Developmental Pathways

INTAKE & ENROLLMENT

a step-by-step guide

December 2022

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The enrollment process for a Medicaid Waiver and/or State Program involves multiple steps & team members. We'll need to partner closely to complete all steps quickly & get you the care you need.

1 REFERRAL

A referral is made to our Intake team to request services. You're given a Request for Disability Determination form to begin the process.

<90 days to submit eligibility docs

2 DISABILITY DETERMINATION

You'll submit eligibility documents, including cognitive/adaptive testing & evidence of intellectual disability or neurological impairment. You'll be assigned an Intake Case Manager (CM) who assesses whether you meet the State's criteria for developmental delay (*0-4 years) or disability (*5+ years). *The disability determination must be redone when turning 5 years old. This disability determination is different than a Medicaid disability determination.

3 PROGRAM OPTIONS

If determined to meet the State's definition of delay/disability, your Intake CM will discuss program and waiver options.

If you don't meet eligibility criteria at any point in the process, we'll refer you to other resources.

4 DOCUMENT COLLECTION

DP collects copies of documents needed for enrollment, including:

- Social Security Card
- Photo ID
- Birth Certificate
- Professional Medical Information Page (PMIP)

5 APPLYING FOR MEDICAID

If you select a waiver program, a Benefits team member will provide information on applying for Medicaid Benefits and application options. A Medicaid application may not be needed if you are receiving Social Security Income (SSI).

<90 days to process Medicaid application

6 WAIVER OFFER

Once the Medicaid application and/or SSI is confirmed, you'll be assigned an Enrollment CM who will offer enrollment into the waiver program contingent upon meeting functional eligibility, Medicaid eligibility, and the program's targeting criteria.

7 LEVEL OF CARE ASSESSMENT

An Enrollment CM schedules the Level of Care (LOC) Assessment (and other assessments as needed) to determine functional eligibility for Medicaid waiver programs. If functionally eligible, they will help you determine what services meet the needs identified in the LOC Assessment.

<60 days to choose service providers

8 PROVIDER SELECTION

Your Enrollment CM will discuss necessary services with you and assist in completing a Request for Proposal (RFP) to help you find service providers.

9 SERVICE PLAN

After Long-term Care (LTC) Medicaid approval, your Enrollment CM will schedule a Service Plan meeting to discuss your goals, needs, and waiver requirements for the upcoming year.

BEGIN SERVICES

After LTC Medicaid approval and providers are identified, we'll set a service start date & providers will begin supports. An Active CM will initiate ongoing case management & meet with you at least four times a year.

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ENROLLMENT CHECKLIST

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After an individual meets the State's criteria for a disability/delay, they can enroll in various programs/waivers. Here is what you can expect from this process:

1 – Learn about Program Options

- [ ] Discuss waivers and community resources to meet current needs, including criteria, services, requirements, and enrollment process.
- [ ] Identify needs and services desired; ensure matches eligibility criteria for programs.
- [ ] Provide information on current benefits and assets: SSI, Medicaid, private insurance, etc.

2 – Submit Documents

- [ ] Provide required documents (**not all of these are needed before starting services*):
  - [ ] Birth Certificate
  - [ ] Social Security Card
  - [ ] Photo ID or signed Affidavit of Identity
  - [ ] Adoption paperwork
  - [ ] Name Change paperwork
  - [ ] Guardianship paperwork
  - [ ] Special Needs Trust State Approval Letter

3 – Apply for Medicaid and Medicaid Disability (as needed)

- [ ] Discuss documentation/applications required to obtain Long-term Care (LTC) Medicaid with the Benefits team.
- [ ] Submit necessary documents/applications to Health First Colorado Medicaid. Health First Colorado Medicaid has up to 90 business days to process requests.
- [ ] Watch for requests from Medicaid for additional documentation and approval or denial letters.

4 – Complete Eligibility Assessment(s)

- [ ] Once active Medicaid OR Medicaid documentation is confirmed to have been submitted to Medicaid, verify the desire to pursue a waiver.
- [ ] Participate in functional eligibility assessment and other assessments as necessary for waiver enrollment.
- [ ] Obtain and submit the Long-Term Care Professional Medical Info Page (PMIP) with a doctor's signature and diagnosis to the CM.
- [ ] If determined functionally eligible for a waiver, the individual will move forward.

5 – Find Providers

- [ ] Identify services necessary to meet current needs and communicate preferences for providers.
- [ ] The CM will send referrals to providers and share information about those who responded.
- [ ] Review provider options and interview the main point of contact to make a selection that is right for you.

6 – Receive LTC Medicaid Approval

- [ ] Health First Colorado Medicaid will communicate approval for LTC Medicaid.

7 – Complete Service Plan (SP)

- [ ] Participate in an SP meeting to identify a goal and the frequency and details of services, including start date.
- [ ] Provide any missing documents needed to obtain services.
- [ ] Sign necessary documentation consenting to services and understanding of rules/requirements.

8 – Receive Ongoing Support

- [ ] Move to an Active CM who will provide ongoing support and guidance.
- [ ] Participate in quarterly monitoring meetings with the team (4 times yearly, including the annual SP meeting).

NOTES: