

"Indiana Medicaid Home and Community-Based Services Waiver Programs: A Guide for Consumers"

Who is Eligible for Waiver Services?

You must meet eligibility guidelines for "regular Medicaid" (also called the "state plan") in order to qualify for a Medicaid waiver. In fact, you must also apply for and be accepted by regular Medicaid before you may receive waiver services. You must also meet the criteria required for admission into a long-term care facility, state institution or group home.

When you are "targeted" for the waiver (notified you have been chosen) you may contact your case manager for assistance in applying for regular Medicaid, if you have not already done so. Application for regular Medicaid should be made at a local office of the Division of Family and Children. To speed up the approval process, bring medical records that include a diagnosis and a description of the disabled person's severity level. No specific form is required but a doctor must sign the papers. If needed, medical information packets for 251-A are available at the local DFC office or from your case manager. Because the eligibility rules are different for many waiver users, you should also bring verification of your waiver slot.

When you apply for regular Medicaid, documented evidence of income (i.e. paychecks, child support, Supplemental Security Income, Social Security, etc.) is required. Medicaid has a limit of \$1,500 for owned assets for a single person. Income eligibility levels will vary depending on the type of waiver, medical expenses, marital status, number of dependents, and whether the income is from employment.

You may be eligible for more than one waiver, and may apply for all that are appropriate. Anyone applying for the Autism Waiver could also apply for the Developmental Disabilities (DD) waiver. Although you may only be served by one waiver at a time, some waiver waiting lists are shorter than others. While you are on the Support Services Waiver you can also be on the waiting list for the DD and/or Autism Waivers.

How Do You Apply for Waiver Services?

To apply for a Medicaid waiver, contact your local Area Agency on Aging (AAA) office and ask for a Medicaid waiver intake case manager. If you are a person with developmental disabilities (DD), contact the local Bureau of Developmental Disabilities Services (BDDS) office. Some AAA offices also accept applications for DD waivers. Most waiver programs have a waiting list. The date

and time your application is signed will determine your position on the waiting list. Be sure to keep a copy of your application for documentation purposes.

Your intake case manager will work with you during the enrollment process, to help insure that the appropriate information gets to the various agencies involved. When you are notified that a waiver slot is available, applicants not already on Medicaid must apply for regular Medicaid at the local Division of Family and Children office. The intake case manager will assist with this process. Medicaid eligibility standards may be different if you are in the waiver enrollment process, so be sure to bring verification of your waiver slot when you apply.

What is “Level of Care?”

Waiver services are reserved for people who would be eligible for placement in an institutional setting (i.e. nursing home, residential living) if waiver services and community/family supports were not available. Waiver services, combined with other community supports, replace institutional care. The Area Agency on Aging or Bureau of Developmental Disabilities Services will coordinate, along with other professionals, the assessment of your need for the Level of Care provided in an adult foster home.

Level of Care determination is based on medical, functional, and/or developmental information. If you meet the Level of Care required for placement in a facility, you meet the Level of Care for waiver services as well. Level of Care status is reviewed annually to determine your continuing eligibility for waiver services. If you disagree with the decision regarding your Level of Care, you may request a hearing to appeal the decision.

What is “Person-Centered Planning?”

“Person-centered planning” allows you and your family to customize your “Plan of Care” (“Circle of Support”) and distribute the resources needed to meet your own personal goals. It is re-conducted annually.

What is a “Plan of Care?”

The “Plan of Care” (“Circle of Support”) is completely developed around your personal need, preferences and desires. Based on the initial (or annual) assessment of your needs, a team develops your comprehensive “Plan of Care.”

The team consists of you/your guardian, the case manager, and other people you choose to be involved in the planning process; i.e. friends, family neighbors, co-workers, providers, teachers, etc.

The "Plan of Care" is created to:

- Center around your needs, preferences and desires
- Allow you to make decisions
- Encourage you to be productive
- Accommodate your likes and dislikes
- Work towards your long-term hopes and dreams
- Arranges for you to receive appropriate care and services
- Locates the most reasonable costs for the care and services you need
- Accepts responsibility for your health and quality of life
- Incorporates a range of funded community services

The completed "Plan of Care" includes:

- Documentation of all services to be provided
- All provider choices for each service
- Necessary service information including total hours and cost
- Documentation of unmet needs and the way they will be addressed

What is "Informed Choice?"

