pennsylvania
DEPARTMENT OF HUMAN SERVICES

COMMUNITY HEALTHCHOICES (CHC)

OPERATIONS MEMORANDUM #2019-05

SUBJECT: Circumstances When CHC-Managed Care Organizations (MCO) Must Transmit the Home and Community-Based Services (HCBS) Eligibility/Ineligibility/Change Form (PA 1768)

TO: CHC MCOs

FROM: Bureau of Coordinated and Integrated Services

DATE: ~~November 20, 2019~~ December 29, 2022

PURPOSE

The PA 1768 (Attachment 1) is used to notify the County Assistance Office (CAO) when a CHC Participant is determined clinically eligible for CHC HCBS or when a CHC Participant, who is receiving HCBS, experiences a change affecting his or her eligibility for HCBS. The Independent Enrollment Broker (IEB) is responsible for transmitting the PA 1768 to the CAO when a Participant first applies for HCBS. This Operations Memorandum describes other situations in which the CHC-MCO will be responsible for transmitting the PA 1768 to the CAO in accordance with service coordination requirements found in Section V-J of the CHC Agreement, as well as participant coverage requirements outlined in Exhibit K.

PROCEDURES

The CHC-MCO must transmit the completed PA 1768 to the CAO via fax or the county specific Long-Term Care (LTC) resource email account (see Attachment 2). If a Participant contacts the CHC-MCO after the CAO takes action on the PA 1768 to close the waiver, the CHC-MCO should refer the Participant to the PA IEB to determine HCBS eligibility for enrollment. The CHC-MCO should NOT send a PA 1768 to re-open a CHC waiver code.

Change in Circumstances

The CHC-MCO must complete and transmit the PA 1768 to inform the CAO of the following changes in a CHC HCBS Participant's circumstances.

Stay in Nursing Facility (NF)

The CHC-MCO must transmit a PA 1768 to the CAO when a CHC HCBS Participant is admitted to a NF. Upon discharge from the NF, if resuming CHC HCBS, the CHC-MCO will transmit the PA 1768 to the CAO to open the CHC waiver to ensure the CHC HCBS Participant may resume receiving HCBS as specified in the Participant's Person-Centered Service Plan (PCSP). This is the only circumstance in which a CHC-MCO should send a 1768 for the purpose of opening a waiver code.

An admission for respite care does not qualify as a stay in a NF. The CHC-MCO must not transmit the PA 1768 if the Participant is admitted to a NF for respite care only.

Relevant Section of PA 1768:

> PART II - COMPLETE FOR HCBS RECIPIENTS REPORTING AN UPDATE, CHANGE, TRANSFER, OR TERMINATION
>
> Upon admission to the NF, fill out section: HCBS RECIPIENT ADMITTED TO LTC FACILITY. If the Participant is expected to resume HCBS after discharge, check the "Short Term Admission" box on the PA 1768.
>
> Upon discharge from the NF, fill out section: HCBS RECIPIENT TO BE DISCHARGED FROM LTC FACILITY.
> The following fields must be completed:
> - Date of anticipated discharge
> - Select "HCBS should continue"
>
> *For participants that meet Money Follows the Person (MFP) criteria, the following must also be completed on the PA 1768:*
> PART III – COMPLETE FOR NEW HCBS APPLICANTS
> - ELIGIBILITY/CODING (select the MFP Code based on the participants discharge location)
>   - 16 MFP-Domiciliary Care (DC)
>   - 17 MFP-Own Residence
>   - 18 MFP-Family Member
>   - 19 MFP Group Setting

NOTE: Ensure the NF also issues the Long Term Care Admission and Discharge Transmittal (MA 103) to the CAO upon discharge.

Admission to a Veteran's Home

The CHC-MCO must transmit a PA 1768 to the CAO when a CHC HCBS Participant is admitted to a Veteran's home (MA Provider type/specialty 03/042).

Relevant Section of PA 1768:

PART II - COMPLETE FOR HCBS RECIPIENTS REPORTING AN UPDATE, CHANGE, TRANSFER, OR TERMINATION.

Fill out section: TERMINATION OF HCBS PROGRAM.

Admission to a State Facility

The CHC-MCO must transmit a PA 1768 to the CAO when a CHC HCBS Participant is admitted to a state facility, defined as a public psychiatric hospital or a state LTC unit located at a state mental hospital.

Relevant Section of PA 1768:

PART II - COMPLETE FOR HCBS RECIPIENTS REPORTING AN UPDATE, CHANGE, TRANSFER, OR TERMINATION.

Fill out section: TERMINATION OF HCBS PROGRAM.

Admission to a Personal Care Home that Does Not Provide Residential Habilitation

The CHC-MCO must transmit a PA 1768 to the CAO when a CHC HCBS Participant is admitted to a Personal Care Home that does not provide residential habilitation (res hab). If the Personal Care Home does not provide res hab, it is not an appropriate setting for CHC HCBS.

Relevant Section of PA 1768:

PART II - COMPLETE FOR HCBS RECIPIENTS REPORTING AN UPDATE, CHANGE, TRANSFER, OR TERMINATION.

Fill out section: TERMINATION OF HCBS PROGRAM.

