

	<b>GEORGIA DIVISION OF FAMILY AND CHILDREN SERVICES MEDICAID POLICY MANUAL</b>			
	<b>Chapter:</b>	<b>2100</b>	<b>Effective Date:</b>	<b>June 2021</b>
	<b>Policy Title:</b>	<b>Independent Care Waiver Program</b>		
<b>Policy Number:</b>	<b>2139</b>	<b>Previous Policy Update:</b>	<b>MT 32</b>	

## REQUIREMENTS

The Independent Care Waiver Program (ICWP) is a class of assistance (COA) that provides in home care to individuals who are Severely Physically Disabled (SPD) or who have Traumatic Brain Injuries (TBI). SPD individuals are those who cannot physically care for themselves and require assistance from another for daily functioning. These individuals need more care than can be provided by EDWP. ICWP A/Rs must meet the criteria for nursing home placement although they remain at home.

## BASIC CONSIDERATIONS

To be eligible under this COA, an A/R must meet the following conditions:

- The A/R is between 21 through 64 years of age. Applicants approved prior to age 65 may continue to be eligible after attaining age 65 if they continue to meet all other eligibility criteria.
- The A/R is receiving case management services through a DMA approved ICWP case management provider.
- The A/R is residing in a residential home situation, such as his/her own home.
- The A/R meets the length of stay (LOS) and the level of care (LOC) basic eligibility criteria.
- The A/R meets all other basic and financial eligibility criteria.

ICWP Medicaid recipients receive certain waived services not normally covered by Medicaid, including the following:

- case management
- companion services
- counseling
- emergency response system (ERS)
- environmental modification
- homemaker services
- occupational therapy
- personal care services
- skilled nursing
- specialized medical equipment and supplies
- transportation

**BASIC CONSIDERATIONS (cont.)**

Refer any individuals interested in receiving services under ICWP to  
Alliant Health Solutions  
P.O. Box 105406  
Atlanta, Georgia 30348

(678) 527-3632, (678) 527-3619 or 1-800-982-0411  
Local Fax Line: 678-527-3001  
Toll Free Fax Line: 1-800-716-5358

The case management provider (case manager) submits the LOC information to Alliant Health Solutions (AHS) and initiates the ICWP services approval process.

- The case manager obtains the LOC instrument and sends to DFCS. Receipt of the LOC instrument verifies the LOC for ICWP. A DMA-6 is still a valid LOC instrument for some of the older cases.
- The case manager submits an Individual Plan of Care and a Recipient Application form to the DMA Waivered Services Unit for approval of ICWP services. The Waivered Services Unit notifies the case manager of approval or denial of the A/R for ICWP services.
- If DMA approves the A/R, the case manager submits an Independent Care Waiver Communicator to DFCS, specifying the date case management began, which is used for LOS, and the date of the first waived service, which serves as the slot date for eligibility purposes in the same manner as it is used under EDWP.

**NOTE:** The beginning date of case management and the slot date should be the same in most cases since case management is a waived service under ICWP.

If ICWP services are approved by DMA, the case manager and the A/R decide on service providers.

The A/R may apply for ICWP Medicaid while residing at home, in a hospital or in a nursing home.

**PROCEDURES**

Follow the steps below to determine ABD Medicaid eligibility under the ICWP class of assistance.

- Step 1**      Accept the A/R's ABD Medicaid application.
- Step 2**      Obtain information necessary to process application.
- Step 3**      Verify that the A/R is receiving ICWP services through receipt of an ICWP Communicator from the case manager. The ICWP Communicator should indicate the beginning date of case management and the slot date.

**PROCEDURES (cont.)**

**Step 4** Determine basic eligibility, including Length of Stay (LOS) and Level of Care (LOC). Refer to Chapter 2200, Basic Eligibility Criteria.

**Step 5** Determine financial eligibility. Consider the A/R to be in LA-D.

- See Chapter 2500, ABD Financial Responsibility and Budgeting, for procedures on whose resources to consider and the resource limit used in determining resource eligibility.
- Complete a Medicaid Cap budget to determine income eligibility. See Medicaid CAP Budgeting in Chapter 2510. If client's income exceeds the Medicaid CAP, then client must establish a QIT in order to be determined eligible.

**Step 6** Determine the A/R's cost share using the Community Spouse Maintenance Need Standard (CSMNS) as the personal needs allowance (PNA) and all other policies applicable to patient liability/cost share budgeting.

**NOTE:** If AR is over the Medicaid CAP and has a QIT please remember that there is the potential of a cost share with these cases.

**Step 7** Notify the A/R of eligibility/cost share.

**NOTE:** Do not approve Medicaid under the ICWP class of assistance for any month prior to the month of the slot date. Do not approve Medicaid under the ICWP COA if the A/R is under age 21 or age 65 or older.

**Step 8** Notify the ICWP Case manager by:

- Entering the Case Manager's name and address in the system as an Authorized Representative. The Case Manager will then receive information concerning dates of eligibility and cost share.

**OR**

- Completing Section II of the ICWP Communicator. Enter the Medicaid number on the top of the form. Send one copy to the Case Manager and scan the other into the document imaging system.

<b>SPECIAL CONSIDERATIONS</b>
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**ICWP Communicator (ICWPC)**

The ICWP class of assistance requires the Independent Care Waiver Communicator (ICWC) form as a means for the ICWP Case Manager to communicate with the DFCS Eligibility Worker. The Eligibility Worker may use this form or the system as a means of relaying ICWP approval, denial, or termination information to the Case Manager. Make copies of this form, found at the end of this section, as needed.

The ICWC functions much like the Community Care Communicator (CCC). The form is initiated by the case manager and forwarded to DFCS after the A/R is approved for ICWP services. The case manager completes the following sections of the ICWC:

- The top section, with all identifying information except the Medicaid number unless the A/R is already a Medicaid recipient.
- Section I, giving the date case management began, the slot date, and a request for a determination of Medicaid eligibility (if needed) and cost share amount.

**APPENDIX G**

**INDEPENDENT CARE WAIVER COMMUNICATOR**

The purpose of this form is to establish the Independent Care 30 day length of stay requirement for individuals whose Medicaid eligibility is based on Independent Care Waiver participation. Case Managers are to complete Section I of this form and forward to the appropriate DFCS caseworker.

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Member Name	County	Medicaid Number
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\_\_\_\_\_

Member Name	County	Medicaid Number
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**SECTION I - COMPLETED BY CASE MANAGER**

I. The above member has elected to accept Independent Care Waiver Program services. Case Management began effective \_\_\_\_\_, and the member was placed in an ICWP slot effective \_\_\_\_\_.

- The member is currently receiving Medicaid. Please determine cost share.
- The member has been referred for Medicaid eligibility and cost share determination.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**SECTION II - COMPLETED BY DFCS CASEWORKER**

- II.  The member has been determined Medicaid eligible effective \_\_\_\_\_.
- The member is receiving Independent Care Waiver services and is responsible for contributing \$ \_\_\_\_\_ monthly toward the cost effective \_\_\_\_\_.
- The member has a change in cost share.

\$ _____	Effective _____
\$ _____	Effective _____
\$ _____	Effective _____

The above named member has been determined ineligible for Medicaid effective \_\_\_\_\_

Reason: \_\_\_\_\_  
\_\_\_\_\_

[ ] Other \_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**SECTION III - COMPLETED BY CASE MANAGER**

III. [ ] The above named member is being released from the Independent Care Waiver Program effective \_\_\_\_\_.  
Reason: \_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_