The Family Support Network Answers

Frequently **A**sked **Q**uestions

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

Updated May 2012

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 as they used the Children's or Adult's Home-Based Support Services Program.

This is an organic document. It was first written in 2007 and changes as more information becomes available or the need arises.

The original "Frequently Asked Questions Document" was based on the many questions we received during the "Dreaming New Dreams" Seminars" in the fall of 2007. We even threw answers to few questions you hadn't thought to ask.

We invite you to e-mail us with new questions, clarifications, or even to tell us we're wrong! This document is stronger with the combined voices of all in the DD community who work to support people with disabilities. Contact us with additional information and resources as you are inspired. Charlotte Cronin serves as our volunteer editor. Her e-mail address is charlottecronin@comcast.net.

Also, please note that there are many helpful documents on the Family Support Network webpage, including a link to the Waiver Manual provided by the Division of Developmental Disabilities. http://www.familysupportnetwork.org/helpful-resources/.

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 specific groups of people. 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, very bad budget years.

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, Family CILA, Intermittent 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 Developmental Training as a standalone service. It can be part of their CILA services. Or they may select it as part of their Adult Home-Based Support Services Program.
- **Supported Employment** – In this program an agency supports the individual with an evaluation, helps the individual find a job, and then provides a job coach. Some people receive a mixture of Developmental Training Services and Supported Employment.
- **Children's Home-Based Support Services Program** – This is a relatively new program which began 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 program also began 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.

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. Grant funded programs have suffered significant reductions in recent years as the State of Illinois has been buffeted by ongoing budget crises. Surviving programs often have long waiting lists.

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". They were created together by legislation passed in 1989 with the goal of creating seamless, flexible services across the life spans of individuals with disabilities.

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, 2012, that amount is $698.

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 March 2012 about 149 families are still enrolled. At its highest, enrollment in the Family Assistance Program 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. Families of minor children now have the opportunity to enroll in the Children's Home-Based Support Services Program *when funding becomes available*.

What about Adults with a Primary Diagnosis of Mental Illinois?

The original Adult Home-Based Support Services program was designed for people with developmental disabilities AND also for people with mental illness. Since 2002 when the Adult Home-Based Support Services program was "waiverized", there has been no new enrollment for adults whose primary diagnosis is mental illness. This is because the program approved by the Feds was only for people with developmental disabilities. Many people with mental illness who have been enrolled since before 2002 continue in the program. They do not have to live with the new federal rules and enjoy much more flexibility in how they use their funding. Questions regarding use of the program should be directed to Jan Thompson at DHS: jan.thompson@illinois.gov.

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 at http://www2.illinois.gov/dd/Pages/SignUp.aspx.

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.

Identify your local Independent Service Coordination agency online at http://www.dhs.state.il.us/page.aspx?module=12&officetype=&county=.

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 (708-331-7370), and/or the Illinois LifeSpan Project (800-588-7002).

The Application Process

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

The DHS Division of Developmental Disabilities (DHS/DD) 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/DD enters the criterion into the computer which randomly generates the names of people with disabilities who meet the criteria.

After names are selected, DHS/DD 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 are held open each month for immediately urgent situations such as **abuse, neglect, and homelessness**.

As this document is being edited in May of 2012, several hundred adults have had their names selected from the PUNS waiting list to satisfy terms of the Ligas Lawsuit Consent Decree. They have been receiving letters from DHS/DD inviting them to apply for either CILA or Home-Based Support Services. Learn more at http://www.dhs.state.il.us/page.aspx?item=40989, LIGAS Consent Decree: What It Means To You, or view an information video at http://www.roustaboutmedia.com/efe2011.html.

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. This is not a time to be your strong public self. This is a time to be brutally descriptive of the realities of your life and the life of your loved one.

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.

Again, a savvy applicant will be sure to review this evaluation for accuracy before the packet is sent in.

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 choose a "Fiscal Intermediary", either ACES$ or PPL. (See page 22).

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

Yes. As of April 2012, fourteen hundred (1,400) 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 seventeen thousand, six hundred (17,600) which includes Community Integrated Living Arrangements (CILA), the Adult Home-Based Support Services program (HBSSP), and Developmental Training (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 April 2012, PUNS indicated that over 34,790 people are enrolled in the PUNS. **Over 21,000 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.

It is impossible to know how many of those 21,000 are interested specifically in the Home-Based Support Services programs.

Eligibility

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

E**ligibility 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 developmental disability 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 Waiver 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 equals that year. Every year that amount changes to keep up with inflation. Starting January 1, 2012, SSI is $698 so the amount available is $1,396 per month.

In 2010, a change was made to the Children's Home-Based Support Services program, allowing participants to use up to TWO months funding in ONE month. This change was in recognition that a family's needs could change dramatically over the course of a year especially during the summer months.

It is VERY important to understand that a family CAN STILL ONLY use TWELVE months worth of funding in a calendar year. So careful budgeting must be used to ensure that a family doesn't run out of funding before the year is over. The Family Support Network has developed a "Budget Minder" to help families manage their funding. It can be found at http://www.familysupportnetwork.org/helpful-resources/. .

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, 2012, the individual has access to up to $1,396 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 2012, that amount is $2,094 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.

It is VERY important the process of applying for the Adult Home-Based Support Services program begin SEVERAL months before the individual's 22nd birthday to ensure a smooth transition.

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.

For participants in the Children's Home-Based Support Services Program ALL visits must be in the child's home.

For participants in the Adult Home-Based Support Services Program at least one visit a year is required to be in the participant's 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.

The Service Facilitator must “sign off” on the service plan. It is their responsibility to assure that the service plan is in the best interest of the person with a disability. The service plan cannot proceed without their signature.

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 QHIPs (Qualified Intellectual Disability 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 Service 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 Family Support Network homepage at http://www.familysupportnetwork.org/wp-content/uploads/2012/02/Statewide-Service-Facilitator-List-6.pdf. DHS/DD also has a list at http://www.dhs.state.il.us/page.aspx?item=57220.

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 Kevin Casey, 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.

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 QHIP (Qualified Intellectual Disability Professional).

Most Service Facilitators work for local agencies that provide other services to people with disabilities. However, there are now a very few agencies that provide only Service Facilitation.

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 person receiving services, family members, friends, the Service Facilitator, 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.

In other words, it is his or her responsibility to insure that the needs and safety of the individual are met. The plan cannot be implemented without their approval.

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. However, it does need to have measurable goals and objectives. 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 at http://www.dhs.state.il.us/OneNetLibrary/27896/documents/By_Division/Division%20of%20DD/Waiver%20Provider%20Manual.pdf) or with your Service Facilitator for more in-depth information.

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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 the chosen fiscal intermediary, either ACES$ or PPL
- 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$ or PPL!
- 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
- Therapist must a Medicaid provider

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

$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

Temporary Assistance

- Both Children's and Adults
- 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

- 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 (April 2012)

Developmental Training (DT)

- 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
- Temporary Intensive Staffing (Requires prior approval)
- Transportation is included and cannot be billed outside this rate

Supported Employment (Individual and Group)

- Adults only
- Requires prior approval
- 1100 hours is the limit per year
- 92 hours per month is the average over 12 months
- 115 hours is the limit per month
- Transportation is included and cannot be billed outside of this rate
- Waiver funding for SEP can be approved if federal Vocational Rehabilitation program funding is not available through the Division of Rehabilitation Services

Adult Day Care

- Adults Only Age 60 or Older
- Requires prior approval
- 1100 hours is the limit per year
- 92 hours per month is the average over 12 months
- 115 hours is the limit per month
- Transportation is included and cannot be billed outside of this rate
- Adult Day Care is designed for older adults who want to retire from a traditional DT or SEP program or for those who have a medical condition that prevents them from attending a vocationally-oriented day program services

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.

Out of Home Respite

- Both children and adults
- Outside the monthly maximum (89D)

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 QHIPs 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/DD 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 Waiver 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. This was the last rate increase. Your Service Facilitator should keep you informed as any future increases are announced.

Complete rate information can be found at http://www.dhs.state.il.us/page.aspx?item=38992.

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) of children (any individual who is legally responsible for the child) 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 all appropriate background checks. These are handled by the fiscal/employer agency that you have chosen, either ACES$ or PPL.

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

Yes. This is part of the process of enrolling your employee with your fiscal/employer agency.

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 "Find, Choose, and Keep Direct Support Professionals, A Toolkit for People with Disabilities and their Families" developed in 2006 by University of Illinois "Institute on Disability and Human Development" with funding from Illinois Council on Developmental Disabilities. You can view it online at http://rtc.umn.edu/ildspworkforce/.

