit to be enrolled?

When a new family is enrolled in the Home-Based Support Services Programs program, ACES\$ gets a copy of the award letter and sends the individual/family a letter offering their services. If the family is interested in hiring Personal Support Workers directly, ACES\$ will make a home visit to get all the paperwork completed.

This is generally done on a one-on-one basis. ACES\$ employs full-time enrollment agents, whose job it is to enroll new participants, explain services, and answer questions. They are BRAD ROBINSON at 877-223-7781 x 3000, and QUINTIN BRADLEY at 877-223-7781 x4005.

Individual/families can also either contact ACES\$ themselves (information above) or ask their Service Facilitator to help.

Who monitors monthly spending and billing?

Monthly billing oversight is still the job of the Service Facilitator. The Service Facilitator is responsible for helping the individual/family create a monthly budget based on the needs of the participant.

The amount of funding set aside (or authorized) in the budget to pay Personal Support Workers is communicated to ACES\$ and ACES\$ cannot pay over the amount specified on the service authorization form.

What if a worker works more hours than approved in the plan?

ACES\$ cannot alter a timesheet and cannot pay beyond the time in the plan/budget. Only list the hours approved in the plan on the time sheet or the timesheet will not be paid at all.

If you are paying personally for additional hours, they should be tracked on a separate timesheet.

What happens if you bill more than your ACES\$ authorization is for?

ACES\$ will not pay over your budgeted amount. ACES\$ cannot alter a timesheet. The employer will need to re-submit a corrected timesheet. We will contact them to let them know prior to payroll being run.

If I have more than one Personal Support Worker, do I have to have the individual number of hours for each exactly accurate in my budget? What happens if someone quits, gets sick, or we have to re-arrange hours for some other reason?

Ultimately ACES\$ will need a Service Authorization detailing the exact number of hours a Personal Support Worker works. However, as long as the cumulative budget is not exceeded, paychecks will not be delayed. A Personal Support Worker can interchange hours with another Personal Support Worker provided that they don't exceed the collective total, and they eventually provide ACES\$ with notification of the change. Re-arrangement of hours / budgets can be done at any time at the discretion of the participant/employer. Please note that Personal Support Worker hours are assigned on a monthly basis, therefore if a personal support worker's hours are affected one week due to illness, etc, those hours can be made up later in the month.

Are there any plans to expedite and or simplify turning in time sheets?

Time sheets are as simple as ACES\$ can figure out how to make them based on their needs.

What are the ways to submit timesheets?

You can fax them to 877-808-7014.

You can scan the timesheets and e-mail them to [timesheets@ACES\\$fea.org](mailto:timesheets@ACES$fea.org). The original time sheet MUST have an original signature. Set your messages up with auto receipt and you will have a record of when your timesheet was received.

Is there a way to track how many hours and dollars have been paid by ACES\$ to my Personal Support Workers?

ACES\$ has created online Budget Reporting System at www.acesfea.org where you can look up current billing information. To access this page, please visit ACES\$'s website at www.acesfea.org, and select "NEPA Reporting System" from the Navigation Menu. The site is up and running as of February 1, 2008.

The webpage allows participants to view their 'on-line account' which includes monthly summaries of total \$ amount authorized from Service Authorization and a list of every Personal Support Worker by name and their total # of hours and charges.

It will also include:

- A detailed list of the days and times submitted for each worker
- The hourly rates being paid each Personal Support Worker
- Confirmation of the date/time that timesheets were received.

The webpage is participant driven and will require the participant (or Service Facilitator with participant's consent) to complete an account registration.

The information on the web is updated nightly.

What's the deal with the Power of Attorney form?

The "Power of Attorney" form was demanded by the Illinois Department of Employment Securities. ACES\$ actively advocated on behalf of families not to have to use it. However, they were unsuccessful. The form is necessary to allow ACES\$ to file the State and Federal quarterly taxes on behalf of the "employer".

Brian Rubin has formatted a memo on this issue to families. Brian is an attorney and the father of a young man with Autism. He presents on a statewide level on writing trusts and wills for people with disabilities. We quote below from a memo he wrote in September of 2007. You can read his memo in its entirety on the web at [http://www.familysupportnetwork.org/ACES\\$.pdf](http://www.familysupportnetwork.org/ACES$.pdf).

"Families are now receiving requests to sign forms, including a Power of Attorney, allowing ACES\$ to act as the families' representative or agent as to Illinois Unemployment Tax. Complete them, sign them, and return them. You are simply authorizing ACES\$ to "take care of" the paper work for you. By analogy, I use "QuickBooks" for my law firm's payroll. I signed similar documents to have QuickBooks "take care of" my payroll tax filings. That's all those forms are doing.

Simply stated, the Power of Attorney ONLY gives ACES\$ permission or authority to file the required employment tax forms on your behalf. The Power of Attorney does NOT give ACES\$ any other powers involving or related in any manner to your life, or the life of your child.

Sincerely, Brian Rubin

What about taxes and other deductions?

The following response is from an e-mail the Family Support Network of Illinois sent to its distribution lists in September 2007. The entire e-mail is included with Brian Rubin's memo on our website at [http://www.familysupportnetwork.org/ACES\\$.pdf](http://www.familysupportnetwork.org/ACES$.pdf).

*"Many, many of you and others have expressed **extreme and understandable consternation over the issues of taxes** on direct support workers. Some taxes are just taxes that we all have to pay and come out of our "gross income". Some taxes are taxes that employers pay and that are typically "invisible" to the employee.*

I hate taxes. I think my family loses almost a third of its paychecks to taxes of one kind or another. But, then again, if it wasn't for taxes most of the supports and services we receive would simply not exist. That includes everything from SSI to the Home-Based Support Services Programs to our children's school programs. So we've got to pay them.

So let me characterize the issues as I've sorted them out.

Moving From Being Paid as "Contractual Workers"

First, it is VERY important to remember that the Feds DEMANDED that Illinois use a fiscal intermediary to pay direct care workers. Illinois does NOT have a choice.

