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OVERVIEW OF PUBLIC BENEFITS AND FUNDING SOURCES FOR PEOPLE WITH DISABILITIES

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Medicaid

"Medicaid" encompasses many different programs administered by the Ohio Department of Job and Family Services (ODJFS) which provide health insurance. All of the programs have income and/or resource eligibility criteria, and for the most part are intended to provide health insurance to families with minor children, people with disabilities, or individuals over 65.

Medicaid for the Aged, Blind, and People With Disabilities ("ABD")

This program is for individuals living in the community; this is not "nursing home Medicaid".

Eligibility

- 65 or older, or legally blind, or disabled
- U.S. Citizen or meet Medicaid citizenship requirements
- Ohio resident
- Social Security Number
- Income of less than 64 percent of the Federal Poverty Limit ("FPL")
    - Individual in 2013: $622/mo
    - Married in 2013: $1,066/mo
- Resources of less than $1,500 if single or $2,250 if married

Medicaid Buy-In for Workers with Disabilities ("MBIWD")

Eligibility

- 16 – 64 years old;
- Disabled as determined by the Social Security Administration or ODJFS, or be eligible under the MBIWD medically improved category
- Employed in paid work (includes part-time work)
- Pay a premium
    - Determined by individual's income
- U.S. Citizen or meet Medicaid citizenship requirements
- Ohio resident
- Social Security Number
- Income of less than 250 percent of the FPL
    - Individual in 2013: $2,394
- Resources of less than $11,148

For more information, visit http://jfs.ohio.gov/ohp/consumer.stm

Healthy Start / Healthy Families

Healthy Start and Healthy Families are Medicaid programs for children, pregnant women and families which fall under the "Covered Families and Children's Medicaid" ("CFC") umbrella. Once eligible for Medicaid, each child (birth through age 20) will have access to an important group of services known as Healthchek.

The application for these programs, Form JFS 07216, is also an application for WIC services, Child and Family Health Services, and to request assistance through the Bureau for Children with Medical Handicaps. A family or child does not need to be disabled to be medically eligible for these programs. Eligibility is based on income; there is no corresponding resource test.

Healthy Start

Also known as SCHIP.

Eligibility

- Uninsured children (up to age 19) in families with income up to 200% of the FPL and pregnant women in families with income up to 200% of the FPL.
    - 2013 figures:
        - Family of 2: $2,585
        - Family of 3: $3,255
        - Family of 4: $3,925
- Insured children (up to age 19) in families with income up to 150% of the FPL.
    - 2013 figures:
        - Family of 2: $1,939
        - Family of 3: $2,442
        - Family of 4: $2,944

Healthy Families

Eligibility

- Families with income up to 90% of the FPL.
    - 2013 figures:
        - Family of 2: $1,164
        - Family of 3: $1,462
        - Family of 4: $1,767
- Families must include a child younger than age 19.

Medicaid for 19 and 20 Year-Olds

Unemancipated individuals who live with their parents or who are temporaily absent from their parents' home are considered to be financially dependent upon their parents and parent income is used in the eligibility determination.

Eligibility

Individuals who are age 19 or 20 years old whose countable income does not exceed the Ohio Works First (OWF) cash assistance payment.
For more information, visit http://jfs.ohio.gov/ohp/consumer.stm

Children's Buy-In

This program was repealed by the Legislature effective 10/1/11. The Legislature is phasing out the program as follows (from the LSC Summary of H.B. 153 as reported by House Finance Committee):

- Suspends new enrollments as of the bill's earliest effective date;
- Repeals the Program-authorizing statutes on October 1, 2011;
- Permits persons enrolled in the Program when it is repealed to continue receiving services through December 31, 2011;
- Requires ODJFS to take steps as necessary to transition persons enrolled in the Program to other health coverage options and otherwise conclude Program operations;
- Permits ODJFS to use appropriated funds to satisfy any claims or contingent claims for services rendered prior to October 1, 2011, and to eligible persons who receive services through December 31, 2011;
- Exempts ODJFS from liability for reimbursing any provider or other person for services rendered on or after June 1, 2013.

Medicare

Medicare is the federal health insurance program for individuals 65 years of age or older, certain individuals with disabilities, and people with End-Stage Renal Disease ("ESRD"). It is administered by the Centers for Medicare and Medicaid Services ("CMS"), under the direction of the Secretary of the United States Department of Health and Human Services ("HHS").

Medicare is not a means-tested program, meaning that eligibility for Medicare is not dependent on a person's income or resources. Medicaid and Supplemental Security Income ("SSI") are examples of means-tested government programs.

However, if an individual is eligible for Medicare because he or she is a recipient of Social Security Disability Insurance ("SSDI" or "SSD"), under a work-incentive program, they may be able to *keep* their Medicare coverage for years even if they lose their SSD benefits, if, despite their disabilities,, they become able to engage in substantial gainful activities ("SGA"). 2013 SGA = $1,040 ($1,740 if blind)

Eligibility

- 65 years or older, end-stage renal disease diagnosis, or SSD or Childhood Disability Benefit recipient
- Pay a premium, if applicable
- Citizen of the United States or legal alien resident for at least five years

For more information, visit www.medicare.gov or www.socialsecurity.gov

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 the Ohio Home Care Waiver and Transitions Carve-Out Waiver.

The Ohio Department of Developmental Disabilities ("DoDD") manages the Level One Waiver, Individual Options ("IO") Waiver, Transitions DD Waiver and Self Empowered Life Funding ("SELF") 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. 5101:3-42 (Level One Waiver – JFS rules)
O.A.C. 5123:2-8 (Level One Waiver – DoDD rules)
O.A.C. 5123:2-9 (HCBS Waiver Services)
O.A.C. 5101:3-40-01 (Individual Options Waiver – JFS rules)
O.A.C. 5123:2-13 (Individual Options Waiver – DoDD rules)
O.A.C. 5101:3-41-17, 5101:3-41-20 (SELF Waiver – JFS rules)
O.A.C. 5123:2-9-40-47 (SELF Waiver – DoDD rules)
O.A.C. 5123:2-9-50 (DoDD administration of Transition DD Waiver)

Definitions

"Intermediate Care Facility for the Mentally Retarded ("ICF-MR") Level of Care" prior to March 18, 2013 meant 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.

Beginning March 19, 2013, "ICF-MR-based level of care" means the levels of care as described in rules 5101:3-3-07, 5101:3-3-15.3, and 5101:3-3-15.5 of the Administrative Code. Ohio Admin. Code 5101:3-3-05(B)(15).

"Skilled Level of Care" prior to March 19, 2013 meant 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

Beginning March 19, 2013, "Skilled Level of Care" will be replaced by Ohio Admin. Code 5101:3-3-08 "Criteria for Nursing Facility-Based Level of Care". In addition to "skilled level of care," this section also replaces "Intermediate Level of Care".

The criteria for the skilled level of care is met when:

- the individual's LTSS needs exceed the criteria for the protective level of care
- the individual's LTSS needs exceed the criteria for the intermediate level of care
- the individual's LTSS needs exceed the criteria for the ICF-MR-based level of care
- the individual requires a minimum of one of the following:
- one skilled nursing service within the day on no less than seven days per week; or
- one skilled rehabilitation service within the day on no less than five days per week.
- The individual has an unstable medical condition

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 2013 is **$710.00**. Therefore, in 2013, the special income level is **$2,130**.

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 $1,385 and $2,130 will be subject to Patient Liability. Amounts are determined under O.A.C. 5101:1-39-24.

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 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 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.

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 funding 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
- 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
- Emergency

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 for Ohio.

IO Waiver services include:

- Homemaker/personal care
- Transportation
- Respite
- Adult Foster Care
- Environmental accessibility modifications
- Social work
- Nutrition
- Interpreter
- Home-delivered meals
- Adaptive and assistive equipment
- Adult day support
- Vocational habilitation
- Supported employment (enclave, community, adapted equipment)
- Non-medical transportation
- Remote Monitoring
- Community Respite

The Transitions DD waiver contains substantially similar 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 DD Waiver began to be managed by DoDD on 1/1/13.

Self Empowered Life Funding (SELF) Waiver was approved by CMS and became available in July 2012.

The SELF Waiver is designed to promote consumer management of at least some part of the services. Overall cost limits: Children (under 22) - $25,000; Adults - $40,000. DoDD is currently predicting to serve up to 500 individuals for the first year, 1000 in year 2, and 2000 by year 3. The SELF Waiver will serve up to 100 children with intensive behavioral needs based on a checklist developed in collaboration with Nisonger.