You can buy a copy ($30) by contacting Katie Keiling Arnold 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 by reaching 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 the fiscal/employer agency (ACES$ of PPL)?

For a Personal Support Worker to begin employment they must pass a variety of background checks. These are handled by the fiscal/employer agency (either ACES$ or PPL). This can be a challenge as background checks can take up to 2 weeks. Neither ACES$ or PPL can 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$ or PPL. 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$ and PPL are under contract as a financial intermediaries 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. This has not been an issue to 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 a fiscal/employer agency such as ACES$ or PPL. The service provider 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 is paid by the state for the provided service. That organization is then responsible for paying the employee as well as their taxes, etc.

Fiscal Intermediaries - ACES$ and PPL

Who or What are ACES$ and PPL?

ACES$ (Avenues to Consumer Employer Services & Support) and PPL (Public Partners Limited) are "fiscal/employer agencies" (FEA's), sometimes referred to as "fiscal intermediaries". FEA's 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 (PSW's) directly.

The Feds demanded that Illinois use fiscal/employer agencies for Personal Support Workers that are 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 FEA is also responsible for doing other work such as criminal background checks.

Illinois has contracted with both ACES$ and PPL to provide FEA services 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.

You get to choose which organization you want to be your FEA.

When do I have to use them?

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

Neither PPL nor ACES$ 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.

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

They are both 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 are paid through ACES$ or PPL.

Do PPL or ACES$ have websites where I can learn more about them?

Yes! Here they are: www.acessfea.org or www.Publicpartnerships.com. More contact information follows.

Contact ACES$ at the following **http://www.acessfea.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
Illinois Project Director
Ext. 3005
cmorrison@acessfea.org

Billy Pace
Customer Service Supervisor
Ext. 3002
bpace@acessfea.org

Haydee Padilla
Background Specialist/
Bilingual Customer Service Representative
Ext. 3010
hpadilla@acessfea.org

Kneoca Roberson
Customer Service Representative
Ext. 3008
kroberson@acessfea.org

Kathleen Harris
Customer Service Representative
Ext. 3001
kharris@acessfea.org

Deanna Russell
Customer Service Representative
Ext. 3007
drussell@acessfea.org

Zachary Blakemon
Enrollment Agent
Ext. 3009
zblakemon@acessfea.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
Ext. 4005
qbradley@acessfea.org

Tamara Moore
Office Manager
Ext. 4000
tmoore@acessfea.org

Louis Harris
Enrollment Agent
Ext. 4008
lharris@acessfea.org

Fax timesheets to: 1-877-808-7014
Or e-mail to: timesheets@acessfea.org

Additional Enrollment Questions:
zblakeman@acessfea.org
lharris@acessfea.org

This contact information is accurate as of April 2012.

Contact PPL at the following: **www.Publicpartnerships.com**

Program Manager: Mark Altieri
617-336-2923
maltieri@pcgus.com

Customer Service and New Enrollment
Nathan Gomez
888-866-0582
Admin Fax: 866-826-7287

How do I get started? How are PPL and/or ACES$ made aware that a family needs a home visit to be enrolled?

For ACES$: When a new family is enrolled in the Home-Based Support Services Programs program, ACES$ and PPL get copies of the award letter and sends the individual/family letters offering their services. If the family is interested in hiring Personal Support Workers directly, ACES$ or PPL (depending on your choice) 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 Louis Harris at 877-223-7781 x 4008 (lharris@acessfea.org), and Zachary Blakemon at 877-223-7781 x 3009 (zblakemon@acessfea.org).

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

For PPL: Customer Service Specialist Nathan Gomez is the primary contact for newly enrolling individuals. Nathan can provide support on both the PPL enrollment materials, provider credentialing process, and provide online support with the PPL Web Portal. Nathan can be reached at 888-866-0582 (Ngomez@pcgus.com).

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 your chosen FEA. Neither organization can pay over the amount specified on the service authorization form.

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

Neither PPL nor ACES$ can alter a timesheet or 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 authorization is for?

Neither ACES$ or PPL will pay over your budgeted amount. They cannot alter a timesheet. The employer will need to re-submit a corrected timesheet.

ACES$ will contact you to let you know before payroll is run.

