

Eligibility Process

DD Case Manager Support Call
March 9, 2026



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WYOMING MEDICAID
DIVISION OF HEALTHCARE FINANCING

Welcome



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Thank you for joining us for this month's training presentation on eligibility process for Case Managers. My name is Destiny Rhoden, and I am a Benefits and Eligibility Specialist with the Home and Community-Based Service Section, Division of HealthCare Financing within the State of Wyoming's Department of Health.

Purpose

- ▶ The purpose of this training is to review the initial eligibility process and continued eligibility for individuals participating in or applying for the DD Waivers.
- ▶ This training will explain the case manager's role in supporting applicants and participants through eligibility.



The purpose of this training is to review the initial eligibility process and continued eligibility requirements for individuals participating in or applying for the DD Waivers. We will review and explain the case manager's role in supporting the applicant, participant, or LAR through the eligibility process.

Acronyms & Terms

- ▶ **HCBS** - Home and Community-Based Services
- ▶ **LAR** - Legally Authorized Representative
- ▶ **IPC** - Individualized Plan of Care
- ▶ **TCM** - Targeted Case Manager
- ▶ **BES** - Benefits and Eligibility Specialist
- ▶ **LTC** - Long Term Care Unit
- ▶ **Division** - Wyoming Department of Health, Division of Healthcare Financing
- ▶ **Care Case Management System** - a software platform designed to help users assess, plan, implement, coordinate, and monitor a participant's waiver status and individualized plan of care. Currently, this system in EMWS and then will be WYSERVES.



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Before we get started, we'd like to review the acronyms, abbreviations, and terms you'll see in today's training. The Medicaid system uses a lot of acronyms and although you may already know these, we want to avoid any confusion for those that may not.

- HCBS stands for Home and Community-Based Services
- LAR means Legally Authorized Representative (this may include guardians, parents, or others)
- IPC is short for Individualized Plan of Care
- TCM is for Targeted Case Manager
- BES - Benefits and Eligibility Specialist
- LTC - Long Term Care Unit of Medicaid
- Division refers to the Wyoming Department of Health, Division of Healthcare Financing.
- The Care Case Management System is a software platform designed to help users assess, plan, implement, coordinate, and monitor a participant's waiver status and individualized plan of care. Currently, this system in EMWS and then will be WYSERVES.

CHOICE



- ▶ Choice is paramount to human dignity.
- ▶ The participant or applicant must be consulted and their wishes/choices considered every step of the way.
- ▶ Throughout the eligibility process, case managers have an obligation to offer each individual choice, document the choices that the individual makes, and ensure that the individual's choice is respected.



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We want to take a moment to remind you about the importance of choice. You hear us say it often on these calls because we want it to be in the forefront of your mind. Having choice is paramount to human dignity. Choice is a basic tenet of Home and Community-Based Services.

Even before receiving home and community-based services, individuals have choice regarding these programs. If they choose to apply for Waiver services, they immediately have choice in who their case manager will be. They then work with the case manager they selected to complete the eligibility process, which includes creating a Targeted Case Management Plan of Care that outlines their support needs. Once they are determined eligible and have received a funding opportunity, they have ultimate choice in the services they receive, who provides those services, and how their services will be delivered.

Case managers have a responsibility to offer each individual choice, document the choices that the individual makes, and ensure that the individual's choice is respected.



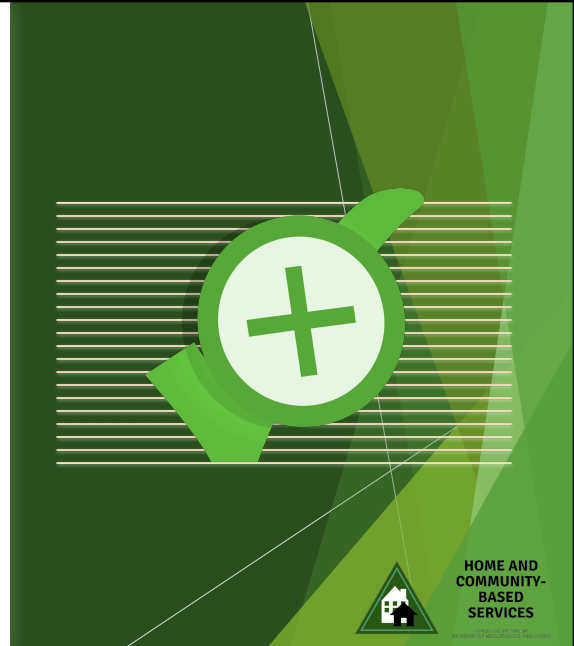
The initial eligibility process can be daunting for an applicant or LAR who is new to Waiver services. The case manager is responsible for helping the applicant through the process. Remember, the case manager is the professional, and should have the knowledge and expertise to support the applicant, answer questions, and provide guidance as necessary.

