The Independent Living (IL) Waiver provides services to beneficiaries who, but for the provision of such services, would require the level of care found in a nursing facility. The IL Waiver is a Medicaid home and community-based waiver operated jointly with the Mississippi Department of Rehabilitation Services. The waiver is operated statewide.

Eligibility is limited to individuals age sixteen (16) or older who have severe orthopedic and/or neurological impairments and possess maximum medical improvement potential. Maximum medical improvement potential, as defined by DOM, has been achieved when **all** of the following criteria are met:

- Beneficiary is able to communicate effectively with caregivers, personal care attendants (PCAs), counselors, case managers and others
- Beneficiary is certified as medically stable by their ~~primary~~ physician. Medical stability is defined as the **absence of** the following:
  - An active, life-threatening condition (e.g., sepsis, respiratory or other condition requiring systematic therapeutic measures)
  - Intravenous drip to control or support blood pressure
  - Intracranial pressure or arterial monitoring
  - A diagnosis of dementia, Alzheimer's, mental illness, mental retardation or any related condition of such severity that renders the individual unable to direct his/her own care

Clinical eligibility for waiver services will be determined through the utilization of a comprehensive pre-admission screening tool ~~which~~ that encompasses the following areas: activities of daily living, instrumental activities of daily living, sensory deficits, cognitive deficits, client behaviors, medical conditions, and medical services. Pre-admission screening data will be entered into a scoring algorithm ~~which~~ that will generate a numerical score. The score will be compared to a set numerical threshold ~~which~~ that determines eligibility. Those scores equal to or above the set numerical threshold will be deemed clinically eligible. ~~Refer to Section 64, Long Term Care/Pre-Admission Screening (PAS), for additional information.~~ Refer to Provider Policy Manual Section 64.0 for Long Term Care/Pre-Admission Screening (PAS) policy.

~~Individuals must be Medicaid eligible either as an SSI recipient or meet the 300% of the SSI Federal benefit rate required as the institutional income limit for individuals entering a nursing facility.~~

Medicaid Beneficiary Eligibility

Individuals must also qualify for full Medicaid benefits in one of the following Categories of Eligibility (COE):

- SSI – COE-001
- Low Income Families and Children Program – COE-085

- Disabled Child Living at home program – COE-019
- Children Under Age 19 Under 100% of poverty – COE-091
- Disabled Adult Child – COE-094
- Protected Foster Care Adolescents – COE-007
- CWS Foster Children and Adoption Assistance Children – COE-026
- IV-E Foster Children and Adoption Assistance Children – COE-003
- **OR** an aged, blind, or disabled individual who meets all factors of eligibility can qualify if income is under 300% of the SSI limit for an individual. If income exceeds the 300% limit, the individual must pay the amount that is over the limit each month to the Division of Medicaid under an Income Trust, provided the individual is otherwise eligible. COE – 065 denotes eligibility in the Independent Living Waiver.

It is the responsibility of all waiver providers to check the beneficiary's eligibility status. The eligibility status must be checked at least monthly, or when deemed necessary.

Prior approval must be obtained from the Division of Medicaid before a beneficiary can receive services through the Home and Community-Based Waiver Program. ~~To obtain approval, the following forms must be submitted to the HCBS division of the Bureau of Long Term Care:~~ To obtain approval the waiver provider must complete and submit current DOM approved forms as follows:

- ~~DOM~~ Pre-Admission Screening (PAS) Tool
- ~~DOM 301 HCBS~~ Plan of Care Form
- ~~HCBS 105 Home and Community-Based Services Recipients~~ Admitted and Discharged Form

~~DOM~~ Pre-Admission Screening (PAS) Tool

Clinical eligibility for waiver services will be determined through the utilization of a comprehensive pre-admission screening tool which encompasses the following areas: activities of daily living, instrumental activities of daily living, sensory deficits, cognitive deficits, client behaviors, medical conditions, and medical services. Pre-admission screening data will be entered into a scoring algorithm which will generate a numerical score. The score will be compared to a set numerical threshold which determines eligibility. Those scores equal to or above the set numerical threshold will be deemed clinically eligible. **The PAS will generate a Summary and Physician Certification page that must be signed by the physician.**

After the applicant has made an Informed Choice, understands the criteria for the waiver, and meets clinical eligibility, as determined by the PAS score, the application along with the Plan of Care (POC), which includes all of the service needs of the applicant, will be forwarded electronically ~~or "hard copy~~" to the Division of Medicaid, Division of LTC/HCBS.

~~Refer to Section 64, Long Term Care/Pre-Admission Screening (PAS), for additional information.~~
Refer to Provider Policy Manual Section 64.0 for Long Term Care/Pre-Admission Screening (PAS) policy.

~~DOM 301 HCBS~~ Plan of Care

The ~~DOM 301 HCBS~~ Plan of Care form is completed by the case manager. This form, in conjunction with the ~~DOM~~ Pre-Admission Screening (PAS) Tool, contains objectives, types of services to be furnished, and frequency of services. The form must be submitted to the Division of Medicaid, Division of LTC/HCBS.

~~HCBS 105 Home and Community-Based Services Recipients~~ Admitted and Discharged Form

The ~~HCBS 105~~ Admitted and Discharged form is used to admit and discharge a beneficiary into and from the Home and Community-Based Services waiver program. It must be completed at the time of the initial certification into the program, at each recertification, and anytime there is a change in the beneficiary's status.

At the time of initial certification, the DOM Pre-Admission Screening (PAS) Tool, the ~~DOM 301~~ Plan of Care form, and the ~~HCBS 105 Home and Community-Based Services Recipients~~ Admitted and Discharged form must be completed jointly by the IL counselor AND registered nurse. Forms completed as part of recertification may be completed by the counselor OR the registered nurse.

DOM HCBS staff will review/process all documents. If approved, an enrollment date will be established, appropriate forms will be forwarded to the fiscal agent, and the beneficiary will be locked into the waiver program. DOM HCBS staff will indicate program approval/denial, retain a copy of all forms and forward originals to the IL counselor/registered nurse to retain as part of the case record.

A beneficiary may be enrolled in only one DOM HCBS waiver program at a time. Any request to add services listed on the approved plan of care requires prior approval.