Utah Department of
**Health & Human Services**
**Services for People with Disabilities**

# INTAKE CHECKLIST

*Acquired Brain Injury*

**Contact the Intake Help Desk at 1-844-275-3773**
**to ask questions and get help filling out intake forms.**

## Intake Steps

1. Send DSPD Intake all applicable eligibility documents.
2. Intake specialist reviews your documents.
3. Intake specialist contacts you to schedule an appointment to complete the Needs Assessment Questionnaire (NAQ) and the Comprehensive Brain Injury Assessment (CBIA).

## Eligibility Documents

### REQUIRED FOR EVERYONE

- ☐ Form 1-1 Request for Determination of Eligibility for Services
- ☐ Social History
- ☐ Copy of Social Security Card
- ☐ Copy of Birth Certificate
- ☐ Form 18 Request for ICD Code (Completed by a licensed psychologist, a doctor of medicine, or a doctor of osteopathic medicine.)
- ☐ Medical Records (Relevant documentation of the diagnosis)

### MAY BE NEEDED TO DETERMINE YOUR ELIGIBLITY

- ☐ Copy of Medicaid Card (If not applicable, note in the Social History.)
- ☐ Release of Information
- ☐ Guardianship Papers (If a guardian is appointed by the court.)

### SEND DOCUMENTS BY EMAIL, MAIL, OR FAX.

**Email:** dspdintake@utah.gov

**Mail:** Division of Services for People with Disabilities Intake 475 W. Price River Dr. #262 Price, UT 84501

**Fax:** 801-538-4279

Utah Department of
Health & Human Services
Services for People with Disabilities

# REQUEST FOR DETERMINATION OF ELIGIBILITY FOR SERVICES

Form 1-1
Version Date: Feb. 2024

## Instructions

Complete and return this form to start the eligibility process. This form requires a signature. It can be filled out and signed electronically. Return completed forms by email or mail. If you print the form, it must be scanned before returning by email.

Email completed forms to DSPDIntake@utah.gov.

Mail completed forms to 475 W Price River Dr #262 Price, UT 84501.

Contact DSPD Intake by email or call 1-844-275-3773 for help completing the Form 1-1.

## Applicant Information

Legal Name (First, Middle, and Last): _____

Phone Number: _____ Email: _____

Date of Birth: _____ Legal Sex: _____

Social Security Number: _____ County: _____

Address (include Zip Code): _____

### CONTACT PERSON

Same as Applicant ☐

Name: _____ Phone Number: _____ Relationship: _____

## Signature

I, the Applicant, understand that by signing and returning this form that I am officially requesting the Utah Division of Services for People with Disabilities to determine my eligibility for services. To determine eligibility, DSPD will collect and review medical and psychological information about me.

Signature _____ Date _____

Signer is the: Applicant ☐ Parent ☐ Legal Guardian ☐

Utah Department of
**Health & Human Services**
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# REQUEST FOR ICD-10 CODE

Form 18
Version Date: Feb. 2024

## Instructions

The Division of Services for People with Disabilities (DSPD) requests confirmation of an ICD-10 diagnostic code for the applicant identified below in order to determine whether they meet service eligibility requirements. Form must be completed and signed by a licensed psychologist, medical doctor, or osteopathic doctor. Please return this form within 10 days to start the eligibility process. If you need help completing this form, please contact DSPD at 1-844-275-3773, Monday through Friday from 8 am to 5 pm.

**SEND COMPLETED FORM BY EMAIL, MAIL, OR FAX.**

**Email:** dspdintake@utah.gov

**Mail:** Division of Services for People with Disabilities Intake Unit 475 W. Price River Dr. #262 Price, UT 84501

**Fax:** 801-538-4279

## Applicant Information

Name: _____ DOB: _____

## Physician Information

Name: _____ Phone Number: _____

Credentials: Licensed Psychologist ☐ MD ☐ DO ☐

Address: _____

### PHYSICIAN CERTIFICATION

It is my conclusion that the Applicant 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: _____ Date: _____

Utah Department of
Health & Human Services
Services for People with Disabilities

# AUTHORIZATION TO FURNISH INFORMATION AND RELEASE FROM LIABILITY

Form 1-2
Version Date: Feb. 2024

Name: _____ Date of Birth: _____

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

- ☐ School District: _____
- ☐ Vocational Rehabilitation
- ☐ Mental Health Provider: _____
- ☐ Physician: _____
- ☐ 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 | ☐ Inpatient Records | ☐ Vocational Testing |
| ☐ Psychological/Cognitive Tests | ☐ Brain Injury Records | ☐ IEP/Educational Testing |
| ☐ Outpatient Records | ☐ Physical Examination Records | ☐ Other _____ |

Please include records from _____ to _____

(Recipient Information: If the information released relates 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. Disclosure Expiration Date: _____

- 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 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.