The DD Board Service and Support Administrators will be responsible for Level of Care assessment, developing service plans and providing a single point of accountability. The Waiver allows families/participants to get the services of an independent Support Broker who will act as agent for the participant. Support Brokers may be paid up to $8,000/yr. except that family members cannot be paid for these services. Participants will also have access to state-wide Financial Management Services to assist in budget and other financial management issues.

To be eligible, the participant or representative must be willing and able to perform the duties associated with participant direction.

Covered services include:

- Support Brokerage
- Functional Behavioral Assessment
- Clinical/Therapeutic Intervention
- Remote Monitoring & Equipment
- Respite: Community & Residential
- Integrated Employment
- Participant/Family Stability Assistance
- Community Inclusion (Personal Assistance, Transportation)
- Participant-Directed Goods and Services
- Adult Day Supports
- Vocational Habilitation
- Supported Employment - Enclave
- Non-Medical Transportation

Eligibility for DD Waivers

Waivers available through the DD are open to all ages. In addition, in order to be considered eligible for any DD 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 DD have established waiting lists for DD 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 believes 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

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)

O.A.C 5101:3-14-01 ff. (Healthchek; EPSDT)
O.A.C. 5101:3-14-05 (Covered Services)

O.A.C. 5101:1-38-05 (County JFS duties for Healthchek/EPSDT)

O.A.C. 5101:3-26-05 (Managed Healthcare)
O.A.C. 5101:3-26-08.4 (Managed Healthcare: Member Rights)

R.C. 5101.35 (Appeal process with ODJFS)
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 20, 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 Federal provisions governing the EPSDT program, 42 U.S.C. § 1396a(a)(43); 42 U.S.C. § § 1396d (a)(4)(B) and 1396d(r).

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

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 January 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).

In *G.D. v. Riley*, U.S. District Court of Ohio, Southern District Case No. 2:05-cv-00980, resulted in a consent decree which addressed methods of ensuring adequate notice of Healthchek benefits. The court is still reviewing the definition of medical necessity.

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.

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. The child must also be deprived of parental support. *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 § 5101:2-47-12 to 22.

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.

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).

County Boards of Developmental Disabilities

Summary

The general duties of a county County Board of Developmental Disability ("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 generally 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 screening instruments known as the OEDI (for adults) and COEDI (for children). Ohio Rev. Code § 5126.041; OAC § 5123:2-1-02. Eligibility requirements vary by age:

Age	Developmental delay or established risk
<3	1
3-6	2

	Substantial Functional Limitation
6-15	3 of 6 major life activities
16+	3 of 7 major life activities

Major Life Activities include:

self-care,
Receptive/ expressive language,
learning,
mobility,
self-direction,
capacity for independent living,
capacity for economic self-sufficiency (16+).

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.

DD Boards may develop waiting lists when resources are inadequate to meet demand. The waiting list statute defines priority groups, with emergencies given ultimate priority.

Sources

O.R.C. Chapter 5126
O.A.C. Chapter 5123

ADAMH Boards

Summary

The Alcohol, Drug Addiction, and Mental Health Services Board ("ADAMH Board") 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/drug/alcohol treatment programs and facilities, set priorities, and submit a yearly plan to the Department of Mental Health and Department of Alcohol and Drug Addiction Services with a summary of services and proposed expenditures for non-Medicaid covered mental health and drug/alcohol treatment services.

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 non-Medicaid mental health/drug/alcohol treatment services and facilities. Beginning on July 1, 2011, ADAMH Boards will not be involved in administration or oversight of Medicaid mental health or drug alcohol services; by July 1, 2013, these services will be under the direct control of the Ohio Department of Job and Family Services.

Sources

O.R.C. Chapter 340

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.

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). 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".

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

Peterson Scholarships

The Peterson Scholarships provide funding up to $20,000 per year for education programs for children with disabilities other than autism. Programs must be provided by approved providers. Rules are at OAC 3301-101-01 et seq. More information at http://education.ohio.gov.

Funding varies depending on the disability:

Speech or language only	$7,196
Specific Learning Disability, Cognitive Disability or OHI-Minor	$7,608
Hearing or Vision Impaired or Severe Behavior Disability	$14,832
Orthopedic Impairment or OHI-Major	$17,902
Multi-handicapped	$20,000
Autism, Traumatic Brain Injury, or Hearing and Vision Impaired	$20,000

Basic Requirements:

- Must have a current IEP approved by the IEP team of the school district of residence and meet specified criteria for eligibility, including type of disability
- There can be no official dispute proceedings between parent and district when initial application is made; disputes will not affect subsequent applications
- Parent must select a certified provider who will apply to the Department of Education on the student's behalf
- Initial applications must be made as follows:
  April 15 - for school terms beginning between July 1 and December 31
  November 15 - for school terms that begin between January 1 and June 30
- Upon approval of the scholarship and acceptance by the parent, the district is no longer responsible for providing education and related services except that the district must provide IEPs and evaluations required under IDEA. The parent has, in effect, withdrawn the child from the district during the time of the scholarship.
- The student is entitled to transportation to alternative program
- Parents are responsible for all costs in excess of scholarship amounts
- Peterson scholarships cannot be used with other scholarships (Autism, educational choice)

Family and Children First Council

General

The Family and Children First (FCFC) system was created by statute on the state and local levels to provide coordination, planning and funding for children with needs beyond the scope of any single public entity. Counties have different structures for implementing the FCFC mandates especially in funding for children with complex needs; some counties create a pool of funds which is used to fund services; others determine allocation of support on a case-by-case basis without a fixed pool. Most FCFC funding is short-term and designed to allow the local systems to devise and implement an adequate local support plan.

State Level

Family and Children First Cabinet Council which includes the Superintendent of Public Instruction and representatives from other Cabinet members who serve children. The Cabinet Council was established "to help families seeking government services … not … to usurp the role of parents but solely to streamline and coordinate existing government services for families seeking assistance for their children." RC 121.37(A)(1). The Cabinet Council has a variety of specific functions, including providing "assistance as the council determines to be necessary to meet the needs of children referred by county family and children first councils." RC 121.37(A)(3)(B). The Family and Children First Cabinet Council has an advisory board to evaluate and guide its operations. RC 127.374.

The cabinet council, upon request from a local Family and Children First Council ("FCFC"), may grant an exemption from any rules or interagency agreements of a state department participating on the council if an exemption is necessary for the council to implement an alternative program or approach for service delivery to families and children. RC 121.31(B)(4)(b).

County Level

Each county must develop an FCFC, which must include representatives from a variety of entities within the county, including the major child services agencies, family representatives who have received services from the FCFC, the largest municipality in the county, and a representative from the County Commissioners. A juvenile court judge acts as judicial advisor. RC 121.37(B)(1).

In general, a local FCFC must "streamline and coordinate existing services for families seeking services for their children." RC 121.37(B)(2). Duties include reviewing needs of children with multiple needs and identifying resources to meet those needs. RC 121.37(B)(2)(a). The local FCFC must refer to the State Cabinet Council those children whose needs cannot be met locally. Ohio law specifically directs the county FCFCs 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." RC 121.37(B)(2)(b).

The FCFC must designate an administrative agent which carries out the daily activities of the FCFC, including "financial stipends, reimbursements, or both, to family representatives for expenses related to council activity." RC 121.31(B)(5)(a)(ii).

Each FCFC must develop a county service coordination mechanism providing procedures to designate service responsibilities among the local children's services agencies, including Help Me Grow programs. The county coordination mechanism shall include elements listed in the statute, including family participation in the development of a family coordination plan and a local dispute resolution mechanism. RC 121.37(C).

Each FCFC must develop a family service coordination plan which, *inter alia:*

- Designates service responsibilities among the various state and local agencies that provide services to children and their families, including children who are abused, neglected, dependent, unruly, or delinquent children and under the jurisdiction of the juvenile court and children whose parents or custodians are voluntarily seeking services;

- Designates a case manager with the family's consent;

- Addresses needs of the family, including crisis situations and safety concerns;

- Diverts children, including unruly children, from Juvenile Court.

RC 121.37(D), (E).

Local Dispute Resolution

Each FCFC must develop a local method for resolving disputes among members. A mandatory local dispute resolution process to resolