State of Utah

GARY R. HERBERT
Governor

SPENCER J. COX
Lieutenant Governor

Department of Human Services

ANN SILVERBERG WILLIAMSON
Executive Director

Division of Services for People with Disabilities
ANGELLA D. PINNA
Director

Thank you for making contact with us. We are looking forward to getting to know you. We hope we can help you get the services that you need. We provide services for people with intellectual disabilities and closely related conditions, acquired brain injury, and physical disabilities.

We have enclosed the following documents with this letter:

- Intake Checklist
- Form 1-1 Request for Determination of Eligibility for Services
- Intake Social History
- Division of Services for People with Disabilities Needs Assessment
- Form 1-2 Authorization to Furnish Information and Release from Liability
- Form 18 Request for ICD 10 CM Code from a Licensed Physician
- Frequently Asked Intake Questions
- Acquired Brain Injury Waiver Fact Sheet (English)
- Acquired Brain Injury Waiver Fact Sheet (Spanish)
- Family to Family Network

Please complete the items on the Intake Checklist and mail, email, or fax them to us using the information below:

Division of Services for People with Disabilities
Intake Unit – 3rd Floor
195 N 1950 W
Salt Lake City, UT 84116

DSPDIntake@utah.gov

Fax: 801-538-4279

If you have any questions or need help completing the attached forms, please contact the Intake Help desk at 1-844-275-3773 #1.

We look forward to receiving your application.

Angella D. Pinna, Director
Division of Services for People with Disabilities

Division of Services for People with Disabilities
Acquired Brain Injury Intake Checklist

_____ Form 1-1 - Request for Determination of Eligibility for Services

_____ Social History

_____ Copy of Social Security Card

_____ Copy of Birth Certificate

_____ Copy of Medicaid Card – *If not applicable, please indicate in* the *Social History*

_____ Medical Records – *Relevant documentation of the Brain Injury*

_____ ICD CM Code and Diagnosis Letter – *Completed by MD sent to/by DSPD*

When the above documentation is received and reviewed, an appointment will be set up to complete an assessment (CBIA).

Please mail, email, or fax documentation to:

Division of Services for People with Disabilities
Intake Unit – 3rd Floor
195 N 1950 W
Salt Lake City, UT 84116

DSPDIntake@utah.gov

Fax: 801-538-4279

If you have any questions or need help completing the attached forms, please contact the Intake Help desk at 1-844-275-3773 #1.

If you are interested in registering to vote, go to: https://secure.utah.gov/voterreg/index.html?formtype=dis

Form 1-1 REQUEST FOR DETERMINATION OF ELIGIBILITY FOR SERVICES

Information on APPLICANT (Person with Disabilities): [Please print the following information]			
First Name	Middle Name		Last Name
Home Phone	Work Phone		Cell Phone
Date of Birth	Gender Male Female		Social Security No
Address			City
County	State	Zip Code	e-mail

I, the Applicant, understand that by signing below and returning this form I am officially requesting the Division of Services for People with Disabilities to collect information about me to see if I am eligible for services.

_____ and/or _____ _____

Applicant's signature *Parent/Guardian's signature* *Date*

CONTACT PERSON (if different than applicant):		
Name	Phone Number	Relationship to Applicant

Please return this form to start the eligibility process. The form can be mailed to DSPD – Intake Unit, 475 W Price River Dr Suite 262, Price, UT 84501; or you can scan and email this form to DSPDIntake@utah.gov. If you need help completing this form, please contact the toll free Intake Help Line at 1-844-275-3773 from 8:00 a.m. to 5:00 p.m., Monday through Friday.

Intake Social History

Today's Date:_____/_____/_____
MM DD YYYY

1. Applicant's Personal Information

First Name	Middle Initial	Last Name
Nickname	Date of Birth	

Race	Ethnicity
American Indian/Alaska Native ☐ Native Hawaiian or other Pacific Islander ☐ Black or African American ☐ Caucasian ☐ Asian ☐ Other ☐	Hispanic/Latino Yes ☐ No ☐

Primary Way of Communicating	Primary Language	Need for a Translator?
Speaking ☐ Other ☐		Yes ☐ No ☐ Language:_____

2. Applicant's Physical Address (Where the applicant currently resides)

Address			
City	State	County	Zip Code

3. Applicant's Mailing Address (if different)

Address			
City	State	County	Zip Code

4. Applicant's Telephone Number(s) and Email Address (if applicable)

Home Phone	Mobile/Cell Phone	Email Address

5. Primary Persons of Contact (Please list all legal guardians if applicable and one person who does not live with the Applicant)

Name	Date of Birth	Lives with Applicant?	Relationship to the Applicant
		Yes ☐ No ☐	
Address			
City	State		Zip Code

Home Phone	Work Phone	Mobile/Cell Phone	Email Address

Are you the Applicant's legal or court appointed legal guardian? Yes ☐ No ☐
If yes, please provide a copy of the guardianship papers if the Applicant is not a minor child.
If no, list the Applicant's legal or court appointed guardian if applicable._____
Are you in need of a translator? Yes ☐ No ☐ If yes, what language:_____

Primary Persons of Contact (cont.)

Name	Date of Birth	Lives with Applicant?	Relationship to the Applicant
		Yes ☐ No ☐	
Address			
City	State		Zip Code
Home Phone	Work Phone	Mobile/Cell Phone	Email Address

Are you the Applicant's legal or court appointed legal guardian? Yes ☐ No ☐
If yes, please provide a copy of the guardianship papers if the Applicant in not a minor child.
Are you in need of a translator? Yes ☐ No ☐ If yes, what language:_____

Primary Persons of Contact (If applicable or needed)

Name	Date of Birth	Lives with Applicant?	Relationship to the Applicant
		Yes ☐ No ☐	
Address			
City	State		Zip Code
Home Phone	Work Phone	Mobile/Cell Phone	Email Address

Are you the Applicant's legal or court appointed legal guardian? Yes ☐ No ☐
If yes, please provide a copy of the guardianship papers if the Applicant in not a minor child.
Are you in need of a translator? Yes ☐ No ☐ If yes, what language:_____

6. Applicant's Educational History (Please list the current or last school attended)

Name of School	Type of School	Contact Information

Does/did the applicant receive early intervention services? Yes ☐ No ☐
Does/did the applicant receive special education services? Yes ☐ No ☐
If still in school, when will the applicant transition out? _____
MM/YYYY

7. Applicant's Employment History (FOR AGES 16 AND OVER)

(Please list Applicant's most recent job)

Employer	Avg. Hours/WK	Hourly Wage	Nature of Work	Start Date	End Date
			Paid with benefits ☐ Paid without benefits ☐ Volunteer/Unpaid ☐		
Job Title/Description:					
Type of Employment (please check one): Integrated Employment: Individual (e.g. Applicant holds/held own job in the community ☐ Work Crew (e.g. Applicant holds/held own job in the community as part of a work crew) ☐ Facility-Based (i.e. participated in a sheltered workshop, work activity, etc.) ☐					
Work Related Issues (i.e. problems with reliability, other employees, employer, etc.):					
Work Related Successes, Special Skills, etc.:					

Has the Applicant received Supported Employment through Vocational Rehabilitation? Yes ☐ No ☐
If yes, what year did the Applicant receive Vocational Rehabilitation services? _____
Is the Applicant seeking employment that would require ongoing support? Yes ☐ No ☐
Does the Applicant currently have an open case with Vocational Rehabilitation? Yes ☐ No ☐
If yes, which office:_____ Contact number:_____

8. Areas of Concern (List any major health, psychological, substance abuse related or physical, other related problems, and diagnosis that currently affect the Applicant's life)

Area of Concern	Receiving Support?	Need Support?	If marked yes, please describe the concern
Behavioral	Yes ☐ No ☐	Yes ☐ No ☐	
Mental Health	Yes ☐ No ☐	Yes ☐ No ☐	
Medical/Health Related	Yes ☐ No ☐	Yes ☐ No ☐	
Substance Abuse	Yes ☐ No ☐	Yes ☐ No ☐	
Safety	Yes ☐ No ☐	Yes ☐ No ☐	
Other	Yes ☐ No ☐	Yes ☐ No ☐	

9. Brain Injury (Has the Applicant suffered a brain injury):

Yes ☐ No ☐ If yes, please answer the following questions)

When (what date) did the brain injury occur? _____	Did the brain injury occur pre or post birth? Pre ☐ Post ☐
Describe the cause of the brain injury:	

10. Applicant's Use of Medical/Specialized Equipment (e.g. wheel chair, walker, g-tube, etc.)

Does the Applicant currently use any specialized equipment? Yes ☐ No ☐

If yes, please describe the specialized equipment used.

11. Applicant's Recent Hospitalizations (Please list any hospitalizations within the past year including psychiatric/residential hospitalizations including the Utah State Hospital)

Name of Facility	Reason for Admittance	Treatment Start Date	Discharge Date

12. Applicant's Stay in a Nursing Facility (NF) or Intermediate Care Facility (ICF/ID)

Is the Applicant now, or have they ever been a resident of a Nursing Facility? Yes ☐ No ☐

Is the Applicant now, or have they ever been a resident of an ICF/ID? Yes ☐ No ☐

If yes, please enter the following information:

- Admission Date _____
- Name of the Facility _____
- Discharge Date _____

13. Agencies (Is the Applicant involved with any city, state, or federal agencies? If so, enter the following)

Name of the Agency	Agency Contact Person	Agency Phone Number	Email Address
Division of Child and Family Services (DCFS)			
Adult Protective Services			
Office of Public Guardian			
Veteran Affairs (VA)			
Juvenile Justice Services			
County Aging Services			
Mental Health			

14. Applicant's Professional Relationships (This includes Doctors, School Representative, Speech or Occupational Therapist etc., not listed in section 14)

Professional's Name	Type of Professional	Phone Number	Email Address

15. Court Orders/Court Involvement (Is the Applicant currently affected by any court orders? If so please list)

What Kind of Order is it?	Date of the Order

16. Applicant's Benefits (If the Applicant receives a benefit, enter the following information)

Type of benefit (e.g. earned, retirement, Social Security, etc.)	Amount	Frequency the benefit is received? (e.g. weekly, monthly, one–time, etc.)

17. Does the Applicant receive Medicaid or Medicare benefits?

Insurance Type	Insurance Identification Number
Medicaid: Yes ☐ No ☐	
Medicare: Yes ☐ No ☐	

Social History Completed By: _____ Date: _____

Assessed by:_____ **Date:**_____
Consumer Name:_____**PID:**_____

Section 1. Urgency of Need (U) (to be completed by the worker on all new intakes and re-score requests. This section is not completed as part of the annual waiting list survey.)

U1. After following up with APS/CPS in the case of a positive electronic match, is the applicant a good candidate for ESMC referral?	**YES**	**NO**
U2. Has the applicant been court ordered to receive services?	**YES**	**NO**
U3. Has the applicant been approved for funding under a cooperative agreement?	**YES**	**NO**
U4. Is the applicant either currently, or at risk of in the next 30 days, living on the street or in a homeless shelter?	**YES**	**NO**
U5. Is the applicant at risk of profoundly endangering self or others in the next 30 days? (i.e. death, dismemberment, permanent injury)	**YES**	**NO**
U6. Is the applicant without a caregiver to meet his/her life-sustaining needs?	**YES**	**NO**
U7. Is the applicant at risk of not having a primary caregiver in the next 30 days?	**YES**	**NO**

Section 2. Severity of the Applicant's Disability (A) (to be completed by the family with assistance from the worker if needed). Workers are responsible for confirming responses and documenting supporting evidence when needed.

A1. If over the age of 10 years, for how many hours can the applicant be left home alone? (check one)
___0 hours ___1-3 hours ___4-7 hours ___8-12 hours ___13+ hours

---

A2. How many hours do family members/household members spend providing supports to the applicant (not including time when the applicant is asleep, at school/work, or at another activity outside of the home)?
_____ **HOURS PER (DAY WEEK MONTH)**
(Enter a number) ***(circle one)***

A3. Which of the following tendencies does the applicant currently have (check all that apply):
____**Hurtfulness to self/others:** Kicking, biting, pinching. poking, head-banging, stabbing, hair-pulling, or otherwise leaving a lasting physical mark (i.e. red skin, bruises, bleeding) visible within an hour or later time either to the individual themselves, another person, or an animal.
____**Property destruction:** Ripping, burning, taking apart, or otherwise permanently making useless and necessitating replacement of a possession belonging to the applicant or someone else.
____**Running/Bolting:** Quickly disappearing from the caregiver's supervision with the threat of injury present. For example, an individual who runs out of their house and perhaps runs into traffic.
____**Social offensiveness:** Urination, defecation, expectoration (spitting), yelling/screaming, using crude language or gestures, exposing of genitals, touching or talking to others in a sexual manner, self-touching of genitals, or otherwise exhibiting lewd behavior in the company of another person.

A4. For how many hours do caregivers spend providing medical assistance to the applicant? (includes: administering medications, treatments, therapy, transporting to/attending doctor/dental appointments)
_____ **HOURS PER (DAY WEEK MONTH)**
(Enter a number) ***(circle one)***

A5. Does the applicant have any unmet medical needs? **YES** **NO**
If yes, explain (continue at bottom of form if needed):

Definitions:
The **applicant** is the person with a disability applying for DSPD services.
A **caregiver** is anyone who provides supports to the applicant.
The **primary caregiver** is the person who provides the majority of supports to the applicant.
The **household** includes anyone living in the same dwelling as the applicant.
Supports includes paying bills, supervising (while the applicant is awake), helping clean, transporting, completing forms, shopping, grooming, or otherwise caring for the applicant.

Section 3. Parental/Caregiver Ability (C) (to be completed by the family with assistance from the worker if needed). Workers are responsible for confirming responses and documenting supporting evidence when needed.

C1. Is the primary caregiver a paid caretaker (i.e. applicant lives in supported/assisted living setting, group home, or with a paid caretaker)? ***(circle one)*** **YES** **NO**
→If "YES", you may skip questions C2-C6 and return this form now.
→If "NO", answer questions C2-C5 do be evaluated for poverty level. **Leaving any question blank** will result in disqualification for poverty consideration and **could have a negative impact on your waiting list placement.** Also answer question C6 if applicable.

C2. What is the *household*'s annual gross (before taxes) income (enter a dollar amount)**.** $_____

C3. How much does the household/family pay (out of pocket) in medical expenses each month for the applicant? **Includes co-payments for office visits and other out-patient treatments, hospitalizations, prescriptions, over the counter medicines, ointments, creams, incontinence garments/pads, diapers (if over the age of 3 years), dietary supplements if prescribed by a medical provider, and Medicaid spend-down.** $_____

C4 What is the household size (including the applicant)? _____

C5. How many individuals in the household are under 18 (including the applicant if applicable)? _____

C6. Does the caregiver have any of the following limitations ***(check all that apply)***
____Only one potential caregiver (i.e. single parent, only 1 competent adult relative in vicinity).
____Someone else in the house other than the applicant needs daily one-on-one intense care (not including young children UNLESS they have a disability).
____The household does not have a working and registered automobile (and public transportation does not meet the applicant's needs).
____Caregiver has a history of perpetrating abuse, neglect, or exploitation.
____Caregiver is over the age of 59 years.
____Caregiver is undergoing treatment for cancer or other terminal illness.
____Caregiver has a condition related to heart, blood pressure, or ulcers exacerbated by stress.
____Caregiver has arthritis, scoliosis, fragility, brittle bones, or is small in stature and the applicant needs lifting/carrying at times.
____Other significant barriers to caring for the applicant.
Explain (continue at bottom of form if needed):

Section 4. Time Without DSPD Services (T) (system-generated based on time spent waiting whether with a future or immediate need.)

T1. For how many months has the applicant been waiting for DSPD services? _____

Additional Comments:

Definitions:
The **applicant** is the person with a disability applying for DSPD services.
A **caregiver** is anyone who provides supports to the applicant.
The **primary caregiver** is the person who provides the majority of supports to the applicant.
The **household** includes anyone living in the same dwelling as the applicant.
Supports includes paying bills, supervising (while the applicant is awake), helping clean, transporting, completing forms, shopping, grooming, or otherwise caring for the applicant.

utah department of human services
Division of Services for People with Disabilities

Authorization to Furnish Information and Release from Liability

Name:_____ DOB: _____

I am: ☐ The individual named above ☐ The individual's legally authorized personal representative

The following have my permission to disclose my protected health information:

☐ School District:_____
☐ Division of Rehabilitation Service:
☐ Mental Health Centers listed: _____
☐ Physicians and Psychologist as listed:
Other:_____
_____
_____
_____

You are hereby authorized to release to the **Department of Human Services Division of Services for People with Disabilities (DSPD)** or its authorized representatives, verbally or in any written form, any information you have regarding the following subjects:

☐ Developmental Testing ☐ Brain Injury Records ☐ Vocational Testing
☐ Psychological/Cognitive Tests ☐ Inpatient /Outpatient Records ☐ IEP/Educational Testing
☐ Physical Examination Records ☐Other:_____
Please include records from: _____ to _____

(*Recipient Information: If the information released related to drug or alcohol abuse, the records are protected by federal confidentiality laws and you are prohibited from making further disclosures of this information without the specific written authorization of the person of whom it pertains or as permitted by 42 CFR Part 2. A general authorization for the release of information is NOT sufficient for this purpose. Federal law restricts using drug or alcohol abuse information for criminal investigation or prosecution.)

The purpose of this disclosure is:

☐ To establish eligibility for DSPD services ☐ Expiration Date (please specify):_____

- I understand that I may refuse to sign this Authorization, and my health care provider cannot refuse to provide treatment, payment or deny eligibility for benefits based upon my refusal.
- I understand that I may revoke this authorization in writing at any time. I understand that my revocation is not effective until received by the health care provider. My revocation is not effective to the extent the health care provider already released information in reliance on this authorization.
- I understand that federal privacy laws may no longer protect information released to DSPD and the information may be re-disclosed.
- I understand that this information is required by the Department of Human Services for the Division of Services for People with Disabilities.

I, the Individual and/or Authorized Personal Representative, understand that by signing below am requesting the Division of Services for People with Disabilities to collect information about me to see if I am eligible for services.

Individual's Name *(printed)*: _____

Individual's Signature/Date: _____

Authorized Personal Representative's Name *(printed)*: _____

Authorized Personal Representative's Name *(printed)*: _____

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

Request for ICD-10 CODE
From A Diagnosing Professional

The Division of Services for People with Disabilities (DSPD) is requesting an ICD-10 Code and Diagnosis for the above identified patient for the purposes of identifying if he/she meets eligibility requirements. DSPD serves people with Intellectual Disabilities or Related Conditions, Acquired Brain Injuries, and physical disabilities resulting in the functional loss of two or more limbs.

Please return this form within 10 days to start the eligibility process. If you need help completing this form, please contact DSPD at 1-844-ASK-DSPD (1-844-275-3773) from 9:00 a.m. to 5:00 p.m., Monday through Friday.

From:
Name of Professional: _____

Credentials: ☐ Licensed Psychologist ☐ MD ☐ DO

Address: _____

Telephone: _____

To:
Division of Services for People with Disabilities
Attn: Intake Unit
475 West Price River Drive #262
Price, UT 84501-2858

Regarding:
Patient Name: _____ DOB: _____

Response from Diagnosing Professional:
Per your request for an ICD-10 Code and Diagnosis, I have reviewed _____, medical documentation.
Patient's Name

It is my conclusion that the patient listed above meets the following primary ICD-10 Code and Diagnosis.

ICD.10 Code: _____Diagnosis: _____

If additional ICD 10 CM Codes and Diagnoses apply, please list below:

ICD.10 Code: _____Diagnosis: _____

ICD.10 Code: _____Diagnosis: _____

ICD.10 Code: _____Diagnosis: _____

Signature: _____Today's date: _____

Frequently Asked Intake Questions

Q: How does DSPD determine if my case is eligible for DSPD services?

A: DSPD makes the eligibility decision using the documentation you provide. Your case may go inactive or be determined ineligible for DSPD services if we do not receive all of information we need. If the documentation does not meet DSPD requirements, your case may be determined ineligible.

Q: How long do I have to turn in the documentation to DSPD?

A: You have 90 Days to return the intake packet and the supporting documentation from when your intake worker sends out the intake packet. After 90 days your case will be inactive. Your intake worker will send you a letter to let you know that 90 days has passed. If you are still interested in applying and need more time please contact your intake worker and they can help you if you are having trouble gathering documentation.

Q: What documentation is needed?

A: DSPD needs the following:

Social History/Intake Packet (Your intake worker will send you this)

Social Security Card and Birth Certificate

- DSPD can continue the intake process without these documents, but we won't be able to *make an eligibility decision* until we have received them. DSPD can help you get in touch with the agency that provides these documents.

Psychological Evaluation

- An evaluation completed within the last 5 years is required. A developmental assessment can be used for children under the age of 7.
- *School Testing may meet this requirement*. We will need a copy of the psychological evaluation and/or testing that was completed by the school psychologist. A diagnosis is also necessary to determine eligibility. IEPs, even ones with goals, are not acceptable for eligibility purposes.

Medical Records

- Only records/information related to the disability needs to be supplied. We do not require every record your doctor has on file.
- For medical conditions: A letter from a doctor can be sufficient if it is *signed and dated* by the physician and includes the individual's *name*, *diagnosis, current ICD diagnosis code (your doctor will know what this is), and functional limitations*

Release of Information (Included in the intake packet)

- Without the release of information filled out, we cannot contact anyone on behalf of your case to obtain the documentation we need.
- Please list the doctors on the form with their phone numbers and your intake worker can contact them directly to obtain the necessary documentation

ICAP Assessment (Our Division Assessment that is completed by your intake worker)

- When the above documentation is received and reviewed your intake worker will contact you to complete an assessment of the applicant's functional limitations.

Q: Does the person applying need to register to vote to be eligible for DSPD Services?

A: No. As a state agency, DSPD must give you the option of applying.

Q: What happens after all the documentation has been submitted?

A: Once all documentation is received and reviewed, your intake worker will contact

For any additional questions about DSPD services, please contact your intake worker or visit the DSPD website at: http://www.hsdspd.utah.gov

you. The intake worker will set up what is called an ICAP assessment, which determines where the most support is needed. This is part of the eligibility process.

Q: How will I know when a decision has been made?

A: Once all documentation is received and reviewed, an informational letter called a Notice of Agency Action (NOAA) will be sent to you. This letter will state whether the applicant is eligible (and placed on the waitlist) or ineligible for DSPD services.

Q: What happens if I am Ineligible?

A: You will be sent an informational letter (NOAA) that will let you know in writing that you are not eligible for services. Attached to all Notice of Agency Actions is a Hearing Request form. You can request to appeal the decision made by DSPD on this form, however it needs to be returned to DSPD within 30 days of the postmark. You can contact DSPD if you have questions regarding the appeal form.

Q: What happens if I am eligible?

A: You will be sent an informational letter (NOAA) that will let you know in writing that you are eligible for services. This letter will include a Hearing Request form which is included whenever a Notice of Agency Action is sent. You do not need to return the appeal form if you are found eligible for services.

Q: How long will I be on the waiting list?

A: Funding is provided to those with the most critical needs. DSPD does not work on a first come first serve basis. Placement on the waitlist is primarily based on need, and wait times vary according to need and available funds. For more specific information you can contact your intake worker or visit the DSPD website.

Q: How does DSPD follow up with people on the waiting list?

A: Every year DSPD will send a survey to you in the mail. This survey is used to determine your current need, as well as let DSPD know you are still interested in our services. These surveys are sent through the mail so it is important to keep your contact information up to date with your waitlist worker. *If we do not receive a response to this survey, you will be taken off the waitlist.* You can contact your intake worker at any time to update your situation, or check on your status. If you discover you are no longer on the waitlist because you did not respond to the survey, you can contact our intake line at 1-877-568-0084.

Q: What happens when I come off of the wait list?

A: Once we receive funding for your case, all documentation provided to DSPD will be reviewed again, and you will be contacted by a waitlist worker to update any necessary information. You will go through a process similar to the original intake process and may be required to submit additional documentation to re-determine eligibility. You will be transitioned to a state support coordinator who will assist you with available services.

For information about Medicaid please visit: http://medicaid.utah.gov/
For information about ICF/ID or Care Centers please contact:
http://www.health.utah.gov/ltc/CS/CSLinks.htm click on "Community Supports Facts Sheet"

For any additional questions about DSPD services, please contact your intake worker or visit the DSPD website at: http://www.hsdspd.utah.gov

Acquired Brain Injury Waiver

Waiver Services

- Behavioral Consultation
- Chore Services
- Cognitive Retraining Services
- Community Living Supports
- Companion Services
- Consumer Preparation
- Environmental Adaptations
- Extended Living Supports
- Financial Management Services
- Homemaker Services
- Living Start Up Costs
- Medication Monitoring
- Non-medical Transportation
- Occupational and Physical Therapy
- Personal Budget Assistance
- Personal Emergency Response System
- Residential Habilitation
- Respite Care
- Specialized Medical Equipment
- Speech Language Services
- Structured Day Program
- Support Coordination
- Supported Employment

Purpose and Eligibility

Purpose

This waiver is designed to provide services statewide to help people with an acquired brain injury remain in their homes or other community based settings. Individuals are able to live as independently as possible with supportive services provided through this waiver program.

Eligibility Requirements

- Be 18 Years of Age or older.
- Have a documented brain injury.
- Require nursing facility level of care.
- Meet financial eligibility requirements for Medicaid.
- Primary condition cannot be attributable to a mental illness.

Limitations and Contact Info

Limitations

- A limited number of individuals are served.
- There is a waiting list for this waiver program.
- Individuals can use only those services they are assessed as needing.

Contact Information

Division of Services for People with Disabilities
195 North 1950 West
SLC, UT 84116
(801) 538-4200
dspd@utah.gov

UTAH DEPARTMENT OF HEALTH

General Information

Utah Has Six Medicaid 1915(c) HCBS Waivers

- Waiver for Individuals Age 65 or Older
- Acquired Brain Injury Waiver
- Community Supports Waiver for Individuals with Intellectual Disabilities or Other Related Conditions
- Physical Disabilities Waiver
- New Choices Waiver
- Waiver for Technology Dependent, Medically Fragile Individuals

What is a Medicaid Waiver?

- In 1981, Congress passed legislation allowing states greater flexibility in providing services to people living in community settings.
- This legislation, Section 1915(c) of the Social Security Act, authorized the "waiver" of certain Medicaid statutory requirements.
- The waiving of these mandatory statutory requirements allowed for the development of joint federal and state funded programs called Medicaid 1915(c) Home and Community Based Services Waivers.

How does the 1915(c) HCBS Waiver work?

- The Utah Department of Health, Division of Medicaid and Health Financing (DMHF - Medicaid) has a contract with the Centers for Medicare and Medicaid Services (CMS - the federal Medicaid regulating agency) that allows the state to have a Medicaid 1915(c) HCBS Waiver.
- The contract is called the State Implementation Plan and there is a separate plan for each waiver program.
- The State Implementation Plan defines exactly how each waiver program will be operated.
- All State Implementation Plans include assurances that promote the health and welfare of waiver recipients and insure financial accountability.

What are the characteristics of a waiver?

- States may develop programs that provide home and community based services to a limited, targeted group of individuals (example: people with brain injuries, people with physical disabilities, or people over the age of 65).
- Individuals may participate in a waiver only if they require the level of care provided in a skilled nursing facility (SNF) or an intermediate care facility for people with intellectual disabilities (ICF/ID).
- States are required to maintain cost neutrality which means the cost of providing services to people at home or in the community has to be the same or less than if they lived in a nursing facility.
- Services provided cannot duplicate services provided by Medicaid under the Medicaid State Plan.
- States must provide assurances to the Center for Medicare & Medicaid Services (CMS) that necessary safeguards are taken to protect the health and welfare of the recipients of a waiver program.

Programa de Renuncia para Personas con Lesiones de Cerebro Adquiridas

Servicios del Programa

- Servicios de que haceres del hogar
- Soporte en los asilos
- Serviios de compañia
- Asistencia y Apoyo Familiar
- Servicio de Ama de Casa
- Transporte no-médico
- Sistema de Contestación de Emergencia personal
- Servicio de Cuidados Temporales
- Equipos Médicos especializados
- Programa del Día estructurado
- Coordinación de Apoyo
- Empleo de apoyo

Proposito y Elegibilidad

Propósito
Este programa de renuncia esta diseñado para proporcionar servicios a lo largo del estado para ayudar a que las personas con lesión del cerebro adquirida permanezcan en sus casas o en las comunidades de la tercera edad. Los individuos pueden vivir vidas más independientes y evitar tener que residir en un asilo de ancianos

Eligibility Requirements

- Ser mayor de 18 años
- Tener un daño cerebral documentado
- Requerir un nivel de cuidados especiales
- Cumplir con requerimiento de elegibilidad financieros de Medicaid
- La condición primaria no puede ser atribuida a una enfermedad mental

Limitaciones e Información de Contacto

Limitaciones

- Servicio limitado a un número de individuos (165)
- Hay una lista de espera para participar en este programa
- Las personas pueden solo usar esos servicios que son evaluados como necesarios

Información de Contacto
Division of Services for People with Disabilities
195 North 1950 West
SLC, UT 84116
(801) 538-4200
dspd@utah.gov

