Reference Guidelines for Resource Coordinators:

Community Pathways Waiver

Forms

November 2014

Web site: http://dda.dhmh.maryland.gov

REFERENCE GUIDELINES: COMMUNITY PATHWAYS WAIVER FORMS

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COMMUNITY PATHWAYS WAIVER ENROLLMENT CHECKLIST

INDIVIDUAL'S NAME: _____ (FIRST, MIDDLE, LAST)

Current address: _____ **County:** _____
_____ **Zip Code:** _____

DDA FUNDING CATEGORY GROUP ***(CHECK ALL THAT APPLY)***

☐ Transitioning Youth – Fiscal Year _____
☐ Currently receiving State only funding (Conversion)
☐ Money Follows the Person (MFP)
☐ Crisis Resolution/Emergency
☐ Waiting List Equity Fund (WLEF)
☐ Placement from an SRC/SETT/Nursing or State Hospital Facility
Facility Name: _____ Discharge Date: _____

WAIVER SERVICE REQUESTED: (CHECK ALL THAT APPLY)

	Assistive Technology & Adaptive Equipment		Environmental Accessibility Adaptations		Support Brokerage
	Behavioral Supports		Environmental Assessments		Supported Employment
	Community Learning Service		Family and Individual Support Services		Transition Services
	Community Residential Habilitation		Live-In Caregiver Rent		Transportation
	Community Supported Living Arrangement/Personal Supports		Medical Day Care		Vehicle Modifications
	Day Habilitation		Respite		
	Employment Discovery & Customization		Shared Living (formerly Individual Family Care)		

DOCUMENTS:

√	Document Name	Date Completed
	Medicaid Application (Long or Short Form)	
	Level of Care – Initial Certificate of Need	
	Freedom of Choice Form (WC-3B)	
	Individual Plan (IP) – Traditional Model: The most recent IP (Initial or Annual)	
	Individual Plan (IP) – Self-Directed Model: IP and Self-Directed Budget	
	Waiver meeting minutes and sign in sheet.	

For Regional Office Use Only

√	Document Name	Date Completed
	Service Funding Plan (SFP) with Regional Office Sign-Off	

Resource Coordinator (printed name):_____

Resource Coordination Agency (printed name):_____

Office Address: _____

Email Address: _____

Phone: _____ Fax: _____

Resource Coordinator (signature): _____ Date: _____

DDA Regional Waiver Coordinator: _____ Date: _____

RESOURCE COORDINATION
MAINTAINING WAIVER ELIGIBILITY CHECKLIST

Waiver Participant: _____

LOC – Recertification of Need ("RECON")

____ Check LOC Certification on PCIS2 "Waiver" Tab (Note Date Listed: _____)

____ Check DDA Quarterly LOC Report for Current Date (Indicate Date Due: _____)

____ Review Current Needs and Individual Plan

____ Complete LOC – Recertification of Need form (if criteria met)

____ Complete WC12-B Form (if criteria no longer met) and Submit to Regional Office

Financial Redetermination ("REDET")

____ EDD Redetermination Target Date (Indicate Date Due: _____)

____ Check EVS (e-Medicaid) for Eligibility:

- ____ DRW – Community Pathways
- ____ NRW – Community Pathways – Self Direction
- ____ Eligible for Date of Service (for Community Medicaid)
- ____ Not Eligible (for Community Medicaid)

____ Check PCIS2 Waiver Screen

____ Review EDD Notification Letter:

- _____ Inform participant and authorized representatives of upcoming redetermination requirement(s).
- _____ If the person is receiving residential habilitation services; contact the provider to inquire about the status of submitting required documents.
- _____ Ask if assistance is needed to submit required documents.
- _____ Complete the MA "Long" Form for participants receiving MA benefit other than SSI.

NOTE: Document all activities in PCIS2 as monitoring and follow-up activities and record on the Monitoring Form as either a comprehensive review or focused review.

Resource Coordinator:_____ Date:_____
Signature

MEDICAID SYSTEM CHECK FORM

CONFIDENTIAL INFORMATION

Please ensure the security of this information.

This form is used for determining whether a waiver applicant shall complete the "***short***" or "***long***" Medicaid Application or the "***Intent to Apply for Waiver Services***" (OES 014) form. If a person is currently active in a specified coverage group that does not have an end date, they may complete the "short" version of the Medicaid Application form. If a person recently (within 6 months) applied for long term care services, they may complete the OES 014 Form.

