March 2025

ELIGIBILITY

PURPOSE

This policy contains the following information about 1915(i) behavioral health supports and services, referred to as "1915(i)" in this policy:

- who is eligible and can apply,
- application process, and
- how eligibility is determined and redetermined.

1915(i) applicants must show a need for 1915(i) services and supports. This policy also describes the two allowed needs-based assessments, qualifying scores, who can administer the assessments, and the requirement that an applicant needs and receives at least one service quarterly.

APPLICABILITY

The policy is for individuals wanting to apply for 1915(i) behavioral health supports and services, individuals assisting applicants, Human Service Zone "Zone" staff, and 1915(i) Care Coordinators.

DEFINITIONS

Alternate contact – means an individual, other than the applicant, identified to assist with the application. Alternate contacts may be family members, friends, or someone who is familiar with the applicant. The only purpose of an alternate contact is to assist in providing the applicant's contact information.

Applicant – means an individual applying for 1915(i) or "an individual properly seeking services" on behalf of another individual. Individuals seeking services on behalf of someone else must be of sufficient maturity and understanding to act responsibly on behalf the individual for whom they are applying. "Individuals properly seeking services" may be an applicant's parent or guardian.

Home and Community Based Setting (HCBS) - means a member's own home or community rather than institutions or other isolated settings.

Institution – means nursing facilities (NF), intermediate care facilities for individuals with intellectual disabilities (ICF/IID), Qualified Residential Treatment Programs (QRTPs), Psychiatric Residential Treatment Facilities (PRTF), IMDs, hospitals, and jails/prisons.

Institution for Mental Disease – means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Members residing in IMDs are not eligible for 1915(i) services.

Needs-based assessment – means the WHODAS 2.0 or DLA-20 assessment tool.

Non-compliant setting – means the setting where services are received is not a home and community-based setting.

Eligibility Criteria

An applicant is eligible for the 1915(i) if all the following criteria are met:

1. **Age** - All ages are eligible to apply. Some services have age limits.

2. **Enrolled in Traditional Medicaid or Medicaid Expansion -** Applicants must be enrolled in Traditional Medicaid or Medicaid Expansion prior to applying for the 1915(i). The application process is the same regardless of the individual's Medicaid enrollment.

3. **Household income is at or below 150% of the Federal Poverty Level -** Medicaid rules regarding applicant income, household size, and poverty level apply to 1915(i) eligibility.

   Children in Subsidized Adoption are categorically eligible for Medicaid, so the sub-adopt parents' income is not considered when determining the Federal Poverty Level for purposes of 1915(i) eligibility. The sub-adopt child's income must be at or below 150% of the Federal Poverty Level to be eligible for the 1915(i). If the applicant's categorically needy Medicaid eligibility status changes, then the Medicaid eligibility worker would follow Medicaid policy based on whatever the change of status is.

4. **Qualified Behavioral Health Diagnosis -** Applicants must possess one or more of the qualified ICD-10 diagnoses, which include substance use disorders, mental health conditions, and brain injuries. The list of approved diagnoses is attached to the application (SFN 741).

5. **Qualifying Needs-Based Assessment –**Members must need assistance with activities of daily living and/or instrumental activities of daily living due to an impairment as evidenced by one of the following:
    1. a complex score of 25 or higher on the World Health Organization Disability Assessment Schedule 2.0 (WHODAS), or
    2. a score of 5 or lower on the Daily Living Activities-20 (DLA).

    NOTE: Applicants only need to have one qualifying score and do not need both assessments. However, if an applicant does not receive a qualifying score on the DLA and the DLA is administered first, the applicant must also be assessed with the WHODAS 2.0.

6. **Compliant Home and Community-Based Settings (HCBS)** – Applicants must reside in a compliant home and community-based setting. This ensures all individuals have personal choice and are integrated in and have full access to their communities including opportunities to engage in community life, work, attend school in integrated environments, and control their own personal resources.

    Applicants residing the following facilities will not be found eligible* for 1915(i):
    - carceral (jail or prison),
    - nursing facility (NF),
    - Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID),
    - Qualified Residential Treatment Program (QRTP),
    - Psychiatric Residential Treatment Facility (PRTF),
    - Institutions for Mental Disease (IMD, like the State Hospital), and
    - hospitals.

