

DEVELOPMENTAL DISABILITIES ADMINISTRATION
Olympia, Washington

TITLE: INTAKE AND ELIGIBILITY DETERMINATION POLICY 11.01

Authority:	RCW 71A.10.020(5) RCW 71A.10.060 RCW 74.04.815 Chapter 71A.16 RCW Chapter 388-823 WAC WAC 388-825-100 through 105 WAC 388-825-120 through 165	<i>Definitions</i> <i>Notice by Secretary</i> <i>Military dependents</i> <i>Eligibility for Services</i> <i>DDA Intake and Eligibility Determination</i> <i>Notification</i> <i>Appeal Rights</i>
Reference:	DDA Policy 5.02 DDA Policy 11.02 DDA Policy 11.04	<i>Necessary Supplemental Accommodation</i> <i>Administration of the ICAP (Inventory of</i> <i>Client and Agency Planning)</i> <i>Determining "Other Condition" Similar to</i> <i>Intellectual Disability</i>

PURPOSE

This policy outlines the procedures for processing all Developmental Disabilities Administration (DDA) eligibility determinations, including initial applications, reapplications, and reviews.

SCOPE

This policy applies to DDA Central Office and Field Services staff.

POLICY

- A. DDA eligibility determinations are based on an evaluation of documentation. Eligibility reviews for existing DDA clients may require additional documentation beyond what is currently in the file. DDA accepts documentation provided by the applicant or their representative. If the applicant cannot obtain documentation, DDA will assist by contacting identified sources and requesting the documentation.
- B. DDA will ensure that eligibility processes and decisions are accurate, consistent, and timely.

- C. If DDA receives a signed request for a DDA eligibility determination ([DSHS 14-151, Request for DDA Eligibility Determination](#)) from an applicant with no previous determinations, DDA will complete the determination unless the applicant withdraws the request before the decision is complete.
- D. When an application or eligibility review is complete, DDA will send a notice containing the eligibility determination and appeal rights under WAC 388-823-0105 and WAC 388-825-100.
- E. The authority to make eligibility decisions is limited to designated intake and eligibility (I&E) staff trained in the:
1. Use of the DDA Determination section in the Comprehensive Assessment and Reporting Evaluation (CARE) application; and
 2. Rules and policies governing DDA eligibility.
- F. Regional employees must also comply with the statewide procedures described in this policy for accomplishing tasks related to eligibility determinations.
- G. Only trained I&E staff or a trained designee may determine eligibility or administer the inventory for client and agency planning (ICAP).
- H. DDA does not pay for assessments for the purpose of determining eligibility. See Procedures Section (F)(9).
- I. All cases must be carried by the region in which the client permanently resides.
1. When a child is residing in foster care, the foster home is considered the child's permanent residence.
 2. For a client in jail or prison, the client's permanent residence is where they lived prior to incarceration.
 3. For a client admitted to a hospital, including a state psychiatric hospital, the client's permanent residence is where they lived prior to admission.
 4. For a client residing at a Residential Habilitation Center (RHC), the client's permanent residence is:
 - a. The RHC if the client is on long-term stay status; or
 - b. Their permanent residence prior to the temporary stay at the RHC if the client is at the RHC for respite or a short-term stay.

5. For active military dependents DDA will not terminate eligibility if Washington remains the client's military home of record.

PROCEDURES

A. Intake Process

1. If DDA receives a request for a DDA eligibility determination, I&E staff must follow regional processes to:
 - a. Respond to eligibility information requests;
 - b. Assist applicants in need of additional support; and
 - c. Inform new applicants about entitlement services such as Medicaid Personal Care or Community First Choice. Refer a person requesting entitlement services to:
 - 1) A DDA case manager in the Specialized Reporting Unit if the client is under age 18; or
 - 2) Home and Community Services if the client is age 18 or older.
2. A person determined ineligible may reapply. DDA will only accept a new application if:
 - a. Eligibility was terminated because DDA could not locate the person but the person has subsequently contacted DDA;
 - b. Eligibility was terminated because the person lost residency in the state of Washington but the person has reestablished residency;
 - c. The person submits additional or new information relevant to the determination that DDA did not review for the previous determination of eligibility.
 - 1) The only acceptable new information considered is diagnostic information, FSIQ tests, or adaptive skills tests.
 - 2) DDA will only accept adaptive skills tests as new information if the person provides evidence that prior scores were invalid or if the person provides evidence of a loss of functioning related to a qualifying condition.
3. If the reapplication does not contain new information, I&E staff must contact the applicant to inform them that the application will be denied unless new

information under subsection (2) is received. If the I&E staff inform the applicant of this requirement but no new information is received, I&E staff must send a planned action notice (PAN) explaining why the application was not processed.