In the past, the State of Illinois paid Personal Support Workers in the Adult Home-Based Support Services Program (HBSSP) directly. There were a lot of problems with that system including that it was not unusual for workers to wait a month or two or MORE to be paid. Direct care workers were considered "contractual". No deductions were made from their paychecks.

The State of Illinois sent the workers a form called a 1099 (instead of a W2) at the end of the year. The State also reported this income to the appropriate state and federal taxing bodies. Workers were then expected to pay all their federal and state income taxes, and ½ of Social Security and ½ of their Medicare. This could be especially hard as workers may not have saved enough from each check to pay these taxes, a nasty surprise. We all know that most of our Personal Support Workers live on a very tight budget.

Now that money is being taken from the worker's paycheck each month. It comes from THE EMPLOYEE'S gross income and is not an additional expense to the HBSSP participant's monthly allotment. If, for instance, you choose to pay a worker \$10 per hour, it's subtracted from the \$10 per hour. At the end of the year, when the employee files his tax return, depending on his circumstances, he may get a lot of that back or he may have to pay more in.

Now Personal Support Workers Are "Employees"

All employers have to make additional payments to the State and Feds on behalf of their employees so that they can participate in some key government programs. They are invisible to the employee but expensive to the employer. They include the other ½ of their Medicare payment, the other 1/12 of Social Security, and their Employee Unemployment Compensation Insurance.

This IS an additional expense that does come out of the Adult or Children's HBSSP participant's monthly allotment. There isn't much we can do about it. Law says that employees have a right to these programs. Do we as advocates really want to be saying that other people shouldn't be able to participate in these basic programs?

Developmental Training (DT)

How is the rate for developmental training developed?

The Developmental Training (DT) payment policy is hard to understand (and to explain).

DHS has an annual rate maximum for DT services which is currently \$11,427 per year. This annual amount is paid on an hourly basis for up to 1,100 hours per year @ \$10.39/hour. This works out to an average of 92 hours per month. Payment is capped at 115 hours per month.

Providers must agree to serve someone for the whole year even if their program is open more hours than could be covered by the rate policy. They can't serve the person for 9 months, bill out the entire annual amount in the 9 months and then refuse to continue to provide services for the remaining 3 months of the state fiscal year.

If the State had to pay for more total hours then they would reduce the hourly rate so that the same annual dollars are paid out. The State has a fixed annual amount of funding to pay for DT services.

Historically, the State has allowed agencies to bill for 12 months of Developmental Training services in the first 10 months of the year. Don't even try to understand.

If you or your family member is enrolled in Developmental Training be sure to work with the provider agency to make sure they divide the annual amount by 12 and only bill that amount each month. Otherwise you'll have fewer dollars to spend on other services the first 10 months of the year (July through April) and an unusually high amount to spend in May and June. (The State's Fiscal Year runs from July 1 to June 30)

Can a developmental training (DT) program charge an extra fee for a lunch program? If so, can I pay for it through my Home-Based Support Services funding?

The Home-Based Support Services program cannot pay for food or lunches in this case. Meals are not included in the DT rate. However, the person can bring a sack lunch from home if they don't want to pay for the lunch the program provides.

Does the Developmental Training (DT) rate include the expense of transportation to and from Developmental Training?

Yes. But, of course, we know that the DT rate is low. Transportation is VERY expensive to provide, regardless of where you live. So providers of Developmental Training are put in a very difficult position. They cannot ask you to pay extra for transportation, either personally or through the Home-Based Support Services Program. Medicaid law says the provider must accept the rate as payment in full.

This is a real barrier to receiving services especially for people living in rural areas.

Using Your Medicaid State Plan Card

What is the difference between Medicaid, MediPlan, and All Kids?

MediPlan is just Illinois' name for Medicaid Insurance.

All Kids is Illinois' name for Medicaid Insurance for Children.

How do adults in the Home-Based Support Services Program receive Medicaid?

Remember that all adults must be eligible for Medicaid Insurance to be enrolled in the Adult Home-Based Support Services Program. So if they are in the Home-Based Support Services program, they have qualified for Medicaid Insurance.

Because adults are no longer legally financially dependent on their parents, only their income is counted in qualifying them for medical benefits such as Medicaid. Therefore family income and assets are not an issue.

Do children in the Home-Based Support Services Program receive Medicaid Insurance?

Yes, through the "All Kids" Medicaid Insurance program.

The Division of Developmental Disabilities was successful in getting the State to waive the parent's income to determine eligibility. In other words, the family's income does not count!

Once a child has received an "Award Letter" enrolling him or her in the Children's Home-Based Support Services Program, the Independent Case Coordination agency will assist the family with this process.

Only the child with the disability will be enrolled in "All Kids".

A family does not have to be in the Children's Waiver Program in order to apply for "All Kids". However, the parent's income will not be waived unless the child is part of the Children's Waiver Program/Children's Home-Based Support Services Program.

How do we integrate our private insurance with Medicaid?

Private insurance and Medicaid often complement each other providing the adult or child with a disability a broad spectrum of services. Private insurance is accepted by far more doctors and therapists than Medicaid. On the other hand, Medicaid often pays for services, treatments, and items that private insurance does not. Having both can be a very good circumstance.

Private insurance is always the primary payer. Medicaid is secondary.

Medicaid can, however, pick up part of the bill IF the amount paid by the primary carrier is LESS than the Medicaid rate. That rarely happens, but it can.

Medicaid is only primary if it is the only coverage a person has. If someone has Medicare and Medicaid, Medicare comes first.

The Arc of Illinois' Family to Family Health Care Information and Training Center is an excellent resource to help you understand either your private insurance or Medicaid. They can be reached at (866) 931-1110 which is toll free.

Finding Doctors and Therapists

For assistance in locating a physician, clients or providers should contact the Illinois Health Connect Helpline at 1-877-912-1999. If a TTY is used, call 1-866-565-8577. The call is free.

