HOPE Waiver - Eligibility

- 65 years or older
- 18 or older with a qualifying disability (SSI/SSDI eligibility)
- Need for at least one waiver service a month
- Meet Nursing Facility Level of Care

Financial Eligibility
- 300% of SSI
- Less than $2000 in resources
HOPE Waiver – Level of Care Criteria

To meet level of care, the consumer must meet one of these 3 criteria:

• Continuing direct care services which have been ordered by a physician and can only be provided by or under the supervision of a professional nurse. procedures or services; Must require these services once every 24 hours.

• The assistance of another person for the performance of any activity of daily living according to an assessment of the individual’s needs

• In need of skilled mental health services or skilled therapeutic services, including physical therapy, occupational therapy, or speech/language therapy in any combination that is provided at least once per week.
HOPE Waiver - Services

- Homemaker Services
- Personal Care Services
- *In-Home Nursing Services*
- Chore Services
- Respite Care
- *Adult Companion Services*
- *Adult Day Services*
- Specialized Medical Supplies
- Specialized Medical Equipment *(including Assisted Technology)*
- Emergency Response Systems
- Meals
- *Nutritional Supplements*
- Environmental Accessibility Adaptations
- *Assisted Living*
LTSS Initiative - Expand HCBS - Completed

- Addition of Chore Services: 10/1/2016
- Expansion of Specialized Medical Equipment definition to include Assistive Technology: 10/1/2016
- Increase in earned income allowance for Assisted Living Waiver consumers: 10/1/2016
- Increase in standard needs allowance for In-home Waiver consumers: 10/1/2016
- Reorganization of Adult Service and Aging to Division of Long Term Services and Supports: 4/2017
- Removal of the requirement for a physician's order for Level of Care determination: 7/2017
LTSS Initiative - Expand HCBS - Planned

Target Date: Fall 2017

- Community Transition Supports
- Community Transition Coordination
- Residential Options
  - Community Living Homes
  - Structure Family Caregiving Homes
Community Transition Services enable an individual to establish a basic household and may include any or all of the following expenses:

- A security deposit required to obtain a rental lease for an apartment or house;
- Moving expenses required to occupy and use the residence;
- One-time non-refundable deposits or installation fees to establish utility and other essential service access, e.g., telephone, electricity, heating and water.
- One-time residential cleaning or pest extermination costs required for the individual to occupy the residence; and
- Non-medical transportation necessary to the transition.
Community Transition Supports

Essential household items necessary for a successful diversion as determined by a needs assessment including:

• Small appliances
• One time/initial set up for groceries;
• Consumable goods (e.g. hand soap, detergent, toilet paper, paper towels, cleaning supplies);
• Bathroom, kitchen, and bedroom linens (e.g. hand towels, bath towels, dishrags, and bed sets
  • The Community Transition Specialist will accompany the consumer to purchase essential household items.
  • The total cost of the essential household items must not exceed $500
Community Transition Coordination

• Available to individuals that are transitioning to a less restrictive setting
• Requires 1 or more Medicaid eligible days
• Assists in identifying, selecting and obtaining paid and unpaid services, integrated housing options
• Available up to 364 days after the date of waiver enrollment
• Available 180 day prior to anticipated transition
Community Transition Coordination for community transitions shall be person-centered and include:

- An initial assessment and the ongoing reassessment of the individual’s strengths and needs;
- Transition care plan development, evaluation and revision;
- Assistance to access service providers;
- Assistance in identifying and securing integrated community housing;
- Information and education on the HCBS Waiver service options, including the individual’s rights and responsibilities; and
- Ongoing monitoring of the transition care plan implementation
## Residential Options

<table>
<thead>
<tr>
<th>Structured Family Caregiving Home</th>
<th>Community Living Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reside with family/fictive kin</td>
<td>Reside with unrelated individual in a smaller, home setting</td>
</tr>
<tr>
<td>Maximum of 2 participants</td>
<td>Maximum of 4 participants</td>
</tr>
<tr>
<td>Family or recipient own home</td>
<td>Private individual or agency own home</td>
</tr>
<tr>
<td>Family enrolls under qualified, Medicaid enrolled agency</td>
<td>Provider enrolls independently or through qualified Medicaid enrolled agency</td>
</tr>
</tbody>
</table>
LTSS Initiative - Expand HCBS - Planned

Target Date: Spring 2018

• Conflict Free/Externalized Case Management
• Self-Direction