DBHDD

Department of Behavioral Health and Developmental Disabilities,
Division of Developmental Disabilities

NOW and COMP Part II Waiver Policy Changes

Darlene M. Meador, Ph.D.
Director, Strategy & Special Projects
Division of Developmental Disabilities

Objectives

- Level of Care Re-Evaluation
- Reduction or Termination of a Participant's NOW/COMP Services
- Miscellaneous Policy Changes
- Appendices

Level of Care (LOC) Re-Evaluation

Chapter 700, Sections 707 and 708

- Continues DMA 6 use for initial LOC determination
- Replaces DMA 6 with new form for LOC re-evaluations
- Re-evaluates LOC based on disability conditions and major life activities

Level of Care (LOC) Re-Evaluation

Chapter 700, Sections 707 and 708

- Specifies policies for these re-evaluations
  - Support coordinator (SC) submits completed form to region
  - SC and participant/representative signs form
  - Regional LOC RN reviews/approves
  - SC's signs no more than 30 days prior to LOC approval date
  - Approval period: annual Individual Service Plan dates (birth date to birth date)
- Establishes new form (part of Appendix C)

Level of Care (LOC) Re-Evaluation

New Form, Instructions, and Protocol

- Form, Instructions, and Protocol to be available on the web
- Review of LOC Re-Evaluation Form, Instructions, and Protocol
  - Level of Care Eligibility
  - Signature Requirements
  - Accompanying Documents

Level of Care (LOC) Re-Evaluation Form

NAME:	**SS#**	**Region**
Support Plan Effective Date:		

Level of Care (LOC) Re-Evaluation Form

Level of Care Eligibility: The individual meets one of the following criteria and is eligible to receive the services provided in an ICF/ID. Check the criteria that are met.	
	The individual's disability is intellectual disability.
	The individual is eligible under the category of Other Closely Related Condition.

Level of Care (LOC) Re-Evaluation Form

Please check all that Apply:			
	Disability Conditions		**Major Life Activities**
	Ambulation Deficits		Self Care
	Sensory Deficits		Understanding and Use of Language
	Chronic Health Problems		Learning
	Behavior Problems		Mobility
	Autism		Self Direction
	Cerebral Palsy		Capacity for Independent Living
	Epilepsy		
	Spina Bifida		
	Prader-Willi Syndrome		
	Other_____ _____		

Level of Care (LOC) Re-Evaluation Form

Medicaid Eligibility:

Individual has a current Medicaid Number. Medicaid # is _____

Level of Care (LOC) Re-Evaluation Form

Eligibility Determination: Check the correct statement:	
	Individual has met Level of Care Eligibility (1) has a Medicaid number (2) and is eligible for Waiver Services.
	Individual has not met the Level of Care Eligibility and is not eligible for Waiver Services.
	Individual is in an ICF-ID and was referred for Medicaid eligibility on _____ Date The result was: Eligible ____ Ineligible ____ Date of Determination_____

Level of Care (LOC) Re-Evaluation Form

Home and Community Based Waiver Level of Care Re-Evaluation (if applicable) ✓ Support Coordinator signs the Level of Care Re-Evaluation ✓ LOC Nurse with the Regional Intake and Evaluation Team signs the Level of Care Re-Evaluation
Support Coordinator: **Date:**
Regional Level of Care RN Signature: **Date:**
Approval Period:

Level of Care (LOC) Re-Evaluation Form

ICF-ID Facility Level of Care Re-Evaluation (if applicable) ✓ For ICF-ID Facility Level of Care, the Regional Level of Care RN signs the Level of Care Re-Evaluation
Regional Level of Care RN Signature: **Date:**
Approval Period:

Level of Care (LOC) Re-Evaluation Form

Individual/Representative Signatures: ✓ **This section is only completed for individuals residing in the community**	
It is the policy of the State of that services are delivered in the least restrictive manner that addresses the service needs of the individual while enhancing the promotion of social integration. Further, it is the policy of the State to recognize the recipient's full citizenship and individual dignity; providing safeguards to protect rights, health and the welfare of recipients. I have been offered waiver services and choose to receive community based supports and services. I understand that I have a choice of enrolled providers.	
Individual Signature:	**Date**
Representative (if applicable):	**Date:**

Reduction or Termination of a Participant's NOW/COMP Services

Chapter 700, Section 709.1

- Written notice of rights from regional office
- Process for requesting a fair hearing

Miscellaneous Policy Changes

Chapter 600

Sections: 601- 602, 606 - 607

- Changes wording for consistency with DBHDD Standards

- Deletes detailed language on Criminal History Check and references DBHDD Policy

- Corrects title for Assistant Commissioner of Developmental Disabilities

Appendices

Appendix A

- Updates DBHDD Regional Office Contact List

Appendix C

- Includes new Level of Care Re-Evaluation Form

Appendix H (NOW Only)

- Corrects Reference to COMP

Questions?