It is important to note that the eligibility process is sequential and the steps must be followed in order. If steps of the process are missed, or if an applicant is determined to be ineligible at any point in the process, the case will go into closure.

As a reminder, in accordance with Chapter 45, Section 9(b) of the Department of Health's Medicaid Rules, case managers must submit all eligibility paperwork within 30 calendar days of being selected as the case manager.

Case Management Selection

- ▶ Applicant chooses a case manager
 - ▶ Ensure your information is up to date on the searchable provider list.
- ▶ Applicant and case manager sign the Case Management Selection Form
- ▶ Case manager requests guardianship paperwork
- ▶ Case manager notifies the applicant that, if determined eligible, they will be placed on the waitlist



HCBS services are person-centered and rooted in choice to promote individual initiative, autonomy, and independence. Applicants for the Waiver must choose a Targeted Case Manager. Applicants are encouraged to take the time to interview case managers and ask questions about the case manager’s caseload, experience, and communication strategies. Case managers should make themselves available to meet with applicants if they are accepting new participants to their caseload. Case managers should be prepared to assist the applicant or their LAR with the application or questions regarding the Waivers.

Applicants and participants often use the searchable provider list to find case managers in their area. Case managers should ensure their contact information, including their phone number and email address are updated with the Division at all times. To request changes to your contact information, case managers must follow the steps outlined in the [Provider Change Guidance Manual](#) located in the [HCBS Document Library](#) on the *Web Portal Guides* tab. For further assistance, you can reach out to the provider credentialing unit through their email address wdh-hcbs-credentialing@wyo.gov.

Once the applicant chooses a case manager, the applicant must complete a Case

Management Selection Form and both the applicant, and/or their LAR, and the case manager must sign and date the form. If the applicant has a legally authorized representative, the case manager should request a copy of the guardianship order at this time to ensure that the individual has the authority to act as the legally authorized representative. The guardianship order will be required to be submitted with the application.

The Division currently maintains a waitlist for the Supports Waiver, which means that even though an applicant may ultimately be determined eligible for DD Waiver services, they will have to wait for a funding opportunity to become available. Case managers should be up front with applicants about the approximate wait time which can vary due to size of the waiting list.

Submit the Application

- ▶ The applicant or their case manager may submit the completed application and Case Management Selection Form.
- ▶ Application can be submitted via:
 - ▶ Mail
 - ▶ Email
 - ▶ Online



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Once completed, the application and Case Management Selection Form need to be submitted to the Division. Applications may be submitted by the applicant or selected case manager to the assigned County BES in a variety of ways, including mail, email, and online. The Case Management Selection Form can be submitted with the online application, but the case manager should let the assigned County BES know that it has been submitted. The eligibility process cannot move forward without a Case Management Selection form. The forms should be reviewed before they are submitted to ensure that the applicant has completed all sections of the form accurately, legibly, and signed as indicated. An incomplete form will cause a lag in the process. It is the case manager's responsibility to ensure that the applicant is able to navigate the process as smoothly as possible, and reviewing forms for accuracy is a simple step the case manager can take to support this outcome.

Targeted Case Management



- ▶ Case managers can be paid for Targeted Case Management services.
- ▶ Targeted Case Management is a required service.
- ▶ Case managers must help applicants connect with non-Waiver services during the eligibility process.



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When a case manager is selected, they can be paid for the support they provide to the applicant throughout the eligibility process, and for ongoing support once an applicant is placed on the waitlist. Targeted Case Management, or TCM, is required by the Centers for Medicare and Medicaid Services (CMS). Even if the case manager chooses not to bill for TCM services, it is required that a TCM plan of care be completed and a TCM service line be initiated in the Care Case Management system. The case manager must complete a TCM plan of Care that is signed and dated by the applicant or their LAR, and it must be uploaded to the Care Case Management System.

