State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
PO BOX 712
TRENTON, NEW JERSEY 08625-0712

DONALD T. DIFRANCESCO
Acting Governor

JAMES W. SMITH, JR.
Acting Commissioner

DEBORAH C. BRADLEY
Acting Director
1-800-356-1561

MEDICAID COMMUNICATION NO. 01-18 **DATE:** September 13, 2001

TO: County Welfare Agency Directors

SUBJECT: Office of Waiver and Program Administration Referral Form

The Department of Health and Senior Services, Office of Waiver and Program Administration (OWAPA), has formalized a referral procedure intended to expedite financial and clinical eligibility determinations for individuals who are seeking eligibility for the Enhanced Community Options Medicaid Waiver for Assisted Living and Alternate Family Care (AL/AFC). The purpose of this procedure is to help ensure that waiver eligibility is simultaneous with the completion of spend-down and that there is no break in provider reimbursement. A copy of the referral, together with instructions is attached.

Effective immediately, for purposes of determining date of application, receipt by the county welfare agency of an OWAPA Referral Form shall be treated as a Medicaid inquiry on behalf of the individual. Date of receipt of the form shall be considered to be the date of application.

In the absence of this referral form, the county welfare agency shall process an application on behalf of an individual seeking waiver services in the normal manner.

This policy shall be brought to the attention of appropriate staff. Questions may be directed to the Department of Health and Senior Services, Assisted Living Alternate/Family Care Unit field staff assigned to your county at (609) 584-4980.

Sincerely,

Deborah C. Bradley
Acting Director

DCB:dl
Attachment
c: George DiFerdinando, M.D., Acting Commissioner
William Conroy, Deputy Commissioner
Department of Health and Senior Services

David Heins, Director
Division of Family Development

Charles Venti, Director
Division of Youth and Family Services

State of New Jersey
Department of Health and Senior Services
Office of Waiver and Program Administration

POLICY

- Use of the Office of Waiver and Program Administration (OWAPA) Referral Form is now Standardized Procedure for Assisted Living and Alternate Family Care (AL/AFC) Service Provider Referrals.

- Use of the OWAPA Referral Form prompts separate but simultaneous financial and clinical eligibility determinations, expediting the time frame for Waiver eligibility determination.

- All AL/AFC Medicaid Service Providers shall use the OWAPA Referral Form (copy attached) to simultaneously refer to the Board of Social Services (BSS)/County Welfare Agency (CWA), Field Operation, and Case Management Sites (CMS), those private pay residents/participants that are "spending down" resources and who are anticipated to become financially eligible for Medicaid within three months. Once clinical eligibility has been established, enrollment will occur after receipt of the Long Term Care Referral (CP-2) from the BSS/CWA. The effective date of Waiver enrollment will reflect the date of the financial eligibility. The facility does **not** use the Client Tracking Form to notify the FO of the admission of spend down individuals.

- All AL/AFC Medicaid Service Providers shall use the OWAPA Referral Form to simultaneously refer to the BSS/CWA, Field Operation, and CMS, those individuals that it anticipates admitting to its facility/program once Waiver eligibility has been established.

- Assisted Living providers and Alternate Family Care (AFC) sponsor agencies shall use the OWAPA Referral Form to simultaneously refer to the BSS/CWA and/or the Field Operation, and CMS those individuals that it plans to admit/service once clinical eligibility has been determined, but before financial eligibility has been confirmed. The provider has performed its own financial assessment and assumes the risk that financial eligibility exists at the time of the Medicaid application.

- Use of the OWAPA Referral Form indicates that the AL/AFC service provider ensures the admission of the applicant as a Medicaid Waiver beneficiary in the facility/program, effective the date of clinical and financial Waiver eligibility.

- The OWAPA Referral Form serves as an official inquiry for Medicaid eligibility and, upon submission to the BSS/CWA, will serve to establish an application date for Medicaid. For individuals who are in receipt of SSI or who will be eligible for SSI under the higher income standards applicable in Assisted Living facilities, the OWAPA Referral Form need not be sent to the CWA/BSS. Instead, the LTCFO will confirm financial eligibility for the Waiver.

- Use of the OWAPA Referral Form ensures that professional staff will initiate the PAS within 14 calendar days of the receipt of the referral for persons living in the community, including those residing in Assisted Living Facilities or Alternate Family Care homes.

- Use of the OWAPA Referral Form introduces the Case Manager to the applicant at the earliest time in the application process. The Case Manager is a resource, available to answer program questions as necessary, and to track the status of the Waiver application.

smw/7/1/01

STATE OF NEW JERSEY
DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF CONSUMER SUPPORT

INSTRUCTIONS FOR OWAPA REFERRAL FORM

Please print and complete all referral information.

Client's Name Enter the first name, middle initial and last name.

Address: Enter client's street address, town and zip code.

Telephone Number: Enter client's telephone number (Include area code).

Social Security Number: Enter the client's own social security number.

Medicaid Number: Enter the client's Medicaid number (if known)

Date of Birth: Enter the client's date of birth (month/day/year).

Spend down: Circle yes if client is current resident; no for non-resident.

Referred by: Enter the name and title of the person completing the OWAPA Referral Form.

Phone #: Enter the telephone number, include the area code.

Contact Person: Enter the name of your facility's/program's contact person, and the complete phone number.

Agency/Facility: Provide the name of your facility or agency.

Date: Enter the date of the referral (month/day/year).

Diagnosis: Provide the applicant's medical diagnosis, if known.

Reason for Referral: The reason the applicant wishes to participate in the AL/AFC Component of the ECO Medicaid Waiver e.g. spend down-converting from private pay.

Care Needs: State the care needs you have identified for the applicant.

Community and Family Supports: List the names and telephone numbers of caregivers and family members.

Pertinent Social Information: Provide current living situation if known, and activities in which the applicant participates on a daily or weekly basis. If applicant lives with a caregiver include the name and telephone number.

Financial Information: To the extent gathered in the interview, provide the following:

a. Monthly Income: Provide the monthly total for Social Security, Pension and any other income.
b. Resources: Include bank accounts, stocks, bonds and sources.
c. Face value of life Insurance policy(ies) (cash value if known).

State of New Jersey
Department of Health and Senior Services
Division of Consumer Support
Enhanced Community Options Medicaid Waiver

Office of Waiver and Program Administration Referral Form

Client's Name: _____ **Social Security #:** _____

Address: _____ **Medicaid #:** _____

_____ **Date of Birth:** _____

Phone #: _____

Spend down: Y N

Referred By (Name & Title): _____ **Agency/Facility:** _____

Phone #: _____ **Date:** _____

Contact Person & Phone # (if different from above): _____

Diagnosis: _____

_____

_____

Reason for Referral: _____

_____

Care Needs: _____

_____

Community and Family Supports: _____

_____

Pertinent Social Information (include present living situation): _____

_____

_____

Financial Information:

a. **Monthly Income**
   - Social Security _____
   - Pension _____
   - Other _____
   - Total: _____

b. **Resources (bank accounts, stocks, bonds, etc.):** _____

_____

_____

_____

c. Face Value of Life Insurance Policy(ies) (if known):