Social Service Intake

Chapter 4 describes the function and processes of Social Service Intake. Intake is the point of entry for all applicants seeking a functional eligibility assessment for Apple Health Long Term Services and Supports through Home and Community Services.

Ask the Expert

If you have questions or need clarification on the processes outlined in this chapter, please first contact your local Intake Supervisor. You may also contact:

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WHAT IS THE PURPOSE OF INTAKE?

- Act as a point of entry for information, referral, and requests for service.
- Dedicated to helping people make decisions about the services and supports that are best suited for the individual's particular needs based on self-referrals and referrals from other professionals such as primary care providers, hospitals, Long-Term Services and Supports (LTSS) providers, families, or friends.
- Gather brief information needed to refer to the most appropriate program and service(s) based upon the needs of the individual and the availability and requirements of all the services, including Medicaid Transformation Project (MTP) programs, Medicaid Alternative Care (MAC) or Tailored Supports for Older Adults (TSOA), that focus on supporting unpaid family caregivers. For more detailed information about the intake process for programs in the Medicaid Transformation Project programs, MAC and TSOA, see Chapter 30b of the LTC Manual.
- Provide information about Medicaid and service requirements.
- Provide education and inform applicants of eligibility requirements to access services
- Have a process that is consistent and understood by the public and agencies that refer individuals to our services.
- Take necessary action prior to Case Manager assignment and functional assessment.

WHAT DOES SOCIAL SERVICE INTAKE DO?

Social Service Intake workers provide professional level assistance to applicants by doing the following:

- Educate the applicant about LTSS, including functional and basic financial eligibility requirements.
- Inform the applicant or representative about all the LTSS offered by HCLA and the settings for which they are offered.
- Inform the applicant of the possibility of a cost of care for services and that Estate Recovery laws may apply.
- Refer applicants to alternative community resources if HCLA LTSS are not needed or are declined, including other state or federally funded programs offered through the aging and disability network including Older American's Act and Family Caregiver Support Program (FCSP).

> For more detailed information about the intake process for programs in the Medicaid Transformation Project programs, MAC and TSOA, see Chapter 30b of the LTC Manual.

- Document relevant safety issues that an assessor should be aware of prior to making a home visit.
- Determine whether the applicant may need assistance in completing an application.
- Assign the case for a functional eligibility CARE (Comprehensive Assessment Reporting & Evaluation) assessment to be completed if the applicant is interested in receiving care in a Nursing Facility or services in another Home and Community Based setting.
- Assign the case for a Presumptive Eligibility (PE) screening if the applicant is choosing Medicaid Transformation Project (MTP) programs such as Medicaid Alternative Care (MAC) or Tailored Supports for Older Adults (TSOA), or Long-Term Services and Supports Presumptive Eligibility (LTSS PE).

WHAT IS THE DIFFERENCE BETWEEN A REQUEST FOR SERVICES AND A REFERRAL?

A ***request for services*** is any request that comes to Home and Community Services (HCS) regardless of source or eligibility. A request for service may not generate a referral.

A ***referral*** is any request for service that is accompanied by a Medicaid application or for a client with current Medicaid eligibility. A referral generates an intake. HCS is expected to assist individuals who may need assistance in completing an application.

WHAT IS THE DIFFERENCE BETWEEN AN APPLICANT, REFERENT, AND A REPRESENTATIVE?

An ***applicant*** is the individual seeking long-term services and support.

A ***representative*** is a person who the applicant has chosen or has been appointed by a court whose primary duty is to act on the applicant's behalf to make decisions about long-term services and supports. An applicant may also choose a representative who is not a DPOA or guardian (i.e., a parent, family member, advocate, or other person authorized by the applicant) to serve as a representative in connection with the provision of services and supports. Decisions made by informal decision makers (not legally appointed with verifying documents confirming the legal relationship) must be confirmed with the applicant. A representative that is not legally

The intake and referral form (DSHS 10-570) and instructions can be found on the Electronic DSHS Forms website.

appointed, must be redesignated and documented in a SER note at each Initial, Annual, and Significant Change Assessment. See Chapter 3, Assessment and Care Planning, for more information.