It is important for case managers to understand their obligations in supporting applicants during the eligibility process and while they are placed on the waitlist. This obligation includes linking people with non-Waiver supports and services, conducting regular monitoring and follow-up, and providing crisis intervention and stabilization in situations requiring immediate attention or resolution. Additional information on TCM can be found in the *Comprehensive and Supports Waiver Service Index*, under the Case Management Services definition.



A critical federal eligibility requirement of Home and Community-Based Waiver services is that participants of these programs must meet the same level of care as someone who needs institutional care, such as a skilled nursing facility or an intermediate care facility like the Wyoming Life Resource Center. Requirements for institutional level of care are established in Chapter 46, Section 6 of the Wyoming Medicaid Rules.

In order to demonstrate institutional level of care, applicants and participants with a developmental or intellectual disability are assessed using the LT104 assessment, which is completed by the chosen case manager. Applicants and participants with an acquired brain injury are assessed using the LT101 assessment, which is completed by a public health nurse (PHN).

For initial applicants, institutional level of care must be established before the next step in the eligibility process can occur. For current Waiver participants, institutional level of care must be established annually.

LT104 Assessment

- ▶ The LT104 assessment must be completed for individuals with an intellectual or developmental disability.
- ▶ Case managers must submit the initial LT104 within thirty (30) calendar days of being selected and annually thereafter once the participant is receiving services.
- ▶ The LT104 assessment will be reviewed by the Division.



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When an applicant is applying for the DD Waiver due to an intellectual or developmental disability, the case manager must complete and submit the LT104 assessment through the Care Case Management System within thirty (30) calendar days of being selected.

The LT104 requires at least one (1) criteria to be met in the functional section and at least one (1) criteria in either the medical or psychological sections of the assessment. A qualifying diagnosis is also required for the assessment.

Once the LT104 assessment is submitted in the Care Case Management System, a BES will review the assessment to determine if the applicant meets the prescreening criteria for clinical eligibility. For initial applicants, this assessment demonstrates potential eligibility. When the case manager and plan of care team develop the IPC, the IPC must support the responses submitted in the LT104. In subsequent LT104 submissions, the case manager must ensure that the responses are supported by information included in the participant's IPC.

LT101 Assessment



1. The LT101 assessment must be completed for an applicant with an acquired brain injury.
2. For applicants, the LT101 must be completed by the Public Health Nurse within seven (7) business days of the applicant being determined financially eligible.



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If an applicant has a diagnosis of an acquired brain injury, a public health nurse (PHN) will administer an LT101 assessment. Case managers should remind the applicant that a PHN will be contacting them to schedule and complete an assessment in their residence. This will help alleviate some of the confusion and anxiety when applicants and participants are contacted.

For applicants, the case manager must ensure that the PHN has contacted the applicant and completed the LT101 assessment within 7 business days after the PHN has received the referral, which takes place after financial eligibility has been determined.

Reassessment is required every year to confirm continued eligibility once the participant is receiving services. The PHN has thirty calendar days to complete the reassessment upon receiving notification that the reassessment has been referred.



Next, let's review financial eligibility. In order to be financially eligible for the DD Waivers, an individual must be eligible for Medicaid in Wyoming. Medicaid eligibility is determined by the Long Term Care (LTC) Eligibility Unit as part of the initial eligibility process, and annually thereafter. Although this step in the process is not handled by the HCBS Section, the case manager still plays an important role in ensuring that the applicant submits the required paperwork within the established timelines.

Financial Eligibility

- ▶ Once selected, case managers should support the applicant in submitting required financial eligibility paperwork to the LTC Eligibility Unit.
- ▶ Applicants have 30 calendar days after the financial task populates in the Care Case Management System to submit financial eligibility paperwork.



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Case managers are responsible for supporting the applicant in completing financial eligibility paperwork and gathering necessary supporting documentation and verifications for submission to the Long Term Care (LTC) unit. Although the case manager may not actually collect documentation or complete the application, the case manager should be available to answer questions, communicate with the assigned LTC workers, and troubleshoot any areas of confusion or concern.

The financial task in the Care Case Management System populates in a different order for applicants who are assessed with the LT101 and LT104. For applicants who are assessed with the LT104, the financial task will populate after the LT104 is completed. For applicants who are assessed with the LT101, the financial task populates after the case manager is selected. The applicant has 30 calendar days after the financial task populates to complete and submit their paperwork, or the LTC Eligibility Unit will initiate closure of the case. The case manager must ensure that the applicant is aware of the timeline.

