New Freedom Budget-Based Participant Directed Services (Limited availability based upon county of residence)

The purpose of this chapter is to educate staff about the New Freedom waiver and the benefits it offers to participants as well as to provide instruction on how the program works.

Ask the Expert

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BACKGROUND

What is Participant Directed Services?

Participant Directed Services is a philosophy and orientation to home and community-based services that gives participants the authority to make choices about services and supports that work best for them, regardless of the nature or extent of their disability.

Participant direction empowers participants and their families by expanding their degree of choice and control over the long-term services and supports they need to live at home. This is done in Collaboration with the Area Agency on Aging (AAA) Care Consultant. Participants can share authority with or delegate authority to family members or others close to them. Designation of a representative enables adults with cognitive impairments or those who would rather not be fully responsible to be involved in participant direction.

Participant direction represents a major paradigm shift in the delivery of publicly funded home and community-based services. In the traditional service delivery model, decision-making and managerial authority is vested in professionals who may either be state employees/contractors or service providers. Participant direction transfers much (though not all) of this authority and responsibility to participants and their families (when chosen or required to represent them).

What is New Freedom (NF)?

New Freedom is a voluntary budget-based program that provides participants who are eligible for Home and Community Based Services (HCBS) through the 1915c Medicaid Waiver Program. It offers participants a choice in how they receive services in their home. NF offers Participants the opportunity for increased responsibility, choice and control over their services and supports.

The goal of NF is to provide the opportunity for qualified participants to choose from a wide array of approved services to meet their needs within a set monthly budget. NF Participants can choose the amount and type of services **(within the definitions in this chapter and the state and federal regulations)** that meet their needs as long as they have sufficient funds within their individual monthly service budget. NF provides flexibility to adjust services and allows participants to exercise more decision-making authority and to take primary responsibility for obtaining services.

Participants who choose NF receive an individual monthly service budget that they can use to purchase items and services that meet their care needs that enable them to live as independently as possible in the community. The program provides participants the ability to save for and purchase services, equipment or supplies that decrease their need for Medicaid services and/or increase safety in their home environment.

Participants in New Freedom have the choice to decide:

- What qualified services, goods and supports they need within their approved service budget.
- When and how those services and supports are to be delivered.
- Who will provide those services and supports.
- Who will provide personal care assistance (individual provider/homecare agency).

New Freedom Roles

New Freedom participants work with a Care Consultant and a Financial Management Service vendor (ACES$) to design and implement their individual participant spending plan. Each play an important role in working with participants to develop an individualized monthly service budget that details approved authorizations and guides the participant's purchasing of services/supports to meet their needs.

Role	Summary of Responsibilities
Participant or Authorized Representative	Participant or Authorized Representative will work with their Care Consultant to make choices about approved services and supports that work best for them within their approved New Freedom budget. They will work with ACES$ Financial Management Services to obtain those approved services and supports. This may entail monitoring their own services including the budget and informing the Care Consultant of any changes.
Care Consultant	Assists the participant in development and management of their New Freedom budget. The Care Consultant is available to advise participants in how to gain access to needed services, assisting in the development of the New Freedom Spending Plan, coaching the participant on how to monitor their services included in the budget, and updating the service plan as necessary. The Care Consultant reviews and approves all purchases and adds them to the New Freedom Spending Plan. In addition, the Care Consultant provides ongoing functional eligibility determinations for participants enrolled in the program.
ACES$ Financial Management Services (FMS) provider	Handles all financial transactions for New Freedom participants outside of monthly personal care. All New Freedom expenses incurred, except personal care, by participants are billed through ACES$ Financial Management Services (FMS). The only supports/services that will be allowed under New Freedom have been approved by the Care Consultant under the guidance of this chapter and the appropriate state and federal regulations. .
New Freedom Program Manager	Manages the New Freedom program including all policy. • Responsible for updating program related documents. • Continuing education and training. Darrelyn Nuesca: darrelyn.nuesca1@dshs.wa.gov

WHAT ARE THE ELIGIBILITY REQUIREMENTS FOR NEW FREEDOM?

To determine functional eligibility, a personal care assessment, also known as your Comprehensive Assessment Reporting & Evaluation (CARE) assessment, must be completed. The financial and functional eligibility requirements for New Freedom are the same as the other Medicaid waiver programs, such as

the COPES waiver. **New Freedom is also available if a Community First Choice (CFC) participant meets the waiver eligibility criteria, has a need that cannot be met by CFC and wants to enroll in New Freedom.** New Freedom is currently an option available only to participants who live in participating counties and choose to receive in-home services.

Participants who receive services through the New Freedom Waiver meet each of the following criteria (WAC 388-106-1410):

Participants are eligible for New Freedom Consumer Directed Services (NFCDS)-funded services if they reside in their own home and meet **all** the following criteria. The participants' needs will be assessed using CARE and determine that:

(1) They are in NFCDS HCBS waiver specified target groups of:

(a) Eighteen or older and blind or have a disability; or

(b) Sixty-five or older; and

(C) They reside in a county where New Freedom is offered (King, Pierce, Ferry, Pend Oreille, Spokane, Stevens, or Whitman County).

(2) They meet financial eligibility requirements described in WAC 182-513-1315. This means the participant's finances will be assessed if their income and resources fall within the limits, and determine the amount they may be required to contribute, if any, toward the cost of their care as described in WAC 182-515-1505; and

(3) They:

(a) Are not eligible for Medicaid Personal Care services (MPC); or

(b) Are eligible for MPC services, but it is determined that the amount, duration, or scope of their needs is beyond what MPC can provide; and

(4) Their CARE assessment shows they need the level of care provided in a nursing facility as defined in WAC 388-106-0355; and

(5) They live in their own home or will be living in their own home by the time NFCDS start.

A participant must also be willing and able to self-direct their services or select an Authorized Representative.

WHAT SERVICES ARE COVERED UNDER NEW FREEDOM?

Federal rule requires that waiver services not replace other services that can be accessed under state plan, Medicaid, Medicare, health insurance, Long Term Care (LTC) insurance, and other community or informal resources available to them.

- If a participant has other insurance or resources, case managers must document the denial of benefits before the participant can access waiver services. This documentation must be in the participant's file.
- Waiver services may not be used when the vendor refuses the reimbursement (from the FMS) or considers the payment inadequate from the other resources.
- Waiver services may not supplement the reimbursement rate from other resources.
- Exceptions To Rule are not allowed for the above circumstances.

All purchases under New Freedom must be pre-approved by the Care Consultant and meet the following criteria:

1. Be allowable under WAC 388 106 1400: What services may I receive under New Freedom consumer directed services (NFCDS)?
    a. Be for the sole benefit of the participant.
    b. Be of reasonable cost and meet a therapeutic need identified in the participant's CARE assessment.
    c. Meet the participants identified needs and outcomes from the CARE assessment and address the health, safety, and welfare of the participant related to their medical diagnosis, Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and health-related tasks (for example, nurse delegation and PERS units).
    d. Be documented on the participant's New Freedom Spending Plan;
2. The Care Consultant and/or Financial Management Service may require a physician or other licensed professional, such as an Occupational or Physical Therapist to recommend a specific purchase in writing. This recommendation is required to ensure the service, support, or item will increase, maintain, or delay decline of functional abilities, and to ensure the purchase supports the participants' health and welfare.
3. Medicare or Medicaid state plan benefits or other insurance must be used prior to using NF funds if the goods or services are covered under these programs.
4. A participant may use their individual budget to purchase services, supports, or items that fall into the following service categories (as defined in the WAC 388-106-1400):
    a. Personal Assistance Services
    b. Treatment and Health Maintenance
    c. Individual Directed Goods, Services and Supports
    d. Environmental or Vehicle Modifications
    e. Training and Educational Supports
5. A participant may receive comprehensive adult dental services.
    a. New Freedom funds may be used for dental services that are medically necessary and not covered by the Medicaid State Plan, Medicare, or other programs or services.
6. Trained Service Animals (for specific coverage see Trained Service Animals section).
7. Non-medical transportation: Taxi scripts or ride-share such as "Uber" rides may be authorized for grocery shopping and other essential shopping.
    a. The FMS cannot prepay for a taxi or ride-share. The participant must have prior authorization, prepay, and be reimbursed.
        i. Receipts must have time, date, name of transportation company, cost, and name of location (such as "Safeway") on the receipts.
        ii. The participant cannot be reimbursed for the tip.
    b. A bundled amount of either a specific number of trips per month or a maximum dollar amount per month may be authorized, not to exceed the care plan year.
    c. Non-emergency medical and mental health appointments are offered by the state plan and are not covered under New Freedom.