A ***referent*** is the person who referred the applicant for long-term services and supports (i.e., homeless shelter staff, hospital discharge planner/social worker, facility staff, external agency partner, etc.). A referent can be contacted initially to facilitate setting up an appointment for an assessment, but a completed Consent Form (DSHS #14-012) would be needed for continued communication.

WHEN IS AN APPLICATION NEEDED?

An application is needed if the individual is not active on Medicaid.

HOW DOES THE INDIVIDUAL APPLY?

For Home and Community Services, the individual needs to apply using one of the following:

- Washington Connection online application site
- Washington Health Benefit Exchange (for Community First Choice and Medicaid Personal Care only)
- Submitting a completed HCA 18-005 form (classic Medicaid programs) or HCA 18-008 form (Medicaid Transformation Project, TSOA program).

FOR APPLICANTS CURRENTLY IN AN ACUTE CARE HOSPITAL

Applicants in acute care hospitals may apply using one of the following:

Paper Applications: Hospital staff or applicant will submit an HCA 18-005 with the Expedited Acute Care Hospital coversheet using the dedicated fax line of 1-888-220-4575. The fax line is the only way to ensure expediated timeframes for case assignments.

Washington Connection: Application completed online at Washington Connection. When completing the application, the client/hospital representative should indicate the name of the hospital on the address line, and state that the client currently resides in a hospital in the additional comments section of the application.

WHEN IS AN APPLICATION FOR SERVICES NOT NECESSARY TO COMPLETE AN INTAKE REFERRAL?

There are times when an individual may not need an application to generate a referral and assignment to an assessor. These exceptions include, but are not limited to:

Adult Protective Services (APS) referrals related to abuse, neglect, or financial exploitation referrals must be reported using the APS intake phone line or online reporting site. Refer to APS Policy & Procedure for more information on the APS intake process.

- Individuals on Hospice
- Imminent risk of hospitalization or nursing facility admission
- Individuals currently residing in an Acute Care hospital
- When the individual requests assistance completing the application, regardless of the setting type
- Other circumstances on a case-by-case basis as reviewed and approved by a supervisor
- Individuals residing in a Nursing Facility that are active on an Apple Health benefit.
- In these instances, assign from Form 10-570: Intake and Referral (Home and Community Services)

HOW DO I PROCESS AN INTAKE REFERRAL?

HCS workers will process referrals in date of order received, unless they are notified by any source about situations that warrant prioritization.

HCS workers will do the following in the identified computer programs and by phone:

1) ***Barcode/ACES Online****:* Review the application and the applicant's Electronic Case Record (ECR) to obtain the following information:
    a. Determine whether there is a communication (DSHS 07-104) from the Public Benefits Specialist that provides an estimated cost of care or other important financial eligibility information. Functional and financial eligibility are conducted concurrently and therefore details such as cost of care may not have been determined and that should not cause a delay in processing a referral.
    b. Identify whether the applicant needs an interpreter
    c. Identify whether the applicant has an informal decision maker, authorized representative (AREP), attorney-in-fact, or court appointed agent
    d. Identify the applicant's current location/setting

2) ***CARE:*** See CARE Web Help File/Assessor's Manual for detailed instructions for these steps.
    a. Search CARE for an existing client record:

- If the case is active, review the Service Episode Records (SERs) to see whether any action is needed, and create an Information and Referral (I&R) record as needed.
- If the case is active and already assigned to a worker, an I&R record is not needed. Instead, notify the worker of referral and determine if the case needs to be reassigned to another unit.
- If the case is not active, then reactivate the case in CARE.
- If no record exists, create a client record and the intake in CARE.

b. Once determined active in CARE, enter a SER to document the date the referral was received by the intake unit.
   - Use Purpose Code "Intake Referral Received" and enter the contact date that the intake unit first became aware of the referral by any method (e.g., phone, fax, DMS, etc.).
     - ✓ Use this SER purpose code **ONLY** to document the receipt of a referral. Other information may be included in this SER if it is relevant to the referral.
   - Use Purpose Code "Intake/Eligibility (HCS)" for all other intake related SER documentation (or other relevant SER codes). It is important to use this SER purpose code, using the criteria outlined here because the contact date associated to this SER will be used as a data point for reporting on intake and assessment timeliness.

c. Search to see if client record exists in ProviderOne. If yes, link to the ProviderOne record. If no, a record must be created completing the following steps:
   - Complete the Residence Screen. Ensure the correct address is entered for "Residence, Mailing, and Temporary" addresses when applicable:
     - ✓ CARE Web: Client Details > Contact Details
   - Complete all client demographics. If there is a current ACES record use the current information from ACES:
     - ✓ CARE Web: Client Details > Demographics
   - Complete the Client Contact information:
     - ✓ CARE Web: Client Details > Contact Details
   - Complete all known Collateral Contacts relevant to the applicant's upcoming assessment:
     - ✓ CARE Web: Client Details > Contact Details

d. Go to the ProviderOne Screen in CARE Web and link the client between CARE and ProviderOne following the steps in the CARE Web Assessor's Manual > Demographics > **ProviderOne** section.

IMPORTANT: It is very important to ensure linking of the correct records. Double check name spelling, Date of Birth and Social Security Number, especially when no match is found **BEFORE** creating a new record. If a new record is created when one already existed, it will cause payment problems.

If the individual is already residing on a private pay basis in a licensed facility that accepts Medicaid and needs to convert to Medicaid for ongoing payment purposes, skip to #4

3) Phone: Call the applicant and/or representative and discuss the following:

- Reason the individual is requesting services
- Identify the type of service(s) being requested
- Diagnoses and/or current challenges
- Activities of Daily Living/Instrumental Activities of Daily Living needs
- Is there anybody who is currently helping them with:
  - ADLs/IADLS
  - Finances
  - Getting to appointments
- Where does the individual want to receive services (In-home or residential)?
  - If in home, do they have an identified choice of provider (agency provider or Individual Provider)?
  - If residential, have they started searching for a facility type (Adult Family Home or Assisted Living Facility or specific facility)?
- The possibility of client responsibility and Estate Recovery
- If the referral came from anyone other than the applicant, ensure the referent is aware that participation in HCS services is voluntary for the applicant.
- The CARE assessment process takes about 2 ½ -3 hrs., is in-person and if conducted in a location other than where services will be provided, a home visit will be required. (Not pertinent to MAC/TSOA programs)
- Safety issues or concerns:
  - Document relevant information that an assessor should be aware of prior to making a home visit such as whether there are locked gates, unmarked roads, physical/environments hazards (i.e. extreme weather conditions or broken steps on stairways) that staff may encounter at the address, or lack of adequate cellular service.
  - Ask the client if they or others in the home have any concerns with their assigned Primary Case Manager completing a home visit to conduct their assessment. This includes but isn't limited to asking about the following:
    - ✓ Are there perfume or animal allergens to consider that the client, household member, or staff member must refrain from?
    - ✓ Are there animals in the home that must be restrained prior to the home visit?

- ✓ Have there been any recent illness exposures amongst household members?
- ✓ Are there any environmental concerns such as mold or bed bug/cockroach infestations?
- ✓ Do any household members own have weapons, and are these secured?
- ✓ Is there any illegal drug use or paraphernalia within the home?

- If LTSS are requested, assign a Primary Case Manager (PCM) in CARE by adding in the Overview screen. Add the PCM's supervisor as well. (**Note**: skip this step for MAC and TSOA applicants.). Send the applicant the booklet entitled Washington Apple Health and Long Term Services and Supports (DSHS 22-916(X)).
- Based on the applicant's preferred setting for LTSS, complete the following:
  - If in-home: Determine if the applicant would like to choose an Individual Provider (IP) or a home care agency provider. If they identify a person they know, who would like to become an IP employed by the Consumer Directed Employer (CDE), obtain the name and phone number of the individual. For more information on referring client and IPs to CDWA, refer to Long Term Care Manual Chapter 11.
  - If Residential: Send the applicant the booklet entitled, Choosing an AFH or Assisted Living Facility

4) ***CARE HCS Intake Dashboard:*** In CARE, input the applicant into the HCS Intake. The following minimum data elements are required:

Name	Referral Type
ACES ID	ZIP
Received Via	LEP – Yes/No; if Yes, list language

MAKING CONTACT WITH AN INDIVIDUAL

1) HCS Intake staff will make an attempt to reach the applicant or representative using all telephone numbers available to them.
2) If the applicant cannot be reached and the Intake staff does not receive a call back within 5 calendar days, the Intake staff will send a letter documenting the attempts to reach the applicant and give 10 calendar days to contact the Intake staff or the case will be closed. *See 10 day Letter*
3) Send a copy of the letter to DMS.
4) If the applicant or representative does not respond to the [1]10-day letter:

[1] Following a no response action to the 10-day letter, for applicants who (are active or pending an appropriate financial program) make contact or leaves a voicemail on the intake phone line after 10 calendar days, intake should consider a 30-day grace period to re-activate a case and process the intake interview or make one more call attempt to the applicant. If there is no answer then, there is no need to restart the intake process by making a second phone call and sending another 10-day letter.

a. Inactivate client record in CARE
b. Update the intake database to 'Information and Referral'
c. Send a 14-443 to financial documenting outcome

5) Document all activities in the SER in CARE

WHAT IF THE REFERRAL IS FROM A NURSING FACILITY?

A nursing facility must submit a Nursing Facility Notice of Action (NOA) (15-031) for all Medicaid clients in the facility (for financial). The facility must also submit an Intake and Referral form so that a Social Service Specialist (SSS)/Nursing Facility Case Manager (NFCM) is assigned to the case.

1. Once a referral is received from a Nursing Facility, the Intake staff will review Barcode to determine financial status within 2 business days, check eligibility in ACES, and determine if the individual is in CARE. If an application is submitted or the individual is Medicaid eligible, assign to appropriate NFCM for functional assessment and refer to Chapter 10 of the LTC Manual for clarification.
   1) If the client record is active in CARE and assigned to the AAA or HCS case worker, determine if:
      - there is a current assessment
      - how long the client has been out of their residence (more or less than 30 days)
      - the client is choosing to return to their prior living situation or to change their living situation upon discharge
   2) Submit a 14-443 to Public Benefits Specialist to notify them of the client's hospitalization
   3) The holding agency (AAA or HCS) will transfer the case to NFCM as appropriate
   4) Document all activities in a SER in CARE
   5) If the client record is active in CARE and assigned to a Developmental Disabilities Community Services Case Resource Manager or DDA PASRR RU, assign to appropriate NFCM for NFLOC assessment in CARE and document all activities in a SER in CARE. Refer to Chapter 10 of the LTC Manual for clarification.

WHAT IF THE REFERRAL IS FROM A HOSPITAL?

1) By the next business day after receipt of any hospital referral, Intake staff will review Barcode to determine what documents have been received and financial status.
2) Check eligibility in ACES and determine if individual is in CARE.
3) Contact the referring discharge planner at the hospital to determine the following, if the information was not already provided:
   - Is the individual still at the hospital?
   - If so, what is the anticipated date of discharge?

  - If unable to confirm discharge date and application was submitted (if needed) assign to SSS within 24 hours.
- If not Medicaid eligible, has an application been submitted? If so, what was the date submitted?
- If the client record does not already exist in CARE, create the record using instructions from the CARE section above and assign to appropriate HCS SSS
- If the client record is active in CARE and assigned to the AAA or HCS case worker, determine if:
  - there is a current assessment
  - the client has been out of their residence for less than 30 days
  - the client is choosing to return to their prior living situation
  - the client is choosing to change living situations (e.g., it is unsafe for them to return to an in-home setting, and they request residential services)

4) Submit a 14-443 to the Public Benefits Specialist to notify them of the client's hospitalization
5) The Holding agency will transfer the case as appropriate
6) Document all activities in the SER in CARE

For further information regarding Hospital assessments, refer to Long Term Care Chapter 9/Hospital Assessment

WHAT IF AN APPLICANT WITHDRAWS THEIR REQUEST FOR SERVICES DURING THE INTAKE PROCESS?

It is not uncommon for an individual to withdraw a request for services prior to completing an intake. When an individual withdraws an application for services, attempt to connect the individual with other local resources that may be able to meet their needs and do the following in CARE:

- Enter a SER noting the reason for withdrawing
- Save the record as an Information and Referral (I&R) via the HCS Intake Dashboard.
- Inactivate the client record
- Send a 14-443 to notify the Public Benefits Specialist of the individual withdrawing (only when an individual has applied for or is active on Medicaid with HCS).
  - For Skilled Nursing Facility (SNF) residents: If a client is active on a Medicaid Medical program, Nursing Facility Case Managers (NFCMs) still have an obligation and responsibility to determine Nursing Facility Level of Care (NFLOC) and confirm ongoing functional eligibility for the Nursing Facility services by statute. Though a client may withdraw a request for community LTSS, it is unlikely that they would close out their established medical benefit which is paying for their SNF care.