Utah Department of Health

Medicaid 1915(c) Home & Community Based Services Waivers

Información General

Utah tiene Seis programas de Renuncia a la Vejez de Medicaid 1915(c) HCBS

- Programa de Renuncia para los Individuos mayores de 65 años
- Programa de Renuncia para personas con Lesión de Cerebro adquirida
- Programa de Renuncia de Soporte de la comunidad para los Individuos con Disbilidades Intelectuales o Otras Condiciones Relacionadas
- Programa de Renuncia de Disabilidades Físicas
- Programa de Renuncia de nuevas opciones
- Programa de Renuncia para los Niños Tecnológicamente Dependientes (solamente manejado por el Buró de Manejo de Cuidado de UDOH)

¿Que es el programa de Renuncia a la Vejez de Medicaid?

- En 1981, El congreso aprobó la ley que permite a los estados más flexibilidad en proveer servicios a los individuos que viven en comunidades de la tercera edad.
- Esta legislación, Sección 1915(c) del Acta del seguro social, autorizó el "la renuncia" de ciertos requisitos estatutarios de Medicaid.
- La Renuncia de estos requisitos estatutarios obligatorios permitieron el desarrollo de programas conjuntos federales y estatales y consolidó los programas llamados Medicaid 1915(c) Servicios de Renuncias basadas en el Hogar o Comunidades de la Tercera Edad.

¿Como trabaja este programa de la sección 1915(c)?

- El Departamento de Salud de Utah, División de Medicaid y Financiamiento de Salud (DMHF - Medicaid) tiene un contrato con los Centros para Medicare y Servicios de Medicaid (CMS – la agencia federal que regula el medicaid) que permite al estado tener el programa de renuncia Medicaid 1915(c) de HCBS.
- El contrato se llama el Plan de Aplicación Estatal y hay un plan separado para cada programa de renuncia.
- El Plan de Implementación Estatal define exactamente cómo cada programa de renuncia se operará.
- Todos los Planes de Implementación estatal incluyen convicciones que promueven la salud y bienestar de los destinatarios del programa y aseguran responsabilidad financiera.

¿Cuales son las características de este programa?

- Los Estados pueden desarrollar programas que proporcionan servicios basados en el hogar o en una comunidad de la tercera edad a un grupo limitado de individuos (ejemplo: las personas con lesiones del cerebro o las personas con disabilidades físicas)
- Los individuos sólo pueden participar en el programa si ellos requieren el nivel de cuidado proporcionado en un asilo de ancianos hospitalario (NF) o una facilidad de cuidado de intermedio para las personas con retraso mental (ICF/MR).
- Se exigen a Estados que mantengan neutralidad del costo, lo que significa el costo de proporcionar servicios a las personas en casa o en la comunidad tiene que ser el mismo o menos de si ellos vivieran en un asilo de ancianos.
- Los servicios proporcionados no pueden reproducir servicios proporcionados por Medicaid bajo el Plan de Medicaid Estatal
- Los Estados deben proveer aseguramiento al Centro de Medicare & Servicios de Medicaid (CMS) que sea necesario para proteger la salud y bienestar de los destinatarios de un programa de renuncia a la vejez.

Family to Family Network

The Family to Family Network is a statewide parent support network that is designed to educate, strengthen, and support families of persons with disabilities, especially those who are on the wait list or in DSPD services. Network leaders are parents of individuals with special needs and link families to local resources, services, and disability-friendly events.

Contact Us!

For more information, please call:
801-272-1051
Toll-Free in Utah 1-800-468-1160
Email: FtoFN@utahparentcenter.org

Online at:
www.utahfamilytofamilynetwork.org
www.facebook.com/utahfamilytofamilynetwork

Get Connected!

"This is the first time that we have ever gotten to fully enjoy any event like this. We usually end up dealing with major sensory overload. Today's event was perfect, no overload, and enjoyed by all."
- Amy W, Utah County

Get Involved!

Connect with other families in person, on social media, through listservs, and in local activities. We're also always looking for new leaders and volunteers! Please contact us if you would like to be involved in the Network.

Utah Parent Center
Special needs, extraordinary potential

The Family to Family Network is a volunteer program of the Utah Parent Center, funded by the Division of Services for People with Disabilities (DSPD) and community sponsors.

www.facebook.com/utahfamilytofamilynetwork www.utahfamilytofamilynetwork.org