Change of Address

The CHC-MCO must transmit a PA 1768 to the CAO when a CHC HCBS Participant moves from one address to another in the same county, from one county to another county in a CHC zone, or out of state.

Relevant Section of PA 1768:

PART II - COMPLETE FOR HCBS RECIPIENTS REPORTING AN UPDATE, CHANGE, TRANSFER, OR TERMINATION.

Fill out section: CHANGE OF ADDRESS.

~~Until the final phase of CHC is implemented on January 1, 2020, CHC-MCOs who are aware that a Participant plans to move out of a CHC zone into a non-CHC zone must refer the CHC Participant to the IEB using the Inter-County Transfer Form (Attachment 3), to avoid a gap in services.~~

Death of Participant

The CHC-MCO must transmit a PA 1768 to the CAO if a CHC HCBS Participant dies. The PA 1768 must include the date of death.

Relevant Section of PA 1768:

PART II - COMPLETE FOR HCBS RECIPIENTS REPORTING AN UPDATE, CHANGE, TRANSFER, OR TERMINATION.

Fill out section: INFORMATION REGARDING DEATH OF HCBS RECIPIENT.

Incarceration

The CHC-MCO must transmit a PA 1768 to the CAO if a CHC HCBS Participant is incarcerated.

Relevant Section of PA 1768:

PART II - COMPLETE FOR HCBS RECIPIENTS REPORTING AN UPDATE, CHANGE, TRANSFER, OR TERMINATION.

Fill out section: TERMINATION OF HCBS PROGRAM.

Voluntary Termination

A CHC Participant may choose to voluntarily terminate HCBS and disenroll from CHC HCBS. The CHC-MCO must inform the Participant of the consequences of voluntary termination from the CHC HCBS waiver and obtain the Participant's signature on a Voluntary Withdrawal Form (Attachment 7). The CHC-MCO must transmit the PA 1768 to the CAO to disenroll the CHC Participant.

Relevant Section of PA 1768:

> PART II - COMPLETE FOR HCBS RECIPIENTS REPORTING AN UPDATE, CHANGE, TRANSFER, OR TERMINATION.
>
> Fill out section: TERMINATION OF HCBS PROGRAM.

CHC HCBS to Office of Developmental Programs (ODP) HCBS

When the ODP Administrative Entity (AE) has identified a CHC HCBS Participant to be enrolled in an ODP HCBS waiver, the ODP AE will notify the CHC-MCO via email and confirm capacity in the ODP HCBS waiver. For Participants who are transitioning from the CHC HCBS waiver to an ODP HCBS waiver, the CHC-MCO will complete and send the PA 1768 form. The CHC-MCO must coordinate the waiver transfer with the ODP AE to determine an appropriate end date for CHC HCBS waiver Services.

Relevant Section of PA 1768:

> PART II - COMPLETE FOR HCBS RECIPIENTS REPORTING AN UPDATE, CHANGE, TRANSFER, OR TERMINATION.
>
> Fill out section: TRANSFERRING HCBS PROGRAMS.

<u>Disenrollment</u>

~~The processes outlined in this Disenrollment section apply to all Participants except those transitioning into Phase 3 that do not have a PCSP authorized earlier than one month prior to implementation or those in the Continuity of Care period as defined in the CHC Agreement, Section V-C-2.~~

The CHC-MCO must transmit a PA 1768 to the CAO to disenroll a CHC HCBS Participant from the CHC HCBS waiver in the following circumstances.

Unable to Contact

If the CHC-MCO is unable to contact the Participant after attempting to contact the Participant by phone three times on three different days at three different times of the day (e.g., morning, afternoon, and evening), the CHC-MCO must send the Participant's Service Coordinator (SC) or other CHC-MCO representative to visit the Participant in-person at his or her home. If, after 30 days, the CHC-MCO is still unable to contact the participant, the CHC-MCO will then provide the Participant with written notice of the contact attempts and pending termination of HCBS via a certified letter (Attachment 4). The letter must provide the Participant with at least 10 days to respond prior to the issuance of the PA 1768.

Relevant Section of PA 1768:

PART II - COMPLETE FOR HCBS RECIPIENTS REPORTING AN UPDATE, CHANGE, TRANSFER, OR TERMINATION.

Fill out section: TERMINATION OF HCBS PROGRAM.

Refusal of HCBS Services

If the Participant refuses to receive services, the CHC-MCO representative must discuss the consequences of refusing HCBS with the Participant or Participant's representative, power of attorney (POA), or guardian over the phone or in-person. The CHC-MCO must continue to attempt providing services. If for 30 days, the Participant has refused to receive HCBS services, the CHC-MCO must provide the Participant with written notice of the pending termination of HCBS via a certified letter (Attachment 5). The letter must provide the Participant with at least 10 days to respond prior to the issuance of the PA 1768. If the Participant does not respond to the letter from the CHC-MCO within the required 10 days, the CHC-MCO must proceed with disenrollment.

Relevant Section of PA 1768:

PART II - COMPLETE FOR HCBS RECIPIENTS REPORTING AN UPDATE, CHANGE, TRANSFER, OR TERMINATION.