Subsequent determination of financial eligibility will occur annually. It is important for case managers to be aware of participants' Medicaid eligibility renewal dates so they can assist with the timely completion and submission of the renewal application.

Best Practice



Case managers should contact the Long Term Care Eligibility Unit to ensure a financial eligibility packet is sent to the applicant or participant.



APPLY OR RENEW
ONLINE



PAPER APPLICATION



APPLY OR RENEW OVER
THE PHONE

APPLY ONLINE

RENEW BENEFITS
ONLINE

APPLICATION IN
ENGLISH

APLICACIÓN EN
ESPAÑOL

1-855-294-2127

TTY/TDD 1-855-329-
5204



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During the initial eligibility process, applicants have a lot of information coming at them from all directions. Case managers should ensure the applicant has received the financial eligibility application. If the applicant hasn't received a financial eligibility application, or isn't sure if they have, case managers should contact the LTC Eligibility unit to ensure an application has been sent. Once an individual is receiving Waiver services, case managers should receive notification in the Care Case Management System that the participant is due for re-confirmation of financial eligibility annually. Case managers should remind the participant or legally authorized representative of the importance of completing and submitting the financial renewal application with all associated documentation, and provide support when needed. Information on how to apply for Medicaid or submit a renewal application can be found online at <https://health.wyo.gov/healthcarefin/apply/>.



In order for an applicant to be determined eligible for Waiver services, they must meet specific clinical criteria. The applicant cannot pursue clinical eligibility determination until they have been determined financially eligible for Waiver services. Requirements for clinical eligibility are established in Chapter 46, Section 7 of the Wyoming Medicaid Rules.

Clinical Eligibility

- ▶ The psychological evaluation or neuropsychological evaluation must demonstrate that one (1) of the diagnoses are met:
 - ▶ An intellectual disability;
 - ▶ A developmental disability or a related condition; or
 - ▶ An acquired brain injury (ABI).
- ▶ The criteria can be found in the Criteria for DD Psychological and Neuropsychological Evaluations in the HCBS Document Library.



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To be determined clinically eligible for Waiver services, an applicant must have a diagnosis of an intellectual disability, a developmental disability due to a qualifying related condition, or an acquired brain injury (ABI). A psychological evaluation will be used to demonstrate the developmental or intellectual disability diagnosis outlined in Chapter 46, Section 7 of the Wyoming Medicaid Rules as referenced in the Criteria for DD Psychological Evaluations and in the Criteria for DD Neuropsychological Evaluations documents located in the [HCBS Document Library](#), under the *DD* tab. A neuropsychological evaluation will be used to demonstrate an ABI diagnosis, which must meet the definition of an ABI established in Chapter 1 of the Department of Health's Medicaid Rules.

Case Manager Responsibilities



SCHEDULING EVALUATIONS

Schedule a psychological or neuropsychological evaluation



REPORT SUBMISSION

Submit the signed and dated evaluation report to the Division



SUBSEQUENT EVALUATIONS

Schedule subsequent psychological or neuropsychological evaluations as required



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The case manager will receive a task in the Care Case Management system when it is time to schedule the psychological or neuropsychological evaluation. As a reminder, a psychological or neuropsychological evaluation must not occur prior to the Division requesting the evaluation during the eligibility process. If an evaluation is completed prior to the Division's request in the eligibility process, the Division will not pay for the evaluation.

Case managers are responsible for scheduling and notifying the clinician as to whether a psychological or neuropsychological evaluation is needed based on the applicant's diagnosis. Individuals applying for the Supports Waiver will complete the psychological evaluation. If the individual applying has an acquired brain injury (ABI), they must complete the neuropsychological evaluation. Remember, if an individual sustained an acquired brain injury prior to the age of 21, they must apply for the Supports DD Waiver, not Supports ABI.

