HOME AND COMMUNITY – BASED SERVICES (HCBS) ELIGIBILITY/INELIGIBILITY/CHANGE FORM

(Completion Instructions on Pages 4-7)

DEPARTMENT OF HUMAN SERVICES (DHS) OFFICE INFORMATION

County assistance office (CAO) name:	District office name (if applicable):

APPLICANT/RECIPIENT IDENTIFICATION (RID) INFORMATION

Individual's name (last, first, middle initial (if applicable)):	Telephone number:	Social Security number (SSN):	Birthdate (MM/DD/YYYY):

Address (include apartment number, street, city, state, county and ZIP code):	Email (if known):

☐ Individual is a new HCBS applicant **(Complete Part I of this form)**	Medical Assistance (MA) 9-digit record number (2-digit county code/7-digit case number or xx/xxxxxxx)	MA 10-digit (individual) number:

CURRENT HCBS/MA RID INFORMATION

☐ Individual is a current HCBS/MA recipient reporting one of the following:

☐ Update ☐ Change ☐ Transfer ☐ Termination **(Complete Part II of this form)**

If HCBS recipient is admitted for respite care only, do not send this form to the CAO.

PA 1768 ORIGINATOR

☐ PA 1768 Eligibility/Ineligibility/Change Form is being submitted by one of the following:

☐ Enrolling agency (HCBS provider, county mental health/intellectual disability (MH/ID) program, or independent enrollment broker (IEB)/ Area Agency on Aging (AAA))

☐ Service Coordinator (SC)

☐ Additional entity requiring PA 162 notification

Submitter signature:	Title:	Telephone number:

REPRESENTATIVE INFORMATION (IF APPLICABLE)

Name of individual's representative:	Relationship to individual:	Telephone number:

Representative's address (include street, city, state and ZIP code):	Email (if known):

ENROLLING AGENCY INFORMATION (HCBS PROVIDER OR MH/ID AGENCY/IEB/AAA)

Agency contact person:	Telephone number:	Fax number:	Email (if known):

Agency name and address (include street, suite number, city, state, and ZIP code):

SC INFORMATION (IF DIFFERENT FROM AGENCY INFORMATION ABOVE)

SC contact person (if known):	Telephone number:	Fax number:	Email (if known):

SC name and address (include street, suite number, city, state, and ZIP code):

ADDITIONAL ENTITY REQUIRING PA 162 NOTIFICATION

Entity contact person and title (if known):	Telephone number:	Fax number:	Email (if known):

Entity name and address (include street, suite number, city, state, and ZIP code):

COMMENTS

PART I - COMPLETE FOR NEW HCBS APPLICANTS

ASSESSMENT INFORMATION

☐ This is to verify that the individual listed has been determined to meet the level of care appropriate for HCBS through the program indicated below.

Assessment date: _____ **Service begin date:** _____

☐ This is to verify that the individual listed does NOT meet the level of care appropriate for HCBS through the program indicated below.

Assessment date: _____

MFP CODES	WAIVER ELIGIBILITY/CODING	
☐ 16 MFP-Domiciliary Care (DC)	☐ 20 Community HealthChoices Waiver	☐ 70 Infants, Toddlers & Families
☐ 17 MFP-Own Residence	☐ 51 Adult Comm. Autism Program	☐ 77 Consolidated Waiver
☐ 18 MFP-Family Member	☐ 52 Adult Autism Waiver	☐ 79 OBRA Waiver
☐ 19 MFP-Group Setting	☐ 68 Person/Family Directed Support	☐ 81 Community Living Waiver
		☐ 96 LIFE Program

MA RECIPIENT TO BE DISCHARGED FROM A LONG-TERM CARE (LTC) FACILITY

☐ Individual currently residing in a LTC facility	Date of anticipated discharge:

Name and address of facility (include street, city, state, and ZIP code):

PART II - COMPLETE FOR HCBS RECIPIENTS REPORTING AN UPDATE, CHANGE, TRANSFER, OR TERMINATION

ASSESSMENT INFORMATION

☐ This is to verify that the individual listed **no longer meets** the level of care appropriate for HCBS.

