TRAUMATIC BRAIN INJURY WAIVER (TBI)

17.62 THE APPLICATION/REDETERMINATION PROCESS

The application/redetermination process is the same as for SSI-Related Medicaid found in Chapter 1, with the following exceptions:

The Worker is responsible for the following:

- Accepting the referral form for TBI Waiver, the TBI Waiver DHHS-2.FRM with attached letter from the BMS contract agency listed in Appendix I of this chapter that verifies medical necessity for TBI Waiver services eligibility is established. The letter of medical eligibility must not be older than 1 year minus 1 day unless the case is in hearing status or an extension has been granted by the Office of Home and Community-based Services in BMS due to circumstances beyond the individual's control. The referral will originate from one of the following.

  - A case management agency, when the client chooses to use one; or,

  - The BMS contract agency when the client chooses to function as their own case manager.

  The TBI Waiver DHHS-2.FRM has 2 versions. The same information is contained on both, but one includes a third line in the form title which states "Self-Directed Case Management" and the distribution list includes the BMS contract agency instead of the case management agency.

- Completing the Asset Assessment at the individual's or authorized representative's request after receiving the TBI Waiver DHHS-2.FRM with attached letter of medical eligibility.

- Accepting an application for the Traumatic Brain Injury (TBI) Waiver Program after receipt of the TBI Waiver DHHS-2.FRM with attached letter of verification of medical eligibility. SSI, Deemed SSI and all other full coverage Medicaid AG's must provide the TBI Waiver DHHS-2.FRM with attached letter of medical eligibility. A shortened application, the DFA-LTC-5, is required to determine eligibility for payment of Waiver Services for these groups. See Section 17.12.

  NOTE: When the applicant's eligibility for, or enrollment in, this program is pending, due to the lack of a waiver slot or other reason, he must not be refused the right to apply due to his pending status for the TBI Waiver group, but must be evaluated for any or all DFA programs.

  EXAMPLE: John Smith applies for TBI Waiver which requires a medical eligibility decision by the TBI Waiver Program and a financial determination by an Income Maintenance Worker. While his medical eligibility decision is pending, he visits his local DHHR Office and applies for SNAP. Although his medical eligibility

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for TBI Waiver has not been determined and a financial determination cannot be made by the Worker for TBI Waiver, his pending status for this program does not prevent his evaluation for all other Medicaid groups for which he may qualify.

- Processing the application as for any other Medicaid AG, presuming that medical eligibility has been determined. The beginning date of Medicaid eligibility is the later of the following:

  - The first day of the month of application; or

  - The first day of the month in which the individual is eligible for payment of TBI Waiver services after a transfer of resources penalty expires. See Section 17.25.

  The date of application is the date that the client or his representative contacts the local office by phone, fax, mail, e-mail or in person to inquire about making an application.

  If a face-to-face interview is requested, the appointment must be scheduled within 10 calendar days of the date of the contact. The appointment may be scheduled after 10 calendar days only at the request of the client or his representative. Case management agencies who choose to represent clients have been instructed by BMS to request an application within 7 days of the date the medical approval is received.

- Instructing the individual that TBI services will only be paid on or after the TBI approval date.

- Complete a redetermination of eligibility once a year; no interview is required. Medical eligibility must be verified annually at redetermination with a letter from the BMS contract agency. The letter of medical eligibility must have been completed within the past 12 months, unless the case is in current hearing status or the individual was granted an extension by the Office of Home and Community-based Services. Once the redetermination is complete, the same criteria and procedures used for applications are used. Medicaid eligibility is established and the medical eligibility for services is monitored by BMS.

  The Worker receives an alert in RAPIDS when a redetermination is due.

  Information about TBI Waiver Services, including personal options, is found on the Office of Home and Community-Based Services website: http://www.dhhr.wv.gov/bms/hcbs/Pages/default.aspx.