WHAT SERVICES ARE NOT COVERED UNDER NEW FREEDOM?

All purchases under New Freedom must be pre-approved by the Care Consultant and must not be excluded under WAC 388-106-1405 and 1915c waiver. Services and supports that cannot be purchased with New Freedom budgets include:

- Those items identified in WAC 388 106 1405: "What services are not covered under New Freedom Consumer Directed Services (NFCDS)?"
- Any goods, services, or supports that are considered of general utility.
    - **General utility** is defined as an item that is not of direct medical or remedial benefit to the participant. An item that would be a purchase made by any person whether they have a disability or not. Examples include lamps, step stools, air conditioners, rugs, beds, non-specialized clothing etc.
    - The service/good/support is not specific to the individuals' needs based on their disabilities or health conditions as identified in the CARE assessment.
- Services/supports covered by the Medicaid State Plan, Medicare, or other programs or services.
- Any fees related to health or long-term care incurred by you, including co-pays, waiver cost of care (participation), or insurance. This includes costs that other insurances will not pay.
    - If Medicaid funds (Apple Health) are used, then the participant cannot also use New Freedom funds (which are also Medicaid funds) to pay any remaining balance as it would be double dipping into the Medicaid pool of funds.
        - Example: Costs that exceed the participant's medical/dental benefit allowance for using Medicaid funds.
- Concierge or subscription-based services are not allowed as they may supplant or duplicate items or services that are covered by the medical benefit and are not allowable.
- Home modifications or improvements that only add any square footage to the home.
- Home modifications or improvements that are of general utility and are not of direct medical or remedial benefit to the participant.
- Repairs or general maintenance needed prior to a modification being completed (or determined during the modification), including testing and removal or abatement of asbestos or mold or repairs required due to water or pest damage. Repair and general maintenance of a dwelling are the responsibility of the owner.
- Vacation or travel expenses other than the direct cost of provision of personal care services.
    - A participant may not use New Freedom funds to pay travel expenses for their provider.
- Rent/room and board.
- Tobacco or alcohol products.
- Lottery tickets.
- Entertainment items (TV, cable or DVD players), and other electronics, that are nonadaptive in nature.
- Vehicle purchases/maintenance/upgrades that do not include modification related to disability.
- Tickets and related costs to attend sporting or other recreational events.
- Standard household supplies, furnishings, equipment and maintenance, and major household appliances.
- Pets, comfort, or therapy animals and their related costs (including purchase of the pet, comfort or therapy animal, their food or veterinary services).

- Non-routine veterinary services for a Trained Service Animal (Veterinary care over the cost of $500 per occurrence.)
- Postage outside of shipping costs related to prior approved service plan items.
- Experimental or investigational services, procedures, treatments, devices, medications, or application of associated services, except when the individual factors of an individual participant's condition justify a determination of medical necessity under WAC 182-500-0070.
    - This also applies to Trained Service Animals. Experimental or investigational services, procedures, treatments, devices, medications, or application of associated services are not covered.
- Exercise equipment greater than $500 per item.
- Monthly service fees for utilities including ongoing utilities.
- Warranties (for equipment, furnishings, or installations).
- Computers and electronics that do not meet therapeutic need or are not adaptive in nature.
- Cosmetic services and treatments.
- Basic groceries, clothing, and footwear.
- Any item previously purchased through Medicaid funding that is within the Health Care Authority replacement period.

TRAINED SERVICE ANIMALS

What is a Trained Service Animal:

The 1915(c) waiver allows New Freedom funds to be used to pay for Trained Service Animals. WAC 388-106-1405 and WAC 388-473-0040 follow the Americans with Disabilities Act (ADA) definition of a Trained Service Animal and RCW 49.60.040:

ADA:

- Dogs that are trained to perform a task directly related to a person's disability.

RCW 49.60.040 (25):

- Any dog or miniature horse that is individually trained to do work or perform tasks for the benefit of an individual with a disability, including a physical, sensory, psychiatric, intellectual, or other mental disability. The work or tasks performed by the service animal must be directly related to the individual's disability.

Example: If the dog's mere presence provides comfort, it is **not** a Trained Service Animal under the ADA.

If the dog is trained to perform a task related to a person's disability, it is a service animal under the ADA. The tasks that the service animal provides cannot be duplicative. They cannot be tasks that are already covered by another person, device, or service being provided to the participant. To pay for a trained service animal it must also be the most cost-effective option to meet the client's identified need.

Example: If the dog has been trained to sense that an anxiety attack is about to happen and takes a specific action to help avoid the attack or lessen its impact, the dog **is** a Trained Service Animal. This

action must be related to the participant's medical diagnosis, Activities of Daily Living (ADL), and/or IADL (Instrumental Activities of Daily Living) and documented in the participant's Care Plan.

What is Covered:

The New Freedom waiver and WACs allow for the payment of upkeep expenses related to trained service animals such as food, licensing, and routine veterinary services.

- Food:
  - Benefits may be authorized for a Trained Service Animal – up to a 45-day supply at a time.
- Veterinary care:
  - Routine veterinary services for a Trained Service Animal may be authorized when there is a routine medical necessity that would require treatment so that the Trained Service Animal can continue to do the task they have been trained to perform.
    - Routine services such as vaccines, office visits, nail trimming or routine blood tests.
    - Flea medicine may be approved for up to 90 days.
    - Any routine veterinary costs over $500 per occurrence requires an approved Headquarters ETR.
  - All non-routine veterinary services for a Trained Service Animal requires an approved Headquarters ETR.
- Additional Training:
  - Enrollment in a course addressing additional training (new tasks only) specifically related to a participant's Trained Service Animal.
    - All service animal training requires a Headquarters ETR approval.
    - Trainings must be completed by a qualified trainer.
  - This should be limited in scope and for a specific task that relates to a participant's ADL/IADL or medical diagnosis within their care plan.
- Boarding:
  - Benefits may be authorized for boarding for a maximum amount of $300.00 a year if it is determined that the participant needs medical or mental health care and is in a facility in which your Trained Service Animal cannot reside and there is no one who can provide care for your Trained Service Animal.

What is Not Covered:

- All veterinary care beyond the cost of $500 per occurrence without a Headquarters ETR.
  - Veterinary care must be approved in advance and cannot be approved for emergency services.
- Experimental or investigational services, procedures, treatments, devices, medications, or application of associated services are not covered.
- Concierge or subscription based veterinary services.
- Training to become a Trained Service Animal.
- Obedience or other general utility training.
- Purchase of a pet, comfort or therapy animal.
- Pets, therapy animals and their related costs (including food and veterinary services).

- Emotional support or comfort dogs, because providing emotional support or comfort is not a task related to a person's disability.
- Boarding of a Trained Service Animal for purposes of a vacation or other non-medical participant needs.
- Dog walking and grooming services are considered general utility and not covered.
- Travel time for vendors.

What is Not Required:

- There is no requirement of the Care Consultant to request certification for the Trained Service Animal.
- There is no requirement for a Trained Service Animal to wear a vest or other ID that indicates they are a service dog.

AUTHORIZED REPRESENTATIVE

The New Freedom waiver supports participants to use an Authorized Representative to assist them (or manage on the participant's behalf) in managing and directing their budgets. Both the participant and the representative must sign the New Freedom Authorized Representative Form giving the responsibility to the person of their choice. An Authorized Representative is authorized to complete and sign all forms. An Authorized Representative will work with the Care Consultant to use the New Freedom Spending Plan (NFSP) monthly budget to purchase goods, services, and other items to meet the participant's personal care needs as identified in their CARE assessment.

Authorized Representatives can ensure that participants' preferences are known and respected and can manage tasks that they would carry out if they were able. These individuals are surrogate decision makers for those who choose or may need some or total assistance to direct their services and supports. In New Freedom (per WAC 388-106-1435) an Authorized Representative cannot also be a paid provider under the participant's NFSP.

An Authorized Representative Must:

- Act in the participant's best interest
- Respect the participant's preferences
- Maintain regular contact with the participant
- Be willing and able to meet and uphold all program requirements on behalf of the participant
    - Including working and collaborating with the participant's Care Consultant
- Be at least 18 years old

An Authorized Representative CANNOT:

- Be paid for this service
- Be a paid provider for the participant

The participant or Authorized Representative may end this agreement at any time.

HOW DO PARTICIPANTS ENROLL IN NEW FREEDOM?

HCS Case Workers (including Nursing Facility Case Managers):

Prior to transferring the case to an Area Agency on Aging, the HCS case worker must complete the following:

Outside of CARE:

- The participant must sign the New Freedom Participant Responsibility Agreement form (DSHS 16-244) prior to completing enrollment.
    - The participant cannot be on the program unless this document is signed.
- Provide the participant with a copy of the New Freedom Participant Handbook.
    - This does not require a signature and can be emailed to the participant.
- Provide the participant with the link to the ACES$ Washington Participant Enrollment Packet.
    - To be completed online by the participant. Completion is not required prior to transfer to the Area Agency on Aging (AAA).
    - Inform the participant that enrollment in ACES$ is a requirement of the program.
- If applicable, provide the participant with a copy of the New Freedom Authorized Representative form.

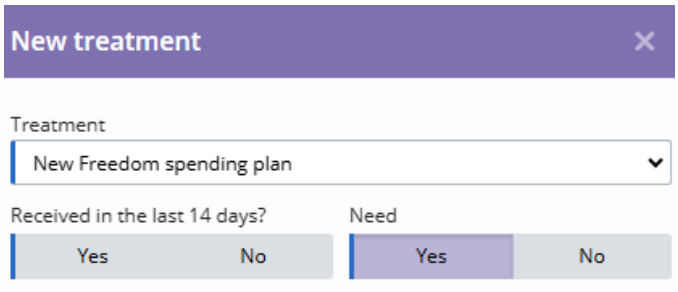
In CARE (For step-by-step instructions see the Choosing New Freedom in CARE section):

- Add the treatment "New Freedom spending plan" to the Medical screen.
- Select New Freedom on the 'Client chosen program' on the Care Plan screen.
- Enter in the number of hours the participant has chosen to use for personal care on the Care Plan screen.
- Add "ACES$ Financial Management Services – New Freedom" agency (ACES$ 208768001 to the Care Plan Supports screen and assign the task "New Freedom Spending Plan".

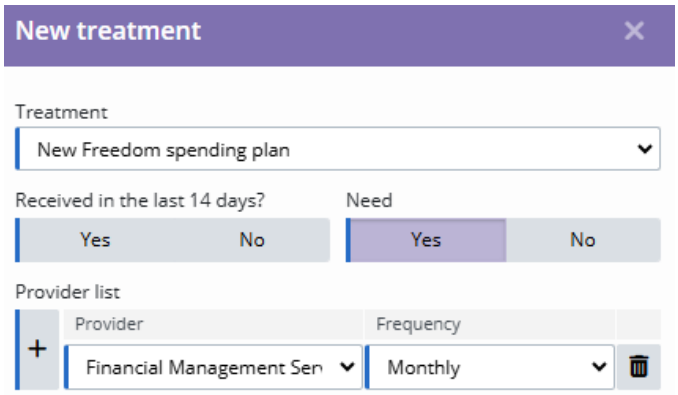
Choosing New Freedom in CARE:

1. Complete the CARE assessment to determine functional eligibility.
2. Obtain a financial eligibility determination;
3. Offer New Freedom as an option when the participant is determined financially and functionally eligible.
    a. The financial and functional eligibility requirements for New Freedom are the same as the other Medicaid waiver programs, such as the COPES waiver. New Freedom is also available if a Community First Choice (CFC) participant meets the waiver eligibility criteria, has a need that cannot be met by CFC and wants to enroll in New Freedom.
    b. New Freedom is currently an option available only to participants who live in participating counties and choose to receive in-home services.
        i. As of 01/01/2025, participants must reside in a county where New Freedom is offered (King, Pierce, Ferry, Pend Oreille, Spokane, Stevens, or Whitman County).
4. If the participant chooses New Freedom, start by adding New Freedom as a Treatment
    a. On the "Medical" screen, add a New Treatment.

b. Select the treatment "New Freedom spending plan".



c. Select No for "Received in the last 14 days?" and Yes for "Need".
d. In the Provider List drop down, add "Financial Management Service" with a frequency of Monthly.

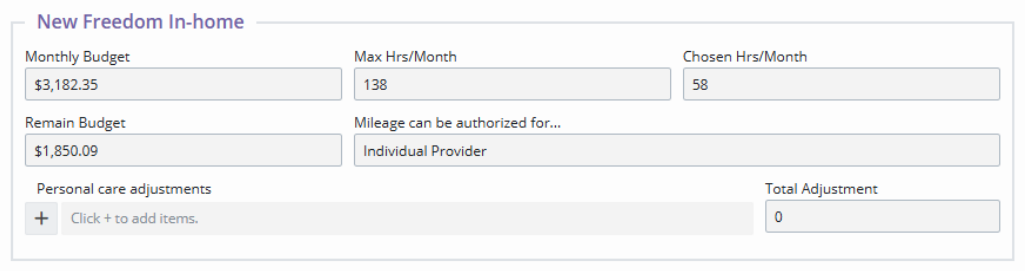


e. Select "Add Treatment"

5. Once the Treatment screen is completed, add New Freedom to the "Care Plan" screen:
   a. On the "Care Plan" screen in CARE, select New Freedom on the 'Client chosen program' screen.

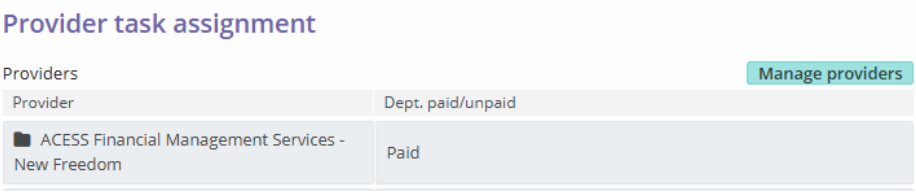


b. Once the CARE classification has been determined, the 'Monthly Budget' will populate in the New Freedom In-Home section of the Care Plan.

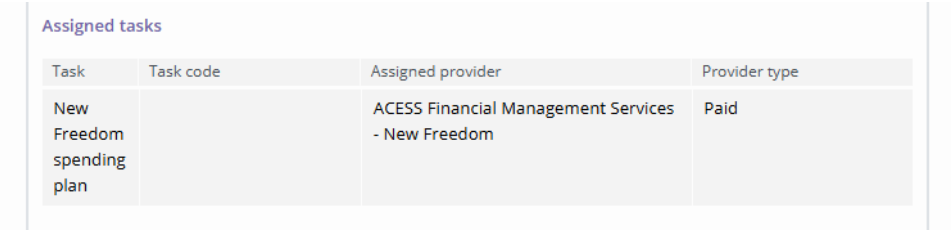


c. Enter in the number of hours the participant has chosen to use for personal care and the "Remaining Budget" amount for goods and services will self-populate.
    i. Per WAC 388-106-1458, participants must choose the number of hours they wish to use for the month before the beginning of that month. After the month starts, the only way to change hours in the current month is through a significant change assessment or an Exception to Rule.
    ii. If a participant elects to use a certain number of hours, and does not use all those hours, they will not be able to convert those hours back to their budget funds.
d. The amount in the 'Remaining Budget' will be transferred to the Financial Management Services (FMS) provider once the Care Plan is brought to current.

6. "Care Planning – Supports" screen in CARE:
    a. Once you have entered New Freedom as the 'Client chosen program', add the PAID caregiver and any UNPAID informal supports to the "Supports" screen and assign tasks as appropriate.
    b. Add "ACES$ Financial Management Services – New Freedom" agency (ACES$ 208768001. DO NOT USE THE 02 LOCATION CODE FOR NEW FREEDOM) on the Supports screen. CMS requires that ALL paid providers be listed as a paid provider and assigned a task.

