

## How to fill out the iBudget Florida Home and Community-Based Services (HCBS) Waiver Eligibility Work Sheet in APD iConnect

APD clients who wish to participate in the iBudget Florida HCBS waiver must meet the level of care criteria for placement in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) and must also be eligible for Medicaid under Supplemental Security Income (SSI) or Title 19 (TXIX). The iBudget Florida HCBS Waiver Eligibility Work Sheet is the document used by the agency to record the client's level of care, Medicaid eligibility, and choice for participation on the waiver.

When a consumer is determined eligible to receive services from APD, the Region will complete an initial determination of level of care for participation in an ICF/IID for waiver participation and placement on the Waiting List, unless approved for waiver enrollment at the time of initial eligibility determination. Once the person enrolls on the waiver, the Waiver Support Coordinator is required to complete a Waiver Eligibility Work Sheet regarding eligibility for Medicaid and waiver services every 365 days from the date it was last signed by the client/legal representative.

### Instructions on how to fill out the Work Sheet:

1. Select the HCBS Waiver Eligibility Work Sheet in the Forms Tab in APD iConnect. Select the Review Type (Initial or Annual). The client's name and SSN are prepopulated on the form. The user will need to enter the Region and Support Plan Effective Date (if the client is on the waiver, or if completing at initial time of determination, leave blank). The SSN is required as a condition of eligibility for Medicaid benefits and is collected for administrative purposes only as authorized under law.

Please Select Type: HCBS Waiver Eligibility Worksheet

Consumer Forms	
Review *	Annual
Review Date *	05/08/2019
Division *	APD
Approved By	
Worker *	
Status *	Draft
Provider/Program *	
Approved Date	

### HCBS WAIVER ELIGIBILITY WORKSHEET

Client First Name:	
Client Last Name:	
*Social Security Number:	XXX-XX-7678 Unmask
Region:	
Support Plan Effective Date:	

2. **Section I. Level of Care Eligibility** - Select the option that best meets the client's eligibility criteria.
3. Select **Option A** if the individual's primary disability is Intellectual Disability with an IQ of 59 or less, as indicated on a standardized test, (as described in Rules 65G-4, F.A.C.). When selecting this option, there is no need to select Handicapping Conditions or functional limitations in Major Life Activities. If the client has a secondary disability or other mental health or medical diagnoses, navigate to the Diagnosis Tab in APD iConnect and enter in the Diagnosis record. Handicapping Conditions and functional limitations in Major Life Activities are only required under Options B or C below.

LEVEL OF CARE ELIGIBILITY
The individual is an APD client with a Developmental Disability who meets one of the following criteria and is eligible to receive services provided in an ICF/DD.
Option A: The individual's primary disability is Intellectual Disability with an intelligence quotient (IQ) of 59 or less.

Select **Option B** if:

- a. The individual's primary disability is Intellectual Disability with an IQ of 60-69 as indicated on a standardized test (described in Rules 65G-4, F.A.C.) **AND** the individual has at least one of the handicapping conditions listed on the Work Sheet; **OR**
- b. The individual's primary disability is Intellectual Disability with an IQ of 60-69 as indicated on a standardized test (described in Rules 65G-4, F.A.C.) **AND** the individual has severe functional limitations in at least three of the major life activities listed on the Work Sheet.
- c. Select ALL applicable handicapping conditions (but at least ONE) **OR** major life activities (but at least THREE).

Option A: The individual's primary disability is Intellectual Disability with an intelligence quotient (IQ) of 59 or less.
Option B: The individual's primary disability is Intellectual Disability with an intelligence quotient (IQ) of 60 to 69 inclusive and has at least one of the following handicapping conditions
OR the individual's primary disability is Intellectual Disability with an intelligence quotient (IQ) of 60 to 69 inclusive and the individual has severe functional limitations in at least three of the major life activities.
Option C: The individual is eligible under the category of Autism, Cerebral Palsy, Down Syndrome, Prader-Willi Syndrome, Spina Bifida, or Phelan-McDermid Syndrome and has severe functional limitations in at least three of the major life activities.
Please check all handicapping conditions and major life activities that apply.
Level of Care Eligibility: <input type="text" value="Option B. v"/>
I certify that I have documentation of the DD Diagnosis on file* <input type="text" value="Yes v"/>
Handicapping Conditions
Major Life Activities

Ambulatory Deficits	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>
Behavior Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Health Problems	<input type="checkbox"/>	<input type="checkbox"/>
Down Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Capacity for Independent Living	<input type="checkbox"/>	<input type="checkbox"/>
Learning	<input type="checkbox"/>	<input type="checkbox"/>
Mobility	<input type="checkbox"/>	<input type="checkbox"/>
Self Care	<input type="checkbox"/>	<input type="checkbox"/>
Self Direction	<input type="checkbox"/>	<input type="checkbox"/>
Understanding and Use of Language	<input type="checkbox"/>	<input type="checkbox"/>

4. Select **Option C** if:

- a. The individual is eligible under the category of one of the following disabilities **AND** the individual has severe functional limitations in at least three of the major life activities (must select at least three major life activities, or more if applicable):
  - i. Autism
  - ii. Cerebral Palsy
  - iii. Down Syndrome
  - iv. Prader-Willi Syndrome
  - v. Spina Bifida
  - vi. Phelan-McDermid Syndrome

The screenshot shows a form with several sections. A red arrow points to the 'Option C' text, and a black arrow points to the 'Major Life Activities' label. The form includes three options (A, B, and C) for disability categories, a section for handicapping conditions, and a section for major life activities.