    Individuals in these settings are receiving 24/7 institutional-level services; therefore, 1915(i) services are considered duplication of services.

    Applicants residing in an institution, enrolled in the Program of All-Inclusive Care for the Elderly (PACE), or on Hospice are not eligible to apply for the 1915(i) while receiving these services.

*PRE-APPROVAL FOR APPLICANTS WHO LIVE IN A NON-COMPLIANT SETTING

Applicants may be "pre-approved" for 1915(i) if the application is submitted with a notation that it is a "PRE-APPROVAL". The application is to be pended for up to 45 days. A member will notify the Customer Support Center/Zone of release and if within the 45-day window the application can be processed for an eligibility determination.

NOTE: An applicant is not eligible if any of the above criteria are not met.

APPLYING FOR 1915(i)

Applicants seeking to receive 1915(i) services will submit completed 1915(i) Eligibility Applications (SFN 741) per directions on the application. The entire application must be filled out and contain required signatures prior to submission. Incomplete applications cannot receive eligibility determinations.

Applicants who are submitting applications on behalf of another individual must have the individual's consent to apply for 1915(i) services, and the individual who will receive services must participate in the eligibility process.

ALTERNATE CONTACT ON APPLICATION

Individuals listed as an alternate contact on an application may not answer any questions about the applicant or their application, make any decisions on behalf of the applicant, or inquire about the applicant's eligibility status.

A 1915(i) provider identified as an alternate contact on an initial eligibility application appears as a conflict or inappropriate relationship but can be overridden in the event no other individuals are available to serve in that capacity. Providers identified as alternate contacts cannot submit a Release of Information between the provider and a Human Service Zone when assisting an applicant with their initial application. Until the applicant has been determined eligible and contacted the provider for services, the provider is to have no other contact with the applicant or the Zone relating to the applicant's 1915(i) eligibility or services.

ELIGIBILITY DETERMINATIONS

1915(i) applications are processed and eligibility is determined by qualified Human Service Zone eligibility workers.

If a 1915(i) application is received for an applicant not yet eligible for Medicaid, the Eligibility Worker shall assist the applicant with being screened for Medicaid eligibility.

INCOMPLETE APPLICATIONS

Incomplete applications submitted by Medicaid-enrolled applicants will be placed in a pended status. In all cases of incomplete applications, Zone workers will inform the applicant in writing of what is missing, how to obtain the information, and how to submit it for consideration. Written notices must be uploaded into FileNet and the 1915(i) Web System.

If the required information is not received within 45 days from the date of the notice, the Zone will formally deny eligibility in the 1915(i) Web System and a denial letter is sent to the applicant. Should an individual wish to re-apply after their application has been denied, a new application will need to be completed and submitted.

If an application is missing or has an incomplete needs-based assessment, the application will be put into pending status and the Zone is responsible to administer the WHODAS to ensure eligibility isn't delayed.

In the event of a pending Medicaid determination or redetermination, a 1915(i) application will be pended until there is a Medicaid determination. The Zone will enter the information provided into the web system and place the application in pending status.

REQUIRED APPLICATION INFORMATION

Diagnosis

It is the responsibility of the applicant to provide proof of diagnosis as part of their application. Section 3 of the application must document the diagnosis, and name and signature of the diagnosing professional or verifying staff person; or documentation containing this required information may be attached to the application replacing the diagnosing professional or verifying staff person's signature. The diagnosing professional or verifying staff person's signature, or attached documentation, must be dated within the prior year from the date of application submission.

The Zone will not verify the diagnosing professional's credentials; however, if fraud or abuse is suspected, Zone workers will report findings to the State.

Needs-Based Assessment – WHODAS 2.0 or DLA

APPLICABLE TIMEFRAMES

Needs-based assessments must be completed within 90 days prior to the date of:

- the initial eligibility application submission; and
- each subsequent eligibility redetermination application submission.

WHODAS 2.0 ASSESSMENT

The World Health Organization Disability Assessment Schedule 2.0 (WHODAS) Assessment is one of the tools used for assessment of needs-based eligibility.