Illinois Health Connect can help clients select a primary care physician, access services, find providers in their region, find providers who are handicap accessible, assist clients in getting disease management services, get help with any special needs and answer their questions.

The Illinois LifeSpan Project may also be very helpful. You can reach them at 800-588-7002 or online at www.illinoislifespan.org/.

Where can we get a current list of Doctors, Occupational Therapists, Physical Therapists, and Behavioral Therapists?

These professionals must be paid the state approved rate and bill as “Medicaid Providers”. The rate is lower than what most doctors and therapists typically charge. The State is also notoriously slow to pay. So many professionals do not accept Medicaid patients.

You can identify participating professionals by contacting the Medicaid Provider Participation Unit at 217-782-0538. They can identify doctors, therapists and other providers enrolled in Medicaid.

Several of the agencies receive a report every six months that lists enrolled providers by county and provider type. These include case managers for DRS, DCFS and DSCC.

Items

Medicaid can be a major resource for participants in the Home-Based Support Services program. It can provide many important items ranging from diapers to lifts to assistive technology. This means that your Home-Based Support Services monthly allotment can be used for other supports and services because purchases under the Medicaid Insurance Card do not count against it.

In other words, MediPlan and All Kids cover medically essential medical equipment and supplies. A physician’s order must be on file to receive these items from an enrolled medical equipment provider. The provider of the items will bill Medicaid for your items.

One mom reports that her son got his DynaVox paid for right away by having his physician write a letter saying he needed it to communicate with his doctors and/or in the emergency room.

Theoretically, you should be able to get just about whatever you need if you have a doctor’s prescription. In reality, we are not finding that to be true, especially if the need is something specific around the individual’s disability. Good examples include diapers that address a need specific to the individual and nutritional supplements that address a person’s allergies. Again, the Family to Family Health Information and Education Center (866-931-1110) can be of great help to you with this.

A list of “durable medical equipment” is available online at <http://www.hfs.illinois.gov/reimbursement/dme.html>.

Why are some meds denied under Medicaid? Our kids have more needs or require more meds and we couldn't get these meds through Medicaid.

The Medicaid program covers almost all prescription medications. However, some of these medications require prior approval before the Medicaid program will pay for them. The prescribing doctor or a pharmacy can request prior approval. All requests are reviewed for medical necessity by a registered pharmacist or physician.

Here is the link to the Health Family Services website regarding forms for prior approval and how to request it. <http://www.hfs.illinois.gov/pharmacy/prior.html>.

How do I get pharmacies to take a Medicaid card? Often when picking up prescriptions, the pharmacy says that Medicaid will not pay and bills my primary insurance. I'm still stuck with expensive co-pays.

The State of Illinois Medicaid program has a list of drugs for which they will pay. There are some brand name drugs that are not on the list. However the generic may be on the list. Your doctor needs to approve to receive the generic. Medicaid is always secondary to private insurance. Medicaid will only pay if there is no coverage. SOMETIMES you can get a special waiver to get the original drug. But, you must be able to prove medical necessity to have the original. Only three brand name overrides are allowed per year.

What do we do about medication not covered in the state plan?

Few drugs are excluded. However, speak to your physician and ask if another medication would be clinically appropriate for you.

Can MediPlan/All Kids be used for Autism diet/vitamin therapy and Kelation?

Medicaid has a special service called Early Periodic Screening Diagnostic and Treatment (EPSDT). These types of needs may fall in this category. The family would have to work directly with their pediatrician to see if these services could be covered.

If a private provider is billing Medicaid, what forms will they use and how can we get access to that form?

Medical providers need to contact the Provider Participation Unit (217-782-0538) in Springfield if they have questions about how to bill Medicaid.

Can families pay a co-pay out of pocket to keep a therapist or doctor that charges more than the Medicaid rate?

All Medicaid and Medicaid waiver providers must accept the State payment as payment in full for the services rendered. That is the State's agreement with them. That is the law.

Dental

The dental package is more comprehensive for children than for adults and includes preventive services. The attached chart depicts the services covered for children and adults and identifies those dental services requiring prior approval. Doral Dental of Illinois is the Department of Healthcare and Family Services' (HFS) Dental Program Administrator responsible for dental provider recruitment and enrollment, client and provider education on dental services, client referral and outreach, payment of dental claims to dentists and prior approval for dental services, as required.

Please see the Adjunctive General Services section on the attached comparison chart. General Anesthesia, sedation, nitrous oxide, conscious sedation and therapeutic drug injection are all covered dental services, but do require prior approval.

The Department of Healthcare and Family Services' (HFS) Dental Program Administrator is Doral Dental of Illinois. They are responsible for assisting HFS participants with accessing dental care. Doral's Customer Service Department can be reached, toll-free, at 1-888-286-2447 or 1-800-466- 7566.

Doral will assist participants who require anesthesia when having dental procedures completed in getting the approval that is needed.

We ask that individuals contact Doral if they are experiencing difficulties in accessing services; however, if they have concerns or complaints about the assistance receive from Doral, they can contact us. We have established a process with the HFS to expedite resolution of problems and complaints.

When individuals are working through these issues, it would be most helpful to:

- 1) Write down the names of the person contacted, the organization they represent, and the date and time of the conversation.
- 2) Make complaints or identify concerns directly to Doral. However, if there is a continuing problem, contact HFS' Bureau of Maternal and Child Health Promotion at 217-557-548. The HFS Dental Program is managed by that bureau.
- 3) When communicating with Doral or HFS on behalf of an HFS participant, it is helpful to have the participant's name, as enrolled with HFS; the participant's recipient number and the participant's date of birth. This information will be needed when talking with either Doral or HFS staff. Please do not send this information by e-mail as names, birth dates, and recipient numbers are protected health information.