4. All DDA eligibility determinations, reviews, and related documentation must be recorded in CARE.
 - a. If the applicant does not have a CARE record, I&E staff must create a new client record. If a name and date of birth match exists in ProviderOne, confirm the match by SSN or other unique identifiers before creating a new record in CARE. Whenever possible a client record must be created using ProviderOne.
 - b. If the applicant has an inactive CARE record, I&E staff must reactivate the client record and open a pending determination. Before linking any cases reactivated in CARE to ProviderOne, confirm the match by name, date of birth, SSN, or other unique identifiers.
 - c. If the applicant or client has a current determination, the I&E staff must open a pending determination.
 - d. For a new application, the I&E Case Resource Manager (CRM) must enter the date the signed application was received in the CARE Document Tracking screen.
 - e. For an eligibility review, I&E staff must enter a comment in the Service Episode Record (SER) on the mailing date of [DSHS 10-301](#), *Notification of Eligibility Review*.
 - f. If DDA receives a signed [DSHS 03-387](#), *Notice of Privacy Practices for Client Confidential Information*, I&E staff must enter the signature date in the HIPAA screen in CARE.
 - g. For all I&E actions not documented in the CARE Determination screens, I&E staff must use I&E purpose codes to document actions in the SER.
5. The I&E CRM must create a paper file in the second section of the client's file. Eligibility documents must not be kept in a folder that can be separated from the client file. If the client's file is more than one volume, all eligibility documents must be kept in the current volume.
6. If an applicant is under age three and the referral was not initiated by the local Family Resources Coordinator (FRC) or an early intervention program, the I&E CRM must refer the applicant to the local FRC and document the referral in the SER. If a county does not have an FRC, I&E staff must process the application.

7. If an applicant withdraws the determination request before a determination is complete, the I&E CRM must:
 - a. Move the pending determination to history (CARE automatically sets the determination to “withdrawn”);
 - b. Send the appropriate eligibility PAN to the applicant after explaining their right to reapply; and
 - c. Document all actions taken in the SER.
 8. An intake application packet must include:
 - a. A self-addressed return envelope;
 - b. [DSHS 14-151](#), *Request for DDA Eligibility Determination*;
 - c. [DSHS 14-012](#), *Consent*;
 - d. [DSHS 03-387](#), *Notice of Privacy Practices for Client Medical Information*;
 - e. [DSHS 14-459](#), *Eligible Conditions Specific to Age and Type of Evidence*; and
 - f. A [Washington State Voter Registration](#) if the applicant is an adult.
- B. Eligibility reviews do not require a reapplication. An eligibility review must be completed by the region in which the person lives. DDA will review eligibility:
1. At age nineteen if the most recent eligibility determination was completed before the 16th birthday;
 2. At age nineteen if determined eligible under another neurological or other condition similar to intellectual disability and academic delays were used as evidence of substantial functional limitations;
 3. Before authorization of any DDA-paid service if not currently receiving paid services and the most current eligibility determination was made before June 1, 2005;
 4. If the evidence used to make the most recent eligibility determination is insufficient, contains an error, or appears fraudulent;
 5. If new information becomes available that does not support the current eligibility determination; or

6. If the client was determined eligible solely for fee-for-service (FFS) medically intensive children's program (MICP) services but the client is no longer eligible for FFS MICP services.

C. Eligibility Review Notification

1. All eligibility reviews require prior notification to the client or the client's legal representative and necessary supplemental accommodations (NSA) representative.
2. The notification must include:
 - a. A self-addressed return envelope;
 - b. [DSHS 10-301](#), *Notification of Eligibility Review*, or [DSHS 10-582](#), *Notification of Age Nineteen Eligibility Review*;
 - c. [DSHS 14-012](#), *Consent*;
 - d. [DSHS 14-459](#), *Eligible Conditions With Age and Type of Evidence*;
 - e. [DSHS 03-387](#), *Notice of Privacy Practices for Client Medical Information*, if a signed copy is not already in the client's file; and
 - f. A [Washington State Voter Registration](#) if the applicant is an adult.
3. I&E staff must mail the notification to the client's last known address.
 - a. If the notification returns with a forwarding address, I&E staff must send it to the correct address.
 - b. If the notification returns due to an incorrect mailing address, I&E staff must document in the SER all reasonable efforts to locate the client and the client's family.
 - c. If the client cannot be located, I&E staff must send a termination PAN to the client's last known address and the client's NSA representative.
 - 1) If there are no paid services the effective date is ten days after the mailing date.
 - 2) If there are paid services, the effective date is the last day of the current month, or the last day of the next month if less than ten days remain in the current month.
 - 3) The case may be closed after the effective date of the PAN.

