17.1 INTRODUCTION

This Chapter describes the Department's policies and procedures for determining long-term care eligibility. Nursing facility (long-term care) services are provided to eligible Medicaid individuals who reside in a nursing care or ICF/MR facility.

In addition to providing nursing facility services to eligible Medicaid recipients, three coverage groups are eligible for alternative long-term care services by virtue of their need for nursing care and the availability of home-based or community-based nursing care services. These three coverage groups are part of the same Title XIX Waiver, even though they were begun at different times. The coverage group for elderly or disabled people is the AD Waiver; another is for intellectually or developmentally disabled individuals and is the I/DD Waiver; and, the third is for individuals with traumatic brain injury (TBI) who choose home and community based services rather than nursing home placement.

Certain programs, such as I/DD, TBI, AD Waiver and ICF-MR, require a medical and/or other determination by a community agency or government organization, other than DFA and a financial determination by an Income Maintenance Worker. When an applicant’s medical eligibility for, or enrollment in, these programs is pending due to the lack of a waiver slot or other reason, he must not be refused the right to apply, but must be evaluated for any or all DFA programs.

This Chapter is organized in the same way as the entire Income Maintenance Manual. Information in other sections of the Manual that also apply here are not repeated. Instead, reference is made to such information.

In determining eligibility for payment of nursing or alternative care, the Worker must ensure that the client, or his representative, is fully informed of the policies and procedures. This is necessary so that the client, his family or his representative is able to make informed decisions about the client's financial affairs.

However, the Worker must not, under any circumstances, suggest or require that the client, or representative, take any specific action in financial matters. The Worker must not act as a financial planner or make suggestions about the client's current or future financial situation. This includes comments about Estate Recovery. The Worker may respond to general questions, but must refer the client, or representative to BMS or their contract agency, for specific information. The Worker must not contact BMS or their contract agency on behalf of the client, but must refer the client or representative to the BMS contract agency listed in Appendix I of this chapter.

The Worker must refer all inquiries about billing issues from the nursing or ICF/MR facility to the BMS contract agency. The Worker must not contact BMS on behalf of the provider, but must refer the provider to BMS.

Questions from county staff about any aspect of long-term care cases must be directed to the Economic Services Policy Unit in DFA, not to BMS.