HFS and Doral are always trying to recruit additional dentists to participate in the HFS Dental Program. If you know a dentist interested in learning more about the HFS Dental Program or enrolling to serve HFS participants, please have them contact Doral at 1-888-281-2076.

You can also access more information about Doral Dental at www.doralusa.com and Illinois client information at <http://www.doralusa.com/Members/MemberDocuments.aspx?state=IL>

Covered Dental Services Comparison for Children and Adults

	Children (< age 21)	Adults (> age 20)	Requires Prior Approval
Oral Exams (For children, limited to one every 12 months per dentist. For adults, limited to 1 st visit per dentist.)	X	X	
X-rays	X	X	
Preventive Services			
Prophylaxis – Cleanings (Once every 6 months)	X		
Topical Fluoride (Annual)	X		
Sealants	X		
Space Maintenance	X		Y
Restorative Services			
Amalgams	X	X	
Resins	X	X	
Crowns (For adults, limited to facial front teeth only.)	X	X	Y
Sedative Fillings	X	X	
Endodontic Services			
Pulpotomy	X		
Root Canals (For adults, limited to facial front teeth only.)	X	X	Y
Periodontal Services			
Gingivectomy	X		Y
Scaling and Root planning	X		Y
Removable Prosthodontic Services			
Complete Denture (upper and lower)	X	X	Y
Partial Denture (upper and lower)	X		Y
Denture Relines	X	X	Y
Maxillofacial Prosthetics	X	X	Y
Fixed Prosthetic Services			
Bridge	X		Y

Oral and Maxillofacial Services			
Extractions	X	X	
Surgical Extractions	X	X	Y
Alveoloplasty	X		Y
Orthodontic Services			
Orthodontia (Coverage limited to children meeting or exceeding a score of 42 from the Modified Salzmann Index)	X		Y
Adjunctive General Services			
General Anesthesia	X	X	Y
IV Sedation	X	X	Y
Nitrous Oxide	X	X	Y
Conscious Sedation	X	X	Y
Therapeutic Drug Injection	X	X	Y

Other Helpful Dental Links:

Children Up to age 21: http://www.hfs.illinois.gov/assets/012406dental_a.pdf

Adults over age 21: http://www.hfs.illinois.gov/assets/012406dental_b.pdf

Doral Office Reference Manual: http://www.hfs.illinois.gov/assets/010108_doral.pdf

HFS Dentists webpage: <http://www.hfs.illinois.gov/dentists/>

Behavioral Intervention Services

Do you have to have an individual service plan in place prior to hiring someone to oversee a behavior program such as Applied Behavior Analysis (ABA)?

Yes, you have to have a service plan and service agreements in place.

Does the Home-Base Support Services Program cover ABA Therapy conducted in the school setting?

No, DHS cannot pay for services conducted in the school setting. That is the responsibility of the school system. ABA can be paid for at home.

How do I find a Behavioral Therapist?

The website for the Behavior Analyst Certification board (http://www.bacb.com/consum_frame.html) has helpful information.

What is the process for paying a Board Certified Behavior Analyst who is overseeing a home applied behavioral analysis program?

The Board Certified Behavior Analyst needs to be in the service plan. He or she needs to agree to accept Medicaid reimbursement. The Service Facilitator must approve the service plan. Then the State Comptroller will pay the Behavior Analyst directly. The rate is determined by DHS and currently is \$77.86 per hour for Level I and \$62.28 per hour for Level II (January 2008). The therapist must enroll as a provider and meet certain qualifications. You can view the rate chart at <http://www.familysupportnetwork.org/2008%20DDD%20Community%20Rate%20Table.pdf>.

Why is there a limit of behavioral support hours for adults?

This may have been based on the utilization data, but DHS/DD is not aware of anyone who has used the max. If people think this limit is too low, they should send their request to their Network Facilitator and support the need.

Crisis Funding for Adults

Why are crisis services available only to adults?

The reasoning is that typically parents have to provide crisis care for their child whether their minor child has a disability or not. Adults however typically make their own arrangements, something a person with a disability probably cannot do.

The \$15,000 Over 5 Years Funding

How will I access needed modifications to my home or van now? What about assistive technology or adaptive equipment?

You have two resources available for funding these purchases now.

Your Medicaid State Plan Card will finance many of these expenses. You must try to access that first.

If your State Plan Card will not, then the Home-Based Support Services Programs should. You must work with your Service Facilitator and receive prior approval (see below).

The State of Illinois pays for items such as assistive technology, home modifications, and van modifications outside the monthly spending allotment. Participants have access to up to \$15,000 worth of equipment and modifications over a five-year period.

Is this funding available in any other programs?

Yes, the \$15,000 Over Five Years Funding is also available to people who are ONLY receiving funding for Developmental Training.

What are the tricks of the trade for getting funding under the \$15,000 over 5 years funding?

The form and the process can be found in the Provider Manual <http://www.familysupportnetwork.org/Waiver%20Provider%20Manual.pdf> .

Your Service Facilitator will fill out the request form with your input and sign off on it. George Bengel at 217-782-3398 is the Division of Developmental Disabilities person in charge of this process.

Your Network Facilitator should also be able to help.

Do you have to hire a professional (such as a carpenter) to do modifications for accessibility or can you do the modifications yourself and just receive reimbursement for materials?

This will need further investigation before we can answer accurately. Two bids are required, however.

Who completes the request form for the \$15,000 Over Five Years Funding if the participant only receives funding for Developmental Training?

When the only service the adult is receiving is Developmental Training (DT), the person who is responsible for their service plan is the QMRP at the DT program. They would assist the individual or family with the request for those additional items.

Are repair and maintenance on equipment covered?

Yes, but the state Medicaid plan must be checked as a source of payment first.

How do we find people for home adaptations and how do they get paid?

DHS/DD doesn't keep "lists of examples" of modifications that have been approved. Needs are very individualized, depending on their home/vehicle and the special needs of the participant. All they know is what other participants have requested.