"Informed choice" is a voluntary decision that you or your family/legal guardian make(s) after becoming familiarized with all potential service choices. Once a person is chosen (or "targeted") to receive a waiver slot, is Medicaid eligible, and has met Level of Care approval, you or your legal guardian will be asked to formulate a "Plan of Care."

You are asked to make an "informed choice" about:

- The types of services you want to receive
- The frequency of each service to be received
- The provider(s) that will supply the requested services
- The case manager who will arrange and monitor your ongoing services

During the provider screening process, the intake case manager will assist in determining eligibility. However, the type of service is always decided by you or your family.

How Do You Select Quality Providers?

Selecting quality providers is critical. It's helpful to think about the issues that are important to you/your family member before you begin the process.

You should take notes when meeting with providers or case managers because it is easy to forget details later. Write down names, titles, date, etc. and ask for copies of any informational handouts.

General topics to discuss with service providers and case managers:

- Discuss all areas of service that are absolute requirements for you/your family member such as: medications always administered on time, 24-hour direct supervision, sign language training, etc.
- What makes you happy? What makes you sad? How will the provider work towards your happiness?
- What do you desire in the future? A job? Member of a church? More friends? Family close-by? Anything else?
- What are your risks? For example, daily seizures, lack of communication skills, short memory, aggression towards others when angry, etc. How can these risks be dealt with?

Questions to ask your case manager:

- How will you work with my family, friends and service providers?
- How will you communicate with me and other team members?
- How will you approach team negotiation and conflict resolution?
- Can I call or page you at any time in the event of an emergency?
- How often will you see/monitor me each month?

Questions to ask prospective service providers:

- What challenges do you think I will create for you?
- What are your strengths and weaknesses as a provider?
- What kind of experience do you have as a provider?
- Who will provide care and service if you are ill, injured, etc.?
- What support do you have? Who do you contact in an emergency?

Questions for family members to ask when visiting your foster family:

- How do you interact with each other? Does everyone get along and treat each other with respect?
- Is the environment comfortable? Are there enough things to do? Are activities offered?
- What kind of food is available and who selects it? Are specific requests encouraged/available? Are diets supervised?
- Do you provide our family member with accessibility to banks, shops, restaurants, etc.? How is transportation handled? Are trips to access these resources planned or are they provided on an "as-needed" basis?
- Is there a telephone available to our family member (with privacy)? Is the telephone accessible (equipped with large buttons, volume control and other access features)?
- Does our family member have his/her own bedroom? Can he/she individually decorate the bedroom?
- Are there restrictions on personal belongings? What are the procedures for lost personal items? Are personal items labeled? Are lost items replaced?
- Are pets allowed? What are the rules regarding pets?
- How much time is spent in active learning (neighborhood, home or community) and leisure activities? Is there a good balance in unstructured time ("free time")?
- Is there evidence that good personal hygiene and grooming (hair, teeth, nails, etc.) are encouraged?
- How are required items such as clothing paid for?

- Does our family member have privacy when he/she wants to spend time alone or with a special friend?
- Does our family member have the opportunity to join churches, clubs, community groups, etc.?
- Do you and your family members knock on doors (and wait for a response) before entering a private room?
- What kind of rules have you created in your home?
- What are the consequences of breaking rules?
- Does our family member have opportunities to pursue his/her own individual interests?

Quality of Life/Consumer Satisfaction Surveys

BQIS conducts "quality of life" surveys based on a sample of people receiving services on waivers. The results of these surveys are compiled to help the Division identify areas of strength and weakness in the service delivery system.

Note: You and your families are not required to participate in the quality assurance surveys and assessments.

Complaint Process

You, your family/guardian, providers, case managers and others can file formal complaints with DDARS when issues are not resolved appropriately or in a timely manner. BQIS oversees complaint investigations and tracks information through the complaint database.

Incident Reporting Process

All providers of waiver services must report any suspected incidents of abuse, neglect or exploitation involving Adult Protective Services or Child Protective Services. In addition, all providers of developmental disability services in community settings, including waiver services, must file an incident report with the BQIS when a critical incident occurs. BQIS establishes definitions of what constitutes critical, reportable incidents. BQIS maintains a database of incidents and follows up on all incidents not resolved within seven days.