Signature: _____ Date: _____

Signer is: ◯ the individual named above ◯ the individual's legally authorized personal representative

Authorized Personal Representative's Name: _____

Utah Department of
**Health & Human Services**
Services for People with Disabilities

# INTAKE SOCIAL HISTORY

Form 824-I
Version Date: Feb. 2024

Date: _____ Completed by: _____

## Applicant's Personal Information

Legal Name (First, Middle, Last): _____ Preferred Name: _____

Date of Birth: _____ Primary Language: _____

Communication Assistance: ☐ None required ☐ Spoken Language ☐ Signed Language ☐ AAC ☐ TTY

**DSPD asks for the following information in order to help our staff use the most respectful language when talking to you. We want to understand who you are. Please help us serve you better by selecting each item that describes you. Thank you.**

Race and Ethnicity:
☐ American Indian or Alaska Native
☐ Hawaiian Native or Other Pacific Islander
☐ Middle Eastern or North African
☐ Prefer not to say
☐ Black or African American
☐ Hispanic, Latino/a/x, or Spanish Origin
☐ Non-Hispanic, Latino/a/x, or Spanish Origin
Prefer to self-describe _____
☐ Asian
☐ Multi-Race
☐ White

Gender Identity:
☐ Female ☐ Male ☐ Non-binary ☐ Transgender ☐ Cisgender
☐ Prefer not to say Prefer to self-describe _____

Sexual Orientation:
☐ Heterosexual ☐ Gay or Lesbian ☐ Bisexual ☐ Queer ☐ Asexual
☐ Prefer not to say Prefer to self-describe _____

Pronoun: ☐ She/Her ☐ He/Him ☐ They/Them Other _____

Guardianship Status: ☐ Own Guardian ☐ Biological Parent ☐ Adoptive Parent ☐ Youth in Care ☐ Guardian

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Domestic Partnership ☐ Widowed

## Applicant's Contact Information

Physical Address: _____ City: _____ UT Zip Code: _____

Mailing Address: _____ City: _____ UT Zip Code: _____

Phone Number: _____ Email: _____

Is the Applicant the primary contact for information? ◯ Yes ◯ No

### IMPORTANT PEOPLE TO CONTACT

Please list no more than 3 people to act as primary and emergency contacts. Include parents and legal guardians if applicable, and at least one person who does not live with the Applicant. Legal guardians must provide a copy of their guardianship papers.

**Contact One**

Lives with Applicant? ◯ Yes ◯ No ☐ Primary contact

Name: _____ Pronoun: _____ Relationship to Applicant: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email: _____ Primary Language: _____

Communication Assistance: ☐ None required ☐ Spoken Language ☐ Signed Language ☐ AAC ☐ TTY

**Contact Two**
Lives with Applicant? ◯ Yes ◯ No ☐ Primary contact

Name: _____ Pronoun: _____ Relationship to Applicant: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email: _____ Primary Language: _____

Communication Assistance: ☐ None required ☐ Spoken Language ☐ Signed Language ☐ AAC ☐ TTY

**Contact Three**
Lives with Applicant? ◯ Yes ◯ No ☐ Primary contact

Name: _____ Pronoun: _____ Relationship to Applicant: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email: _____ Primary Language: _____

Communication Assistance: ☐ None required ☐ Spoken Language ☐ Signed Language ☐ AAC ☐ TTY

## Applicant's Education History

Please list the current or last school attended.

Name of School: _____ Type of School: _____

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, what date will the Applicant graduate or transition out? _____

# Applicant's Employment History

For Applicants aged 16 years and older, please list their most recent job.

Employer: _____ ◯ Part-time ◯ Full-time

Start Date: _____ End Date: _____ Hours per week: _____ Hourly Wage: _____

Job Title/Description: _____

Type of Employment (please check one):

- ◯ Integrated Individual Employment (e.g. Applicant has/had own job in the community)
- ◯ Integrated Work Crew (e.g. Applicant works/worked in the community on a work crew)
- ◯ Facility-Based (i.e. participated in a sheltered workshop, work activity, etc.)

Work Related Issues (i.e. any difficulties that affected job performance):

_____

Work Related Successes, Special Skills, etc.:

_____

Previously received Supported Employment through Vocational Rehabilitation? ◯ Yes ◯ No

If yes, what year did the Applicant receive employment services? _____

Is the Applicant seeking employment that requires ongoing support? ◯ Yes ◯ No

Does the Applicant currently have an open case with Vocational Rehabilitation? ◯ Yes ◯ No

If yes, which office: _____ Office phone number: _____

# Areas of Concern

List any major health (physical, psychological, substance abuse, etc.) concerns, and the related diagnoses that affect the Applicant's life.

