

Chapter IV: Eligibility

4.01 Residency and Fiscal Responsibility

The county where a person established residency is responsible for providing an assessment, care plan and services, except as provided in §46.27(6g) of the Wisconsin Statutes (see Appendix G). An individual must have resided in Wisconsin for at least 180 consecutive days before applying for or receiving COP services (see Section 4.04 C).

4.02 Assessments

A. Program Eligibility

Within the limits of state and federal funds allocated for Community Options and the county's Community Options Plan, the following persons are eligible for an assessment (also see Section 5.04):

1. Any person seeking admission to or about to be admitted to a nursing home or an Institution for Mental Disease. For emergency admissions, the assessment shall be done within ten (10) days of admission; or,
2. Any current resident of a nursing home or an Institution for Mental Disease, who applies for Community Options; or,
3. Any person who meets program eligibility requirements for receipt of Community Options-funded services (see Section 4.04 A).

B. Financial Eligibility

An applicant is eligible for the development of an assessment, regardless of income and assets. The lead agency may charge an applicant a fee for an assessment only in accordance with Section 2.05 B 5 and the Community Options Cost-Sharing Worksheet (see Appendix D).

4.03 Care Plans

A. Program Eligibility

Within the limits of state and federal funds allocated for Community Options assessments and care plans, any person who receives a Community Options assessment is eligible for a care plan (see plan (see Section 5.06 A). The only exceptions to

are if the county determines that the person does not meet program eligibility for services, or that services in the community are not feasible or financially viable.

B. Financial Eligibility

An applicant is eligible for the development of a care plan, regardless of income and assets. The lead agency may charge an applicant a fee for a care plan only in accordance with Section 2.05 B 5 and the Community Options Cost-Sharing Worksheet (see Appendix D).

4.04 Services

A. Program Eligibility

Community Options participants who initially received services prior to January 1, 1986 are grandfathered in for purposes of program eligibility. Community Options participants who initially receive services after December 31, 1985, must meet one of the following criteria:

1. Targeted Groups.

- a. The person has a long term or irreversible illness or disability which without appropriate community services would require long term care in a nursing home at a level of care reimbursable through the Medical Assistance Program in nursing homes. The Community Options Functional Screen (see Appendix B) is used to determine level of care.

Persons denied eligibility on the basis of the Community Options Functional Screen may appeal this finding through the state administrative hearing appeal process (see Section 6.02 A). When a lead agency is notified that an appeal of a denial of program eligibility has been received, it must submit to BLTS:

- 1) a written request to review the determined level of care, and
- 2) a copy of the completed Community Options Functional Screen being appealed, and
- 3) a completed Medicaid Waiver Program Health Form (DCS 810).

BLTS will obtain a third party review of level of care from the Division of Health. As part of this review, lead agencies may be asked to gather additional information.

- b. The Person is in Need of Long-Term Support and Belongs to a Legislatively Targeted Group.

In accordance with §46.27(6r)(b) and (d), certain persons are eligible for Community Options if they meet Level 3 criteria on the Functional Screen. This includes certain persons with Alzheimer's disease and other irreversible dementias, and certain persons with serious and persistent mental illness, including persons who are chronically mentally ill who meet the requirements for receipt of services in an institute for mental disease in accordance with §49.45(6g)(a), 2 or 3 of the statutes.

- c. The Person is Referred through Interdivisional Agreement 1.67 or Relocated From a Nursing Home as the Result of a PASARR Review.

In accordance with §46.27(6r)(b)3 nursing home residents referred for community care by the DSL/BQA through I.A. 1.67, or relocated from a nursing home as the result of a PASARR review under 42 USC 1396(a) (31), or who is no longer level of care eligible for MA-Waiver funded services, are eligible for Community Options.

2. Effects of the Waiver Mandate on Program Eligibility

In addition to the above program eligibility requirements, any individual who is eligible for, or later becomes eligible for, services under a Medicaid community waiver but who refuses an offer of such services is ineligible for Community Options-funded services (see Section 2.04 L).

B. Financial Eligibility

Community Options funding for ongoing services may be used only for persons who are Medicaid eligible or have a level of income and assets that would cause them become medically indigent within 6 months in an institution, as determined by the Community Options Uniform Eligibility and Cost-Sharing Plan. Community Options participants who receive Community Options-funded services may be required to share, based on income and assets, in the cost of services they receive. The extent of a participant's cost-sharing responsibility is determined through use of the appropriate cost-sharing worksheet (see 2.05).

C. Other Eligibility
Restrictions

Regardless of other program or financial eligibility provisions, an individual is ineligible for Community Options-funded services if any of the following applies:

1. The individual has not resided in Wisconsin for at least 180 consecutive days before applying for or receiving COP services (each applicant shall sign a declaration of state residency which the lead agency shall maintain in the individual's case record. There is no residency requirement for receipt of a Community Options assessment or care plan. (See Appendix J, DSL Information Memo 95-19 for more information on this requirement).
2. The individual initially applies for long-term support services on or after January 1, 1990 and is eligible for, or later becomes eligible for, services under a Medicaid community waiver but refuses an offer of such services (see Section 2.04 M).
3. After January 1, 1996, the projected cost of services to the individual who resides or intends to reside in a CBRF would cause the county to exceed its limit on funding for residents of CBRFs.

D. Divestment Policy

The following policies and procedures are required to be in place:

1. An applicant for Community Options, or her/his guardian must, as part of the application process, state on the declaration of income and asset form whether the applicant or his/her spouse have sold or given away any assets within the 36 months previous to the declaration.
2. In the event that the lead agency discovers that assets have been divested, the divested assets are to be included in determining the applicant's financial eligibility and cost-sharing obligation for Community Options unless one of the following conditions applies:
 - a. The transferred resource has no current value.
 - b. The lead agency determines that undue hardship would result to the person or to his or her family from a denial of financial eligibility or from including all or a portion of a transferred resource in the calculation of the amount of cost-sharing required.

3. If an applicant has divested and the county determines that neither of the above conditions applies, the applicant has the right to appeal that determination. Since such a determination may result in a denial of services, the county must inform the applicant of appeal rights.

"Divestment" is the act of changing legal title or other right of ownership of any MA-countable asset to another person or other persons for a value received that is less than its fair market value. Financial abuse of individuals who are either incompetent or frail and vulnerable to such abuse shall not be considered "divestment." Lead agencies are encouraged to be watchful for such abusive situations and make appropriate referrals to the county elder abuse reporting agency.

In general, any assets which are available to the applicant are "countable" unless they are used by the applicant to maintain the applicant's and spouse's homestead, business, farming operation, rental income, or vehicle used to go to and from work, medical providers or for normal community participation.

For further information on what is meant by "divestment" see the Community Options Uniform Eligibility and Cost-Sharing Worksheet – Appendix D. For a more detailed definition of "divestment" see the MA Handbook – Appendix 23: Countable Assets and Appendix 25: Divestment Policies.

E. Hidden or
Misplaced Assets

After providing Community Options-funded services, the lead agency may discover the existence of assets which would have made the participant ineligible for Community Options-funded services, or which would have changed the participant's cost-sharing obligation. In such situations, the lead agency shall:

1. Re-determine the participant's eligibility, counting the newly discovered assets but excluding any "payback" (see below), to determine when and if the participant would have become eligible. If the participant continues to be ineligible, Community Options-funded services must be discontinued. The participant may, however, pay privately for the services in her/his care plan.
2. If the participant would still have been Community Options-eligible despite any newly discovered assets, or has become eligible, recalculate the participant's cost-sharing obligation counting any newly discovered assets but excluding any payback (see below). The participant is responsible for this newly calculated cost-sharing amount. Community Options funds may be used to pay for the cost of any goods or services in the care plan beyond the participant's cost-sharing obligation.

3. Determine the cost of any services provided by Community Options to an individual who was not eligible for services. The cost of any Community Options-funded services which have been provided to an ineligible participant must be repaid to Community Options. The lead agency may:
 - a. Repay Community Options with other appropriate non-Community Options funds; or,
 - b. Attempt to recover all or part of the cost of such services from the participant. This "payback" is excluded from available income and assets for re-determining the participant's current eligibility and cost-sharing obligation.
4. Determine the amount of any higher cost-sharing obligation the participant should have been responsible for in the past. The lead agency may:
 - a. Waive any payback of recalculated cost-sharing obligations; or,
 - b. Attempt to recover any past cost-sharing amounts which would have been owed had the hidden or misplaced assets been included in the cost-sharing determination. This "payback" is excluded from available income and assets for re-determining the participant's current eligibility and cost-sharing obligation.
5. Inform participants of the right to appeal lead agency attempts to recover the cost of services for which the participant was ineligible, or to recover past cost-sharing.

4.05 Notice of Eligibility Determination

Notification is the process of letting applicants and program participants know about any changes in their status or in the services they receive in a format that is understandable and accessible to them. The lead agency shall provide notification of program and financial eligibility determination (including cost-sharing, if applicable and information on appeal and grievance rights) to applicants at the following decision points in the Community Options process:

1. Deciding whether to proceed with an assessment (see Section 5.04B);

2. Deciding whether to proceed with a care plan (see Section 5.06 D);
3. Deciding whether to proceed with ongoing services (see Section 5.08 D).

The notice must also include information on the right to a state appeal under Chapter 227 (see section 6.02 A) and the county grievance procedure.