Fill out section: TERMINATION OF HCBS PROGRAM.

Refuses Comprehensive Needs Assessment

If the Participant refuses to obtain a comprehensive needs assessment for a period of 30 days or more, the CHC-MCO must notify the Participant in writing that the Participant must complete the comprehensive needs assessment to receive HCBS. The CHC-MCO must provide this written notice via a certified letter (Attachment 6). The letter must provide the Participant with at least 10 days to respond prior to the issuance of the PA 1768.

Relevant Section of PA 1768:

PART II - COMPLETE FOR HCBS RECIPIENTS REPORTING AN UPDATE, CHANGE, TRANSFER, OR TERMINATION.

Fill out section: TERMINATION OF HCBS PROGRAM.

Other Scenarios

The CHC-MCO is not required to issue a PA 1768 in these circumstances, but still must take action:

~~**SC Units Only**~~

~~If the Participant has Service Coordination (SC) Units only on their PCSP and the PCSP was authorized earlier than three months prior to the CHC Zone Implementation Date (e.g., prior to October 1, 2018 for the Southeast Zone), the CHC-MCO must refer the Participant to the IEB for follow up. The comments in the referral should indicate that the Participant was "SC Only Prior to 10/1."~~

Loss of HCBS Eligibility

If a Participant is found clinically ineligible for HCBS following their annual level of care redetermination, the Independent Assessment Entity (IAE) will issue a PA 1768 to the CAO disenrolling the Participant. The IAE will send a copy of the PA 1768 to the CHC-MCO. The CHC-MCO must confirm that the Participant's loss of HCBS eligibility is correctly reflected on the Daily 834 File. The CHC-MCO must also monitor the Daily 834 File to confirm that the Participant did not appeal and become eligible during the appeal process.

Following receipt of the PA 1768 indicating disenrollment, the CAO should take action to update the Participant's status within 5 days, but this timeframe may vary depending on CAO location and workload at the time of receipt. Participants who file an appeal within 15 days of the mail date of the PA 162 Advance Notice of Determination letter will be re-enrolled in the CHC HCBS waiver while the appeal is pending, and services must continue during this appeal period, unless the participant requests they not continue. The CHC-MCO must check the 834 Daily File to monitor if the Participant has been re-enrolled.

NEXT STEPS

1. Review this Information with appropriate staff.
2. Contact the Bureau of Coordinated and Integrated Services if you have questions.

ATTACHMENTS

Attachment 1: Home and Community-Based Services (HCBS) Eligibility/Ineligibility/Change Form

Attachment 2: CAO LTC Email Addresses *Redacted due to internal information*

Attachment 3: Intercounty Transfer Referral Form

Attachment 4: CHC HCBS Termination Letter- No Response

Attachment 5: CHC HCBS Termination Letter- Refusal of Services

Attachment 6: CHC HCBS Termination Letter- Refusal of CNA

Attachment 7: CHC HCBS Termination Letter- Voluntary Withdrawal

Attachment 8: MFP Criteria

HOME AND COMMUNITY BASED SERVICES (HCBS) ELIGIBILITY/INELIGIBILITY/CHANGE FORM

RESET

(Completion Instructions on Pages 4-7)

DEPARTMENT OF HUMAN SERVICES (DHS) OFFICE INFORMATION

County assistance office (CAO) name:	District office name (if applicable):

APPLICANT/RECIPIENT IDENTIFICATION (RID) INFORMATION

Individual's name (last, first, middle initial (if applicable)):	Telephone number:	Social Security number (SSN):	Birthdate (MM/DD/YYYY):

Address (include apartment number, street, city, state, county and ZIP code):	Email (if known):

☐ Individual is a new HCBS applicant **(Complete Part I of this form)**	Medical Assistance (MA) 9-digit record number (2-digit county code/7-digit case number or xx/xxxxxxx)	MA 10-digit (individual) number:

CURRENT HCBS/MA RID INFORMATION

☐ Individual is a current HCBS/MA recipient reporting one of the following:

☐ Update ☐ Change ☐ Transfer ☐ Termination **(Complete Part I of this form)**

If HCBS recipient is admitted for respite care only, do not send this form to the CAO.

PA 1768 ORIGINATOR

☐ PA 1768 Eligibility/Ineligibility/Change Form is being submitted by one of the following:

☐ Enrolling agency (HCBS provider, county mental health/intellectual disability (MH/ID) program, or independent enrollment broker (IEB)/ Area Agency on Aging (AAA))

☐ Service Coordinator (SC)

☐ Additional entity requiring 162 notification

Submitter signature:	Title:	Telephone number:

REPRESENTATIVE INFORMATION (IF APPLICABLE)

Name of individual's representative:	Relationship to individual:	Telephone number:

Representative's address (include street, city, state and ZIP code):	Email (if known):

ENROLLING AGENCY INFORMATION (HCBS PROVIDER OR MH/ID AGENCY/IEB/AAA)

Agency contact person:	Telephone number:	Fax number:	Email (if known):

Agency name and address (include street, suite number, city, state, and ZIP code):

SC INFORMATION (IF DIFFERENT FROM AGENCY INFORMATION ABOVE)

SC contact person (if known):	Telephone number:	Fax number:	Email (if known):

SC name and address (include street, suite number, city, state, and ZIP code):

ADDITIONAL ENTITY REQUIRING 162 NOTIFICATION

Entity contact person and title (if known):	Telephone number:	Fax number:	Email (if known):

Entity name and address (include street, suite number, city, state, and ZIP code):

COMMENTS

PART I - COMPLETE FOR NEW HCBS APPLICANTS

ASSESSMENT INFORMATION

☐ This is to verify that the individual listed has been determined to meet the level of care appropriate for HCBS through the program indicated below.

Assessment date: **Service begin date:**

☐ This is to verify that the individual listed does NOT meet the level of care appropriate for HCBS through the program indicated below.

Assessment date:

ELIGIBILITY/CODING

☐ 16 MFP-Domiciliary Care (DC)	☐ 38 Aging Waiver	☐ 68 Person/Family Directed Support
☐ 17 MFP-Own Residence	☐ 40 Attendant Care Waiver	☐ 70 Infants, Toddlers & Families
☐ 18 MFP-Family Member	☐ 42 Independence Waiver	☐ 77 Consolidated Waiver
☐ 19 MFP-Group Setting	☐ 51 Adult Comm. Autism Program	☐ 79 OBRA Waiver
☐ 20 Community HealthChoices Waiver	☐ 52 Adult Autism Waiver	☐ 84 Community Living Waiver
		☐ 96 LIFE Program

MA RECIPIENT TO BE DISCHARGED FROM A LONG-TERM CARE (LTC) FACILITY

☐ Individual currently residing in a LTC facility

Date of anticipated discharge:

Name and address of facility (include street, city, state, and ZIP code):

PART II - COMPLETE FOR HCBS RECIPIENTS REPORTING AN UPDATE, CHANGE, TRANSFER, OR TERMINATION

ASSESSMENT INFORMATION

☐ This is to verify that the individual listed **no longer meets** the level of care appropriate for HCBS.

Evaluation date:

HCBS RECIPIENT ADMITTED TO LTC FACILITY

☐ Individual was admitted to a LTC, Personal Care Home (PCH), or DC Facility. **If admitted for respite care (usually less than 30 days) do not complete this form.**

Admission date:

☐ Short Term Admission (services expected to resume at discharge)

Name of facility:

☐ AAA or IEB has been notified to initiate PCH/DC application (if applicable)

Address of facility (include street, city, state county and ZIP code)

HCBS RECIPIENT TO BE DISCHARGED FROM LTC FACILITY

☐ Individual currently residing in a LTC facility

Date of anticipated discharge:

Name of facility:

☐ HCBS should continue

Address of facility (include street, city, state, county and ZIP code):

CHANGE OF ADDRESS

☐ Individual moved to a new residence within the same county

Date of move:

☐ Individual moved to a new county

Name of new county:

Telephone number:

New address (include apartment number, street, city, state, county and ZIP code):

☐ Services continued

☐ Services terminated

Date of termination:

TRANSFERRING HCBS PROGRAMS

Name of HCBS program transferring from:

Service end date:

Name of HCBS program transferring to:

Service begin date:

TRANSFERRING HCBS SERVICE PROVIDER (NO CHANGE IN PROGRAM OR BENEFITS)

Name of losing service provider:

Date losing provider will stop providing services:

Name and address of gaining service provider (include street, city, state, county, and ZIP code):

PROGRAM WITHDRAWAL INFORMATION

☐ Individual voluntarily withdrew

Date of withdrawal:

TERMINATION OF HCBS PROGRAM

☐ HCBS terminated

Reason:

Date of termination:

INFORMATION REGARDING DEATH OF HCBS RECIPIENT

☐ Deceased

Date of death:

CHANGE OF HCBS RECIPIENT'S FINANCIAL STATUS

☐ Change in individual's financial status. Documentation attached.

COMMENTS (INCLUDE ATTACHMENT IF NECESSARY)

HOME AND COMMUNITY BASED SERVICES (HCBS) ELIGIBILITY/INELIGIBILITY/CHANGE FORM

INSTRUCTIONS FOR COMPLETION OF THE PA 1768

DEPARTMENT OF HUMAN SERVICES (DHS) OFFICE INFORMATION	
County assistance office (CAO) name	Enter the name of the county assistance office where the information is being sent.
District office name (if applicable)	Enter the name of the district office where the information is being sent (if applicable).

APPLICANT/RECIPIENT IDENTIFICATION (RID) INFORMATION	
Individual's name	Enter the individual's name (last, first, and middle initial (if applicable)).
Telephone number	Enter the individual's telephone number ((XXX) XXX-XXXX).
Social Security number (SSN)	Enter the individual's Social Security number (XXX-XX-XXXX).
Birthdate	Enter the individual's date of birth (MM/DD/YYYY).
Address	Enter the individual's address (including apartment number, street, city, state, county and ZIP code).
Email	Enter the individual's email address (if known).
☐ Individual is a new HCBS applicant **(Complete Part I of this form.)**	Check this box to indicate the individual is a new HCBS applicant. **If this box is checked, Part I of this form must be completed.**
Medical Assistance (MA) 9-digit record number	If this individual is a current MA recipient who is now applying for HCBS, enter the individual's MA record number; 2-digit county code/7-digit case number/1-letter category (if known).
MA 10-digit (individual) number	If this individual has ever received MA, enter the individual's 10-digit RID (if known).

CURRENT HCBS/MA RID INFORMATION	
☐ Individual is a current HCBS/MA recipient reporting one of the following: ☐ Update ☐ Change ☐ Transfer ☐ Termination **(Complete Part II of this form.)** **If HCBS recipient is admitted for respite care, do not send this form to the CAO.**	Check this box to indicate that the individual is a current HCBS recipient. Check the appropriate box to indicate whether there is: ☐ Updated information since initial PA 1768 was completed; or ☐ A change in the HCBS recipient's circumstances; or ☐ The recipient is transferring to another HCBS program; or ☐ Services are being terminated. **If any of the above boxes are checked, Part II of this form must be completed.** **Respite care is a short-term stay in a LTC facility usually lasting less than 30 days. If the HCBS recipient is only admitted to a facility for respite care paid for through the HCBS program, do <u>NOT</u> submit this form to the CAO.**

PA 1768 ORIGINATOR	
☐ PA 1768 Eligibility/Ineligibility/Change Form is being submitted by one of the following: ☐ Enrolling agency (HCBS provider, county mental health/intellectual disability (MH/ID) program, or independent enrollment broker (IEB)/Area Agency on Aging (AAA)) ☐ Service Coordinator (SC) ☐ Additional entity requiring 162 notification	☐ Check this box to indicate submission of a completed PA 1768, then check the appropriate box to indicate what authorized person is submitting this PA 1768. ☐ Enrolling agency (HCBS provider, county mental health/intellectual disability (MH/ID) program, or independent enrollment broker (IEB)/Area Agency on Aging (AAA)) submits initial PA 1768; or ☐ Service Coordinator (SC) can report updates, changes, and terminations; or ☐ Additional entity requiring 162 notification may also report updates, changes, and terminations on the PA 1768.
Submitter signature	Enter the signature of the person approved by DHS to submit updates, changes, transfers and terminations.
Title	Enter the submitter's title or agency affiliation.
Telephone number	Enter the submitter's telephone number ((XXX) XXX-XXXX).

REPRESENTATIVE INFORMATION (IF APPLICABLE)	
Name of individual's representative	Enter the name of the individual who is representing the HCBS applicant/recipient.
Relationship to individual	Enter the relationship of the representative to the HCBS applicant/recipient, including Power of Attorney (POA) or Guardian (GDN).
Telephone number	Enter the representative's telephone number ((XXX) XXX-XXXX).
Representative's address	Enter the representative's address (including street, city, state, and ZIP code).
Email	Enter the representative's email address (if known).

ENROLLING AGENCY INFORMATION (HCBS PROVIDER OR MH/ID AGENCY/IEB/AAA)	
Agency contact person	Enter the name of the person from the enrolling agency who may be contacted if information is needed by the CAO.
Telephone number	Enter the contact person's telephone number ((XXX) XXX-XXXX).
Fax number	Enter the agency fax number. This may be a dedicated fax machine that the agency uses only for HCBS documents ((XXX) XXX-XXXX).
Email	Enter the contact person's email address (if known).
Agency name and address	Enter the name of the enrolling agency and the address (including street, suite number, city, state, and ZIP code).

INSTRUCTIONS FOR COMPLETION OF THE PA 1768

SC INFORMATION (IF DIFFERENT FROM AGENCY INFORMATION ABOVE)	
SC contact person (if known)	Enter the name of the person from the service coordinator who may be contacted if information is needed by the CAO.
SC name and address	Enter the service coordinator's name and address (including street, city, state, and ZIP code).
Telephone number	Enter the service coordinator's telephone number ((XXX) XXX-XXXX).
Fax number	Enter the service coordinator's fax number ((XXX) XXX-XXXX).
Email	Enter the service coordinator's email address (if known).
ADDITIONAL ENTITY REQUIRING 162 NOTIFICATION	
Entity contact person and title (if known)	Enter the name and relationship, for example POA or GDN.
Entity name and address	Enter the entity's name and address (including street, city, state, and ZIP code).
Telephone number	Enter the entity's telephone number ((XXX) XXX-XXXX).
Fax number	Enter the entity's fax number ((XXX) XXX-XXXX).
Email	Enter the entity's email address (if known).
COMMENTS	
Comments	Enter any comments that may be useful to the CAO.

PART I - COMPLETE FOR NEW HCBS APPLICANTS

ASSESSMENT INFORMATION

☐ This is to verify that the individual listed has been determined to meet the level of care for HCBS. **Assessment Date:** _____ **Service Begin Date:** _____	Check the box to indicate that the individual was determined eligible for HCBS. In the assessment date box, enter the date that the assessment agency conducted the level of care and functional assessment and found the individual eligible for HCBS. In the service begin date box, enter the date that the individual will start to receive services under a HCBS program (if known). The LIFE program requires a service begin date that falls on the first day of the month.
☐ This is to verify that the individual listed does NOT meet the level of care appropriate for HCBS. **Assessment Date:** _____	Check the box to indicate that the individual was determined **ineligible** for HCBS. In the assessment date box, enter the date that the assessment agency conducted the level of care and functional assessment and found the individual **ineligible** for HCBS.

ELIGIBILITY CODING

In order for an individual to qualify for Money Follows the Person (MFP), and for PA to receive enhanced federal funding for up to 365 days after facility discharge, MA recipients eligible for HCBS program 20, 38, 40, 42, 77, 79, or 96 must:

- Sign a consent form
- Have resided in a qualified (certified) institution for at least 90 days and received MA at least 1 day prior to discharge.
- Be transitioning to a qualified residence.
- Meet the eligibility criteria for the appropriate HCBS waiver program.

NOTE: The individual that acquired the MFP participant's consent form should have also completed a Quality of Life Referral form and sent it to the Temple University liaison.

☐ 16 MFP-Domiciliary Care (DC) ☐ 17 MFP-Own Residence ☐ 18 MFP-Family Member ☐ 19 MFP-Group Setting	Check the appropriate MFP code for the individual's type of qualified residence. In order to be eligible for MFP, an individual must also be enrolled or enrolling in one of the following HCBS programs: CHC waiver, aging waiver, attendant care waiver, independence waiver, consolidated waiver, OBRA waiver, LIFE program.
☐ 20-CHC Waiver ☐ 38-Aging/PDA ☐ 40-Attendant Care ☐ 42-Independence ☐ 51-Adult Comm. Autism ☐ 52-Adult Autism Waiver ☐ 68-Per. Fam. Dir. Sup. ☐ 70-Infant, Toddler ☐ 77-Consolidated ☐ 79-OBRA ☐ 81-Community Living ☐ 96-LIFE Program	Check the appropriate HCBS program for which the individual was determined eligible to receive services.

MA RECIPIENT TO BE DISCHARGED FROM LONG-TERM CARE (LTC) FACILITY

☐ Individual currently residing in a LTC facility	Check the box to indicate that the individual is residing in a LTC facility and is requesting HCBS upon discharge.
Date of anticipated discharge	Enter the date (MM/DD/YY) that the individual will be discharged from the LTC facility.
Name and address of facility	Enter the LTC facility's name and mailing address (including street, city, state, and ZIP code).

INSTRUCTIONS FOR COMPLETION OF THE PA 1768

PART II - COMPLETE FOR HCBS RECIPIENTS REPORTING A CHANGE, TRANSFER, OR TERMINATION	
ASSESSMENT INFORMATION	
☐ This is to verify that the individual listed no longer meets the level of care appropriate for HCBS. **Evaluation Date:** _____	Check the box to indicate the individual was determined no longer eligible for HCBS and provide the evaluation date (MM/DD/YY).
HCBS RECIPIENT ADMITTED TO LTC FACILITY	
☐ Individual was admitted to a LTC, Personal Care Home (PCH), or DC facility. **If admitted for respite care (usually less than 30 days), do not complete this form.**	Check the box to indicate that the individual has been admitted to a LTC facility, PCH or DC facility. **Respite care is a short term stay in a LTC facility usually lasting less than 30 days. If the HCBS recipient is admitted to a facility only for respite care that may be paid for through the HCBS program, do NOT submit this form to the CAO.**
Admission date	Enter the date (MM/DD/YY) that the individual was admitted to a LTC, PCH, or DC facility.
☐ Short term admission (services expected to resume at discharge)	Check the box to indicate that the individual's admission to the LTC facility is for a short period of time and HCBS are expected to resume upon the individual's discharge from the facility.
Name of facility	Enter the name of the facility to which the individual has been admitted.
☐ AAA or IEB has been notified to initiate PCH/DC application (if applicable)	Check the box to indicate that the AAA or IEB has been notified that the individual who was receiving HCBS has been admitted to a PCH or DC facility and an application may be needed.
Address of facility	Enter the LTC facility's mailing address (including street, city, state, and ZIP code).
HCBS RECIPIENT TO BE DISCHARGED FROM LTC FACILITY	
☐ Individual residing in a LTC facility	Check the box to indicate that the individual is residing in a LTC facility and is requesting that HCBS continue upon discharge.
Date of anticipated discharge	Enter the date (MM/DD/YY) that the individual will be discharged from the LTC facility.
Name of facility	Enter the name of the LTC facility.
☐ HCBS should continue	Check the box if the individual received HCBS while residing in the facility and should continue to receive HCBS upon discharge.
Address of facility	Enter the LTC facility's mailing address (including street, city, state, county, and ZIP code).
CHANGE OF ADDRESS	
☐ Individual moved to a new residence within the same county	Check the box to indicate that the individual has moved to a new residence within the same county.
Date of move	Enter the date (MM/DD/YY) that the individual moved.
☐ Individual moved to a new county	Check the box to indicate that the individual moved to a new county.
Name of new county	Enter the name of the new county of residence.
Telephone number	Enter the individual's telephone number ((XXX) XXX-XXXX).
New address	Enter the individual's entire new address (including apartment number, street, city, state, county, and ZIP code).
☐ Services continued	Check the box to indicate that the individual continues to receive HCBS.
☐ Services terminated	Check the box to indicate that the individual's HCBS has stopped.
Date of termination	Enter the date (MM/DD/YY) that the individual's HCBS stopped.
TRANSFERRING HCBS PROGRAMS	
Name of HCBS program transferring form	Enter the name of the current HCBS program providing services to the individual. Services under this program will end and be continued under another HCBS program.
Service end date	Enter the last date (MM/DD/YY) that the individual will be eligible for services. This is the last day that services will be provided under the current HCBS program. An individual should NOT be eligible for two HCBS programs concurrently.
Name of HCBS program transferring to	Enter the name of the NEW HCBS program that the individual will be enrolled in for continued services.
Service begin date	Enter the first date (MM/DD/YY) that the individual will be eligible to receive services under the new HCBS program. An individual should NOT be eligible for two HCBS programs concurrently.
TRANSFERRING HCBS SERVICE PROVIDER (NO CHANGE IN PROGRAM OR BENEFITS)	
Name of losing service provider	Enter the name of the losing service provider agency.
Date losing provider will stop providing services	Enter the last date (MM/DD/YY) that the individual will receive services from the losing provider.
Name and address of gaining service provider	Enter the new service provider's name and mailing address, including street, city, state, county, and ZIP code.

INSTRUCTIONS FOR COMPLETION OF THE PA 1768

PROGRAM WITHDRAWAL INFORMATION	
☐ Individual voluntarily withdrew	Check the box to indicate that the individual requested that HCBS be stopped. Enter the reason in the COMMENTS section.
Date of withdrawal	Enter the date (MM/DD/YY) that the individual requested a withdrawal.
TERMINATION OF HCBS PROGRAM	
☐ HCBS terminated	Check the box to indicate that the individual stopped receiving HCBS.
Reason	Enter the reason the individual stopped receiving HCBS.
Date of termination	Enter the last day (MM/DD/YY) that the individual stopped receiving HCBS. For the LIFE program, terminations must fall on the last day of the month.
INFORMATION REGARDING DEATH OF HCBS RECIPIENT	
☐ Deceased	Check the box to indicate that the individual has died.
Date of death	Enter the date (MM/DD/YY) that the individual died.
CHANGE OF HCBS RECIPIENT'S FINANCIAL STATUS	
☐ Change in individual's financial status Documentation attached.	Check the box to indicate that the individual's finances have changed and that documents are attached to verify the changes.
COMMENTS (INCLUDE ATTACHMENT IF NECESSARY)	
Comments	Enter any comments that may be useful to the CAO.

Intercounty Transfer Referral Form

Proposed Transition Date: ____/____/_____

PA Independent Enrollment Broker

Participant Information

First Name: _____ Last Name: _____

Date of Birth: _____ Social Security Number: xxx-xx-_____

Medicaid ID Number: _____ Select Current MCO:

- ☐ PA Health and wellness
- ☐ UPMC Health
- ☐ AmeriHealth Caritas

Current Address/ Service Coordination Information

Current Address: _____ Current Service Coordinator: _____

Current County: _____ Current County: _____

Email Address: _____ Email Address: _____

Home Phone: _____ Phone number: _____

Cell Phone: _____

Future Address/ Service Coordination Information

Future Address: _____ Future Service Coordinator: _____

Future County: _____ Contact Name: _____

Email Address: _____ County: _____

Home Phone: _____ Email Address: _____

Cell Phone: _____ Phone Number _____

Emergency Contact Information

Emergency Contact Name:	Emergency Contact Name:
Cell Phone Number:	Cell Phone Number:
Home Phone Number:	Home Phone Number:

Signature of person completing form: _____ Date:___/___/_____

OBSOLETED 3/20/2026

P.O. Box 61560
Harrisburg, PA 17106

Call us toll free at
1-877-550-4227

Send a fax to
1-888-349-0264

Email us at
paieb@maximus.com

[Date]

IMPORTANT NOTICE ABOUT YOUR HOME AND COMMUNITY-BASED SERVICES

Dear **[Participant]**:

You are receiving this letter because **[CHC-MCO]** was unable to contact you to discuss your Medical Assistance (MA) Home and Community Based Services (HCBS). **[CHC-MCO]** attempted to contact you by phone on **[date]**, **[date]**, and **[date]** and attempted to visit you in-person on **[date]**, but was unable to reach you.

Because we were unable to contact you in the last 30 days, **[CHC-MCO]** will notify the County Assistance Office (CAO) to take action to end your MA HCBS. You must contact **[CHC-MCO]** within 10 days of the date on this letter to let **[CHC-MCO]** know you want to remain enrolled in MA HCBS. Otherwise, your services will be terminated. You will receive a separate notice from the CAO. That notice will tell you how to appeal if you disagree with the decision to terminate your HCBS.

If you have any questions, or feel this notice was sent to you in error, please call our Participant Services Department at **[CHC-MCO Number].** TTY users, please call **[Toll-free TTY Number].** You can call **[insert days and hours]**.

Sincerely,

[CHC-MCO]

TAG Lines:
CHC-MCO: the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by MA Bulletin 99-17-11:]

The information in this notice is available in other languages and formats by calling [CHC-MCO name] at [Phone #/Toll-free TTY #].

[Date]

IMPORTANT NOTICE ABOUT YOUR HOME AND COMMUNITY-BASED SERVICES

Dear **[Participant]**:

This letter is about your Medical Assistance (MA) Home and Community Based Services (HCBS). Because you have refused to receive MA HCBS for the past 30 days, **[CHC-MCO]** is notifying the County Assistance Office (CAO) to take action to end your MA HCBS.

[CHC-MCO] previously discussed your refusal of MA HCBS with you **[via phone/in-person]** on **[date].** You must contact **[CHC-MCO]** within 10 days of the date on this letter to let **[CHC-MCO]** know you want to remain enrolled in MA HCBS. Otherwise, your services will be terminated. You will receive a separate notice from the CAO. That notice will tell you how to appeal if you disagree with the decision to terminate your HCBS.

[CHC-MCO] is committed to ensuring the services you receive meet your needs. If you would like to receive MA HCBS, or if you have questions, please contact **[CHC-MCO]** as soon as possible. If you delay, you may be required to reapply for MA HCBS. You can reach our Participant Services Department at **[CHC-MCO Number]**. TTY users, please call **[Toll-free TTY Number]**. You can call **[insert days and hours]**.

Sincerely,

[CHC-MCO]

TAG Lines
CHC-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by MA Bulletin 99-17-11:]

The information in this notice is available in other languages and formats by calling [CHC-MCO Name] at [Phone #/Toll-free TTY #].

[Date]

IMPORTANT NOTICE ABOUT YOUR HOME AND COMMUNITY-BASED SERVICES

Dear **[Participant]**:

This letter is in follow up to the letter **[CHC-MCO]** sent you on **[date]**. As we advised you in our earlier letter, you must have a comprehensive needs assessment to receive Medical Assistance (MA) Home and Community Based Services (HCBS) under the CHC Program. The comprehensive needs assessment allows **[CHC-MCO]** to understand what type of HCBS best fits your needs, resources, preferences, and goals.

Because you decided not to receive a comprehensive needs assessment for the past of 30 days, **[CHC-MCO]** will notify the County Assistance Office (CAO) to take action to end your MA HCBS. You must contact **[CHC-MCO]** within 10 days of the date on this letter to let **[CHC-MCO]** know you want to remain enrolled in MA HCBS. Otherwise, your services will be terminated. You will receive a separate notice from the CAO. That notice will tell you how to appeal if you disagree with the decision to terminate your HCBS.

If you have changed your mind and would like to receive a comprehensive needs assessment, or if you have questions, please contact **[CHC-MCO]** as soon as possible. If you delay, you may be required to reapply for MA HCBS. You can reach our Participant Services Department at **[CHC-MCO Number]**. TTY users, please call **[Toll-free TTY Number]**. You can call **[insert days and hours]**.

Sincerely,

[CHC-MCO]

TAG Lines:
CHC-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by MA Bulletin 99-17-21:]

The information in this notice is available in other languages and formats by calling [CHC-MCO Name] at [Phone #/Toll-free TTY #].

[Date]

YOUR REQUEST FOR VOLUNTARY WITHDRAWAL FROM HOME AND COMMUNITY-BASED SERVICES

By signing this form, you are confirming that you want to voluntarily withdrawal from Home and Community Based Services (HCBS) provided through the Community HealthChoices (CHC) Waiver.

[CHC-MCO] will notify the County Assistance Office (CAO) to take action to terminate your HCBS. You will receive a separate notice from the CAO. That notice will tell you how to appeal the decision to terminate your HCBS.

Your CHC HCBS Waiver service plan includes the following services:

1. **[Service]** **[Provider]**
2. **[Service]** **[Provider]**
3. **[Service]** **[Provider]**
4. **[Service]** **[Provider]**
5. **[Service]** **[Provider]**
6. **[Service]** **[Provider]**

[add more lines as needed]

Your signature below means that you understand that the services listed above will end.

Your signature also means that you understand that your eligibility for Medical Assistance may be impacted by your voluntary withdrawal from CHC HCBS.

_____ _____

Participant Signature Date

_____ _____

Service Coordinator Signature Date

_____ _____

Witness Signature Date

Money Follows the Person (MFP) Criteria

For the purposes of correctly completing the PA 1768 to reflect MFP status, please consider individuals who meet all below criteria to be presumed MFP eligible:

The individual:

- Has resided in a nursing (long-term care facility) facility for at least 60 days with at least one day funded by Medicaid;
- Is enrolling in a home and community-based services (HCBS) waiver, such as Community HealthChoices, or the Living Independence for the Elderly (LIFE) program upon discharge; and
- Plans to move to a qualifying residence in the community. An MFP qualifying residence is one of the following:
    - A home owned or leased by the individual or individual's family member;
    - An apartment with an individual lease, with lockable access and egress, which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain or control; or
    - A residence, in a community based residential setting, in which no more than 4 unrelated individuals reside.