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500 - ELIGIBILITY CRITERIA

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POLICY STATEMENT	An applicant/client must meet all the CCSP eligibility criteria to participate in the program.
POLICY BASICS	Eligibility includes both functional and financial eligibility criteria. There are no age requirements for CCSP. Care coordinators determine functional eligibility. The Department of Community Health (DCH) /DMA establishes eligibility criteria for Medicaid and contracts with DFCS to determine financial eligibility. The eligibility criteria for CCSP include the following: • Functional impairment caused by physical limitations **NOTE:** Alzheimer's dementia are physical conditions. • Unmet need for care • Approval of care plan by applicant/client's physician • Services fall within the average annual cost of Medicaid reimbursed care provided in a nursing facility • Approval of an intermediate LOC certification for nursing home placement • Medicaid eligible or potentially eligible after admission to CCSP • Client chooses community-based, rather than institutional services • Health and safety needs can be met by CCSP • Participation in one waiver program at a time • Medicare home health or hospice services does not meet client's needs • Home Delivered Meals is not the only service need
POLICY BASICS	• The home environment is free of illegal behavior and

(contd.)	threats of bodily harm to other persons. A client is not required to be homebound to receive CCSP services.
PROCEDURES	Functional Assessment: Use the Determination of Need Functional Assessment-Revised (DON-R) to determine an applicant/client's level of impairment and unmet need for care for CCSP. • Level of Impairment assesses an applicant/client's ability to perform an activity. • Unmet Need for Care determines an applicant/client's need for care for every identified level of impairment. To be eligible for CCSP, an applicant/client must obtain a level of impairment score of at least 15 and have an unmet need for care. Physician Approval: Request the applicant/client's physician to certify the following: • Applicant/client's condition can/cannot be managed by CCSP service • Applicant/client requires/does not require the intermediate level of care provided by a nursing facility • The care plan completed by the care coordinator addresses the applicant/client's needs. Cost Limit Guidelines: Assure that an applicant/client's care in the CCSP program does not exceed the cost limits established by DHR and DCH by performing the following: • Use only waivered services reimbursed by Medicaid to calculate the cost of an applicant/client's service. **EXAMPLE:** The applicant/client receives waivered services from Medicare and Medicaid. Disregard Medicare service costs and Medicaid Home Health if the

PROCEDURES (contd.)

applicant/client has received less than 50 visits in the calendar year.

- Prepare a care plan which addresses the applicant/client's needs.

- Evaluate whether community-based services are more cost effective than institutional placement.

Level of Care: Use the criteria in the Intermediate Level of Care Indicators chart to determine an applicant/client's degree of disability. An applicant/client must have functional impairment equivalent to the nursing home Intermediate Level of Care.

An approved current Level of Care is required for an applicant/client to participate in the CCSP.

Medicaid Eligibility: Perform the following activities to determine an applicant's eligibility or potential eligibility for Medicaid:

- Ask if the applicant receives Medicaid
- If the applicant is not Medicaid eligible, assess the applicant's income and resource eligibility for CCSP Medicaid or SSI.

Client Choice: Present to the client a choice of the CCSP or institutional placement. Document the applicant's choice on Comprehensive Care Plan (CCP). If the applicant chooses to participate in institutional care instead of CCSP, do not continue the assessment for the initial care plan.

Health and Safety: Determine the health risks and unmet needs if the applicant were admitted to CCSP.

NOTE: If needed, review the CCSP service manuals and ORS manuals to determine if CCSP can meet the client's needs.

Waiver Participation: Explain that a client may receive services in only one waiver program at a time.

Medicare Home Health or Medicare/Medicaid Hospice: Determine if the client has a need not met by Medicare home health or Medicare/Medicaid hospice care.

PROCEDURES (contd.)

	If an individual already receiving CCSP services is admitted to hospice care, the client may continue to receive CCSP, if needed. Clients receiving CCSP and hospice may receive PSSX, HDM, ADH, or ALS. Home Delivered Meals: Refer client who needs only HDM to other resources. Safe Home Environment: Determine if the applicant or others living in the home have inflicted or threatened bodily harm to another person within the past 30 days.
REFERENCES	Chapter 300, Administrative Organization; Chapter 600, Care Coordination; Appendix 500, Level of Care Criteria; Appendix 700, Medicaid Classes of Assistance; Policies and Procedures for Home Health Services; CCSP Annual Progress Report

510 - CCSP MEDICAID ELIGIBILITY

POLICY STATEMENT	The CCSP class of medical assistance provides Medicaid benefits for individuals receiving CCSP waivered services. However, CCSP clients may be eligible for Supplemental Security Income (SSI) or another class of medical assistance.
POLICY BASICS	To be eligible for the CCSP Medicaid an individual must meet the following eligibility criteria: • Be age 65 or older, totally disabled or blind • Be a U.S. citizen or a lawfully admitted alien • Be a resident of Georgia (There is no time limit to establish residency, only the intention to live in Georgia.) • Agree to assign all health insurance benefits to the Division of Medical Assistance • Apply for and accept any other benefits which may help to pay for medical expenses • Have income less than the Medicaid monthly income cap • After applying all exclusions, have resources that do not exceed the limit for this class of assistance • Receive a Medicaid-reimbursable, waivered service every calendar month under a Comprehensive Care Plan developed by a care coordinator. **NOTE:** For any month that DFCS is determining a clients eligibility for CCSP Medicaid, a client must receive a waivered service. SSI Medicaid is not contingent on a client receiving a waivered service. • Meet the length of stay (LOS) requirement. The LOS requirement for CCSP Medicaid is 32 consecutive days, starting with the first day in care coordination/case management or a combination of days in CCSP and other medical treatment facilities (MTF). All continuous institutional
POLICY BASICS	living

(contd.)	living arrangements, regardless of type, are counted to meet LOS requirements. The DFCS Medicaid eligibility specialist will presume the client meets the length of stay requirement unless the care coordinator sends a Community Care Communicator (CCC) to advise the worker the client has left CCSP. To maintain continuous eligibility for CCSP Medicaid, a client must receive a waivered service each calendar month.
PROCEDURES	Follow the same functional assessment procedures for the MAO and potential MAO clients as for current SSI Medicaid clients. A DFCS eligibility specialist determines the client's CCSP Medicaid eligibility and exact cost share amount. Refer clients to DFCS for an eligibility or cost share determination. Send the CCC and LOC to DFCS. **EXCEPTION:** SSI recipients receive SSI Medicaid and are not required to apply for Medicaid at DFCS or cost share. The Social Security Administration determines SSI eligibility**.** Monitor the progress of the Medicaid referral with client and DFCS. Use Chart 520.1 when screening applicants entering CCSP for Medicaid eligibility regardless of whether they are SSI, MAO, or PMAO:

Chart 520.1 - CCSP Medicaid Eligibility Requirements

IF	THEN
Applicant is a single individual applying for CCSP **NOTE:** The individual income limit for CCSP Medicaid is equal to three times the SSI level. The CCSP Medicaid income limit changes in January each year when the SSI level increases.	• Applicant's income must be within the allowable income limit for CCSP Medicaid. **NOTE:** An applicant may establish a Qualifying Income Trust to reduce income. • Countable assets must not exceed the CCSP Medicaid resource limit for an

	individual.
IF (contd.)	**THEN (contd.)**
A couple is applying for CCSP	• Couple's income must be within the allowable income limit for CCSP Medicaid. • Countable assets must not exceed the CCSP Medicaid resource limit for a couple.
Applicant has spouse not applying for CCSP (Spousal Impoverishment)	• Applicant's income must be within the allowable income limit for CCSP Medicaid. • CCSP client and spouse's combined assets must not exceed the limit. The Medicaid applicant must transfer his or her assets, in excess of the individual limit, to the community spouse within one year from the month in which CCSP Medicaid eligibility begins. **NOTE:** Applicant may divert income to community spouse not in CCSP to reduce the cost share.
Applicant dies after care coordination has begun	Applicant is presumed to have met LOS requirements, provided all other eligibility requirements are met, including the receipt of a waivered service.

REFERENCES	Chapter 600, Care Coordination; Section 712, Brokering Services for MAO/PMAO Clients; Section 740, Follow-up Activity; Section 744, Cost Share (Client Liability); Section 930, Interruptions in Services; Appendix 100, Forms and Instructions; Appendix 700, Medicaid Classes of Assistance