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which they apply to be eligible for Medicaid. The need or desire for a Medicaid card only will not qualify an individual for eligibility.

Applicants for ElderChoices must be 65 years of age or older. Applications made by individuals who have not reached their 65<sup>th</sup> birthday will be screened for AAPD Waiver eligibility.

**26115**      **Eligibility Requirements**

**08-01-04**

ElderChoices and AAPD Waiver share most eligibility requirements. To be eligible for either Waiver program, an individual must meet both the non-medical and medical criteria listed below:

I.      **Non-Medical Criteria**

1.      Income - Gross income cannot exceed the current LTC income limit. (Re: SSI Chart at Appendix S). Income is determined and verified according to LTC guidelines (Re. MS 3340-3348). VA A&A and CME/UME will be disregarded as income for eligibility. The spousal rules for income do not apply to either AAPD or ElderChoices as the individual makes no contribution toward the cost of care.
2.      Resources - Total countable resources cannot exceed the current LTC limitations. Resources are determined and verified according to LTC guidelines (Re. MS 20400). The spousal rules for resources at MS 3337 - 3338.12 apply to ElderChoices applicants and recipients. However, these rules do not apply to AAPD Waiver cases.  
  
The transfer of resource provisions will apply. If assets have been transferred during the look back period, a period of ineligibility for Waiver services will be imposed for uncompensated value.
3.      Citizenship - It must be verified that the individual is a citizen of the United States or a lawfully admitted qualified alien (Re. MS 3324).
4.      Residency - The individual must be a resident of Arkansas (Re. MS 2200).
5.      Social Security Enumeration - The individual must meet the Social Security Enumeration requirement (Re. MS 1390).
6.      Cost Effectiveness - The average cost of services provided to individuals in the community must be less than the cost of services for those individuals if they were in an institution. This determination will be made by DAAS.
7.      ElderChoices Recipients must be age 65 or over. AAPD recipients must be age 21 through 64, and must be physically disabled according to SSI/SSA guidelines.

Each eligibility requirement, with the exception of cost effectiveness, will be verified and documented in the case record at initial certification. It may be assumed by DCO that an individual applying for the ElderChoices or AAPD Waiver program will meet the

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costeffectiveness criteria. If at any time DAAS determines that cost effectiveness is not met, DCO will be notified by DHS-3330 and the Waiver case will be closed.

NOTE: Medicaid only cannot be provided to an individual who is eligible for a Waiver program but who is not receiving (or will not receive) Waiver services. When certifying a Waiver case, it may be assumed that there are Waiver services available in the area where the individual lives and that the individual will receive a Waivered service within a month of certification.

It is the responsibility of DAAS to ensure that Waiver services are available. If at any time a Waiver recipient is not receiving a Waiver service, DAAS will notify the DHS county office via the DHS-3330 so the Waiver case can be closed.

II. MEDICAL CRITERIA (This Section is for DAAS use only.)

Intermediate Level of Care - Individuals must be classified as requiring an Intermediate Level of Care if in an institution, as determined by Utilization Review. Individuals classified as Skilled Care patients are not eligible for Medicaid in the ElderChoices or AAPD Waiver program. To be determined a functionally disabled individual, the individual must meet at least one of the following three criteria as determined by a licensed medical professional:

1. The individual is unable to perform either of the following:
  - (A) At least one (1) of the three (3) activities of daily living (ADL) of transferring/locomotion, eating or toileting without extensive assistance from or total dependence upon another person.
  - (B) At least two (2) of the three (3) activities of daily living (ADL) of transferring/locomotion, eating or toileting without limited assistance from another person.
2. The individual has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors which pose serious health or safety hazards to himself or others.
3. The individual has a diagnosed medical condition, which requires monitoring, or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life threatening.

No individual who is otherwise eligible for Waiver services shall have his or her eligibility denied or terminated solely as the result of a disqualifying episodic medical condition or disqualifying episodic change of medical condition which is temporary and expected to last no more than twenty-one (21) days. However, that individual shall not receive Waiver services or benefits when subject to a condition or change of condition which would render the individual ineligible if expected to last more than twenty-one (21) days. However, that individual shall not receive Waiver services or benefits when

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subject to a condition or change of condition which should render the individual ineligible if expected to last more than twenty-one (21) days. NOTE: If an individual requires a Skilled Level of Care as defined below, eligibility for ElderChoices or AAPD Waiver will be denied. Likewise, if an individual has a serious mental illness, except as specified in Section II (2) above, or has mental retardation, the individual will not be eligible for ElderChoices or AAPD Waiver. However, a diagnosis of severe mental illness or mental retardation will not bar eligibility for individuals having medical needs unrelated to the diagnosis of serious mental illness or mental retardation and meeting the criteria set out in Sections I and II above.

III. DEFINITIONS (This Section is for DAAS use only.)

EATING means the intake of nourishment and fluid, excluding tube feeding and total parenteral (outside the intestines) nutrition. This definition does not include meal preparation.

EXTENSIVE ASSISTANCE means that the individual would not be able to perform or complete the activity of daily living (ADL) without another person to aid in performing the complete task, by providing weight-bearing assistance.

LICENSED MEDICAL PROFESSIONAL means a licensed nurse, physician, physical therapist, or occupational therapist.

LIMITED ASSISTANCE means that the individual would not be able to perform or complete the activity of daily living (ADL) three or more times per week without another person to aid in performing the complete task by guiding or maneuvering the limbs of the individual or by other non-weight bearing assistance.

LOCOMOTION means the act of moving from one location to another, regardless of whether the movement is accomplished with aids or devices.

MENTAL RETARDATION means a level of retardation as described in the American Association on Mental Retardation's Manual on Classification on Mental Retardation. For further clarification, see 42 C.F.R. 483.100 - 102, Subpart C - Preadmission Screening and Annual Review of Mentally Ill and Mentally Retarded Individuals.

SERIOUS MENTAL ILLNESS OR DISORDER means schizophrenia, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; or other psychotic disorder. For further clarification, see 42 C.F.R. 483.100 - 102, Subpart C - Preadmission Screening and Annual Review of Mentally Ill and Mentally Retarded Individuals

SKILLED LEVEL OF CARE means the following services when delivered by licensed medical personnel in accordance with a medical care plan requiring a continuing assessment of needs and monitoring of response to plan of care; and such services are required on a 24 hour/day basis. The services must be reasonable and necessary to the treatment of the individual's illness or injury, i.e., be consistent with the nature and

severity of the individual's illness or injury, the individual's particular medical needs, accepted standards of medical practice, and in terms of duration and amount.

- Intermuscular or subcutaneous injections if the use of licensed medical professional personnel are necessary to teach an individual or the individual's caregiver the procedure.
- Intravenous injections and hypodermoclysis or intravenous feedings.
- Levin tubes and nasogastric tubes.
- Nasopharyngeal and tracheostomy aspiration.
- Application of dressings involving prescription medication and aseptic techniques.
- Treatment of Stage III or Stage IV decubitus ulcers or other widespread skin disorders which are in Stage III or Stage IV.
- Heat treatments which have been specifically ordered by a physician as a part of active treatment and which require observation by nurses to adequately evaluate the individual's progress.
- Initial phases of a regimen involving administration of medical gases.
- Rehabilitation procedures, including the related teaching and adaptive aspects of nursing/therapies, that are part of active treatment, to obtain a specific goal and not as maintenance of existing function.
- Ventilator care and maintenance.
- The insertion, removal and maintenance of gastrostomy feeding tubes.

SUBSTANTIAL SUPERVISION means the prompting, reminding or guidance of another person to perform the task.

TOILETING means the act of voiding of the individual's bowels or bladder, and includes the use of a toilet, commode, bedpan or urinal, transfers on and off a toilet, commode, bedpan or urinal, the cleansing of the individual after the act, changes of incontinence devices such as pads or diapers, management of ostomy or catheters and adjustment to clothing.

TOTAL DEPENDENCE means the individual needs another person to completely and totally perform the task for the individual.

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TRANSFERRING means the act of an individual in moving from one surface to another, and includes transfers to and from bed, wheelchairs, walkers and other locomotive aids, and ch

Applicants should be advised that if they accept services from Elder Choices or AAPD Waiver providers while their applications are pending and are subsequently denied for the program, they will be responsible for paying the provider.