To: Division of Recipient Eligibility Programs, DHMH Fax Number: (410) 333-5087 Date:_____

From: _____ Phone Number: _____

Email Address: _____ Fax Number:_____

Agency: _____

Name of Waiver	Applicant Name	Social Security Number	Date of Birth	Medicaid Number	For DREP Use Only			
					OES014 Form	Long Form	Short Form	Comments

****

DREP Determination: Based upon a search of the MMIS and CARES systems for coverage groups under the waiver program and recent long term care applications, the applicant must file the OES 014, the "Long" Form, or the "Short" Form as indicated above. These findings are unofficial and advisory only. When the Eligibility Determination Division (EDD) determines waiver eligibility, it may have different findings and require additional information and verifications. For the OES 014 Form, the date of the long term care application shall be entered in the comments box above.

DREP Representative Name:_____ Date:_____

Phone Number: _____ Email Address: _____

Intent to Apply for Waiver Services (OES 014) Form: This form is used for applicants who have already applied for LTC Medicaid and now intend to apply for waiver services within the six (6) month consideration period of the LTC application. Use the LTC application date noted in the comments box above.

"Short" Form: Complete the DHR/FIA 9709S (Revised 4/1/2013) for the waiver and submit all required documentation.

"Long" Form:

- For any person under 21 years of age, complete the DHR/FIA CARES 9708 for the waiver and submit all required documentation.
- For any person age 21 years or older, complete the DHR/FIA CARES 9709 (Revised 7/1/2011) for the waiver and submit all required documentation.

Developmental Disabilities Administration
Community Pathways Waiver
Freedom of Choice

Individual's Name _____ (*FIRST, MIDDLE, LAST*)

I understand that there are alternative services for which I may be eligible, including services in the community under the waiver, in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID), and licensed nursing/rehabilitation facility. I understand and have considered my options which have been explained to me. I further understand that in order to receive, and continue to receive home and community-based waiver services, I must meet all the eligibility criteria of the Maryland Medical Assistance program and DDA Waiver program.

Please check your choice in services to be received:

☐ I choose to receive home and community-based services under the Maryland Medical Assistance Program/DDA Community Pathways Waiver

☐ I choose to receive services in an institution (ICF/ID)

☐ I choose to receive services in a licensed nursing/rehabilitation facility

****

Acknowledgement of the choice of waiver service delivery model:

The Community Pathways Waiver offers two service delivery models including traditional/provider managed and self-directed services. Individuals may choose a combination of the two.

Please check your choice in services to be received:

☐ Traditional/Provider Managed Services
☐ Self-Directed Services
☐ Combination of Traditional and Self-Directed Services

Acknowledgement of the various waiver services and providers:

I have been advised of the various waiver services and providers licensed by the DDA and informed of my right to choose providers that meet my needs and preferences.

Signature: _____
Individual

Or: _____
Legally Authorized Representative or Guardian/Parent (if applicable)

Signature: _____ _____
Resource Coordinator Date

DEVELOPMENTAL DISABILITIES ADMINISTRATION
COMMUNITY PATHWAYS WAIVER

LEVEL OF CARE
INITIAL CERTIFICATE OF NEED

This is to certify that _____
(FIRST, MIDDLE, LAST)

Medical Assistance Number: _____

In accordance with DDA eligibility criteria, has been determined to need waiver services and meets the appropriate Level of Care effective: _____.

Verification of a "developmental disability" per the DDA PCIS2 Eligibility Category determined on _____ (*insert date*).

Service Delivery Model: (*check one*)

____Traditional/Provider Managed Services

____Self-Directed Services

____Combination of Traditional and Self-Directed Services

Resource Coordinator: _____ Date: _____
Signature

Resource Coordinator *(printed name)*: _____

DDA Review: _____ Date: _____
Signature

DEVELOPMENTAL DISABILITIES ADMINISTRATION
COMMUNITY PATHWAYS WAIVER

LEVEL OF CARE
RECERTIFICATION OF NEED

This is to certify that _____
(FIRST, MIDDLE, LAST)

Medical Assistance Number: _____

In accordance with DDA eligibility criteria, has been determined to need waiver services and meets the appropriate Level of Care effective: _____.