Evaluation date: _____

HCBS RECIPIENT ADMITTED TO LTC FACILITY

☐ Individual was admitted to a LTC, Personal Care Home (PCH), or DC Facility. **If admitted for respite care (usually less than 30 days) do not complete this form.**	Admission date:
	☐ Short Term Admission (services expected to resume at discharge)
Name of facility:	☐ AAA or IEB has been notified to initiate PCH/DC application (if applicable)

Address of facility (include street, city, state county, and ZIP code)

HCBS RECIPIENT TO BE DISCHARGED FROM LTC FACILITY

☐ Individual currently residing in a LTC facility	Date of anticipated discharge:
Name of facility:	☐ HCBS should continue
Address of facility (include street, city, state, county and ZIP code):	

CHANGE OF ADDRESS

☐ Individual moved to a new residence within the same county		Date of move:
☐ Individual moved to a new county	Name of new county:	Telephone number:
New address (include apartment number, street, city, state, county and ZIP code):		
☐ Services continued	☐ Services terminated	Date of termination:

TRANSFERRING HCBS PROGRAMS

Name of HCBS program transferring from:	Service end date:
Name of HCBS program transferring to:	Service begin date:

TRANSFERRING HCBS SERVICE PROVIDER (NO CHANGE IN PROGRAM OR BENEFITS)

Name of losing service provider:	Date losing provider will stop providing services:
Name and address of gaining service provider (include street, city, state, county, and ZIP code):	

PROGRAM WITHDRAWAL INFORMATION

☐ Individual voluntarily withdrew	Date of withdrawal:

TERMINATION OF HCBS PROGRAM

☐ HCBS terminated	Reason:	Date of termination:

DEATH OF HCBS RECIPIENT

☐ Deceased	Date of death:

CHANGE OF HCBS RECIPIENT'S FINANCIAL STATUS

☐ Change in individual's financial status. Documentation attached.

COMMENTS (INCLUDE ATTACHMENT IF NECESSARY)

INSTRUCTIONS FOR COMPLETION OF THE PA 1768

DEPARTMENT OF HUMAN SERVICES (DHS) OFFICE INFORMATION	
County assistance office (CAO) name	Enter the name of the county assistance office where the information is being sent.
District office name (if applicable)	Enter the name of the district office where the information is being sent (if applicable).

APPLICANT/RECIPIENT IDENTIFICATION (RID) INFORMATION	
Individual's name	Enter the individual's name (last, first, and middle initial (if applicable)).
Telephone number	Enter the individual's telephone number ((XXX) XXX-XXXX).
Social Security number (SSN)	Enter the individual's Social Security number (XXX-XX-XXXX).
Birthdate	Enter the individual's date of birth (MM/DD/YYYY).
Address	Enter the individual's address (including apartment number, street, city, state, county and ZIP code).
Email	Enter the individual's email address (if known).
☐ Individual is a new HCBS applicant **(Complete Part I of this form.)**	Check this box to indicate the individual is a new HCBS applicant. **If this box is checked, Part I of this form must be completed.**
Medical Assistance (MA) 9-digit record number	If this individual is a current MA recipient who is now applying for HCBS, enter the individual's MA record number; 2-digit county code/7-digit case number/1-3 letter category (if known).
MA 10-digit (individual) number	If this individual has ever received MA, enter the individual's 10-digit RID (if known).

CURRENT HCBS/MA RID INFORMATION	
☐ Individual is a current HCBS/MA recipient reporting one of the following: ☐ Update ☐ Change ☐ Transfer ☐ Termination **(Complete Part II of this form.)** **If HCBS recipient is admitted for respite care, do not send this form to the CAO.**	Check this box to indicate that the individual is a current HCBS recipient. Check the appropriate box to indicate whether there is: ☐ Updated information since initial PA 1768 was completed; or ☐ A change in the HCBS recipient's circumstances; or ☐ The recipient is transferring to another HCBS program; or ☐ Services are being terminated. **If any of the above boxes are checked, Part II of this form must be completed.** **Respite care is a short term stay in a LTC facility usually lasting less than 30 days. If the HCBS recipient is only admitted to a facility for respite care paid for through the HCBS program, do <u>NOT</u> submit this form to the CAO.**

PA 1768 ORIGINATOR	
☐ PA 1768 Eligibility/Ineligibility/Change Form is being submitted by one of the following: ☐ Enrolling agency (HCBS provider, county mental health/intellectual disability (MH/ID) program, or independent enrollment broker (IEB)/Area Agency on Aging (AAA)) ☐ Service Coordinator (SC) ☐ Additional entity requiring PA 162 notification	☐ Check this box to indicate submission of a completed PA 1768, then check the appropriate box to indicate what authorized person is submitting this PA 1768. ☐ Enrolling agency (HCBS provider, county mental health/intellectual disability (MH/ID) program, or independent enrollment broker (IEB)/Area Agency on Aging (AAA)) submits initial PA 1768; or ☐ Service Coordinator (SC) can report updates, changes, and terminations; or ☐ Additional entity requiring PA 162 notification may also report updates, changes, and terminations on the PA 1768.
Submitter signature	Enter the signature of the person approved by DHS to submit updates, changes, transfers and terminations.
Title	Enter the submitter's title or agency affiliation.
Telephone number	Enter the submitter's telephone number ((XXX) XXX-XXXX).

REPRESENTATIVE INFORMATION (IF APPLICABLE)	
Name of individual's representative	Enter the name of the individual who is representing the HCBS applicant/recipient.
Relationship to individual	Enter the relationship of the representative to the HCBS applicant/recipient, including Power of Attorney (POA) or Guardian.
Telephone number	Enter the representative's telephone number ((XXX) XXX-XXXX).
Representative's address	Enter the representative's address (including street, city, state, and ZIP code).
Email	Enter the representative's email address (if known).

ENROLLING AGENCY INFORMATION (HCBS PROVIDER OR MH/ID AGENCY/IEB/AAA)	
Agency contact person	Enter the name of the person from the enrolling agency who may be contacted if information is needed by the CAO.
Telephone number	Enter the contact person's telephone number ((XXX) XXX-XXXX).
Fax number	Enter the agency fax number. This may be a dedicated fax machine that the agency uses only for HCBS documents ((XXX) XXX-XXXX).
Email	Enter the contact person's email address (if known).
Agency name and address	Enter the name of the enrolling agency and the address (including street, suite number, city, state, and ZIP code).

INSTRUCTIONS FOR COMPLETION OF THE PA 1768

SC INFORMATION (IF DIFFERENT FROM AGENCY INFORMATION ABOVE)	
SC contact person (if known)	Enter the name of the person from the service coordinator who may be contacted if information is needed by the CAO.
SC name and address	Enter the service coordinator's name and address (including street, city, state, and ZIP code).
Telephone number	Enter the service coordinator's telephone number ((XXX) XXX-XXXX).
Fax number	Enter the service coordinator's fax number ((XXX) XXX-XXXX).
Email	Enter the service coordinator's email address (if known).
ADDITIONAL ENTITY REQUIRING PA 162 NOTIFICATION	
Entity contact person and title (if known)	Enter the name and relationship, for example POA or GDN.
Entity name and address	Enter the entity's name and address (including street, city, state, and ZIP code).
Telephone number	Enter the entity's telephone number ((XXX) XXX-XXXX).
Fax number	Enter the entity's fax number ((XXX) XXX-XXXX).
Email	Enter the entity's email address (if known).
COMMENTS	
Comments	Enter any comments that may be useful to the CAO.