- 4) Unless new evidence is expected based on information in the CARE Determinations screens and the SER, eligibility decisions for age 19 reviews are effective on the 20th birthday.
 - 5) All other review decisions are effective according to the timeline requirements for PANs.
 4. If the client moves to a different region, I&E staff must transfer the file to the new region.
- D. Eligibility expirations require reapplication and occur:
 1. At age 3, before the 4th birthday for all clients; and
 2. At age 9, before the 10th birthday for clients eligible under developmental delay or Down syndrome.
- E. Eligibility Expiration Notification
 1. I&E staff must mail expiration notices to the client or the client's parent or legal representative at least six months before the birthdate when their eligibility expires.
 2. I&E staff must document in the SER when they send the expiration notice and send it using:
 - a. [DSHS 10-377](#), *Notification of Age 4 Eligibility Expiration*;
 - b. [DSHS 10-378](#), *Notification of Age 10 Eligibility Expiration*; or
 - c. [DSHS 15-473](#), *Notification of Age 18 Eligibility Expiration*.
 3. If a client or their representative requests an application, send the intake application packet described in Procedures Section (A)(8) and document in the SER.
 4. Upon receipt of a signed application, follow Procedures Section (A)(4).
 5. If DDA does not receive a request for reapplication at least 60 days before the expiration date, the I&E staff must:
 - a. Mail the Expiration of DDA Eligibility PAN as required under WAC 388-823-1005;
 - b. Include the Paid Program Services information on the Expiration of DDA Eligibility PAN if the client is currently receiving paid services;
 - c. Update the client's current paid services CRM;

- d. If the client is receiving entitlement services, such as Medicaid Personal Care or Community First Choice, refer them for an assessment to continue the entitlement service;
 - e. Add a statement to the PAN that states although the client's DDA eligibility is ending, it does not end their eligibility for entitlement services;
 - f. Add contact information for HCS Intake or the DDA Regional Office to the PAN;
 - g. Contact the client and their NSA or legal representative according to [DDA 5.02](#), *Necessary Supplemental Accommodation*; and
 - h. Document all contacts and correspondence in the SER using I&E purpose codes.
6. If the client is receiving a DDA-paid service and does not reapply 30 days before the expiration date, the I&E staff must call the client and the client's parent or legal representative to explain the termination of services.
7. If there is no new eligibility determination or a pending determination and the application is received less than 60 days before the expiration date, the current eligibility ends on the 4th, 10th, or 18th birthday, respectively. Even if an expiration PAN has been sent, I&E staff may continue working with the client to attempt to keep the client eligible. The I&E staff must record these efforts in the SER.
8. If a DDA client is determined ineligible during the year before expiration, the current eligibility ends on the 4th or 10th birthday, respectively.
9. If a client is no longer eligible on their 4th or 10th birthday:
- a. The paid services CRM must end date any payment authorizations and RACs effective no later than the eligibility expiration date;
 - b. The paid services CRM must move the DDA assessment to history;
 - c. The I&E CRM must move the DDA determination to history; and
 - d. The I&E CRM must inactivate the CARE record unless entitlement services will continue under a DDA specialized reporting unit or through HCS.
10. If a client's DDA eligibility ends but they continue to receive entitlement services, the paid services CRM must:

- a. Terminate DDA services – including waiver and State Supplementary Payments; and
 - b. Transfer the case to Home and Community Services for adults or the Specialized Reporting Unit for children.
- 11. If a client is receiving benefits in ACES, the paid services CRM must notify the DDA Long-Term Care Financial Team via Barcode of termination of DDA eligibility.

