Liberty Healthcare Corporation
THE FREEDOM TO SUCCEED™
Idaho Independent Assessment Services Program
8850 W. Emerald St. – Suite 164 | Boise, ID 83704 | 208.258.7980 | FAX: 208.258.7985

INITIAL SELF-DIRECTED BUDGET NOTICE – BRAND NEW INITIAL – NEVER APPLIED FOR SERVICES BEFORE OR SEEN THE LHC BEFORE – A8

DATE THAT THE NOTICE WILL BE MAILED

(Participant Name)
(Mailing Address)
(City, State, Zip)

Dear (Participant's Name):

You have qualified for developmental disability waiver services for this year. You have requested to participate in the Consumer Directed Services option and therefore, your waiver eligibility was reviewed under that option. This letter informs you of your budget under the Consumer Directed Services option.

For the upcoming plan year, your budget is $_____("**Calculated Budget**"). You may ask for an appeal to review (or change) your **Calculated Budget**.

At this point, you need to either contact the Department to schedule a mandatory orientation meeting or mail a completed Appeal Request Form, or to do both.

1. **If you want to <u>submit a Support and Spending Plan using your Calculated Budget</u>:**

   Contact a specialist in your region at the number(s) listed below to schedule a mandatory orientation meeting to learn about the responsibilities associated with the Consumer Directed Services option.

Region	City	Phone
1	Coeur d'Alene	208-665-8908
2	Lewiston	208-799-4382
3	Caldwell	208-334-0751 208-334-0956
4	Boise	208-334-0751 208-334-0956 208-334-0716
5	Twin Falls	208-732-1485
6	Pocatello	208-239-6270
7	Idaho Falls	208-528-5703

   Under the Consumer Directed Services option, you must participate in a person-centered planning process to decide the supports and services that will be provided under your Support and Spending Plan (SSP).

You can also get services using your new budget while you are waiting for a decision in your appeal. At the same time you appeal, you can submit a Support and Spending Plan using your **Calculated Budget**. The Department must approve your plan as long as it is medically necessary and within your **Calculated Budget**.

When you identify services to be part of your SSP, you must work within your Calculated Budget. Your services must cost no more than $_____ (insert budget dollars). IDAPA 16.03.13.190.

2. **If you <u>disagree</u> with the Calculated Budget:**

You may appeal the amount of your Calculated Budget and request a hearing. To appeal and request a hearing at this time, fill-out and send the **Appeal Request Form** (the next page) **within 28 days of this Notice, by _____** (insert due date). Send the Appeal Request Form to the Department at the address listed. **If you fill out and send the form by _____** (insert due date), **your current services will stay the same until a decision is made about your Appeal.** If you appeal and have a **health or safety need** that you believe supports an increase in your **Calculated Budget**, fill out and return one or both of the forms labeled "Health Risk Form" or "Safety Risk Form" (enclosed with this letter) when you submit your **Appeal Request Form** to show either a health or safety need.

You may argue your case yourself, or have an attorney or another person of your choice to represent or help you. If you are not sure about how well you can argue your case, you should have an attorney or another person help you.

If the decision is that the calculation was correct **you may have to repay any extra funds.** 42 CFR § 431.230(b).

3. **If you have a <u>health or safety need</u>, read below:**

You can appeal your Calculated Budget now. Follow the instructions in #2, above. Be sure to fill out and return either a "Health Risk Form" or "Safety Risk Form," or both, when you submit your Appeal Request Form.

Or, instead of appealing your Calculated Budget now, you may submit a service plan to the Department by _____ (insert deadline date)**.** If you have a health or safety need, you may request services in a proposed plan that cost more than the amount of your **Calculated Budget**. To request services that cost more than your **Calculated Budget**, fill out and return one or both of the forms labeled "Health Risk Form" or "Safety Risk Form" enclosed with this letter to your Care Manger when you submit your plan for approval. After the Department reviews your proposed plan, you will receive a service plan notice telling you whether the proposed plan is approved or denied. If you disagree with the Department's decision to approve or deny your plan, you will have the ability to appeal and request a hearing after you receive the service plan notice.

If you have any questions about this Notice, please contact the Department at (208) 334-5747 or the Independent Assessment Provider at the number listed below.

Sincerely,

Independent Assessment Provider (insert telephone number)
cc: Guardian
Support Broker

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Appeal Request Form

Fill-out this form completely and send it within **28 days** if you want to appeal your Calculated Budget.

I wish to appeal by requesting a hearing for [Participant Name] because (fill out extra pages if necessary):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Participant Signature Date

1. Check one box below if you need and want help with this appeal.

☐ I will handle the appeal on my own.
☐ I want someone to help with my appeal. I want _____ ("Appeal Assistant") to help me through the appeal [include name and relationship to you]. His/her address and phone number is:

_____

If you want help with an appeal but do not have anyone to help you, immediately contact:

Your Care Manager at the Idaho Department of Health and Welfare. The Care Managers are listed in this letter.

ACLU of Idaho: (208) 344-9750 extension 1202
The ACLU of Idaho cannot directly help with you with your appeal. But they monitor to make sure everyone who wants help can get help.

2. If you have listed someone who will help you in this appeal, they must sign below to show that they agree to help you:

Appeal Assistant Signature: _____ Date: _____

3. *Submit documents to show a health or safety need.* You may request a higher budget by showing that you have a health or safety need. Fill out and return one or both of the forms labeled "Health Risk Form" or "Safety Risk Form" enclosed with this letter to show either a health or safety need. If you meet the criteria, submit your documentation to the Department at the address below within 20 days from the date that you submit this Appeal Request Form to the Department. Your Appeal Assistant can help you with this.

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4. Get more information. Check the boxes below for the information you want:

☐ I want copies of the Individualized *Budget Calculation* tool used to calculate my budget for the following budget years _____ (fill in budget years). *The Department may not have copies of the budget calculation tools prior to 2008.*

☐ I want the Adult Developmental Disabilities Individualized Budget Model Analysis related to the Department's budget calculating methodology.

☐ I want a copy of my Scales of Independent Behavior-Revised ("SIB-"R") materials.

☐ I want copies of other documents related to this case or in my file, including but not limited to:

Mail or fax the completed Appeal Request Form to:

Administrative Procedures Section
Department of Health and Welfare
450 West State Street
PO Box 83720-0036
Boise, ID 83720-0036
Phone: (208) 334-5564 FAX: (208) 334-6558

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Why Your Budget Has Changed From Last Year

Your budget has changed because of a combination of the following: **Inapplicable because this is your first budget**

1. If the chart below is filled out, then there were changes in your *Scales of Independent Behavior* ("SIB-R") score and/or changes in the responses to your *Inventory of Individual Needs* ("IIN") that changed your Calculated Budget. Your "Respondent" gave the answers for your SIB-R and IIN. Your Respondent this year was: _____.
2. For more information about these changes, see the Cover Sheet and other documents attached to this Notice. Or contact the Department at (208) 334-5747. The changes that affected your Calculated Budget were:

Question	Summary of Question	Last year's response	This year's response	How this change affected your Calculated Budget	The reason for this change is because:
					□ Your answers to the IIN or SIB-R changed from last year to this year and (check one): □ The assessor observed this change □ Your assessor verified this change (if this box is checked, the assessor must provide an explanation) □ Explanation of verification: _____ _____ □ Other reasons (i.e., other than changes to the IIN and SIB-R) (if this box is checked, the assessor must provide an explanation at the bottom of this page)
					□ Your answers to the IIN or SIB-R changed from last year to this year and (check one): □ The assessor observed this change □ Your assessor verified this change (if this box is checked, the assessor must provide an explanation) □ Explanation of verification: _____ _____ □ Other reasons (i.e., other than changes to the IIN and SIB-R) (if this box is checked, the assessor must provide an explanation at the bottom of this page)

3. This year, you received the _____ (upper, mid, or lower) level of your budget. But, last year you received the _____ (upper, mid, or lower) level of your budget. For a more in-depth explanation regarding how level changes happen, please see the attached Cover Sheet.
   ☐ Not applicable

4. Other reasons: (*assessor must explain if applicable*)

Attached Documents:

1. *Cover Sheet* - explanation of your budget calculation (1 page)
2. Attachment 1 - This year's *Inventory of Individual Needs* responses (2 pages) and *Individualized Budget Calculation* (3 pages)
3. Attachment 2- Last year's *Inventory of Individual Needs* responses (2 pages) and *Individualized Budget Calculation* (3 pages) (None)
4. Attachment 3 - *Report of Adaptive Behavior Testing* from your most recent SIB-R test (4 pages)
5. *Health Risk and Safety Risk Forms* - (4 pages)
6. *Health and Safety Criteria* - (3 pages) To review this criteria online, go to:

   Health:
   http://healthandwelfare.idaho.gov/Portals/0/Medical/DevelopmentalDisabilities/HealthRiskFormFillable.pdf

   Safety:
   http://healthandwelfare.idaho.gov/Portals/0/Medical/DevelopmentalDisabilities/SafetyRiskFormFillable.pdf

7. *List of Idaho Department of Health and Welfare Care Managers* - (1 page)

For More Information:
The documents in this envelope include all the information that was used to calculate your Budget. More information, including citations to the laws and regulations affecting your Budget include:

1. Federal regulations about appeals, prompt and accurate responses: Code of Federal Regulations, Title 42, sections 431.200 through 431.246
2. Idaho laws related to disabilities:
   a. Idaho Code sections 66-402(5) and 56-255(3)(e)(ii)
   b. Intermediate Care Facilities for People with Intellectual Disabilities—Medicaid Enhanced Plan rules (Idaho Administrative Code 16.03.10.584)
3. Medicaid Enhanced Plan rules (Idaho Administrative Code 16.03.10)
4. Consumer-Directed Services HCBS Waiver rules (Idaho Administrative Code 16.03.13)
5. Annual Assessment and Calculated Budget Notification Regulations: Code of Federal Regulations, Title 42, section 441.302(c), and Idaho Administrative Code 16.03.10.514 and 16.03.13.190
6. Federal regulations about repayment of benefits: Code of Federal Regulations, Title 42, section 431.230(b)
7. A blank *Inventory of Individual Needs* showing all of the possible responses or explanations in the Inventory is available for your review as well as the *Inventory of Individual Needs* worksheet that was filled out by the assessor during this year's assessment.

   Code of Federal Regulations: http://www.ecfr.gov
   Idaho Code: https://legislature.idaho.gov/statutesrules/idstat/
   Idaho Administrative Code ("IDAPA"): https://adminrules.idaho.gov/rules/current/
   Help in understanding your budget calculation or these statutes or rules is always available through the Department of Health and Welfare, 3232 Elder Street, Boise, Idaho (208) 334-5564.