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OVERVIEW OF PUBLIC BENEFITS AND FUNDING SOURCES FOR CHILDREN WITH DISABILITIES

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TABLE OF CONTENTS

Medicaid Overview (ODJFS Fact Sheet) 1

Medicaid for Older Adults and People with Disabilities (ODJFS Fact Sheet) 4

Health Start and Healthy Families (ODJFS Fact Sheet) 6

Children's Buy-In (ODJFS Fact Sheet) 8

Medicaid Worker Buy-In 10

Medicaid Home and Community Based Waivers 12

- ODJFS Waivers 14
- DD Waivers 15

Medicaid EPSDT Benefits 17

Title IV-E 19

County Department of Job and Family Services 20

DD Boards 21

ADAMH Boards 22

IDEA 23

Autism Scholarships 24

Family and Children First Councils 25

SSI 26

SSDI 30

BCMH 35

Basic Guidelines for Appeals 39

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For individual issues, you should consult your attorney.

Ohio | Department of Job and Family Services

FACT SHEET

Medicaid Program Overview

What is Medicaid?

Medicaid is a public health care program funded by the state and federal government. It provides necessary health care coverage to certain individuals with limited income. In Ohio, a person is entitled to Medicaid health care coverage for free or at a low-cost if they meet specific income and eligibility requirements. As an entitlement program, the state cannot limit the number of eligible persons enrolled in Medicaid or deny access to medically necessary services to control costs.

Who is covered by Medicaid?

Ohio Medicaid provides health care coverage to children, pregnant women, families, adults age 65 and older and people with disabilities. Some consumers may need to pay monthly premiums or co-pays for certain services. Covered groups include:

Monthly Income Guidelines

	Families	Children to age 19 and Pregnant Women
Family Size	90% FPL	200% FPL
1	$813	$1,805
2	$1,093	$2,429
3	$1,374	$3,052
4	$1,654	$3,675

These figures are based on 2009 Federal Poverty guidelines and change annually.

- **Families and Children**: In general, families, children (up to age 19) and pregnant women with limited incomes (see chart) are covered through Medicaid under Healthy Start or Healthy Families programs. Certain youths aging out of the foster care system at age 18 may continue receiving health care coverage until age 21 at no cost to them.

  Families who participate in the Ohio Works First (OWF) cash assistance program are automatically covered by Medicaid. Families who leave OWF for employment are eligible for 6-12 months of coverage during that transitional period.

- **Aged, Blind and Disabled (ABD)**: Ohioans age 65 and older and people with disabilities of any age may also qualify for Medicaid health coverage. To be eligible for Medicaid as an ABD consumer in 2009, an individual's gross countable monthly income must be less than $589. They must also have resources (e.g., cash, savings, stocks etc.) of $1500 or less. Couples applying for Medicaid must have gross monthly income of $1,011 or less and resources of $2250 or less.

- **Medicaid Spenddown program**: In some cases, consumers applying for ABD Medicaid meet eligibility requirements except their income is too high. These individuals can participate in the Medicaid Spenddown program. A spenddown is like a monthly deductible determined by the county caseworker. To qualify for coverage in a given month, consumers must submit proof of medical expenses that equal the spenddown amount. They can also choose to pay their spenddown directly to the county office. Once the spenddown is reached, the consumer is then eligible for Medicaid for the rest of the month.

- **Medicaid Buy-In for Workers with Disabilities (MBIWD)**: MBIWD provides health care coverage to working Ohioans ages 16 to 64 who are disabled. MBIWD was created to encourage Ohioans with disabilities to work and still keep their health care coverage. To qualify for MBIWD, an individual's gross countable income must be no more than 250% of the federal poverty level (FPL), and they must also have resources that do not exceed $10,580. Monthly premiums are required for those eligible for MBIWD with an annual gross income greater than 150% FPL.

- **Medicare Premium Assistance Program (MPAP)**: Low-income Medicare beneficiaries can receive help from Medicaid with all or part of their Medicare cost sharing expense. This includes Medicare Part A and B premiums, co-insurance and deductibles. Different levels of assistance are available depending on income.

Continued

Medicaid Program Overview

- **Breast and Cervical Cancer Project (BCCP)**: Medicaid also provides health care coverage to eligible women screened through Ohio Department of Health's Breast and Cervical Cancer Project. To qualify for ODH's BCCP, women must have income below 200% FPL, be between the ages of 40-65 and uninsured. Once screened and diagnosed as having breast and/or cervical cancer, BCCP Medicaid may be available to women who are in need of treatment services. Women who are covered by BCCP Medicaid have access to the full Medicaid benefit package in addition to their cancer treatment.

Eligibility At A Glance*

Who's Covered?	Income Guideline
Former foster youth age 18 to 21	No income guidelines. Restrictions apply.
Children to age 19 and Pregnant Women	200% FPL
Parents	90% FPL
Disabled Persons	~ 64% FPL**
Workers with Disabilities	250% FPL*
Persons 65 & over	~ 64% FPL**
Medicare beneficiaries in need of premium assistance	200% FPL

* Exceptions and calculations will affect final amount counted toward eligibility. Actual determination of eligibility is done at a county department of job & family services office. Some eligibility categories consider resources other than income and health insurance.

** Deductions and exceptions apply; this is an approximate guide. Persons with incomes higher than 64% of the FPL may have medical expenses deducted from income calculations to "spenddown" to this level.

Eligibility and Application Process

Ohio county departments of job and family services determine eligibility for Medicaid programs with the exception of the BCCP program. Applications can be found at local county offices or online at www.jfs.ohio.gov/ohp/consumers/application. Some programs require a face-to-face interview with a caseworker while other programs accept applications by mail or fax. The Medicaid Consumer Hotline is available to provide application assistance, answer general questions and can direct consumers to their local county office or a health care provider. The Medicaid Consumer Hotline number is: 1-800-324-8680/TTY 1-800-292-3572.

How do consumers receive Medicaid services?

Once enrolled, consumers can get health care services from a Medicaid provider who accepts Medicaid as health insurance. This is generally called fee-for-service Medicaid. Consumers may be required to get their services from a Medicaid managed care plan. Both fee-for-service Medicaid and the managed care plans provide all medically necessary primary, specialty and emergency care, and preventive services.

Ohio Medicaid also provides both home health care and facility-based services for those consumers requiring long-term care services. Home care services allow consumers to remain in their homes and communities. Long-term care services are also available for consumers needing care in nursing homes and facilities for persons with mental retardation. Alternatives to institutional care are offered through home and community-based services waivers (e.g., PASSPORT, Ohio Home Care).

What services does Medicaid cover?

Ohio's Medicaid program includes services mandated by the federal government as well as optional services Ohio has elected to provide. Some services are limited by dollar amount, the number of visits per year, or the setting in which they can be provided. With some exceptions, all medically necessary services are available to all Medicaid consumers.

Continued

Medicaid Program Overview

Page 3

Federally Mandated Services

- Ambulatory Surgery Centers
- Certified family nurse practitioner services
- Certified pediatric nurse practitioner services
- Family planning services & supplies
- Healthchek (EPSDT) program services (screening & treatment services to children younger than age 21)
- Home health services
- Inpatient hospital
- Lab & x-ray
- Medical & surgical vision services
- Medicare Premium Assistance
- Non-Emergency Transportation
- Nurse midwife services
- Nursing Facility care
- Outpatient services, including those provided by Rural Health Clinics & Federally Qualified Health Centers
- Physician services

Ohio's Optional Services

- Ambulance / ambulette
- Chiropractic services for children
- Community alcohol & drug addiction treatment
- Community mental health services
- Dental services
- Durable medical equipment & supplies
- Home and Community Based Services Waivers
- Hospice care
- Independent psychological services for children
- Intermediate Care Facility services for people with Mental Retardation (ICF-MR)
- Occupational therapy
- Physical therapy
- Podiatry
- Prescription drugs
- Private Duty Nursing
- Speech therapy
- Vision care, including eyeglasses

Ohio | Department of Job and Family Services

FACT SHEET

Medicaid for Older Adults and People with Disabilities

What is ABD Medicaid?