One of the purposes of the Service Facilitator and ISSA home visits is to assess the needs of the individual and suggest things to address identified needs. The guidelines are in the provider manual. There must be at least two bids, the vendor or contractor must agree to enroll as a Medicaid Waiver provider and accept reimbursement from the State after the work is completed.

Are sensory equipment for children with Autism or materials used for ABA therapy available options in the \$15,000 Over Five Years Funding?

Anything that is considered approved adaptive equipment and that would be directly related to your child's needs should be eligible. We are still learning. Request it and support the request. Please, let the Family Support Network know your outcomes so we can learn with you.

If a child's disability contributes to health issues does the waiver cover making changes in the home to improve their health?

Not generally speaking, but if you have a significant need you can request an appeal if denied.

Can \$15,000 Over Five Years Funding be used for software, reading programs, or assistive technology?

It depends on the situation, the type of software, and the price of the software. In addition, we can't pay for anything for which Medicaid Insurance will pay. So sometimes DHS will require you to first request through Medicaid Insurance and get a denial.

If you use the Home-Based Support Services Programs to purchase durable medical equipment not covered by Medicaid, will it pay for replacement consumables (filters, batteries, etc.)?

We think so... We are learning, too.

Are computers and/or peripherals considered adaptive equipment?

At the current time, DHS/DD believes that only computers used for communication would fall under adaptive equipment. The funding would come out of the \$15,000 over 5 years.

(Not) Using Two Waiver Programs

Can a child receive services through this waiver while receiving services in another waiver program? Examples include the Division of Rehabilitative Services (DRS) Home Services Program, the Traumatic Brain Injury Waiver, and the Division of Specialized Care for Children Medically Fragile and Technology Dependent Waiver.

No, federal law says that an individual can participate in only one waiver program at a time. The State is working on how to develop and administer a plan to accommodate needed services for individuals whose needs cannot be met under the current funding parameters.

We are currently receiving funding for Personal Support Workers through the Office of Rehabilitation "Home Services Program". Can we hire our workers from that program after we transition to the Division of Developmental Disabilities "Home-Based Support Services Program"?

First, please note that the names for the two programs are very similar. Don't let that confuse you.

No, they are both waiver programs so you have to pick one or the other. You can learn more about that program at <http://www.dhs.state.il.us/page.aspx?item=29738>.

If you are currently using the DRS Home Services Program, the workers you are using can transition with you to the DD Home-Based Support Services Program. They need to do all the appropriate paperwork with ACES\$ as a new provider.

DRS is funding Vocational Rehabilitation Services for our adult child. Can he also receive funding from the Home-Based Support Services Program?

Yes, Vocational Rehabilitation Services are not waiver funded so will not impact receiving Home Based Services. You can receive both.

Funding for Services such as Community College, Horse Back and Music Therapies, Camp and Park District Programs

Many families would like to know how to pay for community college, recreation, Weight Watchers, park district programs, camps and other special programs for people with disabilities. What is the final word on all of these things?

Before the Adult Home-Based Support Services Program was “waiverized” in 2002, all of these things could be paid by the Home-Based Support Services Program. When the programs was “waiverized, the Feds said that that they would not reimburse for activities that were not “trackable”. In other words, if you paid up front for a Y membership, how would they know that you really attended? The same would be true for colleges and activities such as Weight Watchers and Jazzercise. The Feds want to be able to pay for “hours” of tracked service.

The Family Support Network thinks these are really important activities that allow people with disabilities to live truly integrated lives, gain skills, and build relationships in the community.

The FSN and other advocates have worked really hard on this over the last 6 years. The inclusion of Special Recreation in the new waiver was an important first step and a major victory. However, to date this has not worked out. Because of ongoing complications, no Special Recreation Associations have enrolled.

Now DHS/DD is experiencing some implementation problems. The problems are around provider standards and process for special recreation associations seeking to enroll as either personal support or developmental training providers. While DHS/DD is trying to work them out, it may have to become part of the new amendment process that DHS/DD is working on now. That may be time consuming. We don't know how long it might take.

Transportation

What is the scoop with transportation?

This question requires a three-part answer.

1. **Transportation to medical appointments** will be paid by your Medicaid Insurance. Your Service Facilitator should be able to help you with this. Or the participant and/or their family can contact their local DHS office to find out how to use Medicaid to pay for medical transportation. You can identify your local DHS office on the web at: <http://www.state.il.us/agency/dhs/locl.htm>.

The short answer is 'yes'. The mother can enroll with the DHS and be reimbursed for mileage. A more detailed answer follows.

An individual can enroll with DHS as a private auto provider to be reimbursed mileage for transporting a Medicaid participant to and from a source of Medicaid covered medical care. The private auto provider must obtain prior approval from First Transit, and after the transport is completed, bill the DHS for the service just like any other Medicaid-enrolled provider would do.

The information regarding provider enrollment is available on the Health & Family Services website at the following address: http://www.hfs.illinois.gov/assets/070106_tranhandbook.pdf

Or the individual can call the Department's Provider Participation Unit (PPU) at (217) 782-0538.

The application process can appear arduous at first glance because the Department uses the same application for all providers. Following is an unofficial 'private auto cheat sheet' that may be helpful.

First Transit
"A Non-Emergency Transportation Prior Approval Service"
1-877-725-0569

- The service is for transportation to and from medical appointments only,
- The family must be the person to call (or, those families who would have difficulty, a call could be made in the family's presence.),
- The Family must have an eligible Medicaid card and the Nine (9) digit number,
- **Family must be prepared with the following information:**
 1. Family Name
 2. The nine(9) digit Medicaid card #
 3. Name of Doctor or Medical Practitioner (i.e. PT, OT, SLP, SW, etc.)
 4. Address of Medical Office
 5. Phone Number of Medical Office
 6. Appointment Date
 7. Appointment Time
- **FIRST PHONE CALL:**
 1. First Transit Staff will call to verify that the family is eligible,
 2. The staff will provide three transport companies, at random,
 3. The Family contacts the transport companies to find transportation on the date and time of the appointment,
 4. The Family calls back First Transit staff to receive an approval number.
 5. The Family then calls the identified transport company back with the approval number and they arrange the ride.[It is helpful if the family arranges a time well in advance of the appointed time. The transit companies are typically running late.]

(Transportation is provided by First Transit for the following reasons:
Medical diagnostics, hospital admittance-non emergency, hospital discharge, medical appointments, such as PT/OT/SLP/Social Work/ etc.)

- **STANDING ORDER:**
 1. A Family can request a Standing Order Form, to receive approval to up to six(6) months for ongoing appointments. *In other words, families will not have to call five thousand times to make arrangements. They can receive approval for up to six months.*
 2. The Form must be completed, in full, by the medical treatment facility or the treating practitioner and faxed to First Transit. Fax#: 1-312-327-3854

Enrollment documents can be obtained via the HFS website at:
<http://www.hfs.illinois.gov/enrollment/> or by calling HFS Provider Participation Unit at (217) 782-0538.

Private Auto Providers only get \$.24 per loaded mile.

Here is the bare bones information needed to enroll a private auto provider.

HFS 2243 Provider Enrollment Application

Section A

1. Check **X** New Enrollment
2. Provider Type - **073**
3. Provider Name
4. Primary Office Address Street
5. City
6. County
7. State
8. Zip
9. Telephone
12. SSN or 13. FEIN

Section B

23. Category of Service - **055**

Section E

45. Name
46. Telephone
48. Street Address
49. City
50. State
51. Zip
52. SSN or FEIN

Section F

- Signature
- Date
- Printed Name of person signing

HFS 1413T Agreement for Participation for Transportation Providers

Whereas, (Legal Name an any DBA Name)

HFS Provider Number **At this point in time the new provider would not have this information they may leave it blank**

13. Print Name, SSN and % of Ownership (usually 100% in these cases)
15. Print Name, SSN and Position within Company

Provider Signature

Print Name of Signature Above

Date

W-9 Request for Taxpayer Identification Number and Certification

Name

Check appropriate box **X** (Normally Individual/Sole Proprietor)

Address

City, State and Zip Code

SSN **or** FEIN (not both)

Signature of U.S. person

Date

Must send copy of Vehicle Identification Number Card (VIN) from Secretary of State for the vehicle being used.

2. **Other transportation needs** such as to recreation can be paid for out of HBSS funding. There is no cap on mileage.

Families can enroll as Waiver providers of transportation but the mileage for any trips they submit must be "disability-related". An example would be if a mother takes her son with DD to a class at the park district or at the "Y". Even though the Home-Based Support Services Program can't pay for the class fee or the "Y", the transportation to the activity could be covered.

However, the Home-Based Support Services Programs cannot pay for trips to the grocery store or other routine chores we all must do.

3. The **one exception is transportation to developmental training programs**. The rate paid to the provider of developmental training includes transportation to and from the program.

Some providers have asked participants to pay more for transportation. The State says it will not pay again for a service for which it has already paid.

How do you get transportation paid in the Home-Based Support Services Program?

The transportation provider has to accept the Medicaid rate. This is available only in the adult program and must be part of the service plan. The provider of transportation is reimbursed at the end of the month just like any other service provider.

What can be done about the provider agencies' inability to provide transportation to day program services for rural families?

DHS/DD needs to know that because they are under the impression that this is not the case. They can't do anything about it if they don't know there is a problem. Contact your Network Facilitator.

Will HBS pay families for medical trips outside of the service area of Medicaid?

No. Medical trips are not covered under HBSS. However, Medicaid should pay.

Does the person with the disability need to actually be in the vehicle to claim for this service?

YES!!!!

Independent Service Coordination Agencies Providing Individual Service and Support Advocacy

Your local service coordination agency can also be identified online at
<http://www.dhs.state.il.us/page.aspx?module=12&officetype=3&county=>

<p>Access Services Northern Illinois 7399 Forest Hills Rd Loves Park, IL 61111 Phone: (815) 282-8824 TTY: (815) 282-8824 http://www.accessni.com</p>	<p>Counties: Boone, Bureau, Carroll, DeKalb, JoDaviess, LaSalle, Lee, Marshall, Ogle, Putnam, Stephenson, Whiteside, Winnebago</p>
<p>Central Illinois Service Access 101 Madigan Dr Lincoln, IL 62656 Phone: (217) 732-4731 TTY: (217) 732-4731 Fax: (217) 732-4870</p>	<p>Counties: Christian, Logan, Mason, McLean, Menard, Peoria, Sangamon, Tazewell, Woodford</p>
<p>Champaign County Regional Planning 1776 E Washington St Urbana, IL 61802 Phone: (217) 328-3313 TTY: (217) 328-3313</p>	<p>Counties: Champaign, Ford, Iroquois</p>
<p>Community Alternatives Unlimited 8765 W Higgins Rd, 3rd Floor Chicago, IL 60631 Phone: (773) 867-4000 TTY: (773) 867-4168 http://www.cau.org</p>	<p>City of Chicago: Northern Cook County, Chicago northside, Lake County</p>
<p>Community Service Options 6845 S Western Ave Chicago, IL 60636 Phone: (888) 276-4467 TTY: (773) 884-1002 Fax: (773) 838-9362 http://www.cso1.org</p>	<p>City of Chicago: Cook County, Chicago Southside</p>
<p>CSO/RIM - Rock Island/Mercer 3601 Morton Dr, Suite 1 East Moline, IL 61244 Phone: (309) 278-0020 TTY: (309) 278-0020</p>	<p>Mercer, Rock Island</p>
<p>DayOne Network, Inc. 1551 E. Fabyan Parkway Geneva, IL 60134 Phone: (630) 879-2277 Toll Free: (888) 282-0997 Fax: (630) 879-9098 http://www.dayonenetwork.org</p>	<p>Counties: Kane, Kendall</p>