4.06 Eligibility Re-determination

- A. Program Eligibility Once a person has initially established program (level of care) eligibility in Community Options, re-determination of program eligibility is not required. The care plan is reviewed and updated semiannually or whenever changes occur in order to review the type and level of services required. A lead agency may elect to re-determine participants' program eligibility based on level of care if it has adopted a uniform and equitable process for doing so.
- B. Financial Eligibility Financial eligibility must be re-determined whenever a change occurs. In addition, financial eligibility must be re-determined semiannually for persons who are spending down assets in Community Options, and annually for other persons.

4.07 Waiting Lists

- A. Placement on Waiting Lists
1. Assessments and Care Plans.

The only permissible circumstance in which a waiting list for assessments and care plans may be established is when the lead agency has expended all funds available for assessments and care plans. Any applicant denied an assessment or care plan for this reason must be provided an opportunity to be placed on a waiting list for assessments or care plans.
 2. Services.

The only permissible circumstance in which a waiting list for assessments and care plans may be established is when the lead agency has:

- a. Determined that the cost of meeting the community service needs identified in the assessment will cause the lead agency to exceed the state and federal service funds available (service funds are available if they have not already been expended or committed to current Community Options participants), or
- b. Determined that the cost of meeting the community service needs identified in the assessment will cause the lead agency to exceed the allowable average Community Options service cost for all county Community Options participants and the Department has denied a variance to the allowable average Community Options service cost, or
- c. Established a waiting list for the target group of which the applicant is a member for the purposes of meeting minimum significant proportions requirements for other target groups.

Any eligible applicant or current participant who is denied Community Options-funded services for one of these reasons, must be provided an opportunity to be placed on a waiting list for Community Options-funded services.

B. Procedures for Placement on Service Waiting Lists

Lead agencies must use the following procedures for placing new applicants on waiting lists for services:

1. Make a preliminary determination of the applicant's eligibility.
 - a. Document that there has been a contact with the applicant, and that the applicant has long term care needs on the date of placement on the waiting list; and,
 - b. Document that on the date of placement on the waiting list the applicant is eligible for Community Options-funded services as determined by the Functional Screen; and,
 - c. Document that a preliminary determination has been made, based on the applicant's unverified declaration of income and assets, that on the date of placement on the waiting list the applicant is likely to be financially eligible for Community Options- or Medicaid community waiver-funded services;

- d. Document that, based on the applicant's declaration of state residency, on the date of placement on the waiting list the applicant meets the Community Options residency requirement (See Section 4.04 C).
2. Place the name of any applicant determined through the preliminary eligibility determination to be likely to be eligible on the waiting list for Community Options-funded services.
3. Make an offer of an assessment. Offer applicants placed on a waiting list for Community Options-funded services the choice of receiving an assessment at the present time, in which case it must be completed within 45 days in accordance with Section 5.05 D, or, delaying the assessment until a time closer to when Community Options-funded services will become available. Applicants who meet the preliminary eligibility test but elect to delay assessment because they are waiting for services must be placed on a waiting list for services.
4. Provide an applicant or current participant placed on a waiting lists for Community Options-funded services with:
 - a. The applicant's status on the waiting list, and an estimate of when Community Options-funded services may be available; and,
 - b. A copy of the county waiting list policy and procedures; and,
 - c. A copy of the county appeal/grievance procedures; and,
 - d. Information about other long term support programs for which the applicant may be eligible, and how to apply for those programs; and,
 - e. Information about potential estate recovery of the cost of any services provided.

C. Procedures for
Serving Persons
From Waiting Lists

The lead agency policy for serving participants from waiting lists must be in writing, must be included in the County Community Options Plan, and must comply with the following standards:

1. The policy for serving persons from waiting lists must be fair and equitable.

2. New or increased service needs of current program participants which the care manager has identified in the participant's most recent care plan as necessary to maintain the participant in the community (see Section 5.07 G 1), and to adequately provide for the participant's health, safety and wellbeing, shall be given priority over providing services to new participants.
3. The lead agency may, as part of the county Community Options Plan approved by the Long Term Support Planning Committee and the department, establish other priorities for serving persons from waiting lists. In the absence of such priorities, persons shall be served from a waiting list in the order of the date of placement on it.

D. Other Waiting Lists
Policies and
Procedures

A lead agency may establish other policies and procedures for waiting lists if approved by the Long Term Support Planning Committee and the department. Persons who do not have current long term care needs or who are not currently eligible may be placed on Community Options waiting lists only if the lead agency maintains waiting list data in such a way that in reporting to the department it will be able to provide information that includes only those persons who have current long term care needs and who have been determined eligible for the program per Section 4.07 B 1.