Other Quality Improvement Activities

In addition to the processes summarized above, DDARS has implemented the following quality improvement activities that assist the Division of Family and Children in evaluating and making positive changes to the service delivery system:

- **National Core Indicators**

Indiana participates in National Core Indicators (NCI) which is managed by the National Association of State Directors of Developmental Disabilities Services and the Human Services Research Institute. This program includes a quality of life survey for individuals with developmental disabilities. The goal of the NCI is to develop nationally recognized performance and outcome indicators, enabling states to track system performance and outcomes year to year through “annual report” publications. The first report including Indiana information should be available by early this fall and will be posted on the FSSA web site <http://www.state.in.us/fssa/>.

- **Quality Improvement Committee Structure**

The structure is made up of the following committees:

- **Consumer/Community Advisory Council**, which functions as a voice for community/client concerns and input related to the actions of DDARS
- **Standards Committee**, which reviews the Provider and Case Management Standards for Supported Living and recommends amendment of existing standards and the addition of new standards
- **Risk Management Committee**, which reviews aggregate information within incident reports and identifies/analyzes risk management issues
- **Mortality Review Committee**, which reviews information about the deaths of people with developmental disabilities and the services they received through DDARS, identifies trends, suggests training needs and develops recommendations that are designed to improve the quality of services

What Are Your Appeal Rights?

An appeals process is available to any person who is denied initial eligibility for a waiver. This same process is also the right of a person who has been eligible and was receiving services, but has had his or her eligibility taken away in the annual review process. You also have the right to appeal the denial of a specific waiver service (including a non-Medicaid service) such as an assistive technology device, a decrease (or increase) in services, any part of a "Plan of Care" or anything else with which you do not agree.

A waiver provider who decides to stop delivering a service to an individual must give a 30 day written notice to the person receiving service, the case manager and the state provider relations specialist. If proper notice is not given, contact your case manager. People on a DD Waiver can also call the DD Waiver Ombudsman at [1-800-622-4484](tel:1-800-622-4484).

Denial of non-waivered Medicaid services - referred to as "state plan" or "regular Medicaid" services - may also be appealed through a slightly different process.

If the state denies your eligibility for a program or service you will receive a "notice of action" with an effective date on it. The "notice of action" will include the appeal procedure that instructs what should be sent along with the written appeal, to whom it should be sent and the timelines of the appeal. It is important to carefully follow the listed time lines. For example, in the case of loss of eligibility, an appeal must be filed within 30 days. However, if you are currently receiving the benefit want it to continue during the appeals process you must file before the effective date of action. The effective date of action will be listed in the "notice of action" you receive.

If there are any doubts about the procedure talk with your case manager, FSSA's "Hearings and Appeal Section," the Bureau of Aging and In-Home Services, the Family and Social Services Administration or an advocacy organization (such as Indiana Protection and Advocacy Services).

The state will schedule a hearing before an Administrative Law Judge and send a written notice of the hearing at least ten days before the scheduled date.

As the person who has filed an appeal, you have a right to:

- Be represented at a hearing by legal counsel, relative or friend
- Review the entire case file prior to the hearing
- Present witnesses, cross-examine adverse witnesses

- Present evidence

Hearings are usually conducted in a Division of Family Resources office in your county of residence.

The Administrative Law Judge's decision may be further appealed by requesting an "Agency Review." This consists of a review of the record from the hearing and a review of the Administration Law Judge's decision. A Family and Social Services Administration designee then determines if the Administration Law Judge's decision was appropriate. No new evidence is accepted for the review. However, you or your representative may submit a "Memorandum of Law" summarizing the case. To appeal the "Agency Review" decision, you must file for judicial review in a court.

Contact your case manager for further information regarding your appeal rights. You may also contact one of the advocacy agencies for more information or support on appeals or services. If you are in doubt, always request an appeal. The appeals process is the only way to preserve your rights under federal and Indiana administrative law.

Frequently Used Terms

The following terms are frequently used in reference to Medicaid Waivers and other Home and Community-Based Services:

Aged and Disabled Waiver (A&D Waiver)

The Aged and Disabled waiver provides an alternative to nursing homes for adults and children with a disability. The Waiver is designed to provide services in private homes to people that would have required care in a nursing home if waiver services or other supports were not available. Indiana's 16 Area Agencies on Aging act as the entry points for this waiver. Waiver services can be used to help people remain in their own homes, as well as assist nursing home residents in returning to community settings such as their own homes, apartments or congregate community settings like assisted living.