Option A: The individual's primary disability is Intellectual Disability with an intelligence quotient (IQ) of 59 or less.

Option B: The individual's primary disability is Intellectual Disability with an intelligence quotient (IQ) of 60 to 69 inclusive and has at least one of the following handicapping conditions  
OR the individual's primary disability is Intellectual Disability with an intelligence quotient (IQ) of 60 to 69 inclusive and the individual has severe functional limitations in at least three of the major life activities.

Option C: The individual is eligible under the category of Autism, Cerebral Palsy, Down Syndrome, Prader-Willi Syndrome, Spina Bifida, or Phelan-McDermid Syndrome and has severe functional limitations in at least three of the major life activities.

Please check all handicapping conditions and major life activities that apply.

Level of Care Eligibility:

I certify that I have documentation of the DD Diagnosis on file\*

Handicapping Conditions

Ambulatory Deficits	<input type="checkbox"/>
Autism	<input type="checkbox"/>
Behavior Problems	<input type="checkbox"/>
Cerebral Palsy	<input type="checkbox"/>
Chronic Health Problems	<input type="checkbox"/>
Down Syndrome	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>
Capacity for Independent Living	<input type="checkbox"/>
Learning	<input type="checkbox"/>
Mobility	<input type="checkbox"/>
Self Care	<input type="checkbox"/>
Self Direction	<input type="checkbox"/>
Understanding and Use of Language	<input type="checkbox"/>

Major Life Activities

5. **Section II. Medicaid Eligibility –**

- a. If the client already has Medicaid, their Medicaid number will automatically appear in APD iConnect via the FMMIS Interface. Select “No” in response to the question: “Has the Individual been referred for Medicaid eligibility?” **NOTE:** An error message will show up at the bottom of the page requiring completion of three fields. The user will be able to save the form without completing those fields (which are only required when selecting “Yes”).

The screenshot shows two input fields. The first is labeled 'Medicaid Number:' and contains a blurred text field with a refresh icon to its right. The second is labeled 'Has the Individual been referred for Medicaid eligibility?' and has a dropdown menu with 'No' selected.

Medicaid Number:

Has the Individual been referred for Medicaid eligibility?

- b. If the client does not have Medicaid, select “Yes” in response to the question: “Has the Individual been referred for Medicaid eligibility?” In doing so, three additional fields will appear. They are all three required fields, so the answers to these questions must be known before they can be entered and saved. In order to return to the form to enter additional information at a later date, the user must save the form in “Pending” status.

Has the Individual been referred for Medicaid eligibility?

Yes ▾

Referred for Medicaid Eligibility Date:\*

 

Medicaid Eligibility Results:\*

 ▾

Medicaid Determination Date:\*

 

6. **Section III. Eligibility Determination** – Regional Staff (if initial) or WSC (if annual) must select the option corresponding to the client’s Level of Care Eligibility. This section **is required and shall never be left blank.**

Check the correct statement:

Individual has met Level of Care Eligibility, has a Medicaid number and is eligible for waiver services:

Individual has not met the Level of Care Eligibility and therefore is not eligible for waiver services:

7. **Section IV. Choice** – This section must be completed by the client/legal representative. The Regional Staff (if initial) or WSC (if annual) must not check the boxes in this section, unless the client (or legal representative) is present at the time of completion and conveys their wishes to the person completing the form. The user must save the form in “Complete” status, execute the Word Merge, and print the form in order to get the required signatures. The client/legal representative must select one of the two options, attesting to the fact that they received an explanation regarding the iBudget Florida HCBS waiver, and choosing either to receive community-based supports and services through the waiver or institutional services provided in an institutional setting. **Caution:** Once the Work Sheet has been saved in “Complete” status, it cannot be updated again. Please review for completeness and accuracy before saving, executing the Word Merge, and printing for signatures.

CHOICE	
Only to be completed at the time of initial Waiver enrollment and every 365 days thereafter. I have received an explanation of home and community-based services.	
Choose one of the following:	
I have been offered waiver services, and I choose to receive community-based supports and services. I understand that I have a choice of enrolled eligible providers.	<input type="checkbox"/>
I choose to receive institutional services and prefer services to be provided in an institutional setting.	<input type="checkbox"/>

Once the form has been signed by all the appropriate parties, the Regional staff (if initial) or WSC (if annual) must scan, upload, and save it to a Note in APD iConnect as Note Type "Waiver Enrollment" and Sub-Type "Signed Waiver Eligibility Worksheet." The effective date of completion is the date the form was signed by the client/legal representative.

Notes Details	
Division *	APD ▾
Note By *	
Note Date *	05/09/2019 
Program/Provider *	WSC Agency1 ▾ <a href="#">Details</a>
Note Type *	Waiver Enrollment ▾*
Note Sub-Type	Signed Waiver Eligibility Worksheet ▾
Description	Annual LOC Review for Waiver Eligibility 