<p>DD Services of Metro East 2900 Frank Scott Pkwy W, Suite 928 Belleville, IL 62223 Phone: (618) 236-7957 http://www.ddsme.org St. Clair Phone No: (618) 236-7957 Madison Phone No: (618) 656-9663</p>	<p>Counties: Madison, St. Clair</p>
<p>Great River Service Coordination 901 W Morton Ave, PO Box 369 Jacksonville, IL 62650 Phone: (217) 243-2330 Fax: (217) 243-3971</p>	<p>Counties: Calhoun, Greene, Jersey, Macoupin, Montgomery, Morgan, Scott</p>
<p>Livingston County Mental Health Board 310 E Torrance Ave, PO Box 504 Pontiac, IL 61764 Phone: (815) 844-7708</p>	<p>Counties: Livingston</p>
<p>Options & Advocacy McHenry County 365 Millennium Dr Crystal Lake, IL 60012 Phone: (815) 477-4720 Toll Free: (888) 376-8828 http://www.optionandadvocacy.org</p>	<p>Counties: McHenry</p>
<p>Pact Inc. 555 E Butterfield Rd Lombard, IL 60148 Phone: (630) 960-9700 http://www.pactinc.net/</p>	<p>Counties: DuPage</p>
<p>Prairieland Service Coordination 441 W Hay St Decatur, IL 62526 Phone: (217) 875-0800 Fax: (217) 875-0900</p>	<p>Counties: Clark, Coles, Cumberland, Dewitt, Douglas, Edgar, Effingham, Macon, Moultrie, Piatt, Shelby, Vermilion</p>
<p>Service Inc. 1740 McDonough St Joliet, IL 60436 Phone: (815) 741-0800 Fax: (815) 741-1678 Toll Free: (800) 244-8008</p>	<p>Counties: Grundy, Kankakee, Will</p>

<p>Southern Illinois Case Coordination 519 S Locust St, PO Box 588 Centralia, IL 62801 Phone: (618) 532-4300 TTY: (618) 532-4300 Toll Free: (800) 828-7422</p>	<p>Counties: Bond, Clay, Clinton, Crawford, Edwards, Fayette, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jasper, Jefferson, Johnson, Lawrence, Marion, Massac, Monroe, Perry, Pope, Pulaski, Randolph, Richland, Saline, Union, Wabash, Washington, Wayne, White, Williamson</p>
<p>Suburban Access Inc. 925 175th St Homewood, IL 60430 Phone: (708) 799-9190 TTY: (708) 799-9190 Toll Free: (800) 507-5057 http://www.suburban-access.org</p>	<p>Counties: Southern Cook County</p>
<p>Western Illinois Service Coordination 509 N Lafayette St, Suite 203 Macomb, IL 61455 Phone: (309) 833-1621 TTY: (800) 699-3672 Toll Free: (800) 699-3672 http://www.westernillinoiservicecoordination.org/</p>	<p>Counties: Fulton, Henderson, Henry, Knox, McDonough, Stark, Warren</p>
<p>West Central Service Coordination 957 W Washington St Pittsfield, IL 62363 Phone: (217) 285-5227 Toll Free: (888) 279-4812</p>	<p>Counties: Adams, Brown, Cass, Hancock, Pike, Schuyler</p>

MEMORANDUM

TO: Developmental Disabilities Service Providers
Pre-Admission Screening Providers
Statewide Advisory Council for Developmental Disabilities
Other Advocacy Organizations

FROM: Lilia Teninty, Director
Division of Developmental Disabilities

DATE: January 4, 2008

RE: Service Requests and Authorizations

The Department is pleased to announce the release of funds for services to persons with developmental disabilities made available through the Hospital Tax Revenues. With these funds, approximately 800 additional individuals will be served this fiscal year. The funds will be used to serve individuals who are enrolled in the Prioritization of Urgency of Need for Services (PUNS) database.

Along with the release of these funds, the Division of Developmental Disabilities has established new operating procedures whereby individuals will be selected from the PUNS database for these funds and for funds made available through vacancies that occur each month. Under these new procedures, once the names of individuals are selected, they will be shared with the appropriate Pre-Admission Screening (PAS) providers. The PAS providers will be instructed to complete all necessary eligibility assessments and, for those found eligible, assist the individuals (and providers, if applicable) in submitting the necessary service authorization requests.

The selection criteria addresses a variety of factors, including, but not limited to, urgency of need, length of time on the database, statewide geographic distribution, current living arrangements, caregiver situations, randomness, etc. The criteria, which were originally reviewed by the Statewide Advisory Council, will continually be re-evaluated as PUNS data is analyzed. We believe this new selection criteria and process will enhance our ability to ensure fair and equal access to services and facilitate the service authorization process.

In addition to the routine PUNS selection process, the Division will reserve a number of capacities each month to address the needs of individuals in immediately urgent situations. These capacities will be used for individuals whose situations are sudden and unpredictable, e.g., they are abused, neglected, or homeless. These individuals' needs will be recorded on PUNS as part of the authorization process. It is anticipated that ten capacities will be reserved each month for this specific purpose. If a capacity is not used for this purpose, it will be used for the routine selection. The adequacy of the reserve will continually be evaluated.

The Division will continue to process applications for individuals who have special funding allocations, i.e., individuals moving from State-Operated Developmental Centers (SODCs) and individuals transitioning from the Department of Children and Family Services (DCFS). These applications will be submitted and processed as they are now.

Attached are flow charts of the current and new processes. As we release the Hospital Tax funds and implement the new PUNS selection process, there are transition issues and time frames of which we wish to make everyone aware.

Transition Issues

Division network staff are in possession of authorization request packets that have been submitted by PAS and other providers. These packets have been determined to be in accordance with the current priority population criteria and are awaiting available funding. These packets will be funded as quickly as possible. The Hospital Tax revenues will be used to fund a mixture of requests from pending packets and from the PUNS database in general. Thus, many of the current packets will be accommodated through a portion of the Hospital Tax Revenues; the remaining packets will be funded as vacancies occur.