Illinois Participants enrolled with PPL are utilizing the PPL Web Portal for online timesheet submission 70% of the time. The PPL Web Portal will notify (in real time) the employee with a message indicating they are attempting to submit more hours than remain on the authorization. The other 30% are notified through outbound calls from CS representatives when the paper based timesheet is "tested" against the remaining authorization hours. Any hours submitted over the allocation will be placed in a Pending Journal in the PPL Ledgers in the event the more hours are authorized by the

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 the FEA 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 their fiscal intermediary 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.

What are the ways to submit timesheets?

For ACES$ timesheets may be faxed them to 877-808-7014.

OR timesheets may be scanned and e-mailed to timesheets@acessfea.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.

For PPL Employees may submit timesheets online (which will then require the participant to enter the Web Portal, verify the hours submitted and approve for payment – 70% of the current population).

The other methods are mailing or faxing a paper timesheet to the PPL offices in Chelsea, MA. The PPL Administrative Fax # is: 866-826-7287

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

ACES$ has created online Budget Reporting System at www.acessfea.org where you can look up current billing information. To access this page, please visit ACES$'s website at www.acessfea.org, and select "NEPA Reporting System" from the Navigation Menu.

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.

PPL Web Portal users have full access to their budgets including authorized, used and remaining hours. Through the budget module they can also retrieve information on PSW payments including name, hours worked, date worked, check no and amount.

PPL customer service representatives also have access to this information and can readily provide account status to employers and PSWs.

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

The "Power of Attorney" form was demanded by the Illinois Department of Employment Securities. The form is necessary to allow your FEA 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.

> *"Families are now receiving requests to sign forms, including a Power of Attorney, allowing ACES$ (and now PPL) 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*

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

As this is being updated (May 2012), the Illinois State Legislature is debating many changes to how Illinois will provide healthcare through Medicaid Insurance. A new "Integrated Care" model is being phased in across the state, starting with Cook County… but not Chicago… and the collar counties.

Additionally the Illinois State Legislature is considering major revisions to how and what it funds through Medicaid insurance. This is likely to dramatically affect many services provided by Medicaid Insurance.

Please stay abreast of changes by visiting the Illinois Family to Family Health Information and Training Center at www.familyvoicesillinois.org. Or you may contact the Illinois LifeSpan Program at www.illinoislifespan.org.

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. DHS also has a list at http://www.dhs.state.il.us/page.aspx?item=56772.

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 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.

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 1st 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

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

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?

Check out these websites:

- DHS/DD list of providers http://www.dhs.state.il.us/page.aspx?item=56772.
- Behavior Analyst Certification board (http://www.bacb.com/index.php?page=100155)

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.

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.

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 anyone enrolled in the Home and Community Based Waivers. So that includes folks who are enrolled the Adult and Children's Home-Based Support Services Programs, CILA services, Developmental Training, and Supported Employment.

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. The Service Facilitator is always the person responsible for requesting One-Time Funding through the Home-Based Programs. The ISSA must also review the request form, sign off, and then it is sent to the Network Facilitator at DHS/DD. It is a very lengthy and bureaucratic process.

George Bengel at 217-782-3398, George.Bengal@illinois.gov, is the Division of Developmental Disabilities person in charge of this process.

Who completes the request form for the $15,000 Over Five Years Funding if an individual is NOT enrolled in the Home-Based Support Services program but IS enrolled in Developmental Training or Supported Employment as a stand-alone service?

When the adult enrolled in Developmental Training (DT) or Supported Employment is NOT enrolled in the Home-Based Support Services program, they do not have a Service Facilitator. Their QIDP (Qualified Intellectual Disability Professional), generally an employee at the agency providing DT or Supported Employment, is the person responsible for their service plan. They will 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. Request it and support the request. Please, let the Family Support Network know your outcomes so we can learn with you.

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.

To date, May 2012, iPads and similar equipment have not been funded.

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.

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$ or PPL 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 inclusion of Special Recreation in the new waiver was an important first step and a major victory.

However, to date there no Special Recreation Associations have enrolled as providers of service. DHS/DD has demanded that workers at Special Recreation Associations have the same training as our local provider agencies. This does not fit the model of most Special Recreation Associations which depend heavily on students and volunteers.

Transportation

What is the scoop with transportation?

This question requires a three-part answer.

Part 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 Healthcare & 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.

Part 2: Transportation funded by the Home-Based Support Services Program:

Transportation needs such as to recreation can be paid for out of HBSS funding. There is a monthly cap of $500.

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.

Part 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!!!!

Division of Developmental Disabilities

PUNS Selection Process for Waiver Funded Services