PART I - COMPLETE FOR NEW HCBS APPLICANTS	
ASSESSMENT INFORMATION	
☐ This is to verify that the individual listed has been determined to meet the level of care for HCBS. **Assessment Date:** _____ **Service Begin Date:** _____	Check the box to indicate that the individual was determined eligible for HCBS. In the assessment date box, enter the date that the assessment agency conducted the level of care and functional assessment and found the individual eligible for HCBS. In the service begin date box, enter the date that the individual will start to receive services under a HCBS program (if known).
☐ This is to verify that the individual listed does NOT meet the level of care appropriate for HCBS. **Assessment Date:** _____	Check the box to indicate that the individual was determined **ineligible** for HCBS. In the assessment date box, enter the date that the assessment agency conducted the level of care and functional assessment and found the individual **ineligible** for HCBS.
ELIGIBILITY/CODING	
In order for an individual to qualify for Money Follows the Person (MFP), and for PA to receive enhanced federal funding for up to 365 days after facility discharge, MA recipients eligible for HCBS program 20, 77, 79, or 96 must: • Have resided in a qualified (certified) institution for at least 60 days and received MA at least 1 day prior to discharge. • Be transitioning to a qualified residence. • Meet the eligibility criteria for the appropriate HCBS waiver program.	
☐ 16 MFP-Domiciliary Care (DC) ☐ 17 MFP-Own Residence ☐ 18 MFP-Family Member ☐ 19 MFP-Group Setting	Check the appropriate MFP code for the individual's type of qualified residence. In order to be eligible for MFP, an individual must also be enrolled or enrolling in one of the following HCBS programs: CHC Waiver, Consolidated Waiver, OBRA Waiver, LIFE Program.
☐ 20-CHC Waiver ☐ 77-Consolidated ☐ 51-Adult Comm. Autism ☐ 79-OBRA ☐ 52-Adult Autism Waiver ☐ 81-Community Living ☐ 68-Per. Fam. Dir. Sup. ☐ 96-LIFE Program ☐ 70-Infant, Toddler	Check the appropriate HCBS program for which the individual was determined eligible to receive services.
MA RECIPIENT TO BE DISCHARGED FROM LONG-TERM CARE (LTC) FACILITY	
☐ Individual currently residing in a LTC facility	Check the box to indicate that the individual is residing in a LTC facility and is requesting HCBS upon discharge.
Date of anticipated discharge	Enter the date (MM/DD/YY) that the individual will be discharged from the LTC facility.
Name and address of facility	Enter the LTC facility's name and mailing address (including street, city, state, and ZIP code).

