



# **Home and Community Based Waiver Traditional Participant Guide**

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## Index

Page 3.	Introduction
Page 4. & 5.	What is the Home and Community Based Waiver?
Page 6.	Who does what?
Page. 7.	How long will it take my services to begin?
Page 8.	Person Centered Service Plan
	Next Steps
	What if my care plan is not going well?
	Corrective Action Plans
Page 9.	Termination

## Introduction

Welcome to the Medicaid Home and Community Based Services Waiver. This Guide will help you understand how this waiver works. There are a lot of new words and people you will meet on your journey. We hope this guide will help you get to know who the people are and how you can help in making sure you get the help you need when you need it.

Medicaid is funded by the federal and state governments to help people have health insurance who cannot afford it or do not have health insurance offered at their workplace. A person must meet certain medical and financial conditions in order to qualify. Each state is given a choice as to how they want to design their Medicaid program.

Kentucky has chosen to create options for people with disabilities to get the help they need to stay in their homes. These options are called waivers. Waivers are allowed to provide different services depending on the person's disability. This level of need can be different from the standards needed to qualify for regular Medicaid. A waiver is able to offer services that are not included in regular Medicaid. Kentucky has six (6) waivers total. You have chosen the Home and Community Based Waiver to help you with your needs.

The Home and Community Based Waiver has a set of rules to make sure the person meets the income limits and has medical needs that are the same as what the person would need for admission to a nursing home. The waiver gives the person the ability to stay in their home and get the help they need from a number of places. The first one is **Traditional** Home and Community Based Waiver Services. The person will get the help they need from a home health agency, an adult day care center, a personal services agency or any combination of them. These businesses are called **providers**. The services range from help with such things as a bath or dressing, cleaning the house and laundry, going out to church, going to the drugstore or the grocery, going to a movie or dinner with friends, having meals delivered to their home or other special needs of the person.

## What is the Home and Community Based Services Waiver?

The Home and Community Based Waiver you have applied for includes the following services:

- **Attendant Care** provides help keeping you clean and dressed, keeping the house clean, and being able to go shopping or go to church or other activities.

Attendant Care includes:

- Bathing, dressing, grooming, going to the toilet, and shaving, brushing hair, etc.;
- Getting from bed to chair or wheelchair and getting around in the house or outside;
- Eating and cooking;
- Help going to the toilet or dealing with incontinence;
- Laundry and house cleaning; and
- Being taken to places like the grocery, drugstore, barber, church and other places you need to go, as well as to doctor's appointments or therapy or other activities that are considered "therapeutic in nature."

These services may take place in your home, either from an Adult Day Health Center or a Home Health Agency, or in any combination of the providers. You may spend four hours at an Adult Day Health Center and have four hours of attendant care in the evening. The total cost per day can only be \$200 for both the Adult Day Health Center and the Attendant care. Attendant care alone is limited to 45 hours per week.

For example, you might have an attendant give you a bath, dress you at home which might take three hours, and then go to the Adult Day Care Center for the other five hours that day to equal the allowed eight (8) hour day for 5 days a week. On the other hand, you could have attendant care for 8 hours each day for 5 days a week or maybe only 3 hours one day and 8 the next depending on what you need. The schedule will fit you and your caregiver's needs.

- **Specialized Respite** is a type of respite that requires a Registered Nurse to be the care provider. This may be due to your need for medical treatment such as IVs, dressing changes, breathing treatments or watching for signs of a medical emergency. This service can also happen at an Adult Day Health Care Center so the main caregiver can work.

**Respite Service amount is limited to \$4,000 per Level of Care year whether it is non-specialized or specialized or a combination of the two. Respite is also limited to \$200 per day alone or in combination with Specialized Respite.**

- **Adult Day Health Care Centers** allow you to come to their building and get all the services you need, as well as providing you the opportunity to be with other people. Adult Day Health Centers can give your bath, help you dress and get

Activities that are "therapeutic in nature" are those that help you maintain a sense of independence, participation and involvement.

- Shopping
- Restaurants
- Library
- Church
- Family outings
- Social activities

ready for the day. They provide transportation to and from the center. Daily activities may include games at the center or a trip to a park or library. Registered Nurses or Licensed Practical Nurses at the Center provide medical services. They can check blood pressure, give medicines, and check blood levels for diabetes, change dressings and many other medical needs you may have.

**You may attend the ADHC for up to 50 hours per week. This allows your main caregiver time to get to work and be at home when you get there or to pick you up at the Center.**

- **Goods and Services** allow you either to buy one-time things you need, or to buy things you need on a more regular basis. Some examples of 'one time' purchases could be a walker, cane, wheelchair, or shower chair. Some examples of regularly needed supplies could be wipes, gloves, pads, chucks, nutritional supplements, catheter supplies, diabetes related things like testing strips or alcohol pads, or other care items directly related to a particular diagnosis or disability. Any products under this service must relate back to your needs and cannot be experimental in nature.

**This service is limited to \$3,500 per year.**

- **Environmental or Home Adaptations** is a service to help you get around in your home. You may require a change in a bathroom, such as rails on the sides of the toilet, a higher toilet seat to help make transfers from the toilet to a chair or walker easier. This service also can help with shower or bathtub changes, or widen hallways and/or doorways, or to build a wheelchair ramp for a home, or make changes to a floor that is uneven to help prevent falls.

**This service is limited to \$2,500 per year.**

## Who Does What?

### Nurse Assessor

A Nurse Assessor from Medicaid will see you first. They will ask many questions about your health and care needs. This information is used to decide if you meet the requirements for the HCBS waiver. If you meet the requirements of the HCB waiver, you will need to choose a case management agency to follow you through care.

The nurse assessor will give you a list of the case management agencies that are available in your county. You will need to choose one from the list and call them to begin the process once you have received a letter stating you have been approved for Level of Care. You will only be reassessed each year or sooner if your condition changes.

The nurses who will do the assessment will call you a **“participant.”**

### Case Manager

You will need someone to help you understand how to manage your care. After the assessment is completed and you have received your approved Level of Care letter, you will need to choose a case management agency. When choosing an agency you may want to talk to friends or relatives who have used them to help you make a decision. Once you choose an agency, the agency will assign you to one of their case managers. Your case manager must be a part of your Person Centered Care Team Meeting to help you develop your service plan.

Case Managers know all the rules, policies and actions needed to use the waiver. Your case manager will be in contact with you each month either by telephone or a face to face meeting in your home or Adult Day Health Center to make sure you are safe and getting the services outlined on your Person Centered Service Plan. They will check on your health and ask about your service providers. Case Managers will keep a record of the visits and will ask if you are satisfied with your care providers.

Your Case Manager will be your contact, problem solver, advocate and help keep you safe.

### **Case Manager's Role:**

- They are the overseers of your care. They will help you find people to help provide the services you need and make sure they are doing what they have been asked to do.
- They are your problem solvers. If changes need to be made in your plan of care, the case manager will help find solutions.
- They must verify that services are still necessary. They will update your Service Plan at least once a year or when your condition changes.
- They may end your services if they think you are in danger or your disability can no longer be cared for at home.
- They will end services if they find that there is fraud or you are not following the rules of the waiver.
- They will either call you or meet with you every month.

### **How long will it take my services to begin?**

#### **If I am already getting Medicaid?**

- You must fill out an application for HCB Waiver at your local Department for Community Based Services in your county, online at <https://benefind.ky.gov> or by phone at 1-855-306-8959, or you may call 1-877-925-0037 to locate the Aging and Disability resource center in your area. The process will begin when the assessment is completed. The assessment must be reviewed and approved for services. This may take a few weeks to complete. You will receive a letter saying you are eligible for the waiver. You will be assessed by a Medicaid Assessor. The Assessor will give you a list of case management agencies in your county. You will choose one and call them to tell them you are ready to talk about the services you need and to choose providers. The case manager will contact the service providers you have chosen and arrange for a meeting with the team to develop the plan of care.

#### **If I am new to Medicaid?**

This will take a longer time. First, apply for waiver services. When waiver level of care has determined, you may then apply for financial eligibility through your local Department for Community Based Services in your county or by phone 1-855-306-8959.

## **Person Centered Service Plan**

After you choose the case management agency and providers, the case manager you have chosen will set up a meeting with you and anyone you want to come with you. The meeting will include the Case Manager and all other providers you have chosen to help you write a Person Centered Service Plan or PCSP or plan of care. This meeting will figure out what services you need and when you need them and who will do which part of the plan.

### **Next Steps**

Medicaid must approve the Person Centered Service Plan before services can begin. You will receive a letter approving your acceptance for the waiver. Your Case Manager will then notify the providers you have chosen that your services can begin. If there are any problems, your Case Manager will help you fix the problem. If you are new to Medicaid, you must have your financial eligibility approved before services can begin. This may take a few weeks or a few months depending on how quickly the paperwork can be completed before services can begin.

### **What if my care plan is not going well?**

You are primarily responsible for making sure that the rules and policies of the HCBS waiver are being followed. This includes that you stay eligible for the HCB waiver, that your providers are doing what they are supposed to do and are writing it down correctly. Should your health, safety, and welfare be in danger or there is a question about how you or your service provider are managing your care, a Corrective Action Plan (CAP) may be necessary. A CAP is a formal report by the case manager to identify any issues that come up, show a possible solution for the issue, and say what will happen if the issue is not corrected.

### **Corrective Actions Plans**

Your full team, along with your case manager, may be called to attend a meeting to talk about this issue and make a plan to correct it. Some issues that might cause a CAP to be in place might be not letting your service provider do what is in your Service Plan, or either you or the service provider employee threatens or causes you to be uncomfortable or angry with them.

**When writing a CAP, the following information is needed:**



**Identify the Issue:** The case manager should write who was involved in the issue, when the issue happened, where it occurred, and what happened. This part of the report should also include any conversations/letters, notes or email that were sent before the CAP is completed.

**Stating the Regulation/Policy:** The case manager will quote the regulation terms and/or policy language related to this particular issue.

**Agreed Upon Resolution:** The case manager will meet with the team and all people who are a part of the issue to agree on a way to reduce or stop the issue. The issue should be corrected completely between thirty (30) to ninety (90) days after the agreement is complete.

**Potential Consequences:** The report will include what will happen if the issue happens again.

**Prevention:** There will also be a sentence that talks about how this issue could be prevented in the future.

**Signatures:** You and/or your representative, case manager, and any other people who are a part of the issue will sign the plan to show that they know what needs to be done. If any of these people fails to follow the steps in the CAP, it may cause your **Traditional** waiver services to be cancelled.