WHAT IF AN INDIVIDUAL REAPPLIES FOR SERVICES?

If a request for services is received from an applicant who was assessed and found to be functionally ineligible in the past 30 days, the following steps should occur before reactivating the applicant's CARE record and creating a new referral:

1) Call the applicant to review their current situation and request for services.
2) Review the functional eligibility process with the applicant.
3) Since the last assessment was completed, ask if there has been:
    - a change in the individual's condition, situation, or supports
    - any recent hospitalizations
    - any new diagnoses or medical conditions, or
    - any other relevant changes
4) If there has been a change in condition since last assessment, process a new intake.
5) If there has not been a change in condition, and after reviewing the eligibility process, the applicant requests to withdraw the service request, document this conversation in the SER. Do not reactivate the case in CARE
6) If the individual chooses not to withdraw the request, the Intake staff will route the request to the supervisor of the last assessor.

The supervisor will:

1) Review the information identified in #1 of this section
2) Contact the individual
3) Review the previous assessment and determine the most appropriate course of action

If the supervisor determines a new assessment will be completed, the Supervisor will:

1) Determine who the assigned Social Service Specialist will be.
2) Route the request back to Intake for creation of a new referral.
3) Document all activities in the SER.

If the supervisor determines a new assessment will not be completed, the supervisor will:

1) Review administrative hearing rights with the individual, relative to the last assessment.
2) Document all activities in the SER.

WHAT IF THE REFERRAL IS FOR AN INDIVIDUAL WHO RESIDES OUT OF STATE?

An individual cannot be approved for and/or made active on Washington State Medicaid until they are a resident of the State of Washington, but Medicaid financial eligibility determinations can be initiated while the person resides in another state. The individual or authorized representativeAREP can be provided with an Application for Benefits and list of necessary verifications while out of state. Applications should be submitted before arrival in Washington State, but not more than 45 days before the individual becomes a resident.

Social services cannot determine whether an individual is functionally eligible for Medicaid under Washington State guidelines unless the individual is a Washington state resident. Social Service Specialists or nurses do not go out-of-state to conduct CARE assessments ([2]unless there is a Memorandum of Understanding (MOU) with a border state hospital).

If someone is moving to Washington and knows where they will be residing, an assessment can be scheduled prior to or upon their arrival but will occur once the individual is residing in Washington. Coordination with the individual and scheduling of the assessment are critical to ensure services start as soon as possible after arrival in WA.

WHAT APPLICANTS AND THEIR REPRESENTATIVES NEED TO KNOW

- LTSS cannot be approved retro-actively for in-home services or in facilities other than a Nursing Facility.
- DSHS cannot pay for services while a functional eligibility determination is being processed. An exemption to this is the Presumptive Eligibility (PE) process allowing for services to be provided during the PE period (usually less than 60 days) while the final functional and financial determination is being completed. See Chapter 30b/Initiative 2: LTSS - Medicaid Alternative Care (MAC) & Tailored Supports for Older Adults (TSOA), and Chapter 30e/Long-Term Services and Supports Presumptive Eligibility (LTSS PE), for more information on PE.
- It is typically not possible to assess an individual the same day or week they arrive in Washington. This means an individual will need to consider other options, such as:
  - Residing with friends or family until financial and functional eligibility has been determined. If eligible, the client will need to choose in-home or residential services then select a qualified provider; or
  - Moving into their desired service setting *on a private pay basis* until functional and financial eligibility can be determined. Medicaid will not begin to pay for services until both functional and financial eligibility have been established (unless the client has been approved for fast track).
- The intake process can feel complicated. Individuals applying for services or their family members may feel anxious and overwhelmed about how to navigate the system. If a call is received or an individual is greeted at the front desk wanting to understand how to go through this process and Intake staff feels a lack of confidence explaining this, please refer the matter to someone who is knowledgeable (e.g. a Social Service Supervisor or Public Benefits Specialist Supervisor).

[2] Some offices may have an MOU with a border state hospital (Oregon or Idaho) which is acceptable if the individual is active on WA Apple Health. This arrangement is not allowed for Canada residents.

WHAT IF A REFERRAL IS FROM AN INDIVIDUAL WHO IS IN JAIL OR PRISON?

Individuals in a jail or prison in Washington are considered residents of the State of Washington. Referrals for individuals in jails will follow the regular intake process. Medicaid financial eligibility determinations can be initiated while an individual is in either a jail or prison facility. The individual, representative, or staff at the jail/prison can be provided with an application for benefits or directed to the online application. Applications should be submitted as soon as a potential release date is known.

The intake worker should inform the referent and/or individual that the referral should occur when the release date is expected to be less than 30 days. This is because the assessor will need to complete the assessment (move to Current and authorize services) within 45 days after the date of intake, and if the client will not return home within 30 calendar days of incarceration, the case worker will proceed with termination planning.

HOW ARE DEVELOPMENTAL DISABILITIES ADMINISTRATION CASES DIFFERENT?

HCS serves clients aged 18 and older. DDA serves clients from birth to end of life. Both HCS and Developmental Disabilities Administration (DDA) administer 1915c waiver programs, Medicaid Personal Care (MPC), and Community First Choice (CFC) services. Below is a table illustrating the 1915c waivers under each administration:

HCS	DDA
COPES New Freedom Residential Support Waiver	Basic Plus Core Community Protection CIIBS (Children's Intensive In-Home Behavioral Supports) IFS (Individual and Family Services)

Collaboration between DDA and HCS is required to determine which agency will conduct the applicant's CARE assessment and authorize services in the event of possible dual-eligibility, or while initial eligibility or eligibility re-determination[3]** for DDA eligibility is being conducted.

If HCS receives a referral for services from an adult receiving service through DDA:

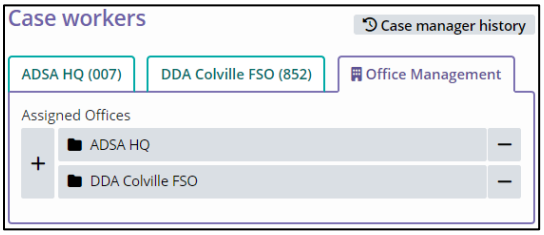
[3] WAC that outlines DDA program eligibility changed in 2005. Any DDA client who was found to be eligible for their services prior to 2005 must go through eligibility re-determination when they apply for a paid service such as MPC or CFC**

1) Consult with a Public Benefits Specialist in the LTC specialty unit to determine the appropriate program. Contact the specialty unit at 1-855-873-0642
2) If financially eligible for MPC or CFC:
    a. Inform the client/representative of the availability of DDA case management to assess, authorize and provide MPC or CFC services.
    b. Refer the client/representative to the DDA Non-Paid Services Intake line at 1-800-567-5582

See Chapter 7 *Intro. To Medicaid, State Plan, and 1915c Waivers* for detailed information.

How do I know a case has DDA involvement?

The Overview screen may look like the following:



The decision whether DDA or HCS will take a case is complex and includes a number of variables. The Intake Supervisor should always be consulted when there is any question about which agency should take action on a case that has existing DDA involvement of any sort.

WHAT IS CLIENT RESPONSIBILITY?

This section is informational. Intake is only responsible for providing basic information on estate recovery and cost of care.

Client responsibility is determined by a Public Benefits Specialist. It is composed of three parts:

1. **Room and board** (R&B) is a portion of the total payment paid by the client to the residential provider for expenses related to food, shelter, heat, utilities, etc. All residential clients with income greater than the current Personal Needs Allowance (PNA) amount must pay towards the cost of Room & Board. Any R&B costs not covered by the client's income are paid for using state-only funds. Clients must pay R&B before the department pays the provider.
2. **Participation** is a portion of the client responsibility paid by the client to the provider to cover part or all their cost of care. Unlike R&B, participation begins the first day the client receives services.
3. **Third-party resource** (TPR) a portion of client responsibility that may include some types of Veterans Affairs benefits, L&I income, Trusts and Long-Term Care insurance. TPR may

also be called Third Party Liability (TPL). Third-party resource amounts may be listed on the ACES award letter and included in the line, "Total amount you must pay."