Autism Waiver

The Autism Waiver provides community supports and services to persons with Autism, including the Autism Spectrum Disorder, who meet eligibility requirements. The waiver is designed to provide services for persons living with family, or in other community settings that assist in gaining and maintaining optimum levels of self-determination and community integration.

Case Management

Waiver case management is a comprehensive service that includes specific tasks and activities designed to coordinate all services required in the person's place of care. Case management is required in conjunction with the provision of any Home and Community-Based Services. *Case management services for people who are on Nursing Facility Level of Care Waivers* are provided by the Division of Aging (DA) certified case managers through one of the local Agencies on Aging. A case manager from the AAA will be assigned to an applicant. After an applicant has been determined to meet the eligibility criteria and approved to receive a Nursing Facility Level of Care Medicaid Waiver, he/she may choose to retain their current AAA case manager or choose a non-AAA or independent case manager, for ongoing case management services. *Case management services for people who are on the ICF/MR Level of Care Waivers* are provided as a Medicaid Administrative service by one case management company and are *not* Medicaid Waiver services.

Cost Comparison Budget / Plan of Care (CCB/POC)

The Cost Comparison Budget (CCB) details the cost of each Waiver service and total cost of the Medicaid services for each person. The Cost Comparison Budget is based upon the Plan of Care (POC). The POC includes written explanation of the person's need for the Waiver services; what provider will be used; how the services protect the person's health and safety; the person's needs that will not be met; and a description of emergency back-up plans. The person receiving services or a guardian must approve and sign the CCB.

Developmental Disability (DD) State Definition

A severe, chronic disability which: 1) is attributable to a mental or physical impairment or combination of mental and physical impairments; 2) is manifested before the person attains age 22; 3) is likely to continue indefinitely; 4) results in substantial limitations in three or more of the seven areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and 5) reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care treatments or services which are of lifelong or extended duration, and are individually planned and coordinated. All criteria must be met for a person to be eligible for Developmental Disability (DD) services.

Developmental Disabilities (DD) Waiver

This Waiver provides services that enable persons to remain in their homes or in community settings and assists those people who transition from state operated facilities or other institutions into community settings. This Waiver is designed to provide supports for persons to gain and maintain optimum levels of self-determination and community integration while allowing flexibility in the provision of those supports.

Developmental Disabilities Waiver Ombudsman

By law, the Ombudsman receives, investigates, and attempts to resolve complaints and concerns that are made by or on behalf of people with developmental disabilities on any of the Waiver programs.

Disability

Any physical, mental or social limitation of a person. Definitions vary depending on the requirements of the specific state or federal program.

Early Periodic Screening, Diagnosis, and Treatment (EPSDT)

Provides a comprehensive set of preventive and health care services to Medicaid-eligible children from birth to 21 years of age and is administered through Division of Family Resources.

Entitlement

An "entitlement" within the Medicaid program means that certain benefits are guaranteed to all people who meet the eligibility requirements for those benefits. Under the Medicaid State Plan, eligible persons are entitled to all services available under that plan as soon as they are found eligible. Medicaid Home and Community-Based Waivers Services are not an entitlement. The number of people who can receive services from Waivers is limited to the number of Medicaid Waiver "slots" that are approved. Therefore, a person may be eligible for Waiver services, but may be on a waiting list until a Waiver slot becomes available.

Federal Poverty Level (FPL)

The federal poverty guidelines are issued each year in the *Federal Register* by the Department of Health and Human Services (HHS). The guidelines are a simplification of the poverty thresholds for use for administrative purposes – for instance, determining financial eligibility for certain federal programs. Programs using the guidelines (or percentage multiples of the guidelines – for instance, 125 percent or 185 percent of the guidelines) in determining eligibility include Head Start, Food Stamps, School Lunch, Low-Income Home Energy Assistance, and the Children's Health Insurance Program.

Habilitation

The coordinated use of medical, social, educational, and vocational measures for training persons with disabilities to the highest possible level of functional ability, usually applies to children or adults with lifelong disabilities. There are several different types of habilitation, including vocational, social, psychological, medical and educational.

Home and Community-Based Services (Medicaid Waivers)

Support services provided in a person's residence or community in order to maintain or restore participation in community activities in order to prevent admission into a nursing facility or group home.