## BEHAVIORAL HEALTH

Receiving support? ○ Yes ○ No

Need Support? ○ Yes ○ No

If Need Support, please describe.

## SUBSTANCE MISUSE

Receiving support? ○ Yes ○ No

Need Support? ○ Yes ○ No

If Need Support, please describe.

## MENTAL HEALTH

Receiving support? ○ Yes ○ No

Need Support? ○ Yes ○ No

If Need Support, please describe.

## SAFETY

Receiving support? ○ Yes ○ No

Need Support? ○ Yes ○ No

If Need Support, please describe.

## PHYSICAL HEALTH

Receiving support? ○ Yes ○ No

Need Support? ○ Yes ○ No

If Need Support, please describe.

## OTHER

Receiving support? ○ Yes ○ No

Need Support? ○ Yes ○ No

If Need Support, please describe.

## Brain Injury

Does the Applicant have a brain injury? ◯ Yes ◯ No

Did the brain injury occur pre or post birth? ◯ Pre ◯ Post

Date the brain injury occurred: _____

Describe the cause of the brain injury.

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## Applicant's Medical/Specialized Equipment

Does the Applicant use any specialized equipment (e.g. wheel chair, walker, g-tube, ventilator, etc.)? ◯ Yes ◯ No

If Yes, please describe the specialized equipment used.

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## Applicant's Recent Hospitalizations

List any hospitalizations within the last year, including psychiatric care and in-patient residential treatment.

Facility Name _____ Facility Name _____

Reason for Admission _____ Reason for Admission _____

Admission Date _____ Discharge Date _____ Admission Date _____ Discharge Date _____

## Nursing Facility or Intermediate Care Facility (ICF)

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

Facility Name _____ Admission Date _____ Discharge Date _____

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

Facility Name _____ Admission Date _____ Discharge Date _____

## Other Agency Involvement

If the Applicant is involved with any other city, state, or federal agencies, fill out the following information.

Agency Name _____ Agency Name _____

Contact Person _____ Contact Person _____

Phone Number _____ Phone Number _____

Email _____ Email _____

## Applicant's Professional Relationships

List any significant professionals (e.g. doctors, school representatives, therapists, service providers, etc.).

Type of Professional _____ Type of Professional _____

Name _____ Name _____

Phone Number _____ Phone Number _____

Email _____ Email _____

## Court Orders

If the Applicant is currently affected by any court orders, list the Order below and provide a copy.

Order Type: _____ Date Signed: _____

## Applicant's Benefits

If the Applicant receives any financial benefits, fill out the following information.

Benefit Type _____ Benefit Type _____

Amount _____ Amount _____

Frequency received _____ Frequency received _____

## Applicant's Health Insurance

Choose all that apply.

- ☐ Medicaid Identification Number: _____
- ☐ Medicare Identification Number: _____
- ☐ Private Insurance

# INTAKE FREQUENTLY ASKED QUESTIONS *Acquired Brain Injury (ABI)*

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

Answer: DSPD uses your documents to decide if you are eligible for services. To be eligible for services, you must have a disability that DSPD serves and meet functional limitations.
Your intake worker will look for an eligible disability in your documents. They will also review documentation and ask your questions todetermine if you meet at least 3 of 7 functional limitations: Memory or Cognition, Activities of Daily Living, Judgment and Self-Protection, Control of Emotion, Communication, Physical Health and Employment

The Intake Checklist illustrates the documents that we need to review. The Checklist is included in your intake packet. DSPD may ask you for additional documents.

### Question: How long do I have to turn in the documents to DSPD?

Answer: You have 90 days to complete the intake packet and send in the eligibility documents. The 90 days begins when your intake worker sends you the intake packet or you start intake through MySTEPS. Your intake worker can help you gather documents.

### Question: What happens if I don't turn in all of the documents within 90 days?

Answer: DSPD switches your case to 'inactive' if we don't have the documents that we need. Your intake worker will send a letter that tells you that the 90 days passed. Contact your intake worker to change your case back to 'active'.

### Question: What documents are needed?

Answer: Here is a list and explanation of the documents that DSPD needs for eligibility. The Intake Checklist lists the documents that we need to review. The Checklist is included in your intake packet.

• Social History

--The social history is included in the intake packet and available in MYSTEPS. DSPD needs social history to decide if you are eligible.

• Social Security Card and Birth Certificate

--DSPD can review other documents before we have your social security card and birth certificate. DSPD needs both documents to decide if you are eligible. DSPD can help you ask for a new card or certificate if you cannot find them.

• Medical Records

--DSPD only needs records and information related to the disability. We do not require every record that your doctor has on file.

--We will send you a Form 18 to document your diagnosis. The Form 18 is completed by your physician. A physician is a doctor of medicine (MD), or doctor of osteopathic medicine (DO).