Clients who do not have to pay client responsibility:

- A client who receives supplemental security income (SSI).
- Clients who just receive CFC and not a home and community-based waiver service.
- Clients enrolled in the MAC and TSOA programs.
- Clients who are otherwise eligible for Medicaid in the community – for example clients who receive SSI-related medical coverage but do not get an SSI payment. Most of these clients receive a type of Social Security disability or retirement benefit.
- Clients who receive MAGI-based coverage (N-track).

Which clients will have to pay client responsibility?

- Clients who are eligible for CFC but need to access a waiver service to be Medicaid eligible:
  - Clients under 65, not eligible for Medicare with income over 133% FPL who do not qualify for coverage through the Healthplanfinder. Before waiver services can be approved for a MAGI client, a disability determination must be made which may take 60-90 days.
  - Clients 65 or older or those under 65 who have Medicare who have income over the SSI benefit rate who do not qualify for regular Medicaid. These clients must access a waiver service to be eligible.
- All clients who live in a residential setting will be required to pay for their room and board. A MAGI client's room and board amount will be calculated by the assigned SSS. Instructions for this are in the Social Services Authorization Manual (SSAM).
- All clients who receive CFC ***and*** a waiver service will potentially be required to pay participation toward the cost of all the services provided, including personal care through CFC.

How much participation will clients pay?

It depends on many variables including where they live, whether they have a spouse or not, whether they have dependents, and whether they have any unpaid medical expenses or allowable deductions. Applicants should be referred to their Public Benefits Specialist to understand what their cost of care will be if they are on any form of "Classic Medicaid."

Explain that participation is like a co-pay. The client's portion is paid first to the provider, and then DSHS pays the remainder of the client's cost of care to their in-home or residential provider. If a client has no income, they are not required to contribute to their cost of care.

There is no cost to the applicant to have a CARE assessment to determine functionally eligibility for services. Also, there is no cost to have a Public Benefits Specialist fully evaluate their case to determine if they will have participation and what the amount would be. Participation will only apply once services are authorized and received.

In-Home: Most clients who are single keep up to 100% federal poverty level as a Personal Needs Allowance (PNA) and pay income over that toward their cost of care. Married clients have a lower PNA but are allowed an allocation to their spouse which reduces their income. Many married clients do not end up paying participation because the allocation to the spouse can be quite high.

Residential: Generally, with most income sources the client retains a portion of their monthly income. This is called a Personal Needs Allowance (PNA). The remainder of their income is paid as room and board and participation. In turn, all their personal care, meals, utilities, and toiletries will be provided by the facility.

WHAT IS ESTATE RECOVERY?

State law requires staff to fully disclose in advance, both verbally and in writing, the terms and conditions of estate recovery to all persons offered LTSS that are subject to recovery of payments. **All HCLA services except services offered through MAC and TSOA and APS are subject to estate recovery.**

The estate recovery program recovers the cost of Medicaid LTSS and related hospital and prescription drug services from a deceased client's estate. The estate recovery laws have changed several times since the program was enacted. The department recovers from estates according to the law in effect at the time the services were received.

More about Estate Recovery:

- DSHS recovers from the estate of a deceased client. "Estate" includes all real property (land or buildings) and all other property (mobile homes, vehicles, savings, other assets) the client owned or had an interest in when the client died.
- A home transferred to a spouse or to a minor, blind or disabled child prior to the client's death, is not considered part of the client's estate. This is a legal transfer under Medicaid rules and does not affect the client's eligibility.
- Some assets are exempt from estate recovery, and this includes most American Indian/Alaskan Native assets.
- DSHS will delay recovery under certain circumstances. Including when there is a surviving spouse who lives in the home or minor, blind or disabled children who still live in the home.

Required Publications

To meet disclosure requirements and to promote understanding by the applicant, DSHS must provide the documents linked below to all prospective and new clients and verbally explain both the estate recovery program and the community service options available.

These documents will be provided to the client/representative at the time of their assessment. If an applicant is hesitant to move forward with an assessment before learning more about estate recovery, the Social Service Specialist (SSS) should mail the documents to the applicant and document this activity in the Service Episode Record (SER). The SSS should ask the individual if they would like to have Home and Community Services continue with their application while they review the information.