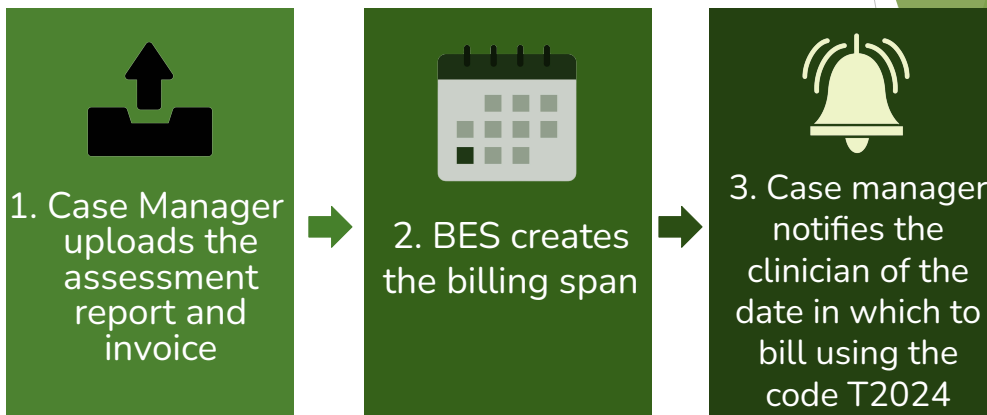
Case managers must ensure that all Waiver initial eligibility or continued eligibility evaluations are completed by a Wyoming Medicaid enrolled psychiatrist, neurologist, or clinical psychologist who is licensed in Wyoming and free of conflicts. Additionally, case managers are responsible for informing the clinician of all the required

assessments that must be included in the evaluation report. Required assessments are outlined in the previously mentioned guidance documents and provide more information on the specific criteria that the evaluation report must demonstrate. These documents are available in the [Document Library](#) on the HCBS website, under the DD tab.

Once the evaluation is complete, the case manager must upload the evaluation report into the Care Case Management System. The report must be in an uneditable format such as a PDF. The case manager must ensure that the report is signed by the clinician, dated, and contains the additional required elements as outlined in the Criteria for DD Psychological and Neuropsychological Evaluations guidance documents provided by the Division.

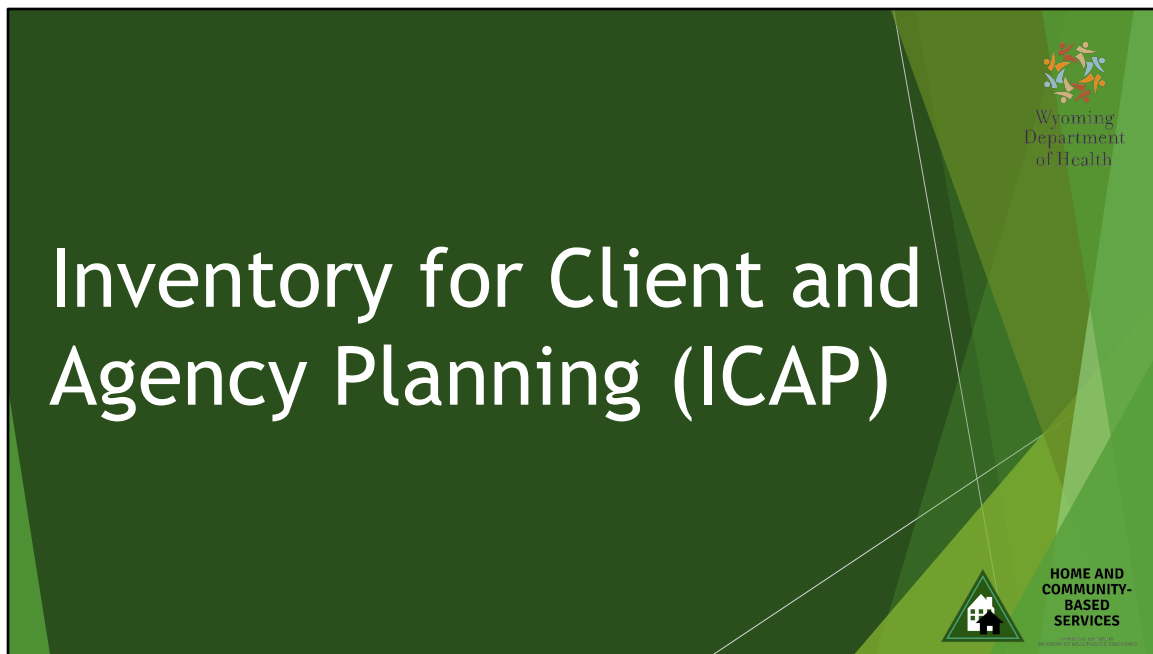
Updated psychological evaluations are required every five years up to the age of 21. After the age of 21, updated evaluations will be requested at the discretion of the Division. Subsequent psychological evaluations must be approved by the Division before being scheduled. An updated neuropsychological evaluation is required every five years.

