Applying For and Receiving
Adult Developmental Disability (DD) Services

Step 1:
You may apply for Developmental Disability (DD) services by submitting an ***Eligibility Application for Adults with Developmental Disabilities*** to your local Bureau of Developmental Disability Services (BDDS) office. An application can be mailed to you, or you may print off a copy of the application from the Adult DD Care Management website located at:
http://www.healthandwelfare.idaho.gov/Medical/DevelopmentalDisabilities/AdultDDCareManagement/tabid/211/Default.aspx
As part of the application process, BDDS staff must first verify your financial eligibility for Medicaid. BDDS will then forward your application, and any additional information you may have submitted that supports your eligibility (e.g. diagnosis, etc.) to the Idaho Center for Disabilities Evaluation (ICDE). If BDDS determines you are not financially eligible for Medicaid, your application will be returned to you and you will be referred to Self-Reliance to apply for a medical card.

Step 2:
Once BDDS forwards your application to ICDE, it will be reviewed by an Independent Assessment Provider (IAP) at the ICDE office.

Step 3:
The IAP will contact you, your guardian, or other representative to set up an appointment to meet with them for an interview.

Step 4:
It is important that you attend your scheduled interview. Make sure you bring your guardian, a friend, or another person that knows you very well to the interview.

Step 5:
At this interview the IAP will:

- Interview you and the person you brought with you to obtain information about you and your needs.
- Complete the Scales of Independent Behavior—Revised (SIB-R) assessment tool with a person who knows you very well.
- Request signatures on Release of Information forms in order to gather more information about your disability.
- Provide you with a *Nursing Service and Medication Administration Form* that must be completed by your primary physician and returned to ICDE (you might need to schedule a visit with your physician to get a physical examination so the form can be completed and signed).
- Conduct a needs inventory that will allow the IAP to calculate your annual budget if you qualify for adult DD services.

After the interview the IAP will review all of the information and determine if you're eligible for DD services. A Notice will be sent to you to let you know the results of the eligibility determination process.

If you are determined DD eligible, you will be eligible for State plan DD services, which include:

- Service Coordination; and
- Developmental Disability Agency (DDA) services.

If you are determined ICF/ID Level of Care eligible, you will be eligible for both State plan services and DD Waiver services. DD Waiver services include:

- Residential Habilitation (Certified Family Home or Supported Living);
- Chore Services;
- Respite;
- Community Supported Employment;
- Transportation;
- Environmental Accessibility Adaptations;
- Specialized Equipment and Supplies;
- Personal Emergency Response System;
- Home Delivered Meals;
- Skilled Nursing;
- Behavior Consultation or Crisis Management;
- Adult Day Health; or
- Consumer Directed Services Option.

Step 7:
If you are determined eligible for DD and/or DD Waiver services, the eligibility notice will include the amount of your annual budget and a timeline for submission of a plan.

If you are determined <u>not</u> eligible for either one of these services, you can request an appeal hearing of this decision by submitting an appeal request to Administrative Procedures Section (APS). Information about submitting an appeal is included on the eligibility notice.

NOTE: The assessment process (Steps 3-7 above) must be completed each year if you wish to continue to receive services.

Step 8:
Once you have been determined eligible for DD and/or DD Waiver services, you will need to choose a Plan Developer/Support Broker.

If you decide to access State plan and traditional waiver services, you will use a Plan Developer to help you write your plan. Once you have selected a Plan Developer you will need to fill out the *Plan Developer Choice Form* and submit it to ICDE. The IAP can provide you with a list of Service Coordination Agencies if you need help finding a Plan Developer.

If you decide to self-direct your services through the Consumer Directed Services option, you will use a Support Broker to help you write your plan. The IAP can provide you with a list of approved Support Brokers if you need help finding a Support Broker.

A list of Plan Developers and Support Brokers can also be found on the Adult DD Care Management website located at:
http://www.healthandwelfare.idaho.gov/Medical/DevelopmentalDisabilities/AdultDDCareManagement/tabid/211/Default.aspx

Step 9:
Once you have chosen a Plan Developer/Support Broker, they will help you to identify family and/or other individuals who are important to you to be part of a person-centered planning team.

Step 10:
You and your person-centered planning team will work together to evaluate your needs and goals and help you to develop a plan. For individuals who choose to access State plan and traditional waiver services, this plan is called an Individual Support Plan (ISP). For individuals who choose to self-direct their services, this plan is called a Support and Spending Plan (SSP). Once the plan is written, it is submitted to the Bureau of Developmental Disability Services (BDDS) for review. A Care Manager in the BDDS office will be responsible for reviewing your plan.

Step 11:
The Care Manager will review your plan to make sure it meets your assessed needs, allows for your health and safety and is within your budget. You and your Plan Developer/Support Broker will be notified by mail if you plan has been approved.

Alternate Steps:

Step 11A:
If the plan does not meet your assessed needs, allow for your health and safety, and/or is over budget, the Care Manager will contact your Plan Developer/Support Broker to discuss the plan. If adjustments are made to your plan so it meets your needs and is within budget, the Care Manager will be able to authorize all of the services on the plan.

However, if your Plan Developer/Support Broker and the Care Manager are not able to agree on the services needed to meet your needs and/or the plan cost continues to exceed your calculated budget, the Care Manager will do one of the following:

- Authorize some of the services on your plan; or
- Deny all of the services on your plan.

The Care Manager will send a Notice to you, your Plan Developer/Support Broker and your guardian (if applicable) to let you know what services were approved and/or denied.

Step 11B:
If you don't agree with the Care Manager's decision to deny some or all of your services, you can request an appeal through Administrative Procedures Section (APS). Information about submitting an appeal is included on the Notice.

Step 12:
If some or all services on your plan are approved, the Care Manager will authorize these services in the Medicaid payment system. The care providers on your plan approved to provide services will also be notified they have been approved to provide services, as well as the date you can begin receiving those services.

Step 13:
If you plan needs to be changed during the plan year, this can be done by your Plan Developer/Support Broker. For State plan or traditional waiver services, a Plan Developer will complete an addendum and provide any documents that support the requested changes. For self-directed services, a Support Broker will do a Plan Change Form. An update to a plan must be submitted in the following circumstances:

For a State plan or traditional waiver plan:

- A change in provider;
- A change in the amount of time you will be receiving a service;
- Adding or deleting a service;
- A change from home and community based services to centered-based services, or vice versa: or,
- A change in address

For a self-directed plan:

- Adding or deleting services in a support category; or
- Moving money from one support category to another.