Medicaid for the Aged, Blind or Disabled (ABD) is available to certain Ohioans to assist with medical expenses. Ohioans who are aged, blind or have a disability (as classified by the Social Security Administration) must meet established financial guidelines in order to be eligible. Some consumers in the ABD Medicaid program (125,000 consumers) access services through managed care while the remaining population access care through a fee-for-service delivery system.

ABD Consumer	Basic Requirements	Countable Monthly Income Standards*	Resources**
Individuals & Couples age 65 and older	Documentation of age	Individuals $589 Couples $1,011	Individuals $1500 Couples $2250
Individuals & Couples younger than age 65	Medical proof of physical or mental impairment that prohibits work and that has lasted or will last 12 months or longer		

* SSI is not counted; certain deductions such as medical expenses may be allowed by a process called "Spenddown".
** Some resources are exempt from asset test such as home, 1 car.

What services are covered under Medicaid?

ABD health care coverage consists of the primary and acute care benefit package and long-term care if a person has the required level of care need. Covered services include prescription drugs*, home care, doctor visits, hospital care, laboratory and X-rays, medical equipment and supplies, dental care, transportation, mental health, vision services, long-term care, alcohol and drug rehabilitation and other services.

What long-term care services are available?

ABD Medicaid provides long-term care services in Nursing Facilities (NFs) and Intermediate Care Facilities for the mentally retarded (ICF-MRs). Home and Community-Based Services Waivers provide home health care to individuals who wish to stay in their home but otherwise need institutional care. The number of consumers that can be enrolled in a waiver program at any one time is limited. There are several types of waivers:

- **Ohio Home Care Waiver** meets the home care needs of individuals, up to age 60, whose medical condition would otherwise require them to live in a nursing home or other institution.
- **PASSPORT Waiver** provides in-home services to individuals age 60 and older.
- **Individual Options and Level One Waivers** provide support services for persons with mental retardation and/or developmental disabilities.

*Medicare beneficiaries who are eligible for Medicaid get prescriptions coverage through Medicare. Some exceptions apply.

Continued

Medicaid for Older Adults and People with Disabilities

- **Assisted Living Waiver** offers more supervision and services than what may be available in a traditional home setting and allows consumers to have more independence and fewer restrictions than a nursing facility.

How to Apply

To apply for ABD Medicaid, an application and an interview need to be completed at the local county department of job and family services. For phone numbers to the local departments, call the Consumer Hotline at 1-800-324-8680.

Medicare Premium Assistance Program

Ohioans who are on Medicare may be able to receive Medicaid assistance to pay for all or some of the Medicare premiums and/or coinsurance and deductibles.

A short, mail-in application is available for the Medicare Premium Assistance program. Call the Consumer Hotline toll-free at 1-800-324-8680 or TTY at 1-800-292-3572 to receive an application or additional information.

What if an Ohioan meets ABD eligibility requirements except their income is too high?

Ohioans who are aged, blind or have a disability may qualify for Medicaid after they have incurred or paid a specific amount of medical bills. This is called Medicaid Spenddown. Spenddown allows individuals to deduct medical expenses from their income so that income will fall within Medicaid income guidelines.

If eligible for Spenddown, the consumer is required to submit proof of medical expenses that meet or exceed the Spenddown amount. Once the spenddown has been met, the consumer is eligible for Medicaid. The date of Medicaid eligibility depends on the date the consumer reaches his or her spenddown. Spenddown eligibility is a monthly process.

Ohio | Department of Job and Family Services

FACT SHEET

Healthy Start and Healthy Families

Healthy Start and Healthy Families are Ohio Medicaid programs which provide eligible Ohio children, pregnant women, and families comprehensive health coverage. In 2008, Ohio Medicaid expanded Healthy Start eligibility guidelines to cover more of Ohio's uninsured.

Ohioans who qualify for Healthy Start and Healthy Families programs gain access to important services like: doctor visits, prescriptions, hospital care, immunizations, vision and dental care, substance abuse, mental health services and more.

Healthy Start

Healthy Start covers children (up to age 19) in families with income at or below 200% of the federal poverty level (FPL).

The program also covers pregnant women (any age) in families with income at or below 200% of the FPL and certain children younger than age 21 aging out of the foster care system.

Pregnant women are eligible for Healthy Start coverage during the entire pregnancy and up to 60 days after the baby is born. Babies born to mothers on Healthy Start are automatically eligible for free health coverage for one full year from the date of birth.

Healthy Start
Monthly Income Guidelines for
Children & Pregnant Women

Family Size	200% FPL
1	$1,805
2	$2,429
3	$3,052
4	$3,675
Based on 2009 federal poverty guidelines and change annually.	

Healthy Start
Monthly Income Guidelines:
Insured vs. Uninsured

Family Size	150% FPL	200% FPL
1	$1,354	$1,805
2	$1,822	$2,429
3	$2,289	$3,052
4	$2,757	$3,675
Based on 2009 federal poverty guidelines and change annually.		

Can children have other health insurance and still qualify for Healthy Start?

Children in families whose income is between 150% and 200% of the FPL must be considered "uninsured" to be eligible for Healthy Start. Please note: Children in families with income below 150% FPL can have other health insurance and still qualify for Healthy Start.

See the chart to the left to see if a child must be uninsured in order to qualify for Healthy Start.

Continued

Healthy Families

Healthy Families provides the same quality health coverage as Healthy Start to parents/caregivers and their dependent children who have income at or below 90% FPL. These families can have other health insurance and still qualify for coverage. The chart below shows how much income a family can have to qualify.

Healthy Families: Monthly Income Guidelines

Family Size	90% FPL
1	$813
2	$1,093
3	$1,374
4	$1,654
Based on 2009 federal poverty guidelines and change annually.	

Application Process

Families can apply for Healthy Start or Healthy Families using the Combined Programs Application (CPA) - JFS Form #07216. No face-to-face interview is necessary. Applications are available:

- Online: http:// jfs.ohio.gov/ohp/
- At Medicaid Consumer Hotline: 1-800-324-8680 (TDD 1-800-292-3572 for the hearing impared). Hotline staff can provide general information or offer assistance in filling out the application over the telephone
- At local county department of job & family services

To complete an application for health coverage, applicants must send their application and copies of the following documents to their local office of job & family services:

- Proof of income
- Proof of pregnancy (if applicable)
- Proof of U.S. citizenship (one-time proof; original document or certified copy) or alien status
- Proof of other health insurance coverage (if applicable)

To maintain coverage, children must reapply every 12 months; families must reapply every 6 months. Families with income slightly higher than what is listed in the income charts above should still apply because a portion of certain monthly expenses will not be counted (e.g., child care, child support etc.)

Still Not Eligible?

The Children's Buy-In (CBI) program is for Ohio's uninsured children in families with income above 300% FPL. CBI allows working families that have uninsured children with special health needs or high monthly insurance premiums to purchase public health coverage for their children. Children must be uninsured for six months prior to enrolling and meet additional criteria in order to qualify. Monthly premiums will be calculated based on income. Please note: This program is not available through the local county departments of job and family services. Interested applicants must apply online: http://jfs.ohio.gov/ohp/cbi

Ohio | Department of Job and Family Services

FACT SHEET

Children's Buy-In Program

Ohio's Children's Buy-In (CBI) program is a state-funded health care program for certain uninsured children in families with income over 300 percent of the federal poverty level (FPL). Applications for CBI are now being accepted, with enrollment beginning June 1, 2008. The program was created as part of Governor Strickland's plan to "Turnaround Ohio," to provide more uninsured Ohioans with access to affordable health care.

Who is Eligible?

- Children younger than 19 years of age
- Must be a U.S. citizen and an Ohio resident
- Family's household income must be more than 300 percent FPL (see chart below for minimum income level requirements)
- Child must have been uninsured for the previous six months

In addition...

The child must meet at least one of the following criteria:

- Unable to obtain insurance coverage due to a preexisting condition
- Lost the only available insurance coverage because of a lifetime benefit limitation
- Cost of the only available insurance is more than twice the premium for CBI
- Child participates in the Ohio Department of Health's Program for Medically Handicapped Children (also known as "BCMH")

What Health Services are Covered?

CBI services include medically necessary:

- physician office visits and immunizations
- inpatient and outpatient hospital services
- emergency room and urgent care services
- prescription drugs based on a limited formulary
- mental health and substance abuse services
- ancillary services, including durable medical equipment, home health care, laboratory work, radiology services and ambulance use
- limited nursing home care
- case management

CBI Income Guidelines

Family Size	Annual Income
2	$43,710
3	$54,930
4	$66,150
5	$77,370
Based on 300% FPL for 2009	

Once a child is found eligible for CBI, benefits will be administered by CareSource, a managed care plan, through a network of contracted health care providers throughout the state.

Continued

What Costs are Involved?

Families with children enrolled in the CBI program will be required to pay monthly premiums for each child enrolled. Depending on their income, some families will be eligible to pay a reduced premium amount subsidized with state funds. The amount of the insurance premium depends on the size of the family and household annual income. Once a child is found eligible, a billing statement will be mailed each month indicating the premium amount. An annual deductible, co-payments and coinsurances are also required for each child. See chart below.

Household Size	Household Annual Income	Household Annual Income	Household Annual Income
2	$43,710 - $58,279	$58,280 - $72,8499	$72,850+
3	$54,930 - $73,239	$73,240 - $91,549	$91,550+
4	$66,150 - $88,199	$88,200 - $110,249	$110,250+
5	$77,370 - $103,159	$103,160 - $128,949	$128,950+
Monthly Premium per Child	$290.58	$435.86	$581.15

How Do I Apply?

Applications will be accepted starting April 1, 2008, on a secure Web site. Applicants will be required to have active email accounts to complete the application process.

Parents or legal guardians may apply for their children if they live in the same household. Once an account is created, the applicant will be asked for information to determine the child's eligibility. (For example, applicants will be asked for social security numbers, telephone numbers, and income and insurance information of everyone in the household.)

Eligible applicants will be given information about associated costs to enroll their child/children. Once the premium is paid in full, the child can be enrolled in the program and begin accessing benefits.

For additional information about CBI, please visit **www.jfs.ohio.gov/ohp/cbi** or call 1-877-872-8042.

Ohio | Department of Job and Family Services

FACT SHEET

Medicaid Buy-In for Workers with Disabilities

Background

The federal Ticket to Work and Work Incentives Improvement Act of 1999 allows states to provide Medicaid to workers with disabilities. Historically, people with disabilities were often discouraged from working because their earnings and resources made them ineligible for Medicaid health coverage. On June 30, 2007, House Bill 119 was signed into Ohio law creating the Medicaid Buy-In for Workers with Disabilities (MBIWD) program. Enrollment in the MBIWD program began April 1, 2008.

What is MBIWD?

MBIWD is an Ohio Medicaid program that provides health care coverage to working Ohioans with disabilities. MBIWD was created to encourage Ohioans with disabilities to work and still keep their health care coverage.

Who is eligible?

To qualify for MBIWD, a person must:

- Be a U.S. citizen or meet citizenship requirements;
- Be a resident of Ohio;
- Be 16 to 64 years old;
- Have a disability as defined by the Social Security Administration (SSA) or be eligible under the MBIWD medically improved category;
- Be employed in paid work (includes part-time and full-time work);
- Pay a premium (if applicable);
- Meet certain financial criteria.

Financial Eligibility Criteria

Income and resources (e.g., cash, stocks, bonds) are used to determine eligibility for MBIWD. The following financial criteria must be met for MBIWD:

- After income deductions, the applicant's annual income must be less than or equal to 250% of the federal poverty level (FPL) (currently $27,084);
- Resources must not exceed $10,580. (This resource limit is adjusted annually.)

Applicants with annual income greater than $27,084 should still apply for MBIWD because certain deductions are given.

Premiums

Monthly premiums are required for those eligible for MBIWD with an annual gross income greater than $16,248 (150% FPL). These enrollees will be sent a monthly statement with the monthly premium amount. To obtain and maintain health coverage, the full amount of the premium must be received by the due date or it will be considered a non-payment. Late payments will be applied to the most delinquent premium. Those who do not pay their premium for two consecutive months will be subject to MBIWD termination. To re-enroll in MBIWD, an individual must pay all MBIWD delinquent premiums and meet eligibility requirements.

Continued

Medicaid Buy-In for Workers with Disabilities

How are premiums calculated?

Premiums are determined through a set of calculations based on income, family size, and certain standard deductions (e.g., health insurance premiums, impairment-related work expenses, etc.). Individuals should direct questions about standard deductions or their premium calculation to their caseworker.

Frequently Asked Questions

How do applicants apply?

Applicants who are new to Medicaid should complete forms **JFS 07200 and JFS 07211** (available online: http://jfs.ohio.gov/OHP/consumers/Application.stm). Existing Medicaid consumers interested in MBIWD should contact their caseworker or the Medicaid Consumer Hotline: 1-800-324-8680. No face-to-face interview is required for this program.

Can MBIWD consumers receive long-term care and waiver services (e.g., nursing home services, assisted living, etc.)?

Yes. Consumers are permitted to receive long-term care and waiver services while enrolled in MBIWD.

Do MBIWD consumers have to pay a Spenddown?

No. There is no Spenddown for those enrolled in MBIWD.

What happens if an MBIWD consumer loses disability status?

If an MBIWD consumer loses disability status, he/she may continue to receive health care coverage through MBIWD's medically improved category. To qualify for the medically improved category, consumers must meet certain conditions. Ask a caseworker for more information.

What happens if an MBIWD consumer loses his/her job?

MBIWD consumers that lose their job will have up to six months of MBIWD coverage if they meet certain conditions. (Please note: Premiums are based on the MBIWD consumer's income. If there is a reduction in income, there will also be a reduction in the premium amount.)

For more information about this program, please contact 1-800-324-8680 (voice) or 1-800-292-3572 (TTY) or visit **www.jfs.ohio.gov/ohp/consumers**.

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Home and Community Based Services Waivers: ODJFS & DoDD

Summary

Medicaid Home and Community Based Services (HCBS) waivers allow participants with disabilities to have more control of their lives and remain active members of the community by providing alternatives to institutional long term care.

The Ohio Department of Job and Family Services (ODJFS) provides funding for all waiver programs within Ohio Medicaid and administers three of programs including; the Ohio Home Care Waiver, Transitions MR/DD Waiver, and the Transitions Carve-Out Waiver.

The Ohio Department of Developmental Disabilities (DoDD) manages the Level One Waiver as well as the Individual Options (IO) Waiver.

Sources

R.C. 5101.35 (Appeal process with ODJFS)
R.C. 5126.042 (DD Waiting Lists)

O.A.C. 5101:1-39-23 (Income criteria for HCBS waivers)
O.A.C. 5101:1-39-24 (Patient liability)
O.A.C. 5101:3-3-07 (Intermediate Level of Care)
O.A.C. 5101:3-41-12 (Prior Authorization)
O.A.C. 5101:3-46-07 (Waiver Enrollment & Waiting List)
O.A.C. 5123:2-8 (Level One Waiver)
O.A.C. 5123:2-9 (HCBS Waiver Services)
O.A.C. 5123:2-13 (Individual Options Waiver)

Definitions

"Intermediate Care Facility for the Mentally Retarded (ICF/MR) Level of Care" means there is a presence of a developmental disability and the individual's needs assistance for economic independence, communication, capacity for independent living and personal care.

"Skilled Level of Care" means that an individual's condition requires medical care beyond what is provided for individuals with intermediate or ICF-MR levels of care.

- the individual requires daily skilled services for an unstable medical condition having either complications or complex treatments
- Skilled services must be performed by a nurse or therapist

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Basic Financial Eligibility for HCBS waivers

The County Departments of Job and Family Services determine financial eligibility for waivers. Financial eligibility is complex and should be reviewed by a knowledgeable individual before any final decisions. The following summary is condensed to show some of the basic concepts which the JFS workers will be considering.

Parent income is not counted for minor children who qualify for the waivers.

Assets cannot exceed $1,500.

The "special income level" is used to compute income for HCBS waiver recipients. The special income level is equal to 300% of the current SSI payment standard for an individual. The SSI payment standard for an individual in 2010 is **$674.00**. Therefore, in 2010, the special income level is **$2,022.00**.

If income exceeds the Special Income Level, there are certain exemptions and disregards which may apply. Individuals found eligible under spenddown provisions are not eligible for HCBS waiver programs.

Individuals with income between $1,315 and $2,022 will be subject to Patient Liability. Amounts are determined under O.A.C. 5101:1-39-24.

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ODJFS WAIVERS

The Ohio Home Care (OHC) waiver is designed for people age 59 or younger to meet the home care needs of consumers whose medical condition and/or functional ability would qualify them for Medicaid coverage in a hospital or nursing home. The services include:

- Adult day health
- Emergency response
- Home-delivered meals
- Home modifications
- Out of home respite
- Personal care aide
- Supplemental adaptive and assistive devices
- Waiver nursing

The Transitions MR/DD waiver contains identical services and benefits included in the OHC waiver but serves consumers who were transferred from the OHC waiver program because they were identified as having an ICF/MR level of care.

The Transitions Carve-Out waiver consists of all the benefits included in the OHC waiver program. However, it is designed to meet the needs of consumers who are age 60 and over. The eligibility requirements include having either an intermediate or skilled level of care and are not eligible to new enrollees. A participant must first be on the OHC waiver and be "transitioned" due to reaching the age of 60.

Eligibility for ODJFS Waivers

To be considered eligible for the OHC waiver, an applicant must meet specific financial criteria, have an Intermediate or skilled level of care and be age 59 or younger. Transitions MR/DD waivers are available to any age group, however an applicant must meet specific financial criteria, have an ICF/MR level of care and have been on an OHC waiver, or on Core Plus when it closed 7/1/06 or on Department of DD waiver and receiving home health benefits. Transitions carve out waivers are available to individuals age 60 or older and must transfer in from the OHC waiver program.

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DD WAIVERS

The Level One waiver is for people with mental retardation or developmental disabilities who require the care given in an ICF/MR but would prefer to live at home and have a network of family, friends and neighbors who can provide the needed care. There is an annual limit of $5,000 for Level One Services and emergency funds up to $8,000 over a three year period. CMS has approved up to 13,000 Level One waivers.

Level One services include:

- Adult day supports
- Day Array (habilitation)
- Environmental accessibility and adaptations
- Homemaker/personal care
- Personal emergency response system
- Respite (informal and institutional)
- Specialized medical equipment and supplies
- Supported employment (community and enclave) – adaptive equipment
- Transportation (medical and non-medical)
- Vocational habilitation

The Individual Options (IO) waivers allow Medicaid recipients who would normally be required to live in an ICF/MR to stay in their homes and get support. Funding levels are determined by the Ohio Developmental Disabilities Profile ("ODDP"). There are currently 17,500 IO slots approved by CMS.

The services include:

- Homemaker/personal care
- Transportation
- Respite
- Adult Foster Care
- Environmental accessibility modifications
- Social work/counseling
- Nutrition
- Interpreter
- Home-delivered meals
- Adaptive and assistive equipment
- Day habilitation – adult day support
- Habilitation – vocational habilitation
- Supported employment (enclave, community, adapted equipment)
- Non-medical transportation

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Eligibility for DD Waivers

Waivers available through the DD are open to all ages. In addition, in order to be considered eligible for either the Level One or Individual Options waiver an applicant must meet specific financial criteria and have an ICF/MR level of care.

Waiting Lists for Waivers

A waiting list exists for the Ohio Home Care Waiver program administered through the ODJFS. When new spots open on the list, applicants on the waiting list are instructed to re-apply. Priority on the waiting list is given to individuals who are in a nursing home and can be discharged to a community setting and to young children who are hospitalized. All other individuals' "place" on the waiting list is determined based on the date of the individual's waiver application.

County Boards of MRDD have established waiting lists for IO and Level One Waivers. Individuals are selected from a waiting list based on the following criteria; 1) Emergencies, 2) Priorities, and 3) Regular Waiting list. The DD waiting list statute is at R.C. 5126.042.

Appeal Process: ODJFS & DD

If a waiver is denied or if an applicant does not believe the county department of job and family services or the county Board of DD made changes which are not consistent with health, welfare and safety of the individual covered by a waiver, the applicant may request a state hearing with the Bureau of State hearings (866-635-3748) under R.C. 5101.35.

Applicants may also challenge their placement on a waiver waiting list managed by an DD Board by contacting the Ohio Bureau of State hearings at the number listed above or by filing an appeal under O.A.C. 5123:2-1-12.

Disputes about funding levels established by the ODDP for IO waivers are subject to two possible types of appeal. If there are questions about whether the ODDP was properly administered, an appeal can be filed under R.C. 5101.35. If the ODDP was done correctly, but the funding range is not sufficient to protect health and safety of the individual, a request for prior authorization of an amount in excess of the funding range can be filed under O.A.C. 5101:3-41-12

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Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Summary

EPSDT is a federally required Medicaid program. Ohio's version of EPSDT is called Healthchek. It provides a group of services to children and teens (birth through age 20) which include: prevention, diagnosis and treatment. The purpose of Healthchek is to discover and treat health problems early. These services are marketed as Healthchek to parents as a set of preventive health screenings with follow-up diagnosis and treatment.

Sources

42 U.S.C. § 1396d(r) (requirement for EPSDT)
R.C. 5101.35 (Appeal process with ODJFS)

O.A.C. 5101:1-38 (Medicaid Application Procedures)
O.A.C. 5101:1-39 (Medicaid for the Aged, Blind Disabled)
O.A.C. 5101:3-14-03 (Covered Services)
O.A.C. 5101:3-26-05 (Managed Healthcare)
O.A.C. 5101:3-26-08.4 (Managed Healthcare: Member Rights)
O.A.C. 5101:6 (State Hearings)

Overview

EPSDT is a mandatory Medicaid program; if a state elects to participate in Medicaid, it must provide EPSDT services. 42 U.S.C. § 1396d(r). The goal of this program is to provide Medicaid eligible children, from birth through age 21, with necessary health care through the use of periodic checkups and needed corrective treatments. EPSDT covers diagnostic and treatment services for both physical and mental conditions. 42 U.S.C. § 1396d(r)(1)(B). The definition of treatment services is broad, and it includes access to all services that Medicaid covers, whether or not the service is included in a state's Medicaid state plan.[1] 42 U.S.C. § 1396d(r)(5). In short, if the treatment is medically necessary and is available under Medicaid anywhere in the country, a child has the right to the service even if the service is not included in Ohio's state plan.

Ohio's state plan references the EPSDT program and asserts compliance with the Social Security Act provisions governing the EPSDT program, 42 U.S.C. § 1396a(a)(43); 42 U.S.C. § § 1396d (a)(4)(B) and 1396d(r). In practice, however, Ohio's EPSDT program does not at all encompass the breadth and purpose of the federal requirements. It is unclear whether many counties even

[1] Medicaid does not cover payment for room and board, except in in-patient settings such as nursing homes, hospitals or intermediate care facilities.

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have the initial and ongoing screening services which are required to be available state-wide under EPSDT.

Two cases have affirmed the importance of EPSDT services and ruled that ABA programs for children with autism are covered by EPSDT. In *Hummel v. ODJFS,* 164 Ohio App. 3d 776 (Lucas App. 2005), discretionary appeal not allowed by *Hummel v. ODJFS* 2006 Ohio 2226, 2006 Ohio LEXIS 1319 (Ohio, May 10, 2006), the Ohio state court held that ABA services were covered by EPSDT. The court found substantial evidence that ABA is medically necessary for the child and that that ABA is a medical service covered by Medicaid.