Individualized Support Plan (ISP)

The ISP translates the person's long and short-range goals into reality by creatively using all available resources to accomplish those goals. It is based at least partly upon the Person Centered Planning process. *(Used with ICF/MR Level of Care Waivers only)*

Individual Program Plan (IPP)

The IPP is developed by the interdisciplinary or support team, which outlines immediate goals, and objectives that a person will be working toward next year. (Used in group home settings and other non-waiver settings)

Informed Choice

Informed choice means the person, family, or legal guardian makes a voluntary decision after learning of all options and alternatives. During the creation of the Waiver Cost Comparison Budget/Plan of Care, the individual and/or legal guardian will be asked to choose types of services desired, the provider of each service and his/her ongoing case manager.

Intermediate Care Facility for People with Mental Retardation (ICF/MR)

An Indiana State Department of Health licensed facility in which persons with developmental disabilities may live. There is 24-hour supervision by paid staff that assists and trains each resident in order to develop daily living skills. These residences may be facilities for nine or more residents (large private ICF/MR) run by private companies or group homes for four to eight residents (small ICF/MR). Each resident has a program plan based upon his/her needs.

Level of Care (LOC)

Nursing Facility Level of Care - For the purposes of Level of Care eligibility for the **Aged and Disabled or the Traumatic Brain Injury Waivers**, a person must have either unstable complex medical condition which require direct assistance from others for the following conditions: decubitus ulcers, comatose condition, or management of severe pain; OR direct assistance from others for medical equipment, such as ventilator, suctioning, tube feeding, central intravenous access (I.V.); OR direct assistance for special routines or prescribed treatments from others such as tracheotomy, acute rehabilitation conditions, administration of continuous oxygen; OR medical observation and physician assessment due to a changing, unstable physical condition; OR other substantial medical conditions. The initial Level of Care determination is made by the Area Agency on Aging. LOC is required in order for the person to be admitted into a nursing facility or initially start Waiver services. The Waiver case manager completes the annual Level of Care for Waiver services.

ICF/MR Level of Care - For the purposes of ICF/MR Level of Care eligibility for the **Autism, DD or Support Services Waivers**, a person must have a disability that is attributable to: 1) Mental retardation, autism, epilepsy, cerebral palsy or a condition (other than mental illness) similar to mental

retardation that results in impairment of functioning similar to that of a person who is mentally retarded; 2) Originates before the person is twenty-two (22) years of age; 3) Has continued or is expected to continue indefinitely, and 4) Constitutes a substantial disability to the person's ability to function normally in society due to substantial functional limitations in three of the six major life areas: self-care, receptive and expressive language, learning, mobility, self-direction and capacity for independent living. The disability must result in the person requiring 24-hour supervision (*For purposes of the Waiver, the person must require access to 24-hour assistance, as needed. This can be provided through emergency beepers, telephone systems or in other ways.*) and needing lifelong or for an extended duration an aggressive program of both specialized and generic services, individually planned and coordinated by an interdisciplinary team, and intended to promote greater self-determination and functional independence. The Level of Care is required in order for a person to be admitted into a group home setting (ICF/MR) or to receive Waiver services.

Group Home Level of Care - Admission is determined by the Bureau of Developmental Disabilities Services Level of Care Unit.

Waiver Services Level of Care - The Initial LOC is determined by the Bureau of Developmental Disabilities Service Coordinator. The Annual Level of Case for Waiver services is determined by the Waiver case manager.

Medicaid (Title XIX)

A Federally aided, state-operated and administered program, which provides medical benefits for people with low incomes and are elderly and/or have a disability. Subject to broad federal guidelines, states determine the benefits covered, eligibility, and rates of payment for providers and methods of administering the program.

Mental Retardation (MR)

The preferred term is intellectual or cognitive disability.

Notice of Action (NOA)

The NOA is the state form used to notify a waiver applicant/recipient of any action affecting the person's Medicaid Waiver benefits, including approving or denying eligibility and/or services, as well as terminating, reducing, increasing, or suspending eligibility or any amount of covered services. The NOA contains appeal rights and instructions for appealing any of the above decisions.

Nursing Facility (NF)

Comprehensive care facility or a health facility licensed by the Indiana State Department of Health that provides nursing care, room, food, laundry, administration of medications, special diets, treatments, and may provide rehabilitative and restorative therapies under the order of an attending physician.