---We can use a letter from your physician if it has the information that we need. We need to know the patient's name, a diagnosis, a current ICD diagnosis code, and a description of functional limitations. Your physician will know what the ICD diagnosis code is. The letter must be signed and dated.

• Release of Information

--The Release of Information allows your intake worker to ask for your protected school and medical information. Send us this form if you want help gathering your documents. The Release of Information form is included in the intake packet. We cannot ask your school, physician, or service provider for your protected information without a signed form. Contact your intake worker if you need another copy of the form.

--Please list the name and phone number of each place that your intake worker can ask for information.

• Needs Assessment Questionnaire (NAQ)

--The NAQ is a DSPD assessment that is done with your intake worker. DSPD needs to review all your documents before we complete the NAQ. Your intake worker will contact you about the NAQ.

--DSPD uses the NAQ results to calculate your critical need score.

• Comprehensive Brain Injury Assessment (CBIA)

--The CBIA is a DSPD assessment that is done with your intake worker. DSPD needs to review all of your documents before we complete the CBIA. Your intake worker will contact you about scheduling the CBIA.

--DSPD uses the CBIA to identify your functional limitations.
Must score between 36-136 points

## Question: What happens after all of the documents are submitted?

Answer: First, your intake worker reviews all of your documents. Then, they contact you to schedule two DSPD assessments. The Needs Assessment Questionnaire (NAQ) and the Comprehensive Brain Injury Assessment (CBIA) are part of the eligibility process.

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

Answer: DSPD will send you a letter called the Notice of Agency Action (NOAA). The NOAA tells you if you are eligible or not eligible for DSPD services.

## Question: What happens if I am not eligible?

Answer: You will be sent a letter called the Notice of Agency Action (NOAA). The NOAA tells you that you are not eligible for services. If you want to, you can appeal DSPD's decision. An appeal tells DSPD that you do not agree with the decision. Attached to the NOAA is a Hearing Request form. Follow the directions on the Hearing Request form to begin the appeal process. The Hearing Request form must be returned to DSPD within 30 days of the postmark on the letter envelope. Contact your intake worker if you have questions about the Hearing Request form or the appeal process.

## Question: What happens if I am eligible?

Answer: You will be sent a letter called the Notice of Agency Action (NOAA). The NOAA tells you that you are eligible for services. The NOAA always includes a Hearing Request form. The Hearing Request form starts a process to appeal DSPD's decision. An appeal tells DSPD that you do not agree with the decision. DSPD does not expect you to appeal a decision that you agree with.

### Question: How long will I be on the waiting list?

Answer: Wait times vary based on each person's assessed need and available funds. The waiting list ranks people by their critical need score. Your critical need score comes from the NAQ and the annual waiting list survey. Funding is offered to people with the most critical needs, not on a first-come-first-serve basis. Contact your intake worker or visit the DSPD website for more information about the waiting list.

### Question: How does DSPD follow-up with people on the waiting list?

Answer: DSPD will contact you to update the NAQ and Waiting List Survey every year. When we call, we will ask you survey questions and review the latest NAQ. We use the survey to confirm that you still want our services. If DSPD cannot complete your survey, we will remove you from the waiting list. If you have been removed from the waiting list and want to reactivate your case, please call intake at 1-844-275-3773. You can contact your waiting list worker at any time to update your needs assessment or check on your case.

### Question: What happens when I come off of the waiting list?

Answer: DSPD will tell you that funding is available for your case. Your waiting list worker will look at all your eligibility documents. You may need to update your documents. Updating your eligibility documents can be a lot like the intake process. Your waiting list worker will tell you if DSPD needs new documents from you. Tell your waiting list worker if you need help getting new documents.

After we update your documents, DSPD will move you to a state support coordinator. A support coordinator helps you pick services and track your budget. Your state support coordinator will help you set-up a service plan.

## Other Information

### MEDICAID INFORMATION

Visit medicaid.utah.gov.

### SKILLED NURSING FACILITY (SNF) INFORMATION

Visit https://medicaid.utah.gov/medicaid long-term-care-and-waiver-programs/.

### DSPD INFORMATION

dspd.utah.gov

MySTEPS
https://mysteps.utah.gov/mysteps/ui/index.html

### UTAH BRAIN INJURY COUNCIL

http://utahbraininjurycouncil.net/

UTAH RESOURCE GUIDE FOR INDIVIDUALS WITH BRAIN INJURIES

http://utahbraininjurycouncil.net/wp-content/uploads/2020/01/Utah-BI-Resource-Guide-3.pdf

# Acquired Brain Injury Waiver

**Waiver Services**

- Behavior 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 & Human Services

# 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 & Human Services, 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 & Human Services

# 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.

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.

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