In *PLEAS v. Jones-Kelley* U.S. District Court of Ohio, Southern District Case No. 2:08-cv-421 decided on June 30, 2008 (revised July 1, 2008), the Court issues a preliminary injunction prohibiting changes in rules which affected ABA services. The Court relied primarily on the EPSDT requirements. The Sixth Circuit affirmed the grant of preliminary injunction. *PLEAS v. Jones-Kelley* 339 Fed. Appx. 542; 2009 U.S. App. LEXIS 16637 (July 29, 2009).

Appeal Process

Applicants who feel they have wrongly been denied Medicaid coverage have the right to a state hearing with the Ohio Bureau of State Hearings (1-866-635-3748). If an applicant disagrees with the Bureau's decision, they must file an administrative appeal within fifteen (15) days of the decision. Appeals are subject to R.C. 5101.35.

Current recipients of Medicaid have the right to appeal denials of services by their mandated Medicaid Managed Care Provider (MCP). The procedure to file an appeal must be described in the MCP's member handbook and, in Ohio; members are NOT required to exhaust the MCP's appeal process in order to obtain a state hearing. In order to properly file an appeal, it must be made, either verbally or in writing, within ninety days from the date of the MCP's denial of services. If an MCP appeal decision is not resolved wholly in the member's favor, written notice must include information regarding the right to request a state hearing and the right to continue to receive benefits pending a state hearing.

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Title IV-E

Title IV-E was inserted into the Social Security Act by the Adoption Assistance and Child Welfare Act of 1980, 42 U.S.C. § § 670 *et seq.* This law was enacted as a congressional effort to protect children in foster care and to help alleviate foster care drift by creating a comprehensive structure for foster care.

Title IV-E provides for partial reimbursement by the federal government of "foster care maintenance payments" or "FCM's" made by the states. Congress defines FCM's as payments to cover the cost of (and the cost of providing) food, clothing, shelter, daily supervision, school supplies. 42 U.S.C. § 675(4)(A). In the case of institutional care, the term "FCM" includes the reasonable costs of administration and operation of such institution to the extent needed to provide the items described in the previous sentence. *See also,* Ohio Rev. Code § 5101.141(B).

Title IV-E covers the cost of child care institutions that have been approved by the state, provided that the institution has no more than 25 children and is not an institution "operated primarily for the detention of children who are determined to be delinquent." 42 U.S.C. § 672(c).

To be "program eligible" for Title IV-E payments, a child must be in the custody of the local children's service agency at the time the placement was made. Ohio Admin. Code § 5101:2-47-13(A). The child must also be deprived of parental support according to the standards of the 1996 Aid to Dependent Children program. *Id.* A placement is "program reimbursable" when the child is "program eligible," the institution is approved and certified by the ODJFS, the court certifies that placement is in the best interest of the child, the court certifies that reasonable efforts have been made to avoid placement, the child meets the age requirement [under 18 or under 19 and reasonably expected to complete high school, Ohio Admin. Code § 5101:2-47-14(E)(2)], the child continues to be deprived of parental support, and the child has continued financial need. Ohio Admin. Code § 5101:2-47-21(C).

For eligible children, Title IV-E, which covers residential costs, can be combined with Medicaid, which covers medical and rehabilitative services, to completely cover the cost of a residential placement.

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County Department of Job and Family Services

The County Department of Job and Family Services ("CDJFS") is the agency that has assumed the duties of administration of child welfare at the county level. It has primary responsibility for all children who are abused, neglected, dependent, or who are at risk. Its mandate is very broad, and there do not appear to be any limits on the children it can serve or on the scope of services it is required to provide. There is no statutory or regulatory provision which states that the services CDJFS provides should be within the limit of available funds.

Specifically, CDJFS has the following responsibilities with respect to children in the county whom the agency considers to be "in need of public care or protective services":

- Investigate any report that a child is abused, neglected or dependent;
- Enter into agreements with state and county agencies and parents, guardians and other persons or entities having custody of the child, with respect to the care, custody, or placement of a child;
- Accept custody of children committed to the CDJFS by a court exercising juvenile jurisdiction;
- Provide care considered by the CDJFS to be in the best interests of any child adjudicated to be an abused, neglected, or dependent child;
- Provide temporary emergency care for any child considered by the CDJFS to be in need of such care, without agreement or commitment;
- Find foster family homes, within and outside the county, for the care of children, including handicapped children from other counties attending special schools in the county;
- Cooperate with, make services available to, and act as the agent of persons, courts, agencies and other organizations both inside and outside Ohio with respect to matters relating to the welfare of children, except with regard to companionship or visitation rights;
- Implement a system of risk assessment in accordance with rules of the Ohio Department of Job and Family Services, to assist in determining the risk of abuse or neglect to a child.

The CDJFS is responsible to "administer funds provided under Title IV-E of the "Social Security Act," 94 Stat. 501 (1980), 42 U.S.C. A. 671, as amended, in accordance with rules adopted under 5101.141 of the Revised Code." Ohio Rev. C. § 5153.16(A)(14).

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DD Board

The general duties of a county DD Board include administration and operation of facilities, programs, and services as provided by Chapter 5126 of the Revised Code; specific duties are listed in Ohio Rev. Code § 5126.05. DD Boards, in general, offer programs to eligible individuals and their families from birth through retirement; programs can include early intervention, pre-school, school age, employment, recreation, residential, service and support administration, and other similar services in accordance with an individual's service plan.

Many services, particularly residential services, are funded through Medicaid. Medicaid waiver programs, which fund most residential services for individuals with DD, give a great deal of flexibility in choice of residence and provider. When Medicaid funding is available, the DD Board is required to pay for the non-federal match, approximately 40% of the cost.

Services can only be provided to those individuals who have been determined to be developmentally disabled through the OEDI and COEDI. Ohio Rev. Code § 5126.041; OAC § 5123:2-1-02.

With the exception of the duty to develop habilitation plans and service and support administration services, a board's duty to provide services in addition to those listed in § 5126.05 is limited by the availability of funds (Ohio Rev. Code § 5126.051(C)), although the duty to pay Medicaid match is not subject to that qualification.

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ADAMH Board

The Alcohol, Drug Addiction, and Mental Health Services Board ("ADAMH") serves as the community mental health planning agency for the county or counties under its jurisdiction. Ohio Rev. Code § 340.03(A)(1). As such, it must evaluate the need for mental health programs and facilities, set priorities, and submit a yearly plan to the Department of Mental Health identifying, among other things, an allocation request for state and federal funds, and a budget. Ohio Rev. Code § 340(A)(1)(c). The plan is subject to approval, and ADAMH Board eligibility for financial support from the Department of Mental Health is contingent upon an approved plan.

County mental health services boards are not direct service providers. Rather, they have authority to contract with public and private agencies for the provision of mental health services and facilities. Ohio Rev. Code § 340.03. There are two groups of services reimbursed: state funded services, which are listed in Ohio Rev. Code § 340.09[2]; and Medicaid's mental health services, which are services listed in the state's Medicaid plan that may be provided to eligible Medicaid recipients (See discussion in Section II.A above for description of Medicaid's mental health services).

Mental health services listed in the state's Medicaid plan qualify for federal funding, or "federal financial participation" ("FFP") of approximately 60% of the cost of the service. The ADAMH Board is responsible to provide the "match" for the federal funds, which is the remaining 40% (approximately) of the cost of the service.

As noted above, Medicaid's mental health services do not include residential services. However, residential services may be provided with purely state or local funds, subject to the constraints of the plan and budget approval process. In other words, a county mental health board is not required or permitted to fund expensive or unlimited residential placements without approval from the ODMH. Approval would necessitate a commitment from the state agency to provide the funds via the planning and budgetary process.

2 These services are outpatient; inpatient; partial hospitalization; rehabilitation; consultation; mental health education and other preventive services; emergency; research; administrative; referral and information; residential; training; substance abuse; service and program evaluation; community support system; case management; residential housing; and other services approved by the board and the director of mental health.

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IDEA: Duties of Local School Districts

Summary

Children with specified disabilities are eligible for a free, appropriate public education from his local school district under the Individuals with Disabilities in Education Act, 20 U.S.C. §1400 *et seq.*("IDEA") This law entitles handicapped children under the age of 22 who have not yet graduated from high school to specially designed instruction, at no cost to their parents, to meet their unique educational needs. 34 C.F.R. § 300.26(a). A child is entitled to receive services in the least restrictive environment ("LRE"), but where the LRE is a residential school setting, the local school district is required to pay for it. 34 C.F.R. § 300.550.

Under IDEA children who qualify are entitled to "related services" – those services which are required to enable him to benefit from his special education. 34 C.F.R. § 300.24(a). Related services can include such programs as behavior intervention plans, psychological services, and counseling services, including rehabilitation counseling. Related services can include the costs of residential care, even out-of-state residential care, if the service is necessary for the child to benefit educationally from instruction. Lack of adequate funding is not a defense for a school district; if a child needs a related service in order to benefit from an education, the school district must provide the service, regardless of the cost.

There is no central or regional authority which can make decisions for the local school districts in providing individual education programs. Each school district is the sole source of responsibility for children residing in that district. If a child is placed outside of a local school district for education services, the school district of residence is ultimately responsible for costs of that placement. The criteria for determining residence are set forth in Ohio Rev. Code § 3313.64.

Soources

- Individuals with Disabilities Education Act, 20 U. S. C. §1401 *et seq.*
- Federal Regs: 34 CFR Part 300
- State Law: ORC 3323; OAC 3301-51
- Operating Standards and Related Guidance for Ohio Educational Agencies Serving Children with Disabilities (on ODE website)

Appeals

IDEA has detailed requirements and procedures for challenging decisions, either through mediation or due process. The procedures are exclusive and must be followed before any court action can be filed. See 20 USC 1415; 34 CFR 300.500 ff.

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Autism Scholarships

Ohio provides up to $20,000 per year per child to permit families of children with autism to purchase educational services from certified autism providers. The scholarship gives parents a choice of sending their child to a special education program, other than the one operated by their child's school district, to receive the services outlined in the child's individualized education program (IEP).

Essential points of the program include the following (taken from "Autism Scholarship Program Questions and Answers" at the ODE website)

- The parent must enroll their child in their public district of residence if the child is not currently enrolled in the district.
- The child must have a current multifactored evaluation (MFE) which states that the child is eligible for services under the category of autism under the Individuals with Disabilities Education Act (IDEA).
- The child must also have a current Individualized Education Program (IEP) that is finalized and all parties, including the parent, must be in agreement with the IEP. **(The IEP must be written by the district of residence.)**
- There can be no administrative or judicial mediations or proceedings pending with respect to the content of the child's IEP.
- The school district of residence is responsible for developing the MFE and IEP and for processing the application for the autism scholarship.
- The provider selected by the parents must be certified by ODE to provide autism services

Rules for the program are at OAC 3301-103-01. Application forms and other information are available at http://education.ohio.gov. Enter search for "autism scholarship".

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Family and Children First Council

Each county must develop a Family and Children First Council (often referred to as a "Cluster") which must include representatives from the major child services agencies in the county as well as a judge of the Juvenile Court. Ohio Rev. Code § 121.37(B)(1).

In general, a Council/Cluster must review needs of children with multiple needs and identify resources to meet those needs. Ohio Rev. Code § 121.37(B)(2)(a). The Council/Cluster must refer to the state Council those children whose needs cannot be met locally. Ohio law specifically directs the county councils to develop and implement a process "...that annually evaluates and prioritizes services, fills services gaps where possible, and invents new approaches to achieve better results for families and children." Ohio Rev. Code § 121.37(B)(2)(b).

County councils are not funding agencies; rather, they are planning agencies. Each Council/Cluster must develop a service coordination plan providing procedures to designate service responsibilities among the local children's services agencies. Ohio Rev. Code § 121.37(C). The plan shall include all of the following:

- A procedure for assessing the needs of any child;
- A procedure for assessing the service needs of the family of the child;
- A procedure for the development of a plan to designate service responsibilities among the state and local agencies that provide service to children and their families;
- A mandatory local dispute resolution process to resolve disputes among the agencies represented on the county council or local cluster concerning the provision of services to children. The dispute resolution is outlined in Ohio Rev. Code. § 121.38.

A county Council/Cluster must file an annual budget with the county auditor and with the board of county commissioners. Its funding is a combination of contributions from participating agencies, dollars received through gifts in furtherance of the Council's purpose, and grants from the Ohio Family and Children First Cabinet Council, a state level children's council.

Councils are a forum for working out service plans for children with multiple problems, but they and their members are not the only, or the final resource. When their funds are exhausted or unavailable, then the state must take on a greater role

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Supplemental Security Income (SSI)

Summary

Supplemental Security Income (SSI) is a Federal income supplement program funded by general tax revenues, not social security taxes. It is designed to help aged, blind, and people with disabilities that have little or no income. SSI provides money to meet basic needs for food, shelter and clothing.

Sources

42 U.S.C. 1381 (Statement of Purpose)
42 U.S.C. 1381a (Basic Entitlements to Benefits)
42 U.S.C. 1382a – c (Eligibility for Benefits)
42 U.S.C. 1382h (Substantial Gainful Activity)

Services

Approved applicants receive a maximum of $674 a month in supplemental security income for individuals; $1011 for couples.

Eligibility

Individuals who are age 65 or older, blind, or disabled and who have a limited income, limited resources (less than $2,000) and are U.S. citizens or nationals, or are in certain categories of aliens, and is a resident of Ohio are eligible for SSI benefits.

Eligibility for DD services or special education or even a chronic illness like diabetes may not automatically qualify your child for SSI

Definitions

Disabled child means he or she is under 18, has a medically determinable physical or mental impairment which:

- results in marked and severe functional limitations in *two* of six areas of functioning (or *one* "extreme" limitation): acquiring and using information (cognitive/communicative); moving about and manipulating objects (gross and fine motor); interacting and relating with others (social); attending and completing tasks (concentration, persistence, and pace); personal care; and health & well-being.

  and

- has lasted or can be expected to last for a continuous period of not less than 12 months or
- can be expected to result in death.

If a child is working and earning more than $1000 a month, they will be found not to be disabled.

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Certain medical conditions are considered so limiting that SSI will make payments immediately and for up to six months while the state agency decides if your child is disabled. These conditions include, but are not limited to:

- HIV infection with severe symptoms
- Confinement to bed or to a wheelchair
- Total Blindness
- Total Deafness
- Cerebral Palsy
- Down Syndrome
- Muscular Dystrophy
- Severe Mental Retardation
- Birth weight below two pounds, 10 ounces

Disabled adult means an individual who is age 18 or older and has a medically determinable physical or mental impairment which:
- Results in the inability to do any substantial gainful activity; and
- Has lasted or can be expected to last for a continuous period of not less than 12 months or
- Can be expected to result in death.

Substantial Gainful Activity is defined as working and earning over $1,000 gross (before taxes) a month (for 2010).

Limited Income is an amorphous term that the SSA has not assigned an exact dollar amount. Income includes:
- Earned income (wages, earnings from self-employment, certain royalties, and sheltered workshop payments)
- Unearned income (Social security benefits, pensions, state disability payments, unemployment benefits, interest income, child support, cash from friends or relatives)
- In Kind income (food or shelter that is received free or less than its fair market value)
- Deemed income (part of the income of your spouse with whom you live, your parents with whom you live, or your sponsor)

Income is important to SSI determination because the more income a recipient (or spouse or parent) has, the less the SSI benefit will be. Certain income, such as the value of food stamps, income tax refunds and home energy assistance, does not count as income for the SSI program.

Resources include, but are not limited to, things such as:
- Cash, bank accounts, stocks, U.S. savings bonds
- Land
- Vehicles
- Personal property
- Life insurance

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- Anything else that is owned and could be converted to cash and used for food or shelter

Resources do NOT include, among other things:

- The home the applicant lives in and the land it is on
- Household goods and personal effects
- Wedding and engagement rings
- One vehicle, regardless of value, if it is used for transportation for you or a member of your household
- Life insurance policies with a combined face value of $1,500 or less

Resources are important to SSI determination because non-exempt resources valued at over $2,000 owned by the recipient (or spouse or parent) can disqualify the recipient from SSI eligibility. Also, if the recipient is the beneficiary of a trust, the trust may or may not count as a resource depending on its terms.

If an individual is attempting to sell real property or resources that put them over the resource limit, you may be able to get SSI benefits while trying to sell them. However, once you sell the resource you may have to pay back the SSI benefits you received for the period in which you were trying to sell the property or other resources.

Appeal Process

Determinations made by the Social Security Administration, such as eligibility for SSI benefits, the amount of the SSI benefit, and issues of overpayment, may be appealed by an established procedure. The levels of appeal are:

Reconsideration

- A reconsideration must be requested in writing or by filling out Form SSA-561 or SSA-789 within 60 days of the initial determination
- If reconsideration is asked for within 10 days, any payments currently being made will continue until a determination has been reached, provided the applicant's income and resources are not over the limit

Administrative Law Judge Hearing

- If an applicant disagrees with the reconsideration determination, a hearing may be requested in writing or by completing a Form HA-501 within 60 days
- In order for benefits to continue until the hearing, a written request must be submitted
- A hearing may take place in front of a judge or an appellee may request a judgment based on the evidence in the applicant's file

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- Travel costs may be reimbursed for applicants traveling more than 75 miles one way

Appeals Council Review

- A judge's decision may be appealed by requesting an Appeals Council review or by completing a Form HA-520 within 60 days after you get the hearing decision
- Newly obtained evidence may be submitted at this level of appeal.
- An appeals council may decide your case or return it to the judge at the administrative law hearing level for further actions

Federal Court

- If an applicant disagrees with the Appeals Council's decision, he or she may file an action with the local U.S. District Court within 60 days after notice of the Appeals Council action is received
- The federal court will review the evidence and the earlier hearings, but will not conduct another hearing

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Social Security Disability Insurance (SSDI)

Summary

Social Security Disability Insurance (SSDI) provides monetary benefits for people who are found to be totally and permanently disabled and who have also met the non-disability requirements of contributing to the Social Security Trust Fund through tax on their earnings. Social Security does not give benefits to individuals with partial or short term disabilities.

Sources

42 C.F.R. 401 - 434

Services

SSDI provides approved individuals, and in some cases member of their family, monthly payments based upon their average lifetime earnings. Unlike Supplemental Security Income (SSI), a poverty program which gives the person with disabilities a maximum of $674 per month in 2010), there is no fixed amount for SSDI payments. For example, a 50 year old individual making $40,000 would receive a payment of approximately $1,196 a month were they qualify. SSDI payments are adjusted for inflation and should be received after a 5-month waiting period from the onset date of disability. Claimants who have under $2,000 in resources may be eligible for SSI during this 5-month waiting period.

Those who are found to be disabled are eligible for Medicare 24 months after receiving their entitlement date.

Eligibility

In order to be eligible for SSDI benefits, an individual must meet the Social Security Administration's definition of disability. Also, the individual must have worked long enough and recently enough to receive the benefits. This is determined by the number of work credits an individual has accumulated during their work history. Currently, one Social Security work credit is earned for each $1,120 in earned wages, but that dollar amount changes yearly. A maximum of four work credits can be earned annually. Generally, an individual must have accumulated 40 work credits, 20 of those earned in the last 10 years, to qualify for SSDI. Younger workers may qualify even if they have not accumulated the necessary 40 credits. A worker younger than 24 may qualify if they have earned 6 credits 3 years before they became disabled. Individuals aged 24-31 may qualify if they have work credit from half the time between when they turned 21 to the time they became disabled. A worker over the age of 31 must have earned at least 20 of his or her credits in the last 10 years before the onset of disability in order to qualify for SSDI.

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An adult who was disabled before the age of 22 may be eligible to collect SSDI "child benefits," formerly called DAC (Disabled Adult Child) benefits, now known as CDB (Child's Disability Benefits), if a parent is deceased or begins receiving retirement or disability benefits. These benefits are considered "child benefits" because they are based on their parent's social security work record. The "adult child" may not be married (unless married to another individual receiving CDB), must qualify as "disabled" under the SSA's definition of the word regardless of when SSA actually makes that determination, and must not have substantial earnings ($1,000 gross per month as of 2010). The child's monthly benefit is 50% of the parent's primary insurance amount (amount due under Social Security Rules) if the parent is alive; the benefit is 75% of the primary insurance amount if the parent is deceased.

Many adult disabled children with limited resources will qualify for SSI (Supplemental Security Income, a poverty program for adults with disabilities who do not have enough work credits on their own) from age 18 until the time their parent retires, becomes disabled, or dies, at which time they become eligible for CDB on their parent's earnings record, and can draw an amount equal to half the parent's benefit amount (not deducted from the parent's benefit). Therefore, documenting an adult child's disability before age 22 is important, even if they are not receiving SSI in the interim. And it is important for a retiring or disabled parent, or the surviving spouse, to file a claim for benefits for a disabled adult child, even if that child is not living at home by then. Medicare becomes available to CDB beneficiaries after two years, and new CDB beneficiaries still on Medicaid are not subject to an increased Medicaid spend-down.

In Ohio, the Bureau of Disability Determination (BDD) is responsible for determining the medical eligibility of all Ohioans applying for SSDI. The BDD is a federally regulated organization and receives 100% of its funding from the federal government. When determining eligibility, the BDD will examine all relevant medical (and sometimes educational) evidence in order to make its decision. This includes medical evidence from doctors and hospitals as well as clinics or institutions and schools. The initial disability determination process typically takes three to six months. Medical evidence of mental and/or physical impairment is the cornerstone for the determination of a disability. Each claimant is responsible for providing evidence that proves he or she is suffering from a severe impairment. Sometimes BDD will send the claimant to a state doctor called a consultative examiner, but evidence from a treating doctor is supposed to be given the most weight.

Definitions

"Disability" as defined by the SSA is concerned with an individual's ability to work. One will only be determined to be disabled if the individual:

- Cannot do work they did before (within the last 15 years)
- Cannot adjust to other work because of medical condition(s); and
- The severe mental and/or physical disability has lasted or is expected to last for at least one year or to result in death.

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Generally, under guidelines called the Medical-Vocational rules or "Grid rules," the older a worker is (especially for unskilled workers over 50, or over 55), the less vocational adjustment and physical capacity is expected in order to be found disabled. Social Security does not look at whether job openings are actually available in the region, only at whether significant numbers of jobs within the claimant's functional capacity exist in the national economy.

Some people with especially severe impairments may "meet a Listing" (for example, an IQ under 70 plus a bad knee, or an impairment of two limbs, or Crohns' disease so severe that, for example, a 5"7' person weighs 110 lbs.) Those who meet a listing should be granted benefits right away.

Appeal Process

If an application for SSDI benefits is denied for non-medical reasons, like insufficient quarters of coverage in the proper time frame, an applicant should contact the local social security office or contact 1-800-772-1213 to request an appeal.

If an application is denied for medical reasons an applicant has several options in the disability appeals process which must be completed in the order below.

Reconsideration

- An applicant must first complete a Request for Reconsideration and an Appeal Disability Report. These forms may be completed online or on paper and turned into the local Social Security office.
- Social Security will then send the forms to the BDD which will evaluate both old and new medical evidence and make a determination. The applicant will be notified of their decision in writing, usually within three to six months.

Hearing

- If an applicant wishes to appeal a denial upon reconsideration, they must complete a Request for Hearing by an Administrative Law Judge and an Appeal Disability Report. Both forms can be completed online and submitted to Social Security or by paper version and submitted to the local Social Security office.
- These forms will be sent to the Office of Disability Adjudication and Review (ODAR) for evaluation. Because of the severe backlogs and delays in our area (typically over a year), many cases are assigned to judges at the National Hearing Center in Falls Church, Virginia, and the hearing takes place via video teleconference, meaning the judge and claimant see each other on large TV screens.