ND Medicaid requires face-to-face administration of the WHODAS 2.0 even though the WHODAS 2.0 itself does not require this.

The WHODAS serves dual purposes for the 1915(i) and is used both in determining initial eligibility for 1915(i) and for development of a member's plan of care for services:

1. It provides a reliable overall complex score to ensure the individual meets the established needs-based eligibility criteria of the 1915(i), and
2. It assesses an individual's level of need and assign a score in each of the six domains:
    - Cognition – understanding and communicating
    - Mobility – moving and getting around
    - Self-care – hygiene, dressing, eating, and staying alone
    - Getting along – interacting with other people
    - Life activities – domestic responsibilities, leisure, work, and school
    - Participation – joining in community activities

While developing the person-centered plan of care, the individual domain scores will assist the 1915(i) Care Coordinator with identifying the member's needs to determine which of the 1915(i) services will be authorized.

WHODAS Administrator Requirements

WHODAS administrations must be "trained, qualified practitioners".

Trained, qualified practitioner - means someone who has completed training on the administration and scoring of the WHODAS 2.0. Human Service Zone eligibility workers can be trained, qualified practitioners for WHODAS 2.0 administration.

Required Training Components

Read and review:

- WHODAS: Part 1 – 1915(i) Policy and Procedures presentation
- WHODAS 2.0 Manual – complete the test used to assess knowledge of WHODAS 2.0 administration in Chapter 10 of the Manual.

Watch:

- WHODAS: Part 2 – Administration and Scoring Training and review revised presentation

Allowed Methods of WHODAS Administration

1. Face-to-Face Assessment with the applicant
   General interview techniques contained in the WHODAS Instruction Guide are sufficient to administer the interview in this mode.
2. Face-to-Face Proxy Assessment with an applicant's representative
   An applicant's representative may provide a third-party view of functioning.
   Representative - means the individual's legal guardian, parent, authorized representative, family member or advocate (teacher, friend, etc.). A 1915(i) provider cannot act as a proxy.

Administration via Telehealth

A face-to-face assessment may include assessments performed by real-time two-way communication between the service provider and the individual using secure video conferencing, or another information technology medium if the applicant receives appropriate support during the assessment and provides informed consent for this type of assessment. **A telephone is not considered telehealth for WHODAS 2.0 assessments.**

Required Forms and Scoring Information

The WHODAS 2.0 36-item assessment version and complex scoring method are required. The complex scoring sheet is located here.

The WHODAS is approved by the World Health Organization for use with individuals across their lifespan. In those cases where a given question may not be applicable, for example in the case of a small child, there is a mechanism outlined in the WHODAS User Manual for how to calculate the score when having dropped a question or two. Another example of a permissible adaptation is using a child's "play" to represent work/school activities in the case of a young child not yet attending school.

Documentation Requirements

SFN 741 REQUIREMENTS

WHODAS 2.0 administrators must complete the WHODAS section of the SFN 741.

Applications must contain

- the overall complex score,
- date administered, and name of the WHODAS administrator. The WHODAS 2.0 assessment and
- 1915(i) score sheet as an attachment, or

- the summary tab of the 1915(i) score sheet or
- The Human Service Center "HSC" Electronic Health Record containing the individual's WHODAS scores may be attached.

See Documentation reference for screenshots showing requirements.

Billing and Reimbursement

Administration of the WHODAS 2.0 as part of an applicant's initial eligibility is not a billable service. Administration of the WHODAS 2.0 as part of a member's redetermination of 1915(i) eligibility may be billed as part of a care coordinator's services.

DAILY LIVING ACTIVITIES-20 (DLA) ASSESSMENT

The Daily Living Activities-20 (DLA) Assessment is another tool used for assessment of needs-based eligibility. The DLA contains 20 daily activities that are affected by mental health and disability. This functional assessment helps behavioral health providers determine the measure of an outcome, showing where treatment is needed.

NOTE: If an individual receives a non-qualifying score on the DLA (score of 6 or higher), a WHODAS assessment will be administered. Should the WHODAS demonstrate that the individual is eligible for the 1915(i) (score of 25 or higher), eligibility will be approved or continued participation granted for those already enrolled in the program.

Should the results of the DLA be that an individual needs a lesser amount of service, the individual's service amounts will not be decreased unless and until the WHODAS 2.0 is administered to confirm the need for less services. The amount of the service reduction will be in accordance with the WHODAS should the assessments be in dispute.

Required Forms and Scoring Information

If a DLA has already been completed for an individual, a printout can be obtained from a HSC case manager.

Documentation Requirements

SFN 741 REQUIREMENTS

DLA administrators must complete the DLA section of the SFN 741.

Applications must contain

- Assessment date
- Score

See Documentation reference for screenshots showing requirements.

ELIGIBILITY DETERMINATION BY HUMAN SERVICE ZONE

Zone eligibility workers will determine an applicant's 1915(i) eligibility within five (5) days of receiving a complete application. The 1915(i) Zone Eligibility Worker will date receipt of the application and send an eligibility approval or denial letter to the applicant containing information on the individual's rights, including their right to appeal the eligibility decision.

The Eligibility Worker will provide eligible applicants with the "Member Rights and Responsibilities" form and "Fact Sheet for Individuals Deemed Eligible", as well as the "Next Steps" sheet, found on the 1915(i) Zone website, providing information on the services available through the 1915(i) and informing them of their next steps to accessing 1915(i) services. The Zone will also inform eligible applicants to contact the Care Coordination agency of their choice to begin the person-centered planning process. If assistance is needed in contacting an agency, members will contact the 1915(i) Navigator.

Except in the case of the Community Transition Service, the authorization of services cannot begin before the date eligibility is determined.

Member Applications when Medicaid is being reviewed at the end of the month

The member's 1915(i) application should be processed as usual. When the applicant's Medicaid closes 1915(i) staff will suspend the member's case in Dynamics for 90 days to allow time for the applicant to complete their Medicaid redetermination.

ELIGIBILITY REDETERMINATIONS

Eligibility redeterminations follows the same process as initial eligibility determinations. Eligibility redeterminations must be completed at least annually and shall take place 30 days or less before the 1915(i) review date. Redeterminations must be completed within five (5) business days from receipt of the completed application.

Applicants and their care coordinators are responsible for submitting complete applications in a timely manner.

ND Medicaid, the member's care coordinator, or the member may request a redetermination prior to the annual timeframe if the member's needs change or a change in their circumstances deem it necessary.

«**No Reasonable Indication of Need for Services**

Members must require 1) at least one 1915(i) service, as documented in their person-centered plan AND 2) receive at least one service per quarter or monthly monitoring as noted in their person-centered plan when services are required on a less-than quarterly basis.

Members not meeting this criteria no longer meet 1915(i) eligibility criteria and will have their 1915(i) Medicaid closed. Members will be sent appropriate written notice of this closure and their appeal rights.»

Changes to Medicaid Affecting 1915(i) Eligibility

When an application is received, the Zone is to review the contact information in SPACES and update any necessary information, such as a change in address or contact number, with the information provided on the application.

When there are Medicaid changes of any kind made in SPACES, 1915(i) Specialist must check FES to see if there is a 1915(i) benefit plan and, if so, they must inform the Eligibility Worker of the Medicaid change(s). The 1915(i) Specialist will then update the 1915(i) Web System with any changes that affect 1915(i) eligibility.

Ongoing communication between the 1915(i) Specialist and the Eligibility Worker is essential to ensure the following updated information from SPACES gets inputted into the 1915(i) Web System and vice versa.

1. Changes to identifying information including parent/legal guardian and alternate contact, if applicable;
2. Changes in address and/or contact numbers;
3. Medicaid date changes;
   a. Transfer from Traditional Medicaid to Expansion
   b. Transfer from Expansion to Traditional Medicaid
4. Medicaid ineligibility;
5. Changes in income and/or household size; and
6. Transition to a non-compliant HCBS setting.

Responsibilities and Requirements of the 1915(i) Zone Eligibility Worker

1. Providing the applicant with the SFN 741 when requested and instructing them on the process for having the application completed;
2. Assisting applicants with enrolling in Medicaid, if needed;
3. Informing the applicant of eligibility requirements;
4. Signing and dating the SFN 741 under the 1915(i) Eligibility Request section on the date the completed application was received and the date eligibility was determined;

5. Verifying the applicant is currently eligible for Traditional Medicaid or Medicaid Expansion;
6. Verifying the applicant's household income is at or below 150% of the Federal Poverty Level;
7. Verifying proof of one or more qualifying 1915(i) diagnoses;
8. Verifying proof of a qualifying needs-based assessment and score;
9. Entering the eligibility information into the 1915(i) Web System as proof of 1915(i) eligibility and enrollment;
10. Informing the applicant or parent/legal guardian, if applicable, of the eligibility decision by providing an approval or denial letter;
11. Providing the applicant with the "Member Rights and Responsibilities" form;
12. If eligibility is approved, providing the eligible applicant with the "Fact Sheet for Individuals Deemed Eligible" and "Next Steps" flyer;
13. Performing redeterminations annually, or earlier when changes occur, or upon request by the individual, their Care Coordinator, or the State;
14. Updating information in the 1915(i) Web System;
15. Informing the applicant or parent/legal guardian, if applicable, of any changes in 1915(i) eligibility by providing a notice; and
16. Ongoing communication between the Medicaid Zone Eligibility Worker and the 1915(i) Specialist to ensure updated information from SPACES gets inputted into the 1915(i) Web System and vice versa.

A request of information cannot be attached to an initial eligibility application. However, a request may be attached to an eligibility redetermination.

Zone Responsibility to Provide Notice to 1915(i) Recipients

Notice means a written statement that meets the requirements of CFR § 431.210. A copy of any notice is to be uploaded into Filenet and the 1915(i) Web System.

Notice of Approval of 1915(i) Eligibility

The Zone will send an eligibility approval letter on the date eligibility was approved. The approval letter informs the eligible individual they are responsible to report all future income exceeding 150% federal poverty level to the 1915(i) Zone Eligibility Worker and their rights, including timely and adequate notice of decisions about eligibility; and their right to appeal.

Upon discharge from a non-compliant HCBS setting, eligibility is reinstated. The Zone sends a notice of approval of eligibility informing the member eligibility has been reinstated.

Notice of Denial of 1915(i) Eligibility

When taking an unfavorable action such as a denial of eligibility, the Zone must send a notice to the individual no later than the date of action. The Zone will send an eligibility denial letter no later than the date eligibility was denied.

This letter informs the eligible individual of their right to appeal the denial. The State assures that individuals have opportunities for fair hearings and appeals.

Notice of Suspension of 1915(i) Eligibility

Eligibility is suspended when a member goes into non-compliant HCBS setting.

Notice

Notice is sent for cases that have been in suspended status for 5 months. The notice informs the member eligibility will close at 6 months if they remain in a non-compliant setting.

Notice

Notice is sent for cases that have been suspended for 6 months. The notice informs the member eligibility has been closed due to residing in a non-compliant HCBS setting.

Notice of Closure of 1915(i) Eligibility

When taking an unfavorable action such as a closure of 1915(i) eligibility, the Zone must send a notice to the individual no later than the date of action. The Zone will send an eligibility closure letter no later than the date of closure.

This letter informs the individual they have the right to appeal this action. The State assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

The 1915(i) Web System automatically closes a case when 1915(i) eligibility has expired. If a case was automatically closed due to expiration, an eligibility closure letter will be generated and sent by the State.

Notice of Eligibility Redetermination

Advance notice must also be provided to a member and their parent/legal guardian, if applicable, of the eligibility redetermination date. The Zone will generate and send out the Notice of Upcoming

Review Date letter 30 days in advance of the member's 1915(i) review date informing the member they must complete and return the 1915(i) Eligibility Application by their review date for redetermination of 1915(i) eligibility.

NOTE: All notices are in the 1915(i) web system. All members have the right to fair hearings and appeals of ND Medicaid decisions to reduce, terminate, or deny their benefits.