The caseworker will have a maximum of 45 days from the date of application to dispose of the application. The caseworker should consider the 45-day time period to begin with the date of application. However, the ElderChoices RN or AAPD Counselor must have sufficient time to complete the in-home visit once the DHS-3330 is received. Section 26125 states "All applicants will be referred within 2 days of the office interview." When possible, the referral will be FAXED to the ElderChoices RN or AAPD Counselor to prevent any unnecessary delay. The ElderChoices RN or AAPD Counselor should receive the referral no later than the 20th day from the date of application. This should allow time for the in-home visit and the request for the physician's signature. Once the DHS-703 is signed by the physician, the application will remain pending until the DHS-704 is received.

NOTE: If the applicant's income is under the SSI/SPA, he/she may be referred to SSA to make a SSI application. However, ElderChoices or AAPD Waiver eligibility is not contingent upon SSI eligibility, and the eligibility determination will not be delayed pending a SSI determination.

**26125      Assessment Process**

**10-01-03**

All applicants will be referred within 2 days of the office interview via DHS-3330 to the ElderChoices RN or AAPD Counselor for coordination of the medical assessment. Utilization Review, via Form DHS-703, will determine if the applicant meets the Intermediate Level of Care requirements.

The assessment results will be routed by the DAAS Central Office staff to the ElderChoices RN or AAPD Counselor and to the county office via Form DHS-704.

If an individual meets the Intermediate Level of Care requirements, and if the individual is otherwise eligible, DAAS will work with the client, family, or other caregiver to ensure that the client receives services necessary to meet his/her needs according to the written Plan of Care.

The DHS RN is required to make 3 or 4 attempts to contact the applicant through telephone contacts and home visits within 14 working days of receiving the referral from the caseworker. The procedures below describe what happens when the RN fails to make contact:

- ◆ If the ElderChoices Nurse or AAPD Waiver Counselor cannot contact the applicant after several attempts, a DHS-3330 will be sent to the caseworker informing him/her of the failed attempts.
- ◆ The caseworker will then send a DCO-700, Notice of Action, to the applicant advising that the application will be denied if the applicant does not make contact with the Nurse or Counselor within 10 days. The caseworker will provide the name and telephone number of the Nurse or Counselor on the notice.

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- ◆ After 10 days, the caseworker will check with the ElderChoices RN or AAPD Counselor to see if the applicant made contact. If not, the application will be denied using reason "Other".

On pending applications, the caseworker will:

- ◆ Check the LTCU Screen within 30 days of application to determine if the DHS-703 has been completed.
- ◆ Contact the ElderChoices RN or AAPD Counselor if the LTCU Screen does not indicate the DHS-703 has been completed.
- ◆ Hold the application pending receipt of the DHS-704 if the DHS-703 has been completed and signed by the physician.

If the caseworker learns the medical assessment has been completed by the ElderChoices RN or AAPD Counselor and the DHS-703 is pending with the client's physician:

- ◆ A DCO-002 will be sent to the applicant stating "Your ElderChoices (or AAPD Waiver) Medicaid application will be denied unless your physician signs and returns the DHS-703, Evaluation of Need for Nursing Home Care, within the next 10 days. If your physician refuses or fails to sign the DHS-703, eligibility cannot be established. It is your responsibility to provide the required information to establish medical necessity."
- ◆ A copy of the DCO-002 will be FAXED to the ElderChoices RN or AAPD Counselor.
- ◆ The application will be denied at the end of the notice period if there is no indication that the DHS-703 has been signed by the client's physician.

If requested, the caseworker will assist in contacting the physician to explain the information needed. In addition, upon receipt of the copy of the DCO-002, the ElderChoices RN or AAPD Counselor will assist the client in securing the physician's signature on the DHS-703 if necessary.

If notified via DCO-002 that the application will be denied due to lack of medical information, it is ultimately the responsibility of the applicant to provide the required information, including securing their physician's signature on the DHS-703. As stated earlier, refusal or failure by the physician to sign the DHS-703 may result in denial.

If the caseworker learns the DHS-703 has not been completed by the ElderChoices RN or AAPD Counselor, the caseworker will:

- ◆ FAX a copy of the original DHS-3330 referring the client for ElderChoices or AAPD Waiver to the ElderChoices RN or AAPD Counselor, and indicate "SECOND REQUEST."
- ◆ FAX a second copy to DAAS, 682-8155, Attn: Program Administrator.

On the 35th day, the caseworker will again contact the ElderChoices RN or AAPD Counselor. If the medical assessment has not been completed, the caseworker will contact his/her Program

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Support Specialist. When possible, DAAS will take the necessary action to complete the medical assessment prior to the 35th day.

**26130      Applications from Nursing Facility Residents**

**04-01-03**

If the county is contacted regarding ElderChoices or AAPD Waiver for a Medicaid certified nursing facility resident who is classified Intermediate Level of Care the county will send a DHS-3330 to the ElderChoices RN or AAPD Counselor who will initiate an assessment as outlined in MS 26135 below.

When the RN or Counselor proceeds with the assessment process:

- ◆ A DHS-3330 will be sent to the county office, along with page 2 of the Plan of Care showing the recipient's election of Waiver services with signature.
- ◆ The signed election of Waiver services will serve as the application for Waiver services.
- ◆ It is not necessary to complete a DCO-777 unless it is time for the annual reevaluation of the LTC case.
- ◆ The ElderChoices or AAPD Waiver application must be registered.

NOTE: When accepting Page 2 of the Plan of Care as described in this section, the Plan of Care must include the client's signature, the election of community services and the date. The date must be later than the date of nursing home admission. The ElderChoices RN's or AAPD Counselor's signature and a physician's signature are not required on the Plan of Care when used for this purpose. The name of the ElderChoices RN or AAPD Counselor will be included on the DHS-3330.

If an ElderChoices or AAPD Waiver application is received from a non-Medicaid eligible nursing facility resident:

- ◆ The application must be registered.
- ◆ The application will not be routinely denied because the individual is institutionalized.
- ◆ The caseworker will send a DHS-3330 to the RN or Counselor who will initiate an assessment as described in MS 26135.

**26135      Assessment Process for Nursing Facility Residents**

**10-01-03**

When an ElderChoices RN or AAPD Counselor receives a referral on a nursing facility resident who elects ElderChoices or AAPD Waiver:

- ◆ The ElderChoices RN or AAPD Counselor will contact the individual to proceed with the assessment process to develop a Plan of Care.

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- ◆ A DHS-703 may not be completed if the individual was classified as Intermediate Level of Care within the preceding 6 months.
  - ◆ If 6 months or more have elapsed since the last determination of Level of Care, or if the ElderChoices RN or AAPD Counselor deems a new assessment to be appropriate, a new DHS-703 will be submitted to Utilization Review.

**26140      Residents of Residential Care Facilities      04-01-03**

If an individual living in a residential care facility (RCF) applies for Waiver services, the caseworker will explain to the applicant that, according to current LTC and RCF policy, he/she does not meet the required Level of Care to receive Waiver services, and the application will be denied.

**26145      Eligibility Determination      08-01-04**

Eligibility determinations for ElderChoices or AAPD Waiver cases will be conducted in the same manner as for AABD long term care cases.

The SSI related income and resource criteria located in the MSP 21000 section will be followed. SSI exclusions are not allowed from gross income in determining eligibility.

When determining an applicant's countable gross income when both spouses apply, each individual will be budgeted separately and his/her income will be compared to the current LTC limit. Only the income of the applicant will be considered for eligibility.

In determining resource eligibility, the current LTC resource limits will apply. A single applicant's resources will be compared to the one-person limit. When there is a married couple and both apply, their combined resources will be compared to the couple's resource limit. If only one individual of a couple applies for ElderChoices, the rules for spousal resources at MS 3337-3338.12 will apply. The DCO-710 will be used to compute the initial assessment. The spousal rules do not apply to AAPD. If only one member of a couple applies for AAPD, their combined resources will be compared to the couples resource limit.

**26150      No Contribution to the Cost of Care      04-01-03**

After the initial eligibility determination has been made, all income of the ElderChoices or AAPD Waiver recipient will be disregarded. Waiver recipients are not required to make a contribution to the cost of their care.

**26155      Approvals for New Applicants      10-01-03**

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This policy, and the process outlined in MS 26156 below that determines the waiver eligibility date, will apply to applicants entering Waiver programs from both the community and from institutions.

If there is a closed case number on file for the client, this number will be used to open the ElderChoices or AAPD Waiver case.

When certifying an eligible couple, each will be entered into the system using separate case numbers.

The gross income of an eligible individual will be entered in the appropriate fields in the system. The total gross income will also be entered as Protected Maintenance, since Waiver recipients will not contribute to the cost of services.

The county office will notify DAAS of certifications and denials via the DHS-3330 on the date the action is taken. The DHS-3330 may be mailed or FAXED to the ElderChoices RN or AAPD Counselor or placed in a designated location at the DHS county office for the ElderChoices RN or AAPD Counselor to collect. A copy of the DHS-3330 will be kept in the case record.

**26156 Provisional Plan of Care**

**10-01-03**

Based on information obtained during the in-home medical assessment, the ElderChoices nurse or Waiver Counselor will develop a provisional Plan of Care for those applicants recommended for medical approval. The provisional Plan of Care will include all Plan of Care information with the exception of the Medicaid number, diagnosis and physician's signature. The provisional Plan of Care will expire after 60 days. The expiration date will be entered on page 1 of the Plan of Care and will be calculated 60 days from the date the Plan of Care is signed by the ElderChoices nurse or AAPD Counselor and the applicant.

A signed copy of the provisional Plan of Care will be mailed to each provider included on the Plan of Care. The provider will have 10 working days to begin services and to notify the ElderChoices or Waiver Counselor via the AAS-9510 that services have started. The ElderChoices Nurse or AAPD Counselor will track the start of care dates. If at least one Waiver service begins within 30 days of the development of the provisional Plan of Care and the applicant is otherwise eligible, the Waiver eligibility date will be established retroactively effective the day the provisional Plan of Care was signed. If no Waiver services begin within 30 days of the development of the provisional Plan of Care, the effective date of service will be the date the approval is keyed into the system or the day a Waiver service started as verified by the ElderChoices RN or AAPD Counselor.

Eligibility beginning before the date the case is approved by the DCO caseworker can be established only when the ElderChoices RN or AAPD Waiver Counselor recommended the applicant for medical approval.

If an application is denied, a new provisional Plan of Care must be developed when a subsequent application is made. Regardless of the reason for the denial, and regardless of when a new Waiver application is made, a provisional Plan of Care will only be utilized on a current Waiver

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application

**26158 Optional Participation**

**10-01-03**

Neither Waiver providers nor Waiver applicants are required to begin or receive services prior to the establishment of Medicaid eligibility. If services are started based on the receipt of a provisional Plan of Care, it is the responsibility of each provider to explain the process and the financial liability to the applicant and/or family members prior to beginning services. The decision to begin services prior to eligibility must be a joint decision between the provider and the applicant.

**26157 Final Plan of Care**

**10-01-03**

Prior to the provisional Plan of Care expiration date, the ElderChoices RN or AAPD Counselor will mail the final Plan of Care, signed by the applicant's physician, to all providers included in the Plan of Care. If the Medicaid application has been approved, the final Plan of Care will include the Medicaid recipient's ID number, diagnosis, Waiver eligibility date and the Plan of Care expiration date. The new Plan of Care expiration date will be 365 days from the date the doctor signed the DHS-703 and/or AAS-9503, whichever is earlier. If the Medicaid application is still pending when not be included. Once the application is either approved or denied, a Plan of Care including the Medicaid ID number or an AAS-9511 giving the date of denial will be sent to

**26159 Denied Applications**

**10-01-03**

Denial reasons include, but are not limited to:

- ◆ Failure to obtain the physician's signature on the required ElderChoices or AAPD forms.
- ◆ Withdrawal of the application by the applicant.
- ◆ Ineligibility based on income or resources.
- ◆ Death of the applicant when no Waiver services were provided.

**NOTE:** If Waiver services were provided and the applicant dies prior to approval of the application, Waiver eligibility will begin the date services began and end the date of death if all other eligibility requirements are met.

If the caseworker denies the application for any reason, the ElderChoices Nurse or AAPD Waiver Counselor will be notified, and the Nurse or Counselor will immediately notify any providers of service via the AAS-9511.

When denying an ElderChoices or AAPD application because the applicant refuses to receive at least one service, is not in need of a service, or the service is not available in their area, denial code "Other", will be used. A manual notice will be sent, notifying the applicant of the denial.

If the ElderChoices or AAPD Waiver application is denied for any reason, and Waiver services were provided during the period of ineligibility, any charges incurred will be the financial responsibility of the applicant.

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If the ElderChoices or AAPD application is denied, the client has the right to appeal by filing for a Fair Hearing. If the individual wins the appeal, and has no unpaid ElderChoices or AAPD Waiver charges, Medicaid coverage will begin the date the appeal is won. However, the Waiver portion of the case will not be opened until the date the caseworker completes the case. If the individual has unpaid ElderChoices or AAPD Waiver charges, and services were authorized by the ElderChoices Nurse or AAPD Counselor, eligibility for both Medicaid and Waiver services will begin the date service began. However, under no circumstances will Waiver eligibility begin prior to the date of application on the DCO-777 or DCO-215, before the provisional Plan of Care is signed or before the date Waiver services began.

When the Office of Appeals and Hearings reverses an Agency decision that an individual did not meet medical necessity requirements, a new DHS-704 will not be issued. The final Agency decision will contain the determination of the Intermediate Level of Care. The Medicaid Begin Date will be the date of the hearing officer's decision and the Eligibility Start Date on the Waiver portion of the case will be the same as the Action Date. As no LVC Review Date will be given, the caseworker will enter a date 12 months after the date of the hearing officer's decision.

**26160      Approvals for Medicaid Recipients Who Leave LTC**

**10-01-03**

The ElderChoices or AAPD Waiver case may be certified when the county is notified by the nursing facility that the recipient has left the facility if all the following conditions are met:

- ◆ The county has received a DHS-3330 and Page 2 of the Plan of Care signed by the recipient.
- ◆ The system shows an Intermediate Level of Care.
- ◆ The Level of Care was entered into the system in the previous 6 months.
- ◆ There is a future Level of Care Review Date.

If the Intermediate Level of Care was entered by the county more than 6 months previously, or if the Level of Care Review Date has expired, the Waiver case may not be certified until the county receives a new DCO-704 verifying Intermediate Level of Care status.

To certify the ElderChoices or AAPD Waiver case, close the LTC vendor portion of the case, but do NOT close Medicaid. The day after closure of the vendor portion of the case, the Waiver portion of the case may be opened.

To clear the pending application screen when approving Non-SSI recipients, counties will need to call the Systems Unit (682-1530) for assistance in clearing the register as an approval.

When approving SSI recipients, first key the Waiver portion of the case, and then the Medicaid portion.

When opening a case in which the Intermediate Level of Care was entered less than six months previously and there is no Level of Care Review Date in the system, show the Level of Care Decision Date and the Eligibility Begin Date as the first day of ElderChoices or AAPD Waiver eligibility. The Level of Care Review Date will be 12 months from the original Level of Care Decision Date.

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If there is a future Level of Care Review Date when closing the LTC case, use that Level of Care Review Date when opening the Waiver case, again showing the Level of Care Decision Date and the Eligibility Begin Date as the first day of ElderChoices or AAPD eligibility.

Counties will review the records of recipients who leave facilities for ElderChoices or AAPD Waiver. If it is time for the annual reevaluation, a reevaluation will be done prior to Waiver certification.

The caseworker will also determine if the LTC recipient has a community spouse. If so, resources should be reviewed, as the couple's combined resources may exceed \$3000 and the LTC recipient will not be eligible for ElderChoices or AAPD Waiver.

NOTE: If a long term care case was closed, then reopened for Waiver services and a retroactive adjustment must be made to the long term care case, send a memorandum to the Office of Long Term Care, MMIS Unit, Slot S-409, P.O. Box 1437, Little Rock, 72203. The memorandum must include the name, case number, month(s) of retroactive change(s), and the new net income amount(s).

No Waiver eligibility date may be established prior to an applicant's discharge date from an institution. Therefore, if a provisional Plan of Care is developed while an applicant is a resident of a nursing home or an inpatient in an institution, the earliest Waiver eligibility date, once Waiver services begin, will be the day the applicant was discharged home.

**26165      Procedure for AAPD Waiver Individuals Turning 65**

**04-01-03**

Individuals receiving services through AAPD lose eligibility when they reach the age of 65. These individuals are usually eligible to continue coverage through ElderChoices. To allow the individual to move from AAPD to ElderChoices without a lapse in coverage, the AAPD recipient must submit a new application for the ElderChoices program. The AAPD recipient will be allowed to submit an application at any time up to 60 days prior to his or her 65<sup>th</sup> birthday. If the individual submits an application more than 60 days before the 65<sup>th</sup> birthday, the application will be denied, and the applicant advised when to reapply.

The system does not close the AAPD case when the individual reaches age 65. The county must manually take action on the case. Counties will receive notice two months prior to the 65<sup>th</sup> birthday of the AAPD recipient. When the county receives the notice, a DCO-700, Notice of Action, will be sent to the recipient stating that eligibility for AAPD Waiver will end on the day before the individual's 65<sup>th</sup> birthday. The notice will also contain information advising the individual to make application for ElderChoices as soon as possible to avoid a break in coverage, as no retroactive coverage is given in ElderChoices.

Medical necessity determined for AAPD will not carry over to the ElderChoices program. The caseworker will send a DHS-3330 to the ElderChoices RN, and the RN will complete an in-home assessment. The DHS-704 establishing medical necessity for ElderChoices must be received before the ElderChoices case can be approved.

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If ElderChoices eligibility is finalized on or before the individual's 65<sup>th</sup> birthday, the Medicaid card will remain active. The Medicaid portion of the case will remain open, but the Waiver portion will be closed the day before the 65<sup>th</sup> birthday. The Waiver portion for ElderChoices will be opened beginning the day of the 65<sup>th</sup> birthday.

If ElderChoices eligibility is not finalized on or before the recipient's 65<sup>th</sup> birthday, the AAPD case will be closed with an end date of the day before the 65<sup>th</sup> birthday. Once ElderChoices eligibility is finalized, the case will be approved or denied following normal procedures.

**26170**      **Reevaluations**

**04-01-03**

ElderChoices and AAPD Waiver reevaluations will be conducted annually by the county office.

Form DCO-777 or DCO-215 and all other forms required at initial application will be completed. After eligibility has been redetermined, the review date will be entered in the system.

Reassessment of medical necessity will also be completed annually by the UCC of OLTC.

**26175**      **Changes/Closures**

**10-01-03**

Recipients will be advised to report any changes in the amount of household income or resources.

If at any time DAAS or the UCC of the OLTC determines that cost effectiveness is not met, that the client no longer meets the requirements for Intermediate Level of Care, or that the client is no longer receiving Waiver services, the county office will be notified by Form DHS-3330 or DHS-704, and the Waiver case will be closed. If the Waiver case is closed for any reason, the caseworker will determine if the client is eligible for any other Medicaid category. If eligible in another category, the recipient can be certified in that category without requiring a new application.

If the ElderChoices or AAPD Waiver client loses eligibility for one month only, the case may remain open with an overpayment submitted for the month of ineligibility. When the county has advance knowledge of ineligibility in a future month (e.g., land rent paid annually), procedures at MS 3341 #1 will be followed, advance notice given, and the case adjusted on the system at the appropriate time. In both instances, a DHS-3330 and a copy of the advance notice must be submitted to the ElderChoices RN or AAPD Counselor the same day the notice is mailed to the client.

If the Waiver client will be ineligible for more than one month, the case will be closed and a new application will be required. If closure was due to a reason other than medical necessity, a new DHS-704 will not be required at reapplication if the following conditions are met:

- ◆ The case is being reopened within 2 months of the closure date.
- ◆ The DHS-704 was signed within 6 months prior to the new application date.
  
- ◆ The ElderChoices RN or AAPD Counselor was notified by a DHS-3330 of the closure within

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3 days of the action taken.

- ◆ The ElderChoices RN or AAPD Counselor was notified by a DHS-3330 of the reopening within 3 days of the action taken.

If all of the conditions above are not met, a new DHS-704 will be needed to reopen the ElderChoices or AAPD case.

When closing an ElderChoices or AAPD case because a recipient refuses to receive at least one service, closure code "Refused Other Procedural Requirement", will be used. A manual notice will be sent to the recipient notifying him/her of the closure. If the client does not refuse services, but the ElderChoices RN or AAPD Counselor determines that the recipient is no longer in need of services or that services are no longer available in the recipient's area, closure code "Other Non-Needs Related", will be used. A manual notice will be sent, notifying the recipient of the closure.

