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**What is a Medicaid Waiver?**

The Medicaid Waiver program began in 1981, in response to the national trend toward providing Home and Community-Based Services (HCBS). In the past, Medicaid paid only for institutionally based long term care services, such as nursing facilities and group homes.

Indiana applies for permission to offer Medicaid Waivers from the Centers’ for Medicare and Medicaid Services (CMS). The Medicaid Waivers make use of federal Medicaid funds (plus state matching funds) for Home and Community-Based Services (HCBS), as an alternative to institutional care, under the condition that the overall cost of supporting people in the home or community is no more than the institutional cost for those people.

The goals of Waiver services are to provide to the person meaningful and necessary services and supports, to respect the person's personal beliefs and customs, and to ensure that services are cost-effective. Specifically:

- **Waivers for individuals with a developmental disability assist a person to:**
  - Become integrated in the community where he/she lives and works
  - Develop social relationships in the person's home and work communities
  - Develop skills to make decisions about how and where the person wants to live
  - Be as independent as possible


**Developmental Disabilities (DD) Waiver**

This Waiver provides services that enable persons to remain in their homes or in community settings and assists transitions from institutions into community settings. This Waiver is designed to provide supports for persons to gain and maintain optimum levels of independence and community integration while allowing flexibility in the provision of those supports.

**Autism Waiver**

The Autism Waiver provides community supports and services to persons with Autism, including the Autism Spectrum Disorder, who meet eligibility requirements. The Waiver is designed to provide services for the person living with family, or in other community settings to assist him/her gain and maintain optimum levels of independence and community integration.

**Support Services Waiver**

The Support Services Waiver is designed to provide limited, non-residential supports to persons with developmental disabilities residing with their families, or in other settings with informal supports.
Who can receive waiver Services?

To receive a Medicaid DD, Autism, or Support Services waiver you must meet both the criteria for a developmental disability and ICF/MR level of care. The criteria for DD is defined in state law and means that a qualifying developmental disability is evident and that it was diagnosed by a medical doctor prior to age 22. ICF/MR Level of Care means that an individual qualifies as deficient in at three of the functional limitations designated in the Code of Federal Regulations.

How do I apply for a Medicaid Waiver?

Once it has been determined that an individual meets the criteria for a developmental disability, that individual will be placed on the appropriate waiver waiting lists. Once a waiver slot becomes available the individual will be offered a waiver placement.

What is the difference between Level of Care and Eligibility?

Individuals meeting the state criteria for a developmental disability and meeting the criteria for an ICF/MR level of care determination are eligible to receive waiver services.

The state criterion for developmental disability is as follows:

A mental and/or a physical impairment (other than a sole diagnosis of mental illness) that begins before the age of 22 and is expected to continue indefinitely. An individual must have substantial limitation in at least 3 of the following areas:

- Self care
- Learning
- Mobility
- Receptive and expressive communication
- Self-direction
- Capacity for independent living
- Economic Self-Sufficiency

The criterion for ICF/MR level of care determination is as follows:

A mental and/or a physical impairment (other than a sole diagnosis of mental illness) that begins before the age of 22 and is expected to continue indefinitely. An individual must have substantial limitation in at least 3 of the following areas:

- Self care
- Learning
- Mobility
- Receptive and expressive communication
- Self-direction
- Capacity for independent living
Why is there a waiting list?

Each year DDRS and the Office of Medicaid Planning and Policy receive a certain number of slots from the federal Centers for Medicaid and Medicare Services based upon the funds available. Unfortunately the demand for waiver slots outpaces the supply of waiver slots and a waiting list is created.

Individuals may be on multiple waiting lists at one time, which means an individual could be on the DD, Autism, and Support Services waiting list at the same time. DDRS continues to make every effort to reduce the size of the waiting list.

What is the Objective Based Allocation (OBA)?

The Objective Based Allocation (OBA) is the method used by the state to determine the level of supports an individual needs in order to live in a community setting. The OBA is determined by combining the Overall ALGO (determined by the ICAP and ICAP addendum), Age, Employment, and Living Arrangement.

For more information on the OBA please refer to training modules that were offered as guidance on the implementation of this new method.

What is an ICAP and ALGO Level?

The Inventory for Client and Agency Planning (ICAP) is one of the most widely used adaptive behavior assessment in the United States. In Indiana, the ICAP is used to assess individuals with developmental disabilities provides information about what type of a person may need for daily living.

The ICAP assessment determines an individual’s level of functioning for Broad Independence and General Maladaptive Factors. The ICAP Addendum, commonly referred to as the Behavior and Health Factors, determines an individual’s level of functioning on behavior and health factors.

These two assessments determine an individual’s overall ALGO level which can range from 0-6. ALGOs 0 & 6 are considered to be the outliers representing those who are the highest on both ends of the functioning spectrum.

The ALGO level is the overall level determined by combining the scores of the ICAP and ICAP Addendum (Health and Behavior Factors). The ALGO level is combined with Living Arrangement, and age to determine an individual’s OBA.

For more information on ICAPs and ALGOs please refer to training modules that were offered as guidance on the implementation of this new method.

What happens if I don’t spend all of my allocation?

An individual should only use the allocation amount they need for services. The allocation amount will not change unless there is a change in living arrangement or age, so the same allocation will be in place in subsequent years, regardless of the prior year’s spend.
How do I transition to a setting with housemates?

Because the ideal housemate arrangement is three-person, a transition plan may need to be in place for an individual.

The transition plan includes a six month window of funding to enable the individual and Team to find suitable living arrangements and housemates.

A case manager may request additional support during the search and move in of a housemate via BMR.

Can an OBA be appealed?

Yes, an OBA may be appealed.

The appeal process, which has not changed with the OBA, is located on the back pages of the NOA and is stated below:

The Right to Appeal and Have a Fair Hearing:

If your application or service is denied, you may file an appeal within 30 days of the decision date shown on this notice. The time limit for filing an appeal is extended by 2 days if this notice is received by mail. Your Home and Community Based Services (HCBS) benefits will continue if you file an appeal within the required time frame of the decision notice. If you appeal and your benefits are continued and you lose the appeal, you may be required to repay assistance paid in your behalf pending the release of the appeal hearing.

How to Request an Appeal:

1) If you wish to appeal this decision, you may request an appeal within 30 days of the date of this notice. The time limit for filing an appeal is extended by 3 days if this notice is received by mail. To file an appeal, please sign, date and return the Hearings & Appeals copy of this form to:
   Office of Hearings and Appeals
   MS 04
   402 W. Washington St. Room E-304
   Indianapolis, IN 46204
   If you are unable to sign, date, and return this form to the above mentioned address, you may have someone assist you in requesting the appeal.

2) You will be notified in writing by the Indiana Family and Social Services Administration, Hearings and Appeals office of the date, time, and location for the hearing. Prior to, or at the hearing, you have the right to examine the entire contents of your case record maintained by the Case Manager.

3) You may represent yourself at the hearing or you may authorize a person to represent you, such as an attorney, relative or other spokesperson. At the hearing you will have full opportunity to bring witnesses, establish all pertinent facts and circumstances, advance any arguments with interference and question, or refute any testimony or evidence presented.
What are Day Services and why are they important?

Services that happen during the day include a variety of therapies, employment and pre-employment services, community and facility habilitation and respite (for individuals residing with family). Day Services are considered to be part of a meaningful day and provide community integration and socialization to individuals.

What are the responsibilities of someone receiving BDDS services?

An individual has the following responsibilities when receiving waiver services:

- To participate in planning your services.
- To choose your providers for your services.
- To work on achieving your goals.
- To keep appointments.
- To inform your Service Coordinator about any changes that are pertinent to your participation in your program, such as changes in benefits or how you feel about your plan.

In addition, by agreeing to receive waiver services individuals are accepting Medicaid dollars and therefore accepting some additional responsibilities.

The primary factor in the Centers for Medicare & Medicaid Services (Federal agency) determining if a state can be approved to provide HCBS waiver services is the state’s commitment to assure participants’ health and welfare. Individuals and their guardians play a significant role in helping the state meet this assurance.

There will be times when a representative of the state will request information or will ask to visit individuals’ homes. These requests and visits are not meant to be intrusive but are necessary to assure that services are being delivered appropriately and whenever possible efforts will be made to schedule these visits in advance.

Specific responsibilities are outlines in the DDRS Policy for Individual and Guardian responsibilities.

What is a Group Home?

Supervised Group Living (SGL or Group Homes) is another residential option and alternative to waiver placements for eligible individuals with developmental/intellectual disabilities needing services. DDRS has homes licensed around the State serving almost 4,000 individuals.

Group homes fall into 9 different categories based on an individual’s level of need:

- Sheltered Living
- Intensive Training
- Child Rearing
- Child Rearing with Special Programs
- Basic Developmental
• Developmental Training
• Small Behavior Management Residence for Children
• Small Extensive Medical Needs
• Extensive Support Needs

The residences are governed by state and federal regulations and are monitored by the Indiana State Department of Health. For specific information reference 431 IAC 1.1.

How do I apply for a group home placement?

An individual should contact their local Bureau of Developmental Disabilities Services District Office. The District Offices can provide the application and provide assistance in finding additional services the individual may be eligible to receive.

What is a Residential Living Allowance (RLA)?

If the individual is receiving Residential Habilitation Services funded through a State Line or waiver budget and their living expenses exceed their benefits and income, they may be qualified to receive a monthly Residential Living Allowance (RLA) to cover the excess costs of room and board.

A RLA budget authorizes the funding of basic residential loving needs of an individual residing in his/her own home (outside of a parent or family home) and is used to support the remainder of an individual’s basic residential living expenses after applying his/her personal income and/or benefits. Additional guidelines can be found on the DDRS Policy page.

What is Voc Rehab?

Vocational Rehabilitation Services (VRS), a program of the Bureau of Rehabilitation Services (BRS), provides quality individualized services to enhance and support people with disabilities to prepare for, obtain or retain employment. Through active participation in their rehabilitation, people with disabilities achieve a greater level of independence in their work place and living environments. VRS Statewide Location Map. DDRS also encourages every individual who applies for BBDS servicers to apply for VRS services.

What is the Employment First Initiative?

Employment First Initiative is a partnership between Vocational Rehabilitation Services and BDDS to emphasize the importance of community integrated employment for individuals with developmental disabilities. Efforts are underway to engage individuals currently in service, on waitlists for services, and applying for services to connect them with VR Counselors in their areas.

Demonstration projects around the State are also being developed to strategize ways to bring greater attention to employment opportunities for individuals with developmental disabilities.