GENERAL CLIENT ELIGIBILITY

An individual 18 years of age or older qualifies for Adult Community Placement (ACP) program services.

Medicaid eligible services

ACP services for a personal care supplement payment are available if the client meets all eligibility requirements. ACP eligibility requirements include all of the following:

- Medicaid (MA) eligibility.
- Certification of medical need.
- Verification of the client's medical need by a Medicaid enrolled medical professional on the DHS-54A, Medical Needs form.
- A completed MDHHS-5534-A, Adult Services Comprehensive Assessment for ACP (in MiAIMS). An individual residing in a community placement facility is eligible for personal care services if they are ranked a level 2 or higher on any Activities of Daily Living (ADL), or medication.

Non-Medicaid eligible services

An ACP case may be opened to supportive services for non-Medicaid related services that would include:

- Providing information and referral to individuals regarding adult community placement facilities.
- Medicaid application assistance while pursing ACP program supplement payment benefit.

MEDICAID DETERMINATION

Clients not on Medicaid who have a determined need for a Medicaid personal care supplement payment should be referred to an Eligibility Specialist (ES) for Medicaid (MA) determination.

If the Medicaid eligibility is not determined within the 45-day standard of promptness (SOP), then the adult services worker must

make a case disposition determination. An adult services worker can:

- Open a case to supportive services to give a Medicaid determination more time.
- Deny a pending application due to the applicant not receiving Medicaid benefits.

No personal care supplement payments can be paid until the Medicaid eligibility has been approved.

Payments can be paid retroactive up to 365 days from the application date to cover extreme delays in Medicaid determinations.

MEDICAID SCOPE OF COVERAGE (MA)

The client may be eligible for MA under one of the following:

- All requirements for Medicaid have been met.
- Medicaid deductible obligation has been met.

The client must have a scope of coverage of either:

- 1F or 2F.
- 1D or 1K (Freedom to Work).
- 1T (Healthy Kids Expansion).
- 3G (Healthy Michigan).
- 8L (Flint).

Clients with a scope of coverage 20, 2C, or 2B are not eligible for Medicaid until they have met their MA deductible obligation.

Note: A change in the scope of coverage in Bridges will generate a system tickler in MiAIMS for active services cases.

Medicaid personal care option

Clients residing in community placement settings can meet their deductible by utilizing the MA personal care option. Medical personal care option in an ACP facility requires the following:

- The licensed provider must determine a daily dollar amount for personal care provided to the residents, which is separate from the room and board costs.
- Licensed provider must submit documentation of the personal care provided to the eligibility specialist.
- The eligibility specialist uses this documentation to approve the client for ongoing Medicaid.
- The licensed provider is then able to submit a claim for the personal care supplement payment.
- Medicaid is authorized from the first day of the month; see **BEM-545, MA Group 2 Income Eligibility**, Exhibit ID.

Note: No portion of the personal care supplement payment to the AFC provider can be used to meet a Medicaid deductible.

APPROPRIATE PROGRAM ENROLLMENT TYPE STATUS

Verify the client's program enrollment type (PET) to make sure there will be no duplication of services which causes the client being ineligible for the ACP program.

The program enrollment type information can be found in MiAIMS under the Client Action section, **Check MA/PET** tab.

DETERMINATION OF ACP ELIGIBILITY

Written Notification of Application Disposition

The following forms are documented under the MiAIMS contact module when they are generated within MiAIMS and are used for notification of program eligibility for the client. These documents act as the file copy for the case record. For this purpose, the form letters used are:

- DHS-1210, Services Approval Notice.
- DHS-1212A, Adequate Negative Action Notice.

Each notification letter includes an explanation of the procedures for requesting an administrative hearing.

Note: The adult services worker must sign the bottom of the second page of all notices (DHS-1210 and DHS-1212A) before they are mailed to the client.

Services Approval Notice (DHS-1210)

If ACP services are approved, the DHS-1210, Services Approval Notice, is used and generated in MiAIMS indicating that services have been authorized for the personal care supplement payment to be paid to the licensed facility.

Adequate Negative Action Notice (DHS-1212A)

The DHS-1212A, Adequate Negative Action Notice, is used and generated in MiAIMS when ACP services have been denied. Appropriate notations must be entered in the comment section to explain the reason for the denial.

Adequate Negative Action Notices **do not** require a 10-business day notice to the client.