To facilitate a smooth transition to the new selection process, the Division will continue to accept packets from PAS providers for individuals who meet the current priority population criteria through January 31, 2008. For those who are determined by network staff to have met the eligibility and priority criteria, authorizations will be released as vacant capacities become available. More detailed information on the new process will be distributed to PAS agencies and others in early 2008.

Time Frames

Time frames for the transition to and implementation of the new process are as follows:

- ❑ By January 31, 2008, no longer accept request packets from PAS providers for individuals without the individuals having first been offered the opportunity to apply per selection through the PUNS database. Packets for those that are abused, neglected, or homeless, as well as packets for individuals transitioning from SODCs and DCFS, are the exception to this.
- ❑ By January 31, 2008, release authorizations for a portion of the current packets using Hospital Tax Revenues and current vacant capacities. (This work began in December.)
- ❑ By February 28, 2008, begin the new process and inform individuals selected from the PUNS database and their PAS providers of the opportunity to apply for services funded through the remaining Hospital Tax Revenues. Applications will be processed as submitted.
- ❑ As of March 1, 2008, routinely address requests through the new PUNS process using vacant capacities and any new funds made available through appropriations.
- ❑ By April 30, 2008, re-evaluate the number of capacities routinely available each month due to vacancies in light of the significant expansion. Modify the number of capacities used each month as appropriate.
- ❑ By June 30, 2008, process all remaining approved packets that are currently with network staff or that will be submitted to them by the end of January 2008. (The ability to meet this time frame will depend on the total number submitted by the end of January.)

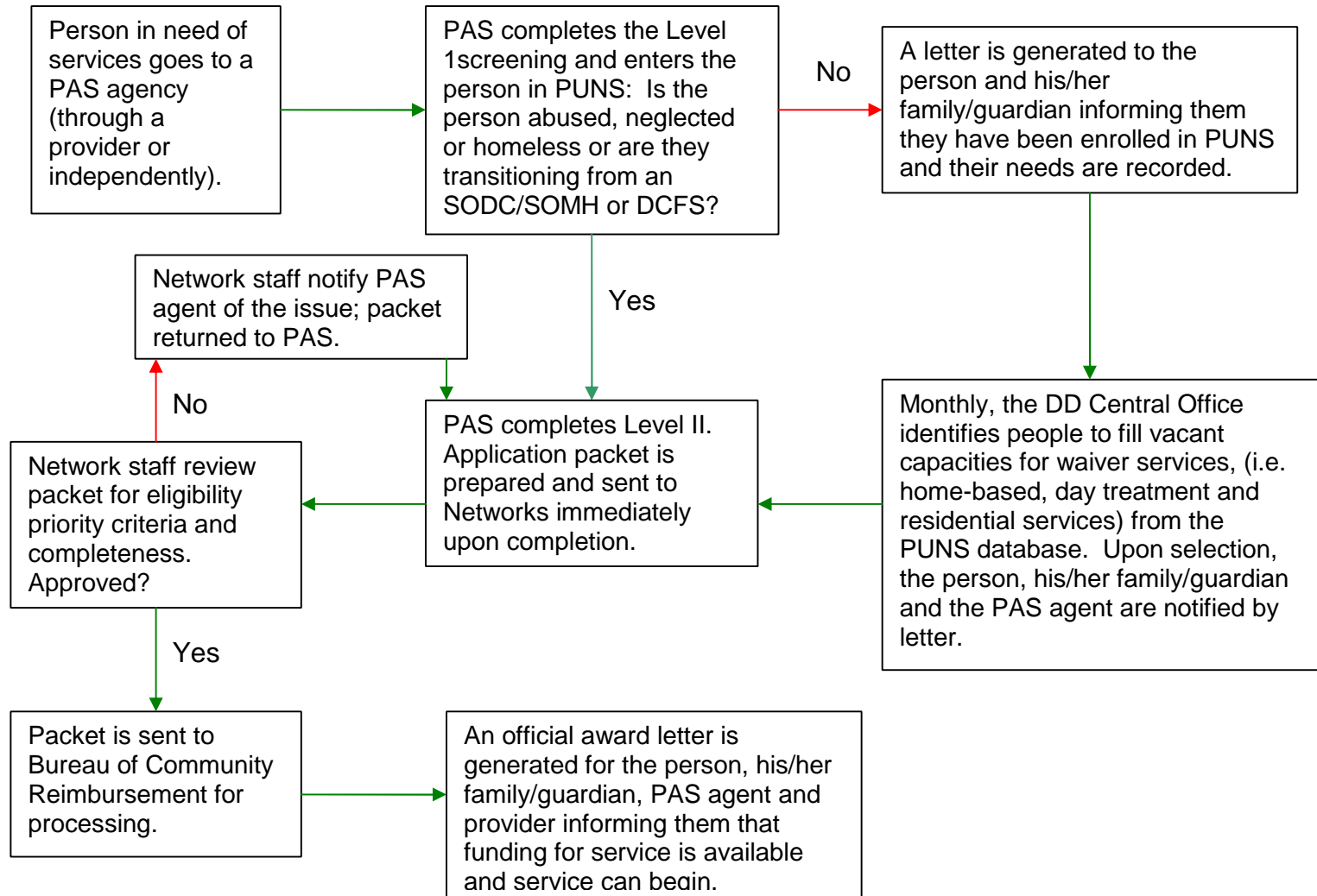
Thank you for your attention to these issues and your cooperation as we move to this new process. If you have any questions, please contact your network facilitator.

Attachments

cc: Grace Hou, Assistant Secretary
All Central Office DDD Staff

Division of Developmental Disabilities

New PUNS Selection Process for Waiver Services



Division of Developmental Disabilities Current Selection Process for Waiver Services