****

Attestation of the choice of waiver service delivery model:

The Community Pathways Waiver offers two service delivery models including traditional/provider managed and self-directed services which was reviewed with the person. Individuals may choose a combination of the two.

The participant chooses to receive services via the following model:

- ☐ Traditional/Provider Managed Services
- ☐ Self-Directed Services
- ☐ Combination of Traditional and Self-Directed Services

Acknowledgement of the various waiver services and providers:

The Community Pathways Waiver offers various waiver services and providers licensed by the DDA for which participants have the right to choose providers that meet their needs and preferences. This information was reviewed with the person.

Resource Coordinator: _____ Date: _____
Signature

Resource Coordinator *(printed name)*: _____

DDA Review: _____ Date: _____
Authorized Signature

DEVELOPMENTAL DISABILITIES ADMINISTRATION

COMMUNITY PATHWAYS WAIVER – Traditional Service Model

Reporting Form

TO: Terri Hartman
DDA Waiver Unit
201 W. Preston Street, 4th Floor
Baltimore, Maryland 21201
Phone: (410) 767-5421 FAX: (410) 767-5850
Email: Waiver.DDA@maryland.gov

INDIVIDUAL INFORMATION:

_____ _____ _____
Last Name First Name Middle Name/Initial

_____ _____ _____
Medical Assistance Number Social Security Number Jurisdiction/County

☐ Remains with _____ or _____ with a change of site address:
(Residential Provider) (Day Provider)
Address: _____ City: _____ Zip Code: _____
Date of Change: _____ Jurisdiction/County: _____

☐ Effective _____ (Date) has had a change in waiver service:
From _____ to _____ (Please write provider/address change above.)
(Type of Service) (Type of Service)
Examples: Residential Habilitation to Personal Supports; Supported Employment to Day Habilitation; FISS to Personal Supports

☐ Has moved from _____ and/or _____to a new waiver provider:
(Residential Provider) (Day Provider)
Provider: _____
Site Address: _____ City: _____ Zip Code: _____
Date of Change: _____ Jurisdiction/County: _____

☐ Has had a change in Resource Coordination Agency from _____ to
_____, _____
(Resource Coordination Agency) (Address)

☐ Has been admitted to:
☐ Nursing Facility: _____ **Admission Date**: _____ **Time**: _____
(Name of Facility)
Discharge Date: _____ **Time**: _____
☐ Chronic Rehabilitation Facility: _____ **Admission Date**: _____ **Time**: _____
(Name of Facility)
Discharge Date: _____ **Time**: _____
☐ Other: _____ **Admission Date**: _____ **Time**: _____
(Name)
Discharge Date: _____ **Time**: _____

_____ _____ _____
Completed By Agency Date

DEVELOPMENTAL DISABILITIES ADMINISTRATION

COMMUNITY PATHWAYS - Self Directed Services

Reporting Form

TO: Terri Hartman
DDA Waiver Unit
201 W. Preston Street, 4th Floor
Baltimore, Maryland 21201
Phone: (410) 767-5421 FAX: (410) 767-5850
Email: Waiver.DDA@maryland.gov

INDIVIDUAL INFORMATION:

_____
Last Name First Name Middle Name/Initial

_____ _____ _____
Medical Assistance Number Social Security Number Jurisdiction/County

☐ New Address: _____ City: _____ Zip Code: _____

Date of change: _____ Jurisdiction/County: _____

☐ Has had a change in Fiscal Management Services from_____

to _____; Effective Date: _____

☐ Has had a change in Support Broker:

New Support Broker: _____

Support Broker's Address: _____ City: _____ Zip Code: _____

Date of Change: _____ Email Address: _____

☐ Has had a change in Resource Coordination Agency from _____ to

_____, _____
(Resource Coordination Agency) (Address)

☐ Has been admitted to:

☐ Nursing Facility: _____ **Admission Date**: _____ **Time**: _____
(Name of Facility)
Discharge Date: _____ **Time**: _____

☐ Chronic Rehabilitation Facility: _____ **Admission Date**: _____ **Time**: _____
(Name of Facility)
Discharge Date: _____ **Time**: _____

☐ Other: _____ **Admission Date**: _____ **Time**: _____
(Name)
Discharge Date: _____ **Time**: _____

_____ _____ _____
Completed By Agency Date

DEVELOPMENTAL DISABILITIES ADMINISTRATION
COMMUNITY PATHWAYS WAIVER
Discharge Reporting Form

TO: DDA Waiver Unit
201 W. Preston Street, 4th Floor
Baltimore, Maryland 21201
Phone: (410) 767-5421 FAX: (410) 767-5850
Email: Waiver.DDA@maryland.gov

INDIVIDUAL'S INFORMATION:

_____ _____ _____
Last Name First Name Middle Name/Initial

_____ _____ _____
Medical Assistance Number Social Security Number Jurisdiction/County

☐ Discharged from **DDA Services:**

☐ Is Deceased: (Date of Death _____)
□ Consumer was residing at site at time of death.
□ Consumer was admitted to hospital on _____ and died in the hospital.

☐ Admitted to SRC/Nursing Facility/Hospital: (Date _____) (Admitting Facility: _____)

☐ Moved Out-of-State: (Date Moved _____)

☐ No Longer Receiving DDA Services: (Effective Date _____)

☐ Moved to a Non-DDA Provider: (New Provider _____) (Effective Date _____)

☐ Other Type of Discharge: (Date_____) Explanation _____
_____

☐ Discharged from **the Waiver Program** and Remains in DDA Service:

☐ Ineligible for Medical Assistance: (Date _____) (Reason _____)

☐ Receiving Fiscal Intermediary Services: (Date _____)

☐ Receiving Services from Another Waiver: (Date _____) (Waiver _____)

☐ Other type of Discharge. (Date_____) Explanation _____
_____

_____ _____ _____
Completed By Agency Date

DEVELOPMENTAL DISABILITIES ADMINISTRATION
COMMUNITY PATHWAYS

Change In Service

TO: Terri Hartman
DDA Waiver Unit
201 W. Preston Street, 4th Floor
Baltimore, Maryland 21201
Phone: (410) 767-5421 FAX: (410) 767-5850
Email: Waiver.DDA@maryland.gov

INDIVIDUAL INFORMATION: SS#: _____

Name: _____ MA#: _____

Residential/CSLA Provider: _____

Day Provider: _____

Resource Coordination Agency: _____

EDD Purpose Only: Does this consumer contribute towards the Cost of Care? _____ Yes _____ No

(Check All That Apply and Provide Requested Information)

√	Waiver Service	Provider (Name or TBD)	Site Address City, County, & Zip Code	Addition or Reduction	Effective Date
	Assistive Technology & Adaptive Equipment				
	Behavioral Supports				
	Community Learning Service				
	Community Residential Habilitation				
	Community Supported Living Arrangement/ Personal Supports				
	Day Habilitation				
	Employment Discovery & Customization				
	Environmental Accessibility Adaptations				
	Environmental Assessments				
	Family and Individual Support Services				
	Live-In Caregiver Rent				
	Medical Day Care				
	Respite				
	Shared Living (formerly Individual Family Care)				
	Support Brokerage				
	Supported Employment				
	Transition Services				
	Transportation				
	Vehicle Modifications				

Signature: _____ Date: _____

DEVELOPMENTAL DISABILITIES ADMINISTRATION

Notice of Case Activity - Financial Reporting

TO: Eligibility Determination Division
6 St. Paul Street, Suite 400
Baltimore, Maryland 21202
Phone: (410) 767-6603 FAX: (410) 333-0109

INDIVIDUAL INFORMATION:

_____
Last Name First Name Middle Name/Initial

_____ _____ _____
Medical Assistance Number Social Security Number Jurisdiction/County

☐ Has had a change in income*:

☐ New amount _____, Source _____, effective _____*

☐ Received lump sum payment of _____ on/for the following period/
reason _____

*It is not necessary to report the COLA (annual increase) for SSI recipients

☐ Has had a change in private insurance:

☐ Added: Insurance Company _____

☐ Cancelled: Insurance Company _____

☐ Changed from_____ to _____

☐ Has had a change in resources: Resources were under **$2,000** and now resources exceed **$2,000** amount to _____

_____ _____ _____
Completed by Agency Date

_____ _____
Email Telephone

DHMH DD WC12-D
Revised: April 9, 2014