Qualifications of 1915(i) Zone Eligibility Workers

The Zone must assure the 1915(i) Zone Eligibility Worker performing 1915(i) determination/redetermination:

1. Is not related by blood or marriage to the applicant or any paid caregiver of the applicant;
2. Is not financially responsible for the applicant;
3. Is not empowered to make financial or health-related decisions on behalf of the applicant;
4. Has completed initial and ongoing training provided by, or approved by, the State.

Zone Input into the 1915(i) Web System (Dynamics)

The 1915(i) Web System is the eligibility system for 1915(i). An entry in the web system is required for all 1915(i) applicants to document approval or denial of eligibility. Any documentation relating to 1915(i) eligibility must be uploaded into FileNet and the 1915(i) Web System.

The 1915(i) Zone Eligibility Worker is responsible for entering initial and ongoing information into the web system and documenting all contacts with the member in the 1915(i) Web System under the "Notes & Attachments" section.

In certain situations, Medicaid Expansion-eligible individuals have a choice to be served under Traditional Medicaid rather than Expansion. Please refer to the table of SPACES COE Codes included in the Web System Cheat Sheet to identify if a member has chosen Traditional or Expansion coverage and input their Traditional or Expansion eligibility dates into the 1915(i) Web System under the appropriate section.

Reader is referred to the Web System Cheat Sheet located on the 1915(i) website.

1915(i) Eligibility/Redetermination Start and End Dates

Eligibility for a new applicant will begin the date 1915(i) eligibility was approved by the 1915(i) Zone Eligibility Worker.

If an eligibility redetermination is approved, eligibility shall continue running with no break in coverage. For example, if prior eligibility was from 2/15/24 – 2/14/25, 1915(i) eligibility would continue and begin on 2/15/25.

If an applicant's 1915(i) eligibility start date is less than 6 months before their Medicaid eligibility redetermination date, then the applicant's 1915(i) end date and 1915(i) review date will be 364 days from the 1915(i) start date. For example, if an applicant's 1915(i) eligibility start date is 2/1/24 and their Medicaid eligibility redetermination date is 5/30/24, the 1915(i) end date and 1915(i) review date would be 364 days from 2/1/24 creating an end date of 1/31/25.

If an applicant's 1915(i) eligibility start date is 6 months or more before their Medicaid eligibility redetermination date, then the applicant's Medicaid eligibility redetermination date is also used as the 1915(i) end date and 1915(i) review date. For example, if an applicant's 1915(i) eligibility start date is 2/1/24 and their Medicaid eligibility redetermination date is 8/31/24, the 1915(i) end date and 1915(i) review date would be the same as the Medicaid eligibility redetermination date, 8/31/24.

1915(i) Eligibility Suspension

When an eligible member enters a non-compliant HCBS setting for 6 months or less, eligibility is suspended, not closed, and services will be paused until the member is discharged. Closure will occur when a member is placed in a non-compliant setting for 6 months or more or whenever their eligibility expires, whichever occurs first.

The 1915(i) eligibility dates will remain in the system. The State will close the FES span the day before the member entered the non-compliant setting and reenter into FES upon discharge.

1915(i) Eligibility Closure Dates

If a 1915(i) member chooses to close their eligibility, the member or their parent/legal guardian, if applicable, must contact the Zone and ask to end their eligibility. A request from the member's care coordinator is not sufficient.

At any time one of the 1915(i) eligibility criteria is not met after a member has been determined eligible, their eligibility must be closed in the 1915(i) Web System per the policy below:

1. When Medicaid eligibility closes, 1915(i) eligibility closes on the same date Medicaid eligibility is closed regardless of when the 1915(i) Zone Eligibility Worker was notified. If Medicaid eligibility closes due to not meeting the client share, 1915(i) eligibility must be closed on the same date Medicaid eligibility is closed. The Zone sends an eligibility closure letter to the member no later than the date of action.

2. When any of the following 1915(i) eligibility criteria are not met, (not Medicaid eligibility – see #1 above), 1915(i) eligibility closes on the date the 1915(i) Zone Eligibility Worker was notified. The Zone sends an eligibility closure letter to the member no later than the date of action.
    - Income exceeds 150% of the FPL
    - No qualifying diagnosis
    - No qualifying needs-based assessment score

3. If a member becomes enrolled in the Program of All-Inclusive Care for the Elderly (PACE), 1915(i) eligibility closes on the day before the member became eligible for PACE. The Zone sends an eligibility closure letter to the member no later than the date of action.