Billing for Psych Services



The process for billing for a psychological or neuropsychological evaluation involves several steps. Once a case manager uploads the signed and dated psychological or neuropsychological evaluation report into the Care Case Management System, the system will prompt the case manager to upload the invoice for the assessment. Once the invoice is uploaded, the assigned County BES will create a billing span for the clinician to use, and send a task back to the case manager via the Care Case Management System. When the case manager receives the task that includes the billing span, the case manager must notify the clinician that they may now bill for the evaluation using the date of the evaluation and the T2024 billing code.

If the case manager doesn't notify the clinician that the billing date has been created, the clinician will not know that they are cleared to bill for the assessment.



The Inventory for Client and Agency Planning (ICAP) is a nationally standardized assessment tool that estimates an individual’s adaptive functioning and the extent to which behavior challenges may limit their inclusion in various settings. ICAP scores are used by the Division to determine eligibility and funding for Comprehensive Waiver services. The Division contracts with the University of Wyoming Institute for Disabilities (WIND) to conduct ICAP interviews for initial, emergency, and continuing eligibility.

While the ICAP is not required for the initial eligibility process for the Supports Waiver, it is required for those on or transitioning to the Comprehensive Waiver.

ICAP

- ▶ ICAPs are only completed for participants on the Comprehensive Waiver or for special circumstances.
- ▶ Respondents are chosen by the participant or legally authorized representative.
- ▶ The case manager will complete the ICAP Authorization form, including signature and date.
- ▶ Case managers may be respondents **only** as a last resort and as approved by the Division.



As a reminder, the ICAP is only completed for participants on the Comprehensive Waiver or for special circumstances such as Personal Care Services for children delivered by a relative provider or when needed for an Extraordinary Care Committee request. An ICAP must be requested by the Division before the assessment can be completed. Once an ICAP is requested, the case manager must complete the ICAP Authorization and Information form, which includes the identification of at least two respondents who have had contact with participant during the past three (3) months and who know their support needs. Respondents should reflect as many environments as possible.

Respondents are chosen by the legally authorized representative or participant. Parents and legally authorized representatives can be respondents. Case managers can not be respondents unless otherwise approved by the Division.

The ICAP Authorization form must be signed and dated by the case manager and participant, or their legally authorized representative. The case manager must upload the form to the Care Case Management System, enter in the respondents and their contact information, and submit the ICAP request forward, at which point WIND will be notified that the assessment needs to be conducted.

The ICAP assessment must be completed every five years, or more frequently at the discretion of the Division. ICAP requirements are established in Chapter 46, Section 8 of the Wyoming Medicaid Rules.



Once the eligibility process is completed, the Division will make a final determination on the applicant's eligibility for Waiver services.



Eligibility Determination

- ▶ Whether the applicant is determined eligible or ineligible, they will receive a letter from the Division.



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Whether the applicant is determined eligible or ineligible, they will receive a letter from the Division. The letters are mailed to the applicant or the LAR, but they are also uploaded to the Care Case Management System for reference.

If an applicant does not meet eligibility criteria outlined in Chapter 46, Section 4, they may be determined ineligible. If an applicant is determined to be clinically or financially ineligible for Supports Waiver services, they will receive a denial of eligibility letter and their case will be closed.

If an applicant is determined eligible, they will receive notification that they have been placed on the waitlist. Being placed on the waitlist means that the applicant is eligible, but they need to wait until there is funding available to begin receiving services.

Individuals on the Waiting List

Case managers continue to assist individuals in the following ways:

- ▶ Obtaining other non-Waiver resources;
- ▶ Checking on the individual;
- ▶ Providing crisis intervention and stabilization;
- ▶ Updating contact information in the Care Case Management System.



An individual who is placed on the waitlist may be waiting for services for several years. Case managers must continue to assist and support them by helping them access non-Waiver resources, such as services through the Division of Vocational Rehabilitation and local service organizations. Case managers must check in on the individual on a regular basis to ensure they are still interested in Waiver services. Case managers must be able to provide crisis intervention and stabilization should a situation requiring immediate attention or resolution arise. Remember, the case manager can bill for Targeted Case Management services provided while the individual is on the waiting list.

As established in Chapter 45, Section 9(d) of the Wyoming Medicaid Rules, case managers must keep each individual's contact information accurate and updated in Care Case Management System, even if they are on the waitlist. The Division uses the contact information in the Care Case Management System to send important communications to individuals including notification of a funding opportunity.

Once Funding is Available



- ▶ Case managers help participants re-confirm eligibility, if necessary.
- ▶ Case managers assist the participant's plan of care team to develop the IPC based on the participant's individual budget amount (IBA).



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Once funding is available, the participant will receive a letter from the Division that includes their individual budget amount (IBA) and the date they will be able to begin services. Before services can begin, the participant may need to re-confirm financial or clinical eligibility, and the case manager or PHN may need to re-administer the appropriate LT assessment. Once continued eligibility has been established, the case manager is expected to work with the participant and plan of care team to develop the Individualized Plan of Care. This may include locating and interviewing potential providers, or discussing the participant's rights and responsibilities related to participant-directed services.



The eligibility of participants currently receiving waiver services must be reassessed periodically in order to continue receiving Waiver services. Let's take a moment to review how often reassessment must occur.

Eligibility Reassessment Timing

LT104
or
LT101

Once per year

Financial
Eligibility

Once per year

Psychological or
Neuropsychological
Evaluation

Once every five (5)
years

ICAP

Once every five (5)
years



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- Once per year, the case manager must complete the LT104 assessment in the Care Case Management System. If the participant has an acquired brain injury, the participant must have an LT101 completed by a Public Health Nurse once per year.
- A financial renewal application must be submitted to the Long Term Care Unit annually in order to maintain financial eligibility for Medicaid.
- Once every five years until the age of 21, a participant must complete a psychological evaluation. After the age of 21, updated psychological evaluations will be requested at the discretion of the Division. Neuropsychological evaluations must be completed every five (5) years. You will receive a task in the Care Case Management System when it is time to schedule an evaluation.
- If a participant is on the Comprehensive Waiver or in special circumstances such as a child receiving Personal Care Services by a relative provider, a new ICAP will need to be completed every five (5) years.



As established in Chapter 46, Section 5 of the Wyoming Medicaid Rules, a participant may be determined ineligible if they do not continue to meet clinical or financial eligibility for the Supports or Comprehensive Waivers.

Loss of Eligibility

- ▶ The Division will notify the participant or LAR in writing within 15 calendar days of the determination.
- ▶ Waiver services shall be terminated no more than forty-five (45) calendar days after the ineligibility determination is made.



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When a participant is determined ineligible for the Supports or Comprehensive Waiver, the Division will notify the participant or LAR in writing within 15 calendar days of an ineligible determination and closure of the case will be initiated. The letter is also uploaded to the Care Case Management System.

Waiver services to a participant shall be terminated no more than forty-five (45) calendar days after the ineligibility determination is made.



TAKEAWAYS

- ▶ Case managers must know the rules that govern eligibility criteria and the eligibility process.
- ▶ Case managers must know and follow the eligibility process.
- ▶ All eligibility steps must be completed sequentially.
- ▶ Case managers must provide ongoing support for individuals on the waitlist.
- ▶ Case managers are responsible for assisting participants with continued eligibility.
- ▶ Case Managers are expected to be advocates for applicants and participants while honoring their choices.



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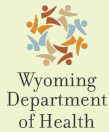
Before we end today's training on the eligibility process and the case manager's role, we'd like to remind case managers of the key takeaways of today's training.

1. Chapter 46, Sections 4 - 8 of the Department of Health's Medicaid Rules establish eligibility criteria and the eligibility process. Chapter 45, Section 9 outlines Case Management Services. Case managers are expected to know where to find the Rule, be familiar with the criteria and processes and ensure they are followed.
2. Case managers must know and follow the eligibility process. The Application Guide for the Supports Waiver is an excellent resource available to case managers as well as applicants and their families. The Guide can be found in the [HCBS Document Library](#), under the *DD* tab.
3. All steps in the eligibility process must be completed sequentially. Failure to complete these steps may result in an applicant's eligibility determination being delayed.
4. Once eligibility is determined and an individual is placed on the waitlist, case managers have an ongoing responsibility to support individuals as needed and as agreed upon in the TCM plan of care.
5. Once a participant is receiving Waiver services, case managers are responsible

1. for supporting and assisting participants through the financial renewal process, and ongoing eligibility reassessments in order to maintain continued eligibility.
2. Case Managers are expected to be advocates for participants while honoring their choices.

THANK YOU

Questions?



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At this time if you have any other questions, please post them in the chat. We'll answer any questions you've posted in writing and get those to you by email and by posting them to the [DD Providers & Case Managers](#) page under the *Case Manager Support Calls* tab in the next few days. Thank you for joining us today!