Person Center Planning (PCP)

Person Centered Planning is a process for a person with developmental disabilities and family/guardian to direct the planning and allocation of resources to meet the person's life goals. This personal life plan is based on the person's preferences, dreams and needs; shows how the person makes decisions; how the person is and can be productive; what the person likes and dislikes; supports long-term hopes and dreams; documents and explains what supports are needed for this lifestyle; documents a short-term support plan based on reasonable costs and needs; includes a range of responsibilities for all participants; and includes a range of supports including funded and community natural supports. Person Centered Planning should be conducted as often as the needs of the person change, or at least annually. Usually, the facilitator for the Person Centered Planning is a case manager. *(For ICF/MR Level of Care Waivers)*

Prior Authorization (PA)

A process within Medicaid, initiated usually by the primary care physician so that a medical procedure, medical supply or therapy, etc. may be paid by Medicaid as long as the procedure, supply or therapy is authorized prior to the procedure, supply or therapy being performed, purchased or provided. HCBS waiver members are required to exhaust all services on the (Indiana Medicaid) State Plan before utilizing HCBS waiver services. HCBS waiver programs are considered funding of last resort.

Provider

A generic term describing any person, organization or company enrolled to deliver specific services. Qualifications vary depending on the type of service.

Rehabilitation

The coordinated use of medical, social, educational, and vocational measures for retraining people with disabilities to the highest possible level of functional ability. There are several different types of rehabilitation, such as vocational, social, psychological, medical, and educational rehabilitation.

Spend Down

People, who are not financially eligible for Medicaid, may become eligible by paying for a certain amount of his/her medical and remedial service costs each month until the specific spend down amount is met. (This spend down amount is determined by the Division of Family Resources at the time of Medicaid eligibility determination.) When the spend down is met, then Medicaid becomes effective and it pays for the remainder of the monthly medical expenses, which can include the Waiver services.

Spousal Impoverishment Provision

Protects some assets and income for the spouse who is not receiving Aged and Disabled Waiver services. This is similar to a provision that protects the spouse of Medicaid nursing home residents.

Support Services Waiver

The Support Services Waiver is designed to provide limited, non-residential supports to persons with developmental disabilities residing with their families, or in other settings with informal supports.

Targeted

A term used to indicate that funding is now available for the person identified (frequently from a waiting list) as a potential recipient of Waiver services. For the **Aged and Disabled and Traumatic Brain Injury** Waivers, the person will be notified by the local Area Agency on Aging. After being targeted, the person will work with the Area Agency on Aging to determine eligibility for Waiver services. For the **Autism, Developmental Disabilities and Support Services** Waivers, the person will receive a letter from the Division of Disability and Rehabilitative Services, indicating that he/she is identified to potentially receive Waiver services. After being targeted, the person will be contacted by the Bureau of Developmental Disabilities Services District Office to determine eligibility for Waiver services.

Traumatic Brain Injury (TBI)

For the purpose of the Medicaid Waiver, TBI is an injury to the brain due to an outside cause, including closed or open head injuries, toxic chemical reactions, anoxia, near drowning, and focal brain injuries. TBI does not include injuries that are vascular in origin (CVA or aneurysm), alcoholism, Alzheimer's disease or the infirmities of aging. As a result of the TBI, the person shows serious physical, cognitive, emotional and/or behavioral impairments.

Traumatic Brain Injury Waiver

Medicaid eligible people of any age who have experienced an external insult resulting in a traumatic brain injury, and who require services ordinarily only available in a nursing facility, may receive services under this Waiver. This Waiver is designed to provide supports such as personal assistance, limited habilitation services, and respite care, as well as limited environmental modifications.

Waiver Program

This program allows Indiana's Medicaid programs to pay for services that are provided in a person's home or other community setting rather than a Medicaid funded facility/institution. Persons must qualify for institutional care in order to be eligible for home and community-based services. Waiver refers to the waiving of certain federal requirements that otherwise apply to Medicaid program services.

State of Indiana and Federal Agencies

This section provides a brief description of the various state and federal agencies mentioned in this booklet that are part of the service system:

Area Agencies on Aging (AAA)

Also known as Area Agencies, AAA, Triple A, Area Agencies are contracted by the Division of Aging to coordinate intake, determine eligibility and to develop plans of care for eligible people who are elderly or have disabilities. These agencies are the single point of entry within a specific geographic area for adults and children who are interested in applying for the Aged and Disabled and the Traumatic Brain Injury Waivers. Area Agencies also provide other non-Waiver home and community-based services such as CHOICE to people with disabilities and people who are aging. See page 40 for a list of offices.

www.in.gov/fssa/elderly/aaa/index.html

Bureau of Developmental Disabilities Services (BDDS)

A part of Family and Social Services Administration/Division of Disability and Rehabilitative Services (DDRS), BDDS administers a variety of services for persons with developmental disabilities, which include the Autism, the Developmental Disabilities, and the Support Services Waiver. There are eight District Offices serving specific counties. The Service Coordinators determine eligibility for developmental disabilities' services and facilitate the determination of Level of Care for ICF/MR services. See page 41 for a listing of local offices.

www.in.gov/fssa/disability/bqis/bddsguide.html

Bureau of Quality Improvement Services (BQIS)

A part of the Family and Social Services Administration/Division of Disability and Rehabilitative Services, BQIS researches trends in service delivery, quality improvement and best practices, analyzes quality data, and assures compliance with quality standards for the Autism, Developmental Disabilities and Support Services Waivers. www.in.gov/fssa/disability/services/bqis.html

Centers for Medicare and Medicaid Services (CMS)

The federal agency within the Department of Health and Human Services, which directs the Medicare and Medicaid programs (Titles XVIII and XIX of the Social Security Act) and conducts research to support those programs. CMS must review and approve all Waiver proposals and amendments submitted by each state.

www.cms.hhs.gov/

Department of Education (DOE) / Division of Exceptional Learners (DEL)

The Indiana Department of Education is the state agency responsible for overseeing the public school services in the state of Indiana. A part of the

Department of Education, the Division of Exceptional Learners oversees special education services for eligible children from ages three (3) through twenty-two (22) in both public and private schools.

<http://ideanet.doe.state.in.us/exceptional/>

Developmental Disabilities Waiver Ombudsman

By law, the Ombudsman receives, investigates, and attempts to resolve complaints and concerns that are made by or on behalf of people with developmental disabilities in any Medicaid Waiver program.

Contact the DD Waiver Ombudsman at 1-800-622-4484.

Division of Aging (DA)

A part of the Family and Social Services Administration, the DA implements the Nursing Facility Level of Care Medicaid Waivers, CHOICE, and other home and community-based services for people who are elderly and/or have disabilities.

www.in.gov/fssa/elderly/services.html

Division of Disability and Rehabilitative Services (DDRS)

A part of the Family and Social Services Administration, DDRS assists people with disabilities and their families who need support to attain employment, self-sufficiency or independence. The Bureaus of Developmental Disabilities Services and Quality Improvement Services are under DDRS' responsibilities. The DDRS implements the ICF/MR Level of Care Medicaid Waivers and other services for people with developmental disabilities.

www.in.gov/fssa/disability/

Division of Family Resources (DFR) and Indiana Department of Child Services (DCS)

The part of FSSA that provides Medicaid and Children's Services, including the First Steps program for infants and toddlers with developmental delays.

Offices in each county serve as a single point of entry for many of the social services available to Hoosiers. Some of these services include Temporary Assistance to Needy Families (TANF), Medicaid, Medicaid-Disability, Food Stamps and Hoosier Healthwise.

www.in.gov/fssa/family/

Family and Social Services Administration (FSSA)

Indiana's social services agency that provides services related to low income, mental illness, addiction, mental retardation, disabilities, aging, and children at risk for healthy development. Contains the Division of Family Resources, the Division of Aging, the Division of Disability and Rehabilitative Services, the Division of Mental Health and Addictions, and the Office of Medicaid Policy and Program.

www.in.gov/fssa/ and www.in.gov/fssa/admin/

Hearings and Appeals Section

An administrative section within FSSA that receives and processes appeals from people receiving services within any FSSA program and many others. Administrative hearings are held throughout the State of Indiana, usually at county Division of Family Resources locations, at which time all parties have the opportunity to present their case to an Administrative Law Judge.

Indiana Protection and Advocacy Services (IPAS or P & A)

A state agency that assists people with physical, emotional and/or mental disabilities to resolve disability related problems with the service delivery system and access discrimination issues. www.in.gov/ipas/.

Office of Medicaid Policy and Planning (OMPP)

A part of FSSA, OMPP is the State Medicaid Agency. It is responsible to the Centers for Medicare and Medicaid Services for administration and oversight of the Medicaid Waiver program, as well as the funding for nursing facilities and group homes. It is also responsible for the State's Medicaid Health Care Program overall.

www.in.gov/fssa/programs/healthcare/index.html

And for Medicaid eligibility requirements:

www.in.gov/fssa/disability/medicaid/elig.html