4. In the event of a death, 1915(i) eligibility closes on the date of death. The Zone sends an eligibility closure letter to the parent/legal guardian, if applicable, no later than the date of action.

When a member has not connected with a care coordinator or followed through with the annual reevaluation requirements, their 1915(i) eligibility will be closed. The 1915(i) Web System automatically closes a case when 1915(i) eligibility has expired, and an eligibility closure notice will be sent by the Zone.

FAQS

Assisting a member with their 1915(i) Eligibility Application (SFN 741):

Q: When should an applicant have the DLA vs WHODAS assessment?

A: DLA Assessment is one provided only at a Human Service Center where a professional administrator would decide if the assessment is necessary. Although there are no age specifications for the DLA, it is often administered to youth age members. The WHODAS Assessment can be used for any age and can be administered by a wide variety of trained individuals. A WHODAS assessment can be obtained at a Human Service Zone. Human Service Zone contact information can be found here - https://www.hhs.nd.gov/human-service/zones

Q: Who can be a proxy for the WHODAS?
A: A member can request to have a proxy on their behalf, which can be anyone the member knows and requests as long as the proxy is not the WHODAS Administrator or a 1915(i) provider.

Q: How can a WHODAS get scheduled?
A: Reach out to the local Human Service Zone to schedule a WHODAS. You can search for your local Human Service Zone here - https://www.hhs.nd.gov/human-service/zones.

If unable to reach the Zone, you may reach out to nd1915i@nd.gov to receive assistance to get a WHODAS scheduled.

Q: How do I check a 1915(i) application status?
A: An applicant can call the Customer Support Center at 1.866.614.6005 or 701-328-1000; 711 (TTY). They can also log into the Self-Service Portal found here - https://www.hhs.nd.gov/applyforhelp.
For questions or assistance with the Self-Service Portal, visit SSP Help | Health and Human Services North Dakota.

Q: How will I know if a member's eligibility redetermination has been approved?
A: Care coordinators work with the member to complete the 1915(i) application for an eligibility redetermination. «Care Coordinators can check a member's eligibility status in MMIS using this how-to document.» Additionally, the member will get a letter from the Human Service Zone letting them know the outcome of their application.

Q: Why are non-specific diagnoses not accepted?
A: Non-specific diagnoses are not included in the qualifying diagnosis list. For example, there are several diagnoses for depression, and unspecified depression doesn't identify which depression diagnosis applies.

Q: Is the redetermination process the same as the initial application?
A: Yes, the redetermination process is the same as the initial application.

Q: When should an eligibility redetermination application be completed?
A: It is recommended to begin the redetermination application at least 4-6 weeks prior to eligibility ending.

After eligibility is approved and member is connected to a provider:

Q: How do I know if a member is in an HCBS compliant facility?

A: Required HCBS settings compliance measures must be completed, and verification of compliance documented in the Plan of Care by the care coordinator prior to submission of the POC and approval of service authorizations. The care coordinator will verify compliance by completing the person-centered planning and self-assessment process.

Each of the identified HCBS settings requirements must be addressed in the member's plan of care. Details can be found in the HCBS policy located here - HCBS Settings Requirements.

Q: What happens if a member receiving services moves to a non-compliant setting?

A: Notify us by email at nd1915i@nd.gov with the date the member entered the noncompliant setting. Their eligibility will then be suspended. Once the member is back in a compliant setting, email nd1915i@nd.gov with the date this occurs, and their eligibility will be reinstated. If they remain in a noncompliant setting for 6 months or longer, their eligibility will be closed and the member will have to reapply.

Q: Who do I contact to notify that a member has had a residence change to a facility?

A: Notify us by email at nd1915i@nd.gov.

Q: How do providers add members into Therap for support services?

A: Providers don't have the ability to add members to Therap. (see next Q&A for instructions on a member getting added into Therap.)

Q: How does a member get added into Therap?

A: When the Care Coordination Request for Services Form is received, we make a referral to the provider in Therap.