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| LOCAL COMMISSIONERS MEMORANDUM |
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DSS-4037EL (Rev. 9/89)

Transmittal No: 96 LCM-73

Date: August 15, 1996

Division: Health and
Long Term Care

TO: Local District Commissioners

SUBJECT: Medicaid Model Waivers
CARE AT HOME I, II & V Program

ATTACHMENTS: Attachment 1- Care At Home I, II, and V
Enrollment and Freedom of Choice Waiver Application

Attachment 2-Care At Home I, II, III,IV & V Fact Sheet

The purpose of this release is to clarify for local social services districts eligibility criteria for enrollment in the Care At Home I, II and V Program. The information should be shared with the LDSS Care At Home Coordinator and Care At Home case management agencies providing services to children in your county.

The Federal government has disallowed from New York's Care At Home Program the use of "care received in an intermediate care facility for the developmentally disabled (ICF-DD) for at least 180 consecutive days" as eligibility criteria for the program. Therefore, any reference to this, as it appears in 86 ADM-4, is no longer applicable to the Care At Home Program.

The revised application form (Attachment 1) for the Care At Home Program which deletes reference to the 180 day rule associated with an intermediate care facility (ICF-DD) is attached. ALL applications to the Care At Home Program must include the 6/96 revised enrollment and freedom of choice form.

To be eligible for inclusion in the Care At Home I, II and V Program, an individual shall meet all the following requirements:

1. Under eighteen years of age;
2. Physically disabled, according to the SSI program criteria;
3. Hospitalized or receiving care in a skilled nursing facility for at least 30 consecutive days;

4. Require the level of care provided in a hospital or skilled nursing facility *;
5. Be capable of being cared for in the community when provided with waiver services in addition to all other services available under Medicaid;
6. Be ineligible for medical assistance in the community because the income and resources of responsible relatives would be deemed to them; and
7. Be capable of being cared for at no more cost in the community than in the appropriate institutional setting *.

(* It is necessary but NOT sufficient for admission to the Care At Home II Program to require frequent or prolonged device-based respiratory, nutritional, or other vital body-function support, with skilled nursing care for the medical disability.)

Attached for your information is a general fact sheet concerning the Care At Home Program, including III and IV administered by OMRDD.

If you have any questions, please contact the following individuals:

Colleen Maloney (AV3270) at 518-473-2345
Julie Elson (AX5670) at 518-474-2262

Martin J. Conroy
Acting Deputy Commissioner
Division of Health and long Term Care

MEDICAID MODEL WAIVERS CARE AT HOME I, II & V Program
APPLICATION FORM

The New York State Department of Social Services' CARE AT HOME I, II & V Programs, authorized by Section 1915(c) of the Social Security Act, are federal waiver programs that extend Medicaid eligibility to children with certain disabilities who have been in a hospital or in a skilled nursing facility (SNF) at least 30 days; are eighteen years of age or under; physically disabled, according to SSI program criteria; require the level of care provided in a hospital or skilled nursing facility; be capable of being cared for in the community when provided with waiver services in addition to all other services under Medicaid; be ineligible for medical assistance and be capable of being cared for at no more cost in the community than in the appropriate institutional setting.

It is necessary but NOT sufficient for admission to the Care At Home II Program to require frequent or prolonged device-based respiratory, nutritional, or other vital body-function support, with skilled nursing care for the medical disability.

The primary purpose of these waivers is to enable children who would otherwise remain in medical institutions to return to their own home and community by providing comprehensive case management and other Medicaid services.

{Print or Type}

1. Child's Name: _____

2. D.O.B.: _____

3. Diagnosis: _____

4. SS#: _____

5. Facility where child is/was a patient:

6. Date Admitted: _____

7. Discharge Date: _____

8. Receiving Medicaid while in facility { }YES { }NO

9. If Yes:
Medicaid Number: _____

10. Name of Parents:

11. Address to which child will be discharged:

Number, Street

City, State Zip Code

County

Telephone Number

12. I will assist in making any required assignment of health or accident insurance benefits. I will file any claims for health or accident insurance benefits to which my child is entitled.

13. _____
Parent Signature

14. _____
Date

Freedom of Choice Waiver

I, _____, am the parent of _____, who is or was a patient at _____. I understand that the _____ Department of Social Services has determined that my child is eligible for services under a federal waiver program authorized by section 1915(c) of the Social Security Act. I understand the availability to my child of case management and other Medicaid services offered by New York State. I have indicated, in the appropriate space below, my decision whether or not to bring my child home to receive these Medicaid services under this waiver program. My decision is voluntary and does not result from coercion or pressure exerted on me by the Department or by the medical institution where my child now resides.

_____ I have decided to bring my child home to receive Medicaid services under this waiver.

_____ I have decided not to bring my child home at this time. I understand that my decision not to bring my child home at this time does not affect my child's eligibility for Medicaid services in the medical institution where my child now resides. I also understand that I may later reapply for services under the program if I should change my mind.

{Parents Signature}

{Date}

{Witness}

NEW YORK STATE MEDICAID MODEL WAIVERS
(CARE AT HOME I,II,III IV and V)

There are currently five Medicaid Model Waivers operational in New York State, each with a capacity of 200.

<u>Program</u>	<u>Administering Agency</u>	<u>Monthly Medicaid Expenditure Cap</u>
Care at Home I (CAH I) and Care at Home V (CAH V) for skilled nursing facility level of care	NYSDSS	\$7,500
Care at Home II (CAH II) for hospital level care with technology dependence*	NYSDSS	\$14,500
Care at Home III (CAH III) and Care at Home IV (CAH IV) for ICF/MR level of care	OMRDD	\$9,000

*It is necessary but Not sufficient to require frequent or prolonged device-based respiratory, nutritional, or other vital body-function support, with skilled nursing care for the medical disability.

GENERAL ELIGIBILITY CRITERIA FOR ALL FOUR PROGRAMS

- . child is under 18 years of age
- . child is determined disabled according to standards in the Social Security Act
- . child is ineligible for Medicaid due to the parents' excess income and/or resources
- . child is Medicaid eligible when parents' income and/or resources are not counted
- . child can be cared for at home safely and at no greater cost than in the appropriate facility

CAH I, II and V institutional (hospital or skilled nursing facility) stay requirement of 30 consecutive days

CAH III request for institutional placement must be made in writing

CAH III and IV no institutional stay requirement

child must have a developmental disability

child must have complex health care needs**

**complex health care needs are defined as needs for medical therapies that are designed to replace or compensate for a vital body function or avert immediate threat to life; that is reliance on medical devices, nursing care, monitoring or prescribed medical therapy for the maintenance of life over a period expected to extend beyond 12 months.

CAH I, II and V State contact Ronita Heller 518-473-5840, DSS,OCP

CAH III and IV State contact Susan Grasso 518-474-5647, OMRDD,44 Holland Ave

Revised 6/30/96