A Waiver client may appeal an adverse decision made on his/her case as outlined in Section 9300 of the Medical Services Policy manual. If the client chooses, the ElderChoices or AAPD Waiver case may remain open until the appeal decision is rendered. Services may continue if agreed upon by the client, the service provider and the ElderChoices RN or AAPD Counselor. Because it is the responsibility of the ElderChoices RN or Counselor to coordinate services in the client's home, he/she must be aware of planned adverse action and the request for an appeal. Therefore, when a Notice of Adverse Action is mailed to an ElderChoices or AAPD Waiver client, a copy will be mailed to the ElderChoices RN or AAPD Counselor the same day. Also, when the caseworker learns that request for an appeal has been submitted on a Waiver case, the caseworker will notify the ElderChoices RN or AAPD Counselor via DHS-3330 immediately

If the county office at any time finds the recipient ineligible for the Waiver program, the ElderChoices RN or AAPD Counselor will be notified immediately by DHS-3330 and the county office Waiver case will be closed.

**26180      Temporary Absences From the Home**

**10-01-03**

Once an ElderChoices or AAPD Waiver application has been approved, Waiver services must be provided in the home for eligibility to continue. Unless stated otherwise below, the county office will be notified immediately by the ElderChoices RN or AAPD Counselor when Waiver services are discontinued, and action will be initiated by the county office to close the Waiver case.

1.      Institutionalization

An individual cannot receive ElderChoices or AAPD Waiver services while in an institution. However, the following policy will apply to active Waiver cases when the individual is hospitalized or enters a nursing facility.

a.      Hospitalization

When a Waiver recipient enters a hospital, the county office will not be notified and no action is necessary unless the recipient does not return home within 20

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days from the date of entry. If after 20 days the recipient has not returned home, the ElderChoices RN or AAPD Counselor will notify the county office via Form DHS-3330, and action will be initiated by the county office to close the Waiver case. For ElderChoices or AAPD services to resume after discharge from the hospital, the individual must make a new application and be reassessed by the ElderChoices nurse or AAPD counselor. A new DHS-704 will be required.

b. Nursing Facility Admission

When a Waiver recipient enters a nursing facility and it is anticipated that the stay will be less than 20 days, the case will remain open if the client does not request vendor payment for the temporary stay. If the Waiver client returns home within 20 days, a new DHS-703 and DHS-704 will not be required unless the last Waiver review was completed more than 6 months prior to facility entry. A new DCO-777 or DCO-215 will not be required unless it is time for the annual case reevaluation. It is not necessary to register a new application in this situation.

If the individual requests payment for the temporary stay in the nursing facility, signed DCO-777 or DCO-215 must be obtained and registered, along with a DHS-703 and DHS-704. If it is time for the annual case reevaluation, the reevaluation must be completed prior to certifying the vendor payment. If all eligibility requirements are met, eligibility for vendor payment will begin effective the date of entry into the nursing facility. If the stay in the facility was less than 30 days, vendor payment may still be authorized because ElderChoices or AAPD Waiver recipients are considered to be "institutionalized" for Medicaid purposes and the Waiver eligibility prior to the facility stay may be applied toward the 30-day institutionalization requirement.

If the individual does not return home, i.e., stays in the facility and requests LTC services, the Medicaid case may be left open while processing the registered LTC application. If found eligible for vendor payment, the case will be closed with a Waiver Stop Date of the day of entry into the nursing facility. Vendor payments will also be authorized beginning the date of entry.

If found ineligible for vendor payments, or if after 20 days in a facility the individual does NOT apply for vendor payment, appropriate notice will be given for case closure.

2. Absence from the Home - Non-Institutionalization

When a Waiver recipient is absent from the home for reasons other than institutionalization, the county office will not be notified unless the recipient does not return home within 20 days. If after 20 days the recipient has not returned home and the providers can no longer deliver services as prescribed by the Plan of Care (e.g., the

recipient has left the state and the return date is unknown), the ElderChoices RN or

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AAPD Counselor will notify the county office via Form DHS-3330 and action will be taken by the caseworker to close the Waiver case.