F. Obtaining Required Documentation

- 1. New applicants provide the documentation necessary to meet DDA eligibility requirements. If additional documentation is needed, the I&E CRM must contact the applicant to request the additional documentation.
- 2. An eligibility review does not require additional information if there is already enough information in the client record to make the determination.
- 3. If the applicant cannot obtain the necessary documentation, the I&E CRM must assist by contacting the identified sources and requesting the documentation.
- 4. All requests for documentation from a source other than the client or applicant must be accompanied by a signed [DSHS 14-012, Consent](#). If there is no signed consent form, the I&E CRM must complete the determination based on the available information.
- 5. I&E staff must record all requests for documents in the SER.
 - a. After a document is received, the I&E CRM must record the documents in the CARE Document Tracking screen.
 - 1) Include the send date of the information request and the date the document was received. CARE does not allow an eligibility determination if a document is listed without a “date received.”
 - 2) CARE will create a numbered documents list.
 - b. The I&E CRM must record all information sources, such as diagnosing physicians or school psychologists, as collateral contacts in CARE.
- 6. When necessary, the I&E CRM must contact the sources if documentation is not received within 30 days and record all attempts in the SER.

7. If DDA does not receive complete information after 60 days from the date of receiving the application, the I&E CRM must:
 - a. Try to contact the applicant and their representatives;
 - b. Provide assistance as necessary;
 - c. When applicable, send [DSHS 14-460](#), *Notice of Insufficient Information*; and
 - d. Document contact in the SER.
8. At 90 days, the I&E CRM may proceed with the determination based on the available information unless there are reasons for waiting longer and these reasons are recorded in the SER. Reasons may include ongoing assistance in obtaining documentation.
9. DDA does not pay for assessments for the purpose of determining eligibility.
 - a. An ICAP may be administered if an acceptable adaptive skills test is not available from the past three years.
 - b. The CARE assessment may be used to document the need for physical assistance.
10. If an applicant or client presents documentation in a language other than English, DDA must translate documents needed for an eligibility determination according to the regional process.

G. Reviewing Eligibility Documentation

1. The I&E CRM bases an eligibility decision on all information received. If DDA does not receive complete information after 90 days of receiving the signed application, the I&E CRM bases the eligibility decision on the information received. The I&E CRM may continue the review if they expect to receive additional information related to eligibility criteria in chapter 338-823 WAC.
2. The I&E CRM must:
 - a. Number each document with the number assigned in the CARE application;
 - b. Review each document and highlight:
 - 1) The self-attestation of residency on the application form;

- 2) The eligible condition diagnosis;
 - 3) Evidence of a substantial limitation for the eligible condition;
 - 4) The outcome of an acceptable FSIQ test; and
 - 5) The outcome of an acceptable adaptive skills test.
- c. If a current acceptable adaptive skills test is not available, the I&E CRM must determine whether an ICAP is required.
- 1) If an ICAP is required, only a trained I&E CRM or designee may administer and score the ICAP.
 - 2) The I&E CRM or designee must document all ICAP activity in the SER.
 - 3) The I&E CRM or designee must enter:
 - a) “DDA” as the collateral contact; and
 - b) The ICAP results into the CARE Document Tracking screen; and
 - c) The I&E CRM who administered the ICAP into the CARE Document Tracking screen.
 - 4) The I&E CRM must enter the ICAP scores into the comments box.
- d. Tab the pages used as evidence with “Post-its.”
- e. Add their initials and the date reviewed to the top of the first page of each document.
3. The I&E CRM must enter into the CARE Evidence Tracking screen all evidence of attestation of residency, eligible conditions, and substantial limitations.
- a. CARE provides choices for evidence of conditions and substantial limitations based on the applicant’s age.
 - b. If there is inconsistent or contradictory evidence in the record, the I&E CRM must consult with the I&E supervisor.
 - c. The I&E CRM must document only the qualifying information in the CARE Evidence Tracking screen.

- d. If evidence supports or contradicts the criteria for required conditions or substantial limitations, the I&E CRM must enter a note in the comment box on the CARE Document Tracking screen. The I&E CRM must record detailed evidence from the document that supports the eligibility decision. Example: *There is an FSIQ using the appropriate test, but WISC FSIQ SS of 90 is too high and was determined invalid by assessor.*
- e. The I&E CRM must document consultations with a field services psychologist in the SER.

H. Making the Eligibility Determination

- 1. CARE will list all eligible conditions with sufficiently documented evidence.
- 2. If the applicant is over age 18, the I&E CRM must document whether the eligible condition originated before age 18.
- 3. In the Eligibility Decisions screen, CARE confirms eligible conditions and auto-populates the eligibility date, decision date, expiration date, and review date.
 - a. For a new applicant or someone who reapplies after their expiration date, the date the last document was received is the eligibility date.
 - b. If the applicant is not eligible, the I&E CRM records the denial in the CARE Eligibility Decisions screen with the date of the decision.

I. Notification Requirements

- 1. Notification of Eligibility
 - a. All applicants must be notified no more than five working days after the date of the determination decision by the I&E CRM.
 - b. For age three or older, I&E staff must give verbal disclosure of estate recovery as required by RCW 43.20B.080. At least two phone attempts must be made; leaving a voicemail is acceptable. The I&E CRM must document all contact or attempts at contact in the SER.
 - c. If services are requested, complete the [Service and Information Request](#) web form.
 - d. Send the eligibility PAN to the applicant, NSA and legal representative. For all new DDA clients, the I&E CRM must also send the following with the eligibility PAN based on the client's age:
 - 1) Under age three:

- a) The [Life Course Resources Toolkit](#);
 - b) [DSHS 22-722](#), *A Guide to Eligibility, Supports, and Services*;
 - c) [DSHS 22-605](#), *Home and Community Based Waiver Services*;
 - d) [Understanding the Role of the Developmental Disabilities Administration](#); and
 - e) [Insurance Navigation Program](#) information.
- 2) Age 3-15:
- a) The [Life Course Resources Toolkit](#);
 - b) [DSHS 22-722](#), *A Guide to Eligibility, Supports, and Services*;
 - c) [DSHS 22-605](#), *Home and Community Based Waiver Services*;
 - d) [DSHS 14-454](#), *Estate Recovery: Repaying the State for Medical and Long-Term Services and Supports*;
 - e) [Estate Recovery for Medical Services Covered by the State](#); and
 - f) [Premium Payment Program](#) information.
- 3) Age 16 and older:
- a) The [Life Course Resources Toolkit](#);
 - b) [DSHS 22-722](#), *A Guide to Eligibility, Supports, and Services*;
 - c) [DSHS 22-605](#), *Home and Community Based Waiver Services*;
 - d) [DSHS 14-454](#), *Estate Recovery: Repaying the State for Medical and Long-Term Services and Supports*;

- e) [DSHS 22-1463](#), *Employment Support Services for Adults with Developmental Disabilities*;
- f) [Estate Recovery for Medical Services Covered by the State](#); and
- g) [Premium Payment Program](#) information.

2. Notification of Denial or Termination of Eligibility

- a. The I&E CRM must contact the applicant or client and their NSA by phone before mailing a denial or termination notice and:
 - 1) Explain the decision and the evidence used to make the decision.
 - 2) Explain appeal rights and timelines.
 - 3) Explain the next steps regarding notification.
 - 4) Assist the person to appeal if they want your help. For example, if the person requests assistance with the appeal, complete and submit the hearing request then refer the person to an advocate or family member for assistance with the appeal process.
 - 5) Using regional processes, share resources with the applicant that may benefit them.
- b. The I&E CRM must send the client or applicant and their NSA:
 - 1) A denial or termination PAN;
 - 2) A printout of the CARE determination showing all documents used as evidence; and
 - 3) Any other relevant information, including resources to help the person find supports in their community.
- c. The I&E CRM must maintain copies of all translated correspondence in the applicant or client's file.
- d. The I&E CRM must record in the SER all interviews and phone contacts made with or on behalf of the applicant or client.

- e. The I&E CRM must notify the client's paid services CRM of the eligibility termination date.
 - 1) The paid services CRM must end date any payment authorizations and RACs effective no later than the eligibility expiration date;
 - 2) The paid services CRM moves the DDA assessment to history;
 - 3) The I&E CRM moves the DDA determination to history; and
 - 4) The I&E CRM inactivates the CARE record unless entitlement services will continue under a DDA specialized reporting unit or through HCS.
 - 5) If a client's DDA eligibility ends but they continue to receive entitlement services, the paid services CRM must:
 - a) Terminate the client's DDA services – including waiver and State Supplementary Payments; and
 - b) Transfer the case to Home and Community Services for adults or the Specialized Reporting Unit for children.
 - 6) If a client is receiving benefits in ACES, the paid services CRM must notify the DDA Long-Term Care Financial Team via Barcode of termination of DDA eligibility.
- f. If a client cannot be located, the I&E CRM must send a termination PAN to the last known address and NSA.
 - 1) If the client is not receiving paid services, the effective date is 10 days after the date of mailing.
 - 2) If the client is receiving paid services, the effective date is the last day of the current month, or the last day of the next month if less than 10 days remain in the current month.
 - 3) The case may be closed after the effective date of the PAN.
- g. For a patient residing at Eastern or Western State Hospital, the I&E CRM must send copies of a denial or termination PAN to:
 - 1) The DDA Mental Health Program Manager; and
 - 2) The Regional Mental Health CRM.