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- A face to face meeting between the applicant and the judge may be arranged if the applicant so wishes. Appearing at your hearing is generally very important for your case, and it is at this stage where most of the applicants not initially granted their benefits finally prevail.

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Appeals Council Review

- If an applicant disagrees with the results of the hearing, a Request for Review of Decision/Order of Administrative Law Judge must be submitted. This can not be done online.
- A paper version must be signed and sent to the local Social Security office.
- The request will be sent to the Appeals Council where a decision will be made. The Appeals Council may consider new evidence. The applicant will be notified of the decision in writing.

Federal Court

- It is highly recommended an applicant have an attorney at this level of appeal.
- The complaint must be filed against the Commissioner of Social Security in District Court and it will be judged on the paper record, without further in-person hearings by a district court judge or, more commonly, a magistrate..
- The applicant will be notified of the decision in writing.

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Bureau for Children with Medical Handicaps (BCMH)

Summary

The BCMH is a tax-supported health care program in the Ohio Department of Health that has been serving children with special health care needs since 1919. BCMH does not cover all services, only those related to the child's BCMH eligible condition. Eligibility for the program is dependent upon age (birth – 21), residency (U.S. resident who physically resides w/in the state of Ohio and intends to remain indefinitely), and has a medically eligible condition.

Sources

O.R.C. § 3701.022 – Medically Handicapped Children Definitions
O.R.C. § 3701.023 – Program for Medically Handicapped Children

O.A.C. 3701-43-15 – Application and Review Procedures
O.A.C. 3701-43-16 – Financial Eligibility Requirements
O.A.C. 3701-43-17 – Medical Eligibility Requirements
O.A.C. 3701-43-23 – Appeal Procedures

Medical Eligibility

A condition is a medically eligible condition if: 1) the condition has a degree of severity that restricts physical development and is expected to impair health functioning for a period of one year or more or at frequently recurring intervals, 2) the condition is amenable to treatment through treatment services or goods, and 3) the condition either is a neoplasm or a congenital anomaly or affects one or more major body systems

Financial Eligibility

A child may be financially eligible for BCMH services if the family's adjusted gross income is equal to or below 185% of the federal poverty level ($40,792.50 for a family of four as of 2010) rounded up to the nearest $500. If a family's gross income exceeds the guidelines, BCMH will estimate their "ability to pay" for medical services. Service level credit of $500, $1,000, or $2,000 is subtracted from the "ability to pay" amount. If the service level credit plus the amount the family pays for health insurance exceeds their "ability to pay", the family is financially eligible. SSI and Medicaid recipients are categorically financially eligible.

Initial diagnostic services to determine whether an individual suffers from a medically handicapping condition are available free of charge to Ohio residents under age 21, regardless of income. If other benefits (i.e. health insurance, Medicaid, etc.) are available, the family must apply these benefits to the cost of the diagnostic services.

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BCMH does not count personal assets such as a home, car or savings account when determining financial eligibility.

Enrollment

BCMH approved doctor must apply to BCMH. The parent or legal guardian must complete the forms in the income eligibility packet that they receive from BCMH and return all required information to BCMH. Parent, legal guardian or client (18+) must sign the Medical Application for of the Release of Information

Public health nurse can begin the process by referring the child to a BCMH approved provider to treat an eligible condition.

Services

- ***Diagnostic Program***: Children can receive services from BCMH approved providers to rule-out a special health care need, diagnose a condition or develop a plan of treatment.

    - What is covered:
        - Visits to BCMH-approved doctors (M.D. or D.O.)
        - Dental Consults
        - Tests and X-rays
        - Occupational, Physical, and Speech therapy consults
        - Public health nurse services
        - Up to 5 days in the hospital

- ***Treatment Program***: BCMH can cover services by BCMH approved providers to treat an eligible condition. The family must also be financially eligible.

    - Areas of Coverage
        - Days in the hospital
        - Public Health Nurse
        - Hearing Aides
        - Glasses
        - Prescription Drugs
        - Dental Care
        - Medical supplies and equipment
        - Physical, Occupational, Speech therapy
        - Nutrition
        - Surgery and anesthesia
        - Special Formula

    - Eligible Conditions (examples, not exhaustive)
        - AIDS
        - Cancer
        - Cleft lip/palate
        - Cystic Fibrosis
        - Diabetes
        - Hearing Loss
        - Heart defects
        - Sickle Cell Disease
        - Spina Bifida
        - Scoliosis

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        - Excluded Conditions (examples, not exhaustive)
            - Acute, infectious, or common childhood conditions, except to prevent a chronic, physically, handicapping condition
            - Allergies
            - Common malocclusions
            - Learning disabilities
            - Parasitic disabilities

    - Length of Services: Services are authorized for one year. If both medical and financial eligibility are maintained, services may be renewed yearly until the child reaches the age of 21

- ***Service Coordination Program***: Helps parents locate and coordinate the services their child may need. This program does NOT pay for medical services.

    - Areas of Coverage
        - Service coordination services by a hospital based service coordinator and a local public health nurse.
        - Development of a plan by the team service coordinator, public health nurse and the family to meet the needs of the child.

    - Enrollment Process
        - See Above Enrollment process AND
        - Team service coordinator must send a Medical Application form to BCMH

    - Length of Services: Services are authorized for one year. If both medical and financial eligibility are maintained, services may be renewed yearly until the child reaches the age of 21

Appeal Process

BCMH functions under state law and the appeal process is found in the Ohio Administrative Code.

In order to appeal a medical or financial denial of a case or service, BCMH must receive, within ***45 days***:
- A letter from the parent, legal guardian, or client (18+) asking for a reconsideration OR
- A letter from a third party (i.e. child's doctor, public health nurse) with written permission from parent, client or legal guardian asking BCMH to reconsider the denial AND
- Any information that will help BCMH to reach a final decision

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When the needed information is received and reviewed, BCMH may:

- Approve the appeal OR
- Ask for more information OR
- Abide by the original decision to deny the case or service

If the appeal is not approved, the parent, client (18+), or legal guardian has ***30 days*** from the denial date in the letter to challenge the decision with the Ohio Department of Job and Family Service's Bureau of State Hearings. The letter of denial explains, in greater detail, how to request an appeal hearing.

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BASIC GUIDELINES FOR FILING AN APPEAL

Understand the Steps in the Process

Each agency has its own procedure to hear appeals. You need to understand all steps in the process and follow them exactly.

Understand the Issue

Each reviewing agency will decide the appeal based on a clearly defined test. The definition of "disabled, " for example is different for Social Security or SSI coverage, DD services, ADA coverage, or educational services under IDEA.

Follow the Timelines

Failure to meet the timelines can cause the appeal to be dismissed. Timelines are set in the rules for the agency conducting the appeal and will vary among the agencies.

Gather all Facts and Reports

Having complete and accurate facts to present to the reviewing body is essential.

Agencies often refuse to approve benefits or services because the information they need has not been supplied. At times a medical provider did not send the proper record or report. At times the family did not supply the needed information.

If you are seeking reports from health care professionals, they need to understand exactly what kind of report the Agency wants, the issue to be addressed and the supporting information needed.

Organize and Simplify

When you present evidence to the reviewing body, the evidence should be clear, relevant and succinct. The evidence should address the issue under review. Exhibits should be clearly labeled and numbered.

If you bring witnesses, they should understand what the issue is and what role they have in the hearing.

Focus on Fact

Facts and law, not emotion, will be considered by the reviewing agency.

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Should you have a lawyer?

Most administrative appeal procedures are designed to allow persons to appeal without the need for a lawyer. When you have a hearing in front of an administrative law judge or hearing officer, however, you will be better off with a lawyer. A lawyer who is familiar with the process will help to gather the necessary information, put the information in order and present the case in a way which clearly addresses the issues. The agency will frequently have a lawyer presenting the agency's position and parents without lawyers will be at a significant disadvantage.

If you have a difficult case which is likely to go to court, it is especially important to have a lawyer in the administrative hearing. The record developed in the hearing is the record which a court will review. It is difficult to put new information in the record after a hearing, particularly if the evidence was available at the time of the administrative hearing.

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