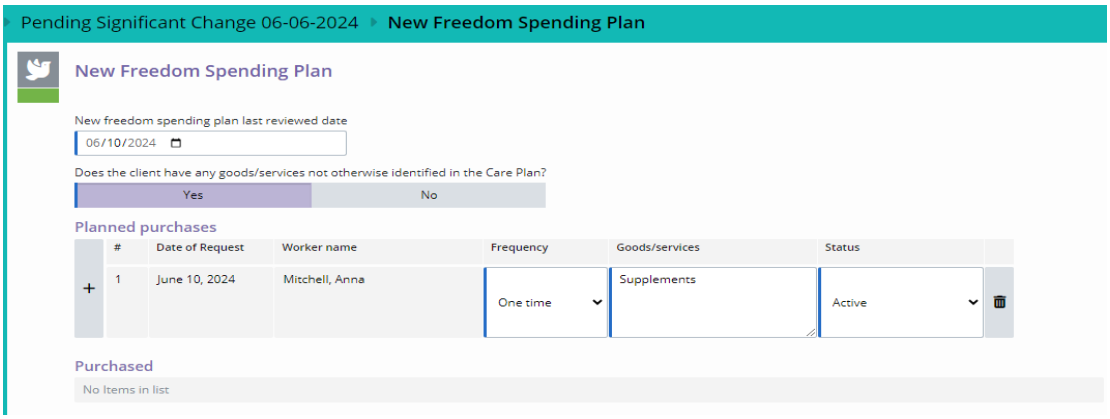


        i. If you add PERS, Environmental Modifications, or Specialized Medical Equipment, assign them to "ACES$ Financial Management Services - New Freedom".
    c. Next assign the task to ACES$ in the Task Summary. CMS requires all paid providers to be in the care plan.



CREATING THE NEW FREEDOM SPENDING PLAN (NFSP) IN CARE

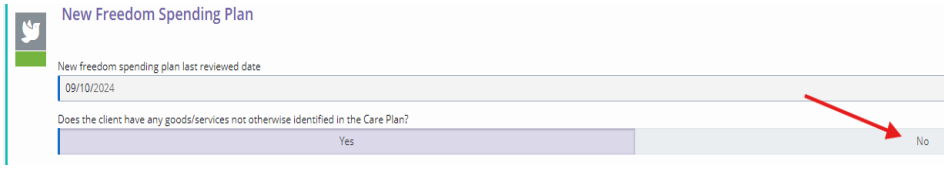
1. After you have entered New Freedom as the 'Client chosen program', the New Freedom Spending Plan section will be created.
    a. This must be completed for every Initial/Annual/Significant Change assessment.
2. "Care Planning - New Freedom Spending Plan" screen in CARE:



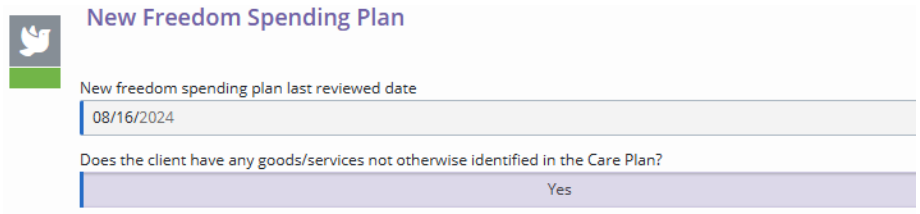
    a. Add at least one Pending or Active, goods or service that the participant has requested (outside of personal care) to the NFSP.
        i. At least one item must be present unless the box under "Does the clients have any goods/services not otherwise identified in the Care Plan?" is marked "No".
            1. If it is marked "No", have a person-centered conversation with the participant about other program options like CFC + COPES.
        ii. For a list of approvable items, please see WAC 388-106-1400.
        iii. "Pending" is for items that are not yet active and require an ETR or additional support documents, such as an insurance denial or a letter from the doctor.
        iv. "Active" is for items that are ready for purchase and can be added to the ACES$ Service Authorization screen in the ACES$ portal.
    b. Select the plus button
        i. The **Date of Request** will auto generate the current date
        ii. The **Worker Name** will auto generate with the name of the Care Consultant that is logged into CARE.
        iii. Select a **Frequency** of "One-Time" if the purchase is for an item occurring only once (such as an adaptive tablet). If the frequency is recurring (such as home delivered meals or PERS) select a frequency of "Monthly".

iv. List the **Goods/Services** (up to 128 characters). Only one Goods/Services should be listed in each box.
v. Select the **Status** as "Active".

4. Approval of the participant regarding the information documented in the CARE assessment that determined their New Freedom budget amount is documented in the Service Summary. The participant needs to approve the plan of care by signing the most recent Initial/Annual/or Significant Change Service Summary, as in all other programs.
    a. Complete and have the participant sign the most recent versions of the standard DSHS enrollment forms and the following forms:
        i. Acknowledgement of Services Form (DSHS Form 14-225).
        ii. The Rights and Responsibilities Form (DSHS Form16-172).
        iii. The New Freedom Participant Responsibility Agreement (DSHS Form 16-244).;
        iv. The Authorized Representative Form (if required).
    b. Complete the Planned Action Notice (PAN) for New Freedom. Assign the total budget amount under the service heading "Individual Directed Goods, Services and Supports".
    c. Create New Freedom RAC 3040.
5. Authorizing personal care and goods and services, where applicable.
    a. If the Participant chooses personal care **only**, HCS workers will authorize personal care services using the T1019, U6 service code in CARE.
    b. If the Participant chooses personal care only, HCS workers will still complete the New Freedom Spending Plan (NFSP) section 'Does the client have any goods/services not otherwise identified in the Care Plan?' with the answer of **No**.



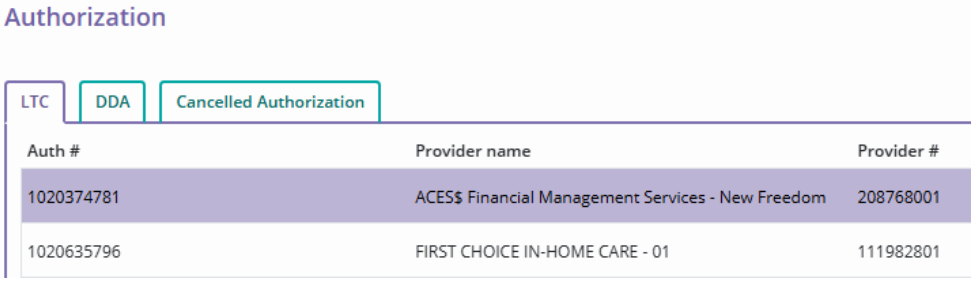
    c. If the Participant **does not** choose personal care (goods and services only) or chooses **both** personal care **and** good and services, the HCS worker will complete the New Freedom Spending Plan section 'Does the client have any goods/services not otherwise identified in the Care Plan?' with the answer of **Yes**.



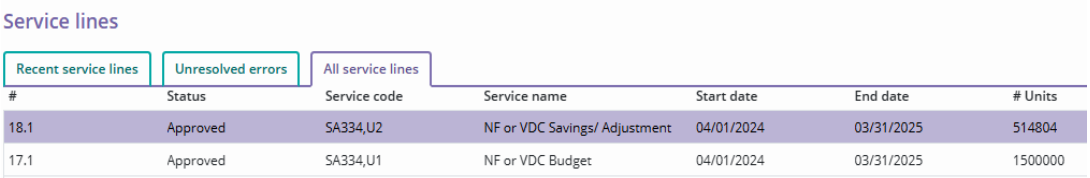
    d. Notify the Public Benefit Specialist of the begin date of New Freedom services using the DSHS Form 14-143;
    e. Transfer CARE and the case file to the appropriate AAA for on-going Care Consultation Services.

ADDING THE AUTHORIZATIONS FOR NEW FREEDOM IN CARE

a. When adding the auth be sure to include only ACES$ Financial Management Services – New Freedom and personal care (either IP or agency).



b. All other authorizations for goods and services such as PERS, home delivered meals etc. will be paid through ACES$.
c. When creating service lines for SA334 U1 or SA334 U2 these lines must span the plan period and cannot exceed 12 months.
d. **Initial Review:** When creating a new plan period authorization (Initial Review only) you will create an SA334 U1 line.
e. **Annual Review or Significant Change:** When creating a new plan period authorization (Annual Review or Significant Change reviews) you will create both an SA334 U1 and SA334 U2 line.
    a. There should only be one line of each service code, as applicable, per plan period.
f. Once ACES$ has been authorized, create Service code **SA334, U1** from the Remaining Budget amount from the Care Planning Screen.
    i. If a participant is saving less than $1,250 per month then you will authorize 900,000 units ($9,000.00).
        1. HCLA-Rate limit for SA334, U1 can be increased at the local level by the supervisor up to $15,000.
    ii. New Freedom Care Consultants should authorize an annual amount of 1,500,000 units ($15,000.00) if a participant is saving $1,250 or more per month.
g. The service code **SA334, U2** represents funds available to the Financial Management System (FMS) vendor to claim against, during a participant's <u>new</u> plan period, that carry over from a participant's previous care plan to the new one. This is based on the FMS' accounting of accrued funds and spending for approved purchases.
    iii. New Freedom budget is determined by participant's functional assessment.
    iv. Any increase in limits due to ETR should be added to the SA334, U2 line.



h. For information related to social service authorizations and payments refer to the Social Services Authorization Manual (SSAM). http://intra.dda.dshs.wa.gov/ddd/p1servicecodes/

Indexing New Freedom Documents and the Document Management System (DMS)

All New Freedom documents will be indexed as a NF type document. HCS/AAA staff must write "New Freedom" and the "ACES Client ID #" at the top of these documents so the Hub Imaging Unit (HIU) can identify them and index them as a NF document.

HCS Public Benefit Specialist (PBS) will:

1. Determine financial eligibility for long-term care services;
2. Advise New Freedom Care Consultant as the authorized representative of any Medicaid eligibility or cost of care changes as they occur. (They will receive the notices of termination, participation changes, eligibility reviews due, etc.)
   (i) If a client has participation, inform them that they will still be responsible for their participation while on the New Freedom program.

Once the case has been accepted by the Area Agency on Aging (AAA):

1. AAA supervisor will assign the case to a New Freedom Care Consultant.
2. The New Freedom Care Consultant will complete a 30-day visit.
3. The New Freedom Care Consultant must ensure that the ACES$ enrollment packet is completed by the client before they can start making purchases.
4. The New Freedom Care Consultant will complete quarterly monitoring calls.

NEW FREEDOM CARE CONSULTANT ROLES AND RESPONSIBILITIES

New Freedom Care Consultation

Care consultation is provided at the direction of the New Freedom participant and includes providing training and support to assist participants to develop and implement their spending plans to obtain approved services within a fixed monthly budget called the New Freedom Spending Plan (NFSP).

The Care Consultant is responsible to assess and assist the participant to determine the services and supports that will address unmet needs identified in the CARE assessment and maintain or increase their ability to maximize independence based on this chapter and state and federal regulations. They help facilitate the participant's control and selection of services to the greatest extent possible to access preferred services and supports available under the New Freedom waiver. This may include providing assistance to identify costs, manage services within budget, assess risks and assist with problem solving related to the implementation of the NFSP. The Care Consultants reviews and approves all New Freedom program purchases of goods and services. Care Consultants are also responsible for authorizing personal care. AAAs are responsible for monitoring Agency personal care providers to ensure they are in compliance with training and contracting requirements. ALTSA is responsible for monitoring CDE agency personal care providers to ensure they are in compliance with training and contracting requirements.

Roles and Responsibilities:
The Care Consultant ensures that participant's choices of goods/services align with what's allowed and disallowed by the regulations. A Care Consultant has the authority to approve or deny a participant's requests/choices.

The Care Consultant is responsible for sending appropriate Planned Action Notices as described in the LTC Manual, chapter 3.

- When a service is removed, or the participant changes programs, it is the responsibility of the Care Consultant to notify the vendor and the FMS that the service has been terminated.

Orientation to Budget-Based, Participant-Directed Services

The Care Consultant will meet with the participant, and others whom the participant may wish to be present, to explain what participant-direction involves. It is important that the participant understands the responsibilities involved in a participant directed budget-based program. During the first visit the Care Consultant will go over the New Freedom Program and offer to send the participant a copy of the New Freedom Participant Handbook, have the participant sign DSHS form 16-244 (New Freedom Participant Responsibility Agreement) and provide the Financial Management Services New Freedom Participant Handbook and document the conversation in SER.

An individual Participant's Budget Allocation is calculated using the average individual provider hourly wage (including mileage), multiplied by the number of units generated by the CARE assessment, multiplied by 0.93, plus the average participant expenditures for non-personal care supports. This will generate a dollar amount automatically in CARE.

Creating the Participant's New Freedom Spending Plan (NFSP)

The participant spending plan documents how the participant will spend their approved service budget dollars to address the needs that were identified in the Care Plan.

Within the authorized budget, participants may choose services and supports not already covered by Medicaid State Plan or Medicare under the following categories (as outlined in WAC 388-106-1400):

Personal Assistance Services (PAS)

Supports involving the labor of another person to help participants carry out everyday activities they are unable to perform independently. Services may be provided in the person's home or in the community. Items in this category must be of reasonable cost and meet a therapeutic need identified in the participant's CARE assessment. The following are included in PAS:

- Direct 'Personal care services' defined as physical or verbal assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL) due to your functional limitations. Assistance is evaluated with the use of assistive devices. as defined in WAC 388-106-0010; These must be provided by a qualified individual provider or AAA-contracted homecare agency.

- Delegated health-related tasks per WAC 246-841-405. (Providers of direct personal care services may be asked to do nurse delegation under the supervision of a nurse);
- Additional personal care may be purchased using the participants' savings, for the remainder of the current month without an ETR. The client must then maximize their chosen hours prior to using their savings for additional months. See ETR process for additional information.

Treatment and Health Maintenance Supports

Supports and services defined as treatments or activities that are beyond the scope of the Medicaid State Plan that are necessary to promote the participant's health and ability to live independently in the community and preventing further deterioration of the Participants level of functioning or improving or maintaining your current level of functioning.

This category includes those supports that are typically performed or provided by people with specialized skill, certification or licenses. Items in this category must be of reasonable cost and meet a therapeutic need identified in the participant's CARE assessment. Some examples of these services are:

- Specialized health care, extended therapeutic treatment;
- Dental, vision, audiology;
  - For specific items that are covered by the participant's Medicaid State Plan, Medicare, or other insurance, please consult the Health Care Authority Billing Guide before submitting an ETR.
- Culturally appropriate health services (culturally and linguistically sensitive health care in the areas of primary care, prevention & wellness, e.g. acupuncture, naturopathic medicine);
- Physical therapy;
- Therapeutic massage complementary to physical therapy or provided as a less intrusive alternative.

Individual Directed Goods, Services and Supports

Services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address and support the participant to function more independently, increase safety and welfare, or help the participant to perceive, control or communicate with their environment. Items in this category must be of reasonable cost and meet a therapeutic need identified in the participant's CARE assessment. Some examples of services are:

- Environmental supports (e.g., snow removal, heavy cleaning); Assistive technology, supplies and equipment;
- Adaptive, specialized clothing (not of general utility);
- Specialized diets;
- Home delivered meals (a maximum of one per day);
- Repairs and maintenance of care-related equipment;
- Equipment and services that reduce the need for on-site supervision in an emergency;
- Transportation not provided by a personal assistant.

- Trained Service Animal: Upkeep expenses related to trained service animals such as food, licensing and routine veterinary services.
    - Routine veterinary care over the cost of $500 per occurrence would require an ETR.
- Assist you to transition from a hospital or nursing facility to your home.

Environmental and Vehicle Modifications

Modifications to a participant's residence or vehicle necessary to accommodate their disability and promote functional independence, health, safety and welfare. Items in this category must be of reasonable cost and meet a therapeutic need identified in the participant's CARE assessment. The alterations cannot be adaptations or improvements that are of general utility or merely add to the total square footage of the home.

Some examples of services are:

- Installation of ramps and grab-bars;
- Widening of doorways;
- Minor household repairs;
- Modification of bathroom facilities;
- Specialized equipment;
- Vehicle modifications include adaptive vehicle controls related to steering, braking, shifting, signaling and acceleration, lift devices, seat adaptations, handrails, and door widening.
    - Vehicles subject to modification must be owned by the Participant or a member of the family that resides with the Participant.
    - Vehicles subject to modification must be in good working condition, licensed, and insured according to Washington state law; and be cost effective when compared to available alternative transportation.

Training and Educational Supports

This service category includes training or education on a participant's health issues or personal skill development (in person within Washington state or online). It can also include training to paid or unpaid caregivers related to the needs of the participant. Items in this category must be of reasonable cost and meet a therapeutic need identified in the participant's CARE assessment. Some examples of supports are:

- Enrollment in a course addressing self-management of diabetes; Drug and alcohol treatment;
- Mental health services;
- Enrollment in a course addressing self-management or training specifically related to a Participant's Diagnosis.
- Enrollment in a course addressing additional training (new tasks only) specifically related to a Participant's Trained Service Animal.

The Participant, with the approval of the Care Consultant, will authorize all purchases from the budget. The development of the NFSP is meant to be a careful process that requires the participant, with the help of their Care Consultant, and representative (if the participant has chosen someone to act in this

role) to make a very intentional plan that balances immediate needs for services like personal care or other goods and services referenced above that are not covered by some other funding source with goals to save funds for a one-time purchase, like a vehicle modification, related to needs identified in the spending plan.

- A 'planned purchase' is any one approved item (e.g. a service, an assistive device, or piece of equipment) that is described in the NFSP for which the participant is saving.
- A participant is allowed to accumulate up to $3,500 in their account to pay for such a purchase without getting additional approval.
- A participant, with the support of their Care Consultant, may request approval to exceed the $3,500 cap for exceptional, planned purchases with preapproval from the New Freedom Program Manager.
- If a single purchase exceeds $3,500, the Care Consultant must notify the New Freedom Program Manager via email. If the purchase is allowable under WAC, no further action is necessary. If the purchase requires an Exception to Rule because it is excluded by WAC or the participant needs additional funds, follow the process outlined below to complete the Exception to Rule. Create an Exception to Rule in CARE and submit to New Freedom Program Manager as discussed in Exceptions to Rule section.
    - Please Note: Personal Care Exception to Rule's must still be submitted to the Long-Term Care Committee. (See Chapter 3 of the Long-Term Care Manual (LTC) for more information on Personal Care Exception to Rules)

The approved purchase NFSP allows participants to identify specific approved planned purchases and the costs associated with the potential purchases. The list is for reference only and is not functionally associated with the budget. Once there is enough funding saved for a specific planned purchase the participant will ask the Care Consultant to create an approved allocation line in the portal so the item can be purchased once the participant submits a completed Participant Purchase/Reimbursement Request Form (PRF) authorizing the Financial Management Services provider to make the purchase.

Once the participant has determined what their spending plan will be the Care Consultant will enter it into the Financial Management Services portal.

The participant's approval of the spending plan verifies his/her involvement in the development of the plan and gives consent to the services and supports outlined in the plan. Obtaining approval of the spending plan is the same process as in other waiver services.

Managing the NFSP

The NFSP must be reviewed quarterly.

All items that the client has requested and are eligible for must be listed in detail on the NFSP under the "Goods/Services" column.

- The information listed must include individual items.
    - As an example, each supplement must be listed.
- All items must be listed clearly and specifically.

  - For example, it is not acceptable to list only a general topic such as "supplements". The specific supplement, like "vitamin B" must be listed.
- All items must list their connection to a diagnosis or identified need within the care plan.
  - For example, it is not acceptable to list only "Epsom salts". You must connect it to the participant's diagnosis or identified need that it is meeting, such as "Epsom salts for Edema".

Status: There are four possible options in the Planned Purchases of the NFSP.

- **"Pending":** Items that are not yet active and require an ETR or additional supporting documents, such as an insurance denial or a letter from the doctor.
  - This item should NOT be listed in ACES$.
- **"Active":** Items that are ready for purchase and can be added to the ACES$ Service Authorization screen in the ACES$ portal.
- **"Purchased":** Items that have been completely or partially purchased during the Care Plan period.
  - This will move the item from Planned Purchases to History and will drop off when the next Annual or Significant Change assessment is created.
- **"Removed":** Items that the client has declined, changed their mind or are no longer eligible for purchase.
  - This will move the item from Planned Purchases to History and will drop off when the next Annual or Significant Change assessment is created.
- **"Delete":** The delete or trash can symbol, should only be used when the Care Consultant added an item in error. This permanently deletes the record of the request and cannot be used when the participant has changed their mind or an item is deemed not allowable.

Procuring Providers and Vendors

The Care Consultant and the FMS will be available to assist the participant in selecting providers and vendors. CDWA will facilitate the contracting of the individual provider. For non-personal care services, the Care Consultant will follow the process outlined in the Contracting Non-Personal Care Providers and Vendors section.

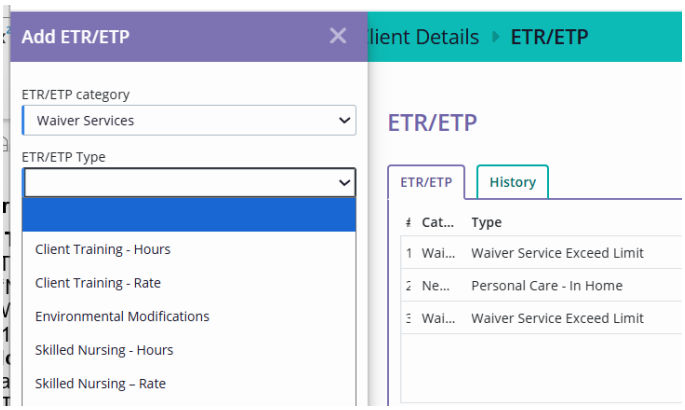
Individual Provider (IP) or Home Care Agency Personal Care (HCA)

The New Freedom budget is calculated based on the assumption that a participant will be hiring an IP for personal care services. If the participant wants to be served by an HCA, there will be no additional charge to their budget, nor will there be additional funds provided to the budget. Depending on the participant's choice of personal care provider the Care Consultant will authorize services as described in the enrollment section of this chapter.

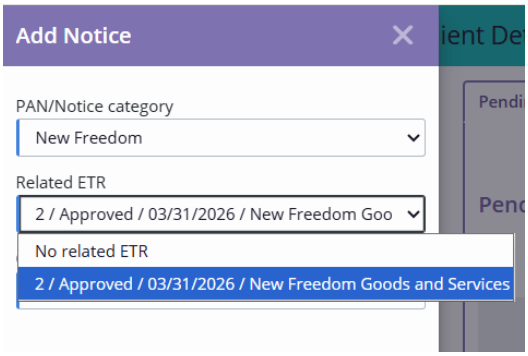
Exceptions to Rule (ETR)

- An Exception to Rule, referenced in Chapter 3, (WAC 388-440-0001) is required to authorize a higher budget amount than indicated in CARE. The standard ETR process will be followed by creating a request in CARE and submitting the request to the New Freedom Program Manager via the "NFETRTEAM".
- New Freedom does not allow local ETRs. All ETRs are processed through Headquarters.

- A one-time Exception to Rule budget amount may be approved if the participant needs a specific support and they do not have savings funds accumulated to purchase the item needed for health or safety concerns. The standard ETR process will be followed by creating a request in CARE and submitted to the New Freedom Program Manager via the "NFETRTEAM".
    - This would be a Waiver Exceeds Limit ETR.
    - This should be set for the plan period and will require annual renewal as needed.



- A one-time ETR may be approved to use participant's existing funds for a service/item which is not usually covered by New Freedom but is needed to address their unique health or safety concerns. The standard Exception to Rule process will be followed by creating a request in CARE and submitted to the New Freedom Program Manager.
    - Participants receiving in-home, personal care services may ask for more hours following the standard Personal Care Exception to Rule process and submitting to the Long-Term Care Exception to Rule Committee.
    - A participant must spend down their savings prior to requesting an ETR for increased personal care.
    - When submitting an ETR request for personal care, please send it to the personal care committee and notify the New Freedom Program Manager.
- ETR requests must relate to a participant's ADL, IADL, and/or their medical diagnosis in their care plan.
- ETRs will be reviewed by the New Freedom ETR Committee within 7 business days of receipt.
- Upon approval or denial of the ETR, the Care Consultant will send out DSHS Form 15-601 "New Freedom (NF) Notice of Exception to Rule (ETR) Decision (Goods and Services)".



- An ETR cannot be approved to supersede a rule from the 1915c waiver.

Note: If an ETR is approved, the additional funds can only be authorized for the service/support that it was requested for.

Quarterly Contacts

Participants in New Freedom may have little or no experience in assuming responsibility for their own service plan and budget. The Care Consultant might need to spend considerable time helping a participant understand, learn and embrace their role in determining what services will best address their individual care needs in addition to hiring and supervising a personal care provider.

The Care Consultant must make quarterly contacts with the participant to:

- Review budget authorizations;
- Review elections for personal care hours;
- Review NFSP and remove those items/services that are no longer needed/wanted and add additional items if appropriate. Check the priority of the items/services on the NFSP to ensure payments can be made timely once funds have been accumulated.
- Confirm that purchases in the past quarter were received; and

Contacts must be made quarterly from the date of assessment. For example, an assessment is conducted on January 9th and moved to current on January 15th. The next contact must be completed by the end of April with the subsequent contacts required by July and October and face-to-face assessments (annual or significant change) may be substituted for one of the quarterly contacts as long as the spending plan information was discussed as above.

- To help the Care Consultant track if they may be overdue for a quarterly contact, document all contacts considered as quarterly contacts in **SER** using **Purpose Code "Monitor Plan".** This will enable an automated Tickler to notify the Care Consultant if more than 4 months have passed since the last Monitor Plan SER entry.

Institutional Stays

A participant who has been institutionalized for 30 days or less (per WAC 388-106-1422**)** with the intent to return to New Freedom upon discharge may stay enrolled in the program with their budget being temporarily suspended. The service budget dollars cannot be used while the participant is institutionalized. Participant funds will not accrue while institutionalized. Upon return home the budget will be reinstated to the amount that was in place when initially institutionalized.

The Care Consultant will notify the New Freedom Program Manager and ACES$ that the participant's budget must be suspended. The New Freedom Program Manager will notify ACES$ not to allow any spending against the budget.

If a participant requires funds to be used during a short institutional stay to prevent additional costs (payment for PERS monthly service vs. payment for reinstallation of PERS unit) or to pay for services already received at the time of institutionalization (Home Delivered Meals), the Care Consultant will need to contact the New Freedom Program Manger to have these expenditures approved.

Challenging Cases Protocol

The Care Consultant should follow the Challenging Cases Protocol for any situation when the spending plan cannot assure the health and welfare of the participant due to participant, environmental, or resource issues (Chapter 5).

A participant's enrollment in the New Freedom program may be ended involuntarily if the participant:

- Moves out of the designated service area or are out of the service area for more than 30 consecutive days; or
- Does not meet the terms for consumer direction of services outlined in the New Freedom Participant Responsibility Agreement when:
    - Even with coaching and collaboration, the participant is unable to develop a NFSP or self-direct services or manage their individual budget or NFSP;
- Any other criteria listed in WAC 388-106-1475.

Skin Observation Protocol

If a participant chooses New Freedom at the time of their CARE assessment (intake/annual/significant change) and the assessment triggers a skin issue, the worker's agency (HCS/AAA) must proceed with the standard skin observation protocol (Chapter 24).

REASSESSING PARTICIPANTS FOR NEW FREEDOM

The Care Consultant *will:*

1. Complete the annual and significant change assessment when applicable in CARE to determine ongoing functional eligibility;
2. Obtain a financial eligibility determination;

3. Offer New Freedom as well as other waiver/state plan options, settings, and providers when the participant is determined financially and functionally eligible;
4. If the participant chooses to remain in New Freedom, the Care Consultant will follow the applicable steps under the enrollment section. *(Note: 14-225 does not need to be re-signed at annual/significant change assessments unless; there was a break in services or an updated version of the 14-225 form and an MB states the new version would need to be signed at participants next annual/significant change assessment)*
5. The Care Consultant will review the assessment with the participant and make any applicable updates to his/her spending plan taking into consideration the information in CARE including triggered referrals.
6. If the participant chooses **not** to remain in New Freedom:
    a. Coordinate the transfer to another ALTSA program of choice that the participant is eligible to receive.
7. When a participant is no longer functionally or financially eligible for NF, the Care Consultant will provide timely Planned Action Notice for termination of services.

WHAT ARE FINANCIAL MANAGEMENT SERVICES?

The Financial Management Services provider, ACES$, is the agency that handles payment and contracting matters on behalf of the participants enrolled in New Freedom. Their responsibilities include accessing the monthly goods and services budget from the Department of Social and Health Services (DSHS); setting up individual accounts for each participant; setting up procedures for verifying qualifications and credentials of providers/vendors of service; implementing efficient and timely participant directed purchasing systems; facilitating payment for labor services and other items needed by participants as identified in the spending plan; and developing contracts with non-personal care providers and vendors.

Contracting Non-Personal Care Providers & Vendors

If the participant needs assistance in identifying appropriate services and supports the Care Consultant will be available to help. This could include assisting the participant to find the service/support at the best possible cost to meet the needs of the participant in terms of quality, quantity, and location.

Once the participant identifies a provider, the participant or the Care Consultant will contact Financial Management Services (FMS) customer service to initiate the 'new vendor' process. The FMS provider will ensure the chosen vendor is qualified to provide the service to the participant, including verifying provider credentials and contracting with vendors (if necessary). If a vendor chooses not to contract with the FMS provider or is not eligible to contract with the FMS provider, the participant will need to choose another vendor.

When the contracting and credentialing is complete, the FMS provider will notify the Care Consultant, the participant and the vendor. The participant will then be responsible to send in the Participant Purchase/Reimbursement Request Form and any other required documentation (receipt, invoice, etc.) to the Financial Management Services provider to allow purchase and/or payment.

Payments for Goods & Services

There are three ways in which a New Freedom participant's services and supports can be paid through the FMS provider.

1. Check payable directly to the approved vendor.
2. Online purchases made on the participant's behalf by the FMS provider.
3. Participant reimbursement for approved services that the participant paid for.
    a. The participant must have the funds available for the purchase.
    b. Receipts must be less than one year old from the date of purchase.
    c. The participant is responsible for providing a clear and legible receipt that has the following information:
        i. Name of vendor.
        ii. Date of purchase.
        iii. Cost of purchase.
        iv. Clearly identified item that was pre-approved for purchase by the Care Consultant.

Participants themselves authorize all services and supports, other than personal care. This is done by completing a Payment Request Form and submitting the form to the FMS provider. Payment requests can be completed without the Payment Request Form (PRF) by using the FMS online portal and uploading any necessary documentation. If a participant is unable to complete the PRF on their own, an authorized representative may be used.

Managing & Reporting of Accounts

The FMS provider will document and track all participant payments, excluding monthly personal care, related to individual spending plans. On a quarterly basis the FMS provider will send participants a budget report that contains expenditures and the budget balance. The Web portal is available to all participants who want to view their account on-line. Participants can register for the portal by visiting the ACES$ website: www.mycil.org.

MANDATORY REPORTING

New Freedom Care Consultants and the Financial Management Services provider are mandatory reporters and must follow all the mandatory reporting laws. *For additional APS information, refer to APS Policy & Procedure in the Long-Term Care Manual chapter 5.

ADMINISTRATIVE HEARINGS

When a participant disagrees or files for an administrative hearing based on a decision made by a Care Consultant or the Financial Management Services provider, the following processes will be used based on the situations outlined below:

If the participant is not satisfied with the outcome of their New Freedom functional eligibility determination (CARE assessment):

- The Care Consultant will follow the Administrative Hearing Process outlined in the ALTSA Long-term Care Manual Chapter 26.

If the participant is not satisfied with the denial of a provider and they contact the Care Consultant or the FMS provider regarding the issue:

- The Financial Management Services provider will:
    - Offer to mail the participant an administrative hearing request form.
    - If the participant files for an administrative hearing:
        - The Financial Management Services provider will contact the participant to see if they would like to schedule a pre-hearing meeting regarding the denial; and
        - If the pre-hearing meeting does not resolve the issue, the FMS provider will prepare a summary statement of the pre-hearing meeting and send the summary statement, notes and any other applicable information to the New Freedom Program Manager as soon as possible and no later than two weeks prior to the hearing unless the pre-hearing is scheduled within a week of the hearing.

- The Care Consultant will:
    - If the provider is not an IP:
        - Refer the participant to the Financial Management Services Representative regarding the provider denial who will follow the steps above.
        - Document the conversation in SER and notify the FMS representative of the issue.
    - If the provider is an IP:
        - Refer to the ALTSA Long-term Care Manual Chapter 11.

If the participant is not satisfied with the denial of a spending plan service or support:

- The Care Consultant will follow the Administrative Hearing Process outlined in the ALTSA Long-term Care Manual Chapter 26.

HOW DO PARTICIPANTS DISENROLL FROM NEW FREEDOM?

Voluntary Disenrollment

New Freedom is a voluntary program, and a participant may choose to disenroll and move to another Long-Term Care program. If a participant wants to disenroll the Care Consultant will work with them to switch to another program as seamlessly as possible. As a general rule if the participant asks to disenroll before the 15th of the month the disenrollment will be effective the first of the following month; if they ask to disenroll the 15th of the month or later, the disenrollment will be effective the first of the second following month (e.g., the participant calls on September 18th; the disenrollment will occur November 1st). On a case-by-case basis the transition can be expedited in order to support the participant's needs.

When a New Freedom participant disenrolls the Care Consultant will contact the Financial Management Services provider to notify them of the disenrollment date.

Involuntary Disenrollment

Participant enrollment in New Freedom may end involuntarily if:

1. The participant moves out of the designated service area or is out of the service area for more than 30 consecutive days, unless the purpose of the longer absence is documented in the SER; **OR**
2. The participant does not meet the terms for participant direction services outlined in the New Freedom Participant Responsibility Agreement (DSHS form 16-244). The terms are as follows:
    a. Even with help from a representative, the participant is unable to develop a spending plan, direct services or manage his/her individual budget or spending plan.
    b. Any one factor or several factors of such a magnitude jeopardize the health, welfare, and safety of the New Freedom participant or others, requiring termination of services under WAC 388-106-0047.
    c. Misuse of program funds and services.

Process for Involuntary Disenrollment

1. The Care Consultant must compose a written notice to the participant that fully documents that one or more of the conditions exist to justify involuntary disenrollment and forward the notice to the ALTSA New Freedom Program Manager.
2. The ALTSA New Freedom Program Manager will notify the Care Consultant of the approval/denial of the request for disenrollment within 15 days of receipt.
3. The Care Consultant will follow the Challenging Cases Protocol as applicable.
4. If the involuntary disenrollment is approved by the ALTSA New Freedom Program Manager, the Care Consultant will follow the disenrollment process noted above for voluntary disenrollment.

The participant may be eligible for other programs.

Loss of Eligibility

1. Participants must meet the functional and financial eligibility to remain in New Freedom. If a participant is determined to no longer meet program eligibility, the Care Consultant will work with the participant on a termination plan.
2. New Freedom is available only to participants who live in their own homes. If a participant wants/needs to move to a residential or long-term placement in a nursing facility, they are no longer eligible for the New Freedom waiver.
3. New Freedom participants who are institutionalized for more than 45 days lose eligibility for the program and must be disenrolled.

RESOURCES

Related WACs and RCWs

Regulation	Description
Chapter 388-106 WAC	Long-Term Care Services
WACs 388-106-1400 through 388-106-1480	New Freedom Budget-Based, Participant-Directed Services
WAC 388-106-1400	What services may I receive under New Freedom consumer directed services (NFCDS)?
WAC 388-106-1405	What services are not covered under New Freedom consumer directed services (NFCDS)?
WAC 182-513-1315	General eligibility for Long-Term Care
WAC 388-106-1435	AREP
WAC 388-106-1458	NFSP
WAC 388-106-0010	ADL/IADL definitions
WAC 388-440-0001	ETR
WAC 388-106-1422	Institutional Stays
WAC 388-106-0047	When can the department terminate or deny long-term care services to me?

Acronyms

- AAA Area Agency on Aging
- ADA Americans with Disabilities Act
- ADL Activity of Daily Living
- CARE Comprehensive Assessment Reporting Evaluation
- CC Care Consultant
- CCG Community Choice Guide
- CFC Community First Choice
- CIL Centers for Independent Living
- CM Case Manager
- COPES Community Options Program Entry System
- DME Durable Medical Equipment
- DMS Document Management Services
- DSHS Department of Social and Health Services
- ETR Exception to Rule
- HCA Health Care Authority
- HCLA Home and Community Living Administration
- HDM Home Delivered Meals
- HQ Headquarters
- IADL Instrumental Activity of Daily Living
- LPN Licensed Registered Nurse
- LTC Long Term Care
- MAGI Modified adjusted gross income
- MCO Managed Care Organization
- MPC Medicaid Personal Care

- NFCDS New Freedom Consumer Directed Services
- OAA Older Americans Act
- OT Occupational Therapist
- PA Prior authorization
- PT Physical Therapist
- RN Registered Nurse
- SER Service Episode Record
- SES Specialized Equipment and Supplies
- SLA Service level agreement
- SME Specialized Medical Equipment
- SOP Skin Observation Protocol
- SSAM Social Service Authorization Manual
- SSI Supplemental Security Income
- WAC Washington Administration Code

Glossary of terms specific to New Freedom

WORD	DEFINITION
Care Consultant (CC)	The person responsible to assist and work with Participants to determine the services and supports that will maintain or increase independence, advises Participants on how to access services and supports, assists in developing the NFSP, assists to procure/monitor services and supports on the NFSP, coordinates with the Financial Management Service responsible for managing Participant's service budget allocation based on the NFSP and updates the NFSP as necessary. The CC also authorizes payments for personal assistance services and determines ongoing functional eligibility using the CARE assessment.
Authorized Representative	A person of the Participant's choice who is authorized to complete and sign all necessary paperwork and work with the CC to create the New Freedom Spending Plan on behalf of the Participant. This person cannot be paid to provide care to the Participant.
Financial Management Services (FMS)	The agency that handles payments for approved items and services purchases on behalf of Participants enrolled in NF. The FMS also ensures vendors are qualified to provide the services per Medicaid rules. FMS are currently being provided by ACES$ Financial Management Services. Email contact: goodservicewa@mycil.org
New Freedom Program	A voluntary budget-based program that provides Participants who are eligible for home and community- based services through the Medicaid Waiver Program a choice in how they receive services in their home.
New Freedom Spending Plan (NFSP)	The individual plan created by Participants and their CC at least annually and updated as necessary, which documents Participants' intention to purchase approved services and supports to meet their assessed needs and to help maintain or increase their independence.
Participant Directed Services	A philosophy and orientation to home and community-based services in which Participants are given the authority to make choices about services and

	supports that work best for them, regardless of the nature or extent of their disability.
Payment Request Form (PRF)	An ACES$ form used by Participants to request payment for an authorized service or item from a qualified vendor/company.
Service Budget (SB)	The amount of service dollars the Participant has available monthly to spend on services and supports to address their care needs.
Services & Supports	Work performed or items that meet an identified therapeutic level of need in a Participants CARE assessment and are documented on his/her spending plan.

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
February 2026	Darrelyn Nuesca	Update to bring chapter in alignment with current guidance. Clarify Trained Service Animal section	TBD
5/19/2025	Darrelyn Nuesca	Update to changes to bring chapter in alignment with current guidance	H25-003