- h. For active military DDA will not terminate eligibility if Washington remains the client's military home of record.

J. CARE Documentation of Discharge or Death

1. If a client does not meet residency requirements under WAC 388-823-0050 or requests to discontinue DDA services, the following must occur:
 - a. I&E staff must work with the paid services CRM to ensure all open services and RACs are end dated;
 - b. The paid services CRM must send a termination PAN;
 - c. I&E staff must move the DDA determination to history; and
 - d. The CARE record is inactivated according to regional processes.
2. If an appeal is filed, eligibility will continue during the appeal. Do not continue paid services during the appeal.
3. If a client passes away, the following must occur according to regional process:
 - a. The date of death must be entered into the CARE Overview screen;
 - b. The paid services CRM must end-dated all open service authorizations and RACs;
 - c. The eligibility determination and DDA assessment must be moved to history; and
 - d. The CARE record must be inactivated with the reason "Death."
4. If a client or their legal representative cannot be located, or a PAN is returned as undeliverable the following must occur according to regional practices:
 - a. Document the contact attempts in the SER; and
 - b. Send a termination PAN to the client's last known address and the NSA.
 - 1) If the client is not receiving paid services the effective date is 10 days after the date of mailing.
 - 2) If the client is receiving paid services, the effective date is the last day of the current month, or the last day of the next month, if less than 10 days remain in the current month.

3) The case may be closed after the effective date of the PAN.

- c. Move the eligibility determination to history after the effective date of the termination PAN;
- d. Close all program records, service authorizations, and RACs; and
- e. Inactivate the CARE record.

K. Appeal Rights

- 1. Expiration of eligibility is effective on the 4th, 10th, or 18th birthday. There are no appeal rights to expiration of eligibility. Services do not continue when termination is due to expiration of eligibility.
- 2. A client may appeal the most recent eligibility decision.
- 3. Under WAC 388-825-145, a client may continue receiving services pending an administrative hearing.

L. Paid Services During Eligibility Reviews

- 1. Categorically needy eligible clients on the no-paid-services (NPS) caseload may be authorized for Medicaid services on a month-to-month basis during the eligibility review process.
- 2. Until the review is complete, the client may receive services necessary to meet critical health and safety needs.

M. Special Populations

- 1. Clients residing at Eastern State Hospital (ESH) or Western State Hospital (WSH)
 - a. The eligibility review process for clients at ESH or WSH must comply with [DDA 5.02](#), *Necessary Supplemental Accommodation*.
 - b. For all required reviews, I&E staff must coordinate with the designated regional Mental Health staff.
 - c. When a client is residing at ESH or WSH, follow the procedures in Attachment A of this policy.
 - d. If an application is denied and an appeal is filed the case must be reviewed with the I&E Program Manager before the hearing. If ESH or WSH staff are subpoenaed to testify, the case must be reviewed with the Assistant Secretary or Deputy Assistant Secretary before the hearing. If ESH or

WSH staff appear at a hearing without a subpoena a continuance should be requested by the Administrative Hearing Coordinator.

2. Adults in Department of Corrections (DOC) Custody

- a. DDA does not automatically terminate a client in DOC custody. The paid services CRM or designee must update the Residence screen in CARE with the client's current status.
- b. An eligibility review must be completed no more than 90 days after the request for paid DDA services. If an ICAP is required and the client is unable to respond, a qualified respondent must be identified under WAC 388-823-0940.
- c. If a client in the custody of the DOC is determined to be ineligible for DDA, notify the Central Office DOC liaison via email according to regional processes.

N. Regional I&E supervisors must:

1. Develop regional procedures that address eligibility reviews and staff responsibilities, staff training, and quality assurance in compliance with WAC 388-823 and all I&E policies and management bulletins.
2. Ensure that eligibility workers who make eligibility determinations or administer ICAPs are trained before performing I&E tasks.
3. Comply with I&E monitoring requirements.
4. Work with administrative hearing coordinators on appeals regarding eligibility decisions. Participate in administrative hearings as required.
5. Before inactivating the CARE record for a person no longer eligible, ensure that DDA payment authorizations, waiver eligibility, and waiver-related Medicaid documents are closed or terminated.
6. Provide quality control and oversight regarding:
 - a. Creation and linking of records in CARE;
 - b. Eligibility decisions;
 - c. Compliance with review timelines;
 - d. Termination of payments and waiver eligibility simultaneous with termination of DDA eligibility; and

e. Proper notification of appeal rights.

O. The Central Office I&E Program Manager must:

1. Coordinate meetings with regional I&E supervisors and other participants as needed;
2. Provide consultation to regional staff as needed;
3. Update WAC and policies as needed;
4. Maintain I&E department forms and notices;
5. Update Internet, Intranet, and SharePoint information as needed;
6. Coordinate I&E training as needed;
7. Consult the Assistant Attorney General and regional staff as needed regarding appeals; and
8. Assist in the development of I&E monitoring requirements with the Quality Compliance Coordination Team.

EXCEPTIONS

Any exception to this policy must have the prior written approval of the Deputy Assistant Secretary.

SUPERSESSION

DDA Policy 11.01
Issued September 15, 2015

Approved: /s/: Deborah Roberts
Deputy Assistant Secretary
Developmental Disabilities Administration

Date: December 15, 2019

Attachment A: *Procedures for Eligibility Re-Determination of Clients Residing at Eastern and Western State Hospitals*

ATTACHMENT A

PROCEDURES FOR ELIGIBILITY RE-DETERMINATION OF CLIENTS RESIDING AT EASTERN AND WESTERN STATE HOSPITALS

- A. DDA patients who have had an eligibility determination since June 1, 2005, do not require an eligibility review unless the current eligibility determination was made in error, the evidence used to make the most recent eligibility determination appears to be insufficient, in error, or fraudulent, or new diagnostic information becomes available that does not support the current eligibility determination.
- B. When an eligibility review is required, DDA will initiate the eligibility review process within thirty days of admission or as soon as clinically appropriate following admission. For patients whose psychiatric status must be stable in order to proceed with the eligibility review, this step may be delayed until such time that the treating hospital psychiatrist makes a review that the patient is stable enough to proceed with the eligibility determination process.
- C. The DDA Mental Health CRM or designee will notify the following individuals via email or fax that DDA will be reviewing eligibility prior to taking further action:
 - 1. The DDA Mental Health Program Manager;
 - 2. The ESH or WSH Habilitative Mental Health (HMH) Social Worker; and
 - 3. The ESH or WSH HMH Program Director.
- D. The DDA Mental Health CRM will coordinate with the ESH or WSH HMH Social Worker and the ESH or WSH HMH Program Director in advance of any mailed notifications.
- E. Prior to initiating an eligibility review, DDA will send a copy of the [DSHS 10-301](#), *Notification of Eligibility Review*, to:
 - 1. The client;
 - 2. The client's NSA representative;
 - 3. The ESH or WSH HMH Social Worker; and
 - 4. The DDA Mental Health Program Manager.
- F. The DDA Mental Health CRM will be available to meet with the HMH treatment team, along with the Regional Support Network/Mental Health (RSN/MH) liaison staff, to address any treatment concerns or considerations this eligibility re-determination may present.
- G. If the eligibility review determines the previously eligible client to be ineligible, the DDA Mental Health CRM will:

ATTACHMENT A

1. Notify the ESH or WSH HMH Social Worker and the ESH or WSH HMH Program Director of the decision;
 2. Continue to participate in treatment planning through the Department's appeal process, if the decision is appealed; and
 3. When termination is final, work with the state hospital treatment team, along with the appropriate RSN/MH liaison staff, to identify any treatment and transition issues. The MH CRM will assist in transition to other appropriate resources as needed and document these efforts in the SER.
- H. If the eligibility application for a review or new application is denied and an appeal is filed the case will be staffed with the Eligibility program manager prior to the hearing. If ESH or WSH staff are subpoenaed to testify, the case will be staffed with the Assistant Secretary or Deputy Assistant Secretary prior to the hearing. If ESH or WSH staff appear at hearings without a subpoena, a continuance should be requested. I&E staff must mail the DDA eligibility PAN to:
1. The client's NSA representative;
 2. The ESH or WSH HMH Social Worker; and
 3. The DDA Mental Health Program Manager.