INSTRUCTIONS FOR COMPLETION OF THE PA 1768

PART II - COMPLETE FOR HCBS RECIPIENTS REPORTING A CHANGE, TRANSFER, OR TERMINATION	
ASSESSMENT INFORMATION	
☐ This is to verify that the individual listed no longer meets the level of care appropriate for HCBS. **Evaluation Date:** _____	Check the box to indicate the individual was determined no longer eligible for HCBS and provide the evaluation date (MM/DD/YY).
HCBS RECIPIENT ADMITTED TO LTC FACILITY	
☐ Individual was admitted to a LTC, Personal Care Home (PCH), or DC facility. **If admitted for respite care (usually less than 30 days), do not complete this form.**	Check the box to indicate that the individual has been admitted to a LTC facility, PCH or DC facility. **Respite care is a short term stay in a LTC facility usually lasting less than 30 days. If the HCBS recipient is admitted to a facility only for respite care that may be paid for through the HCBS program, do NOT submit this form to the CAO.**
Admission date	Enter the date (MM/DD/YY) that the individual was admitted to a LTC, PCH, or DC facility.
☐ Short term admission (services expected to resume at discharge)	Check the box to indicate that the individual's admission to the LTC facility is for a short period of time and HCBS are expected to resume upon the individual's discharge from the facility.
Name of facility	Enter the name of the facility to which the individual has been admitted.
☐ AAA or IEB has been notified to initiate PCH/DC application (if applicable)	Check the box to indicate that the AAA or IEB has been notified that the individual who was receiving HCBS has been admitted to a PCH or DC facility and an application may be needed.
Address of facility	Enter the LTC facility's mailing address (including street, city, state, and ZIP code).
HCBS RECIPIENT TO BE DISCHARGED FROM LTC FACILITY	
☐ Individual residing in a LTC facility	Check the box to indicate that the individual is residing in a LTC facility and is requesting that HCBS continue upon discharge.
Date of anticipated discharge	Enter the date (MM/DD/YY) that the individual will be discharged from the LTC facility.
Name of facility	Enter the name of the LTC facility.
☐ HCBS should continue	Check the box if the individual received HCBS while residing in the facility and should continue to receive HCBS upon discharge.
Address of facility	Enter the LTC facility's mailing address (including street, city, state, county, and ZIP code).
CHANGE OF ADDRESS	
☐ Individual moved to a new residence within the same county	Check the box to indicate that the individual has moved to a new residence within the same county.
Date of move	Enter the date (MM/DD/YY) that the individual moved.
☐ Individual moved to a new county	Check the box to indicate that the individual moved to a new county.
Name of new county	Enter the name of the new county of residence.
Telephone number	Enter the individual's telephone number ((XXX) XXX-XXXX).
New address	Enter the individual's entire new address (including apartment number, street, city, state, county, and ZIP code).
☐ Services continued	Check the box to indicate that the individual continues to receive HCBS.
☐ Services terminated	Check the box to indicate that the individual's HCBS has stopped.
Date of termination	Enter the date (MM/DD/YY) that the individual's HCBS stopped.
TRANSFERRING HCBS PROGRAMS	
Name of HCBS program transferring form	Enter the name of the current HCBS program providing services to the individual. Services under this program will end and be continued under another HCBS program.
Service end date	Enter the last date (MM/DD/YY) that the individual will be eligible for services. This is the last day that services will be provided under the current HCBS program. An individual should NOT be eligible for two HCBS programs concurrently.
Name of HCBS program transferring to	Enter the name of the NEW HCBS program that the individual will be enrolled in for continued services.
Service begin date	Enter the first date (MM/DD/YY) that the individual will be eligible to receive services under the new HCBS program. An individual should NOT be eligible for two HCBS programs concurrently.
TRANSFERRING HCBS SERVICE PROVIDER (NO CHANGE IN PROGRAM OR BENEFITS)	
Name of losing service provider	Enter the name of the losing service provider agency.
Date losing provider will stop providing services	Enter the last date (MM/DD/YY) that the individual will receive services from the losing provider.
Name and address of gaining service provider	Enter the new service provider's name and mailing address, including street, city, state, county, and ZIP code.

INSTRUCTIONS FOR COMPLETION OF THE PA 1768

PROGRAM WITHDRAWAL INFORMATION	
☐ Individual voluntarily withdrew	Check the box to indicate that the individual requested that HCBS be stopped. Enter the reason in the COMMENTS section.
Date of withdrawal	Enter the date (MM/DD/YY) that the individual requested a withdrawal.
TERMINATION OF HCBS PROGRAM	
☐ HCBS terminated	Check the box to indicate that the individual stopped receiving HCBS.
Reason	Enter the reason the individual stopped receiving HCBS.
Date of termination	Enter the last day (MM/DD/YY) that the individual stopped receiving HCBS. For the LIFE program, terminations must fall on the last day of the month.
INFORMATION REGARDING DEATH OF HCBS RECIPIENT	
☐ Deceased	Check the box to indicate that the individual has died.
Date of death	Enter the date (MM/DD/YY) that the individual died.
CHANGE OF HCBS RECIPIENT'S FINANCIAL STATUS	
☐ Change in individual's financial status Documentation attached.	Check the box to indicate that the individual's finances have changed and that documents are attached to verify the changes.
COMMENTS (INCLUDE ATTACHMENT IF NECESSARY)	
Comments	Enter any comments that may be useful to the CAO.