- Columbia Legal Services Article: Estate Recovery for Medical Services Paid for by the State;
- Northwest Justice Article: Native Americans and Alaska Native Property Owners: Exemptions from Estate Recovery
- HCS publication: Medicaid and Options for Long-Term Care Services for Adults (DSHS 22-619x)

RESOURCES

LTSS Definitions WAC
Apple Health Medicaid Manual
Chapter 7 a-h: Medicaid, State Plan, and 1915c Waivers and more
Chapter 30b Initiative 2: LTSS - Medicaid Alternative Care & Tailored Supports for Older Adults
Chapter 9:Inpatient Hospital Assessments and Transitions
Chapter 10: Nursing Facility Case Management and Relocation
Chapter 11: Consumer Directed Employer

Acronyms

A complete list of Washington State Department of Social and Health Services acronyms can be found here.

AAA	Area Agency on Aging	IP	Individual Provider
ACES	Automated Client Eligibility System	LTSS	Long-Term Services and Supports
AREP	Authorized Representative	MAC	Medicaid Alternative Care
APS	Adult Protective Services	MPC	Medicaid Personal Care
CARE	Comprehensive Assessment Reporting & Evaluation	MTP	Medicaid Transformation Project
CDE	Consumer Directed Employer	NFCM	Nursing Facility Case Manager
CDWA	Consumer Direct Care Network Washington	PE	Presumptive Eligibility
CFC	Community First Choice	PNA	Personal Needs Allowance
DDA	Developmental Disabilities Administration	SER	Service Episode Record
DMS	Document Management System	SNF	Skilled Nursing Facility
DSHS	Department of Social and Health Services	SSI	Supplemental Security Income

ECR	Electronic Case Record
FCSP	Family Caregiver Support Program
HCS	Home and Community Services
I&R	Information and Referral
SSS	Social Service Specialist
TPL	Third Part Liability
TPR	Third Party Resource
TSOA	Tailored Supports for Older Adults

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
8/18/2020	Rachelle Ames	Overall changes to word choice and grammar to improve readability	
		Added more specific instructions or steps in multiple sections of the chapter to improve clarity of policy/procedure	
		Added policy related to documenting Intake activities in the SER	H18-049
		Added policy/procedure for referrals that come from jails or prisons	
		Upgrade to new format	
5/2023	Dru Aubert	Updated procedure to remove action steps related to CARE Desktop. If not already, CARE Desktop screens referenced in this chapter will be made read-only after 06/30/2023 CARE change/MB release.	
8/2023	Dru Aubert	Updated links. Removed former APS LTC Chapter reference; replaced with APS P&P policy location. Updated CARE Desktop reference(s) to CARE Web.	
4/2024	Dru Aubert	• Replaced naming conventions from Intake Database to CARE HCS Intake Dashboard. • Added clarification for an existing client under section, HOW DO I PROCESS AN INTAKE REFERRAL? • Added prioritization and clarified NFCM steps when case is active and assigned to DDA/DDA PASRR RU, under section, WHAT IF THE REFERRAL IS FROM A NURSING FACILITY? • Added section, WHAT IS THE DIFFERENCE BETWEEN AN APPLICANT, REFERENT, AND A REPRESENTATIVE?	
10/2024	Dru Aubert	• Added to section, HOW DO I PROCESS AN INTAKE REFERRAL?, for in-home settings, to instruct documentation of relevant information that an assessor should be aware of prior to making a home visit. • Added to section, MAKING CONTACT WITH AN INDIVIDUAL, to implement a 30-day grace period, following a no response action to the 10-day letter, for applicants who (are active or pending an appropriate financial program) make contact or leaves a voicemail on the intake phone line after 10 calendar days.	

4/2025	Anna Mitchell	• Added clarification about informal decision makers, authorized representatives, attorneys-in-fact and court appointed agents	
7/2025	Dru Aubert	• Updated Developmental Disabilities Administration (DDA) to Development Disabilities Community Services (DDCS) naming.	
07/2025	Natalie Lehl	• Updated Chapter owner • Made overall changes to formatting and word choice	
04/2026	Natalie Lehl	• Updated link and chapter title to Chapter 9 • Update to contact timeframes	
07/2026	Natalie Lehl	• Added clarification to NFCM intake process • Added Acute Care Hospital fax number and cover sheet for expedited support • Added additional policy for clients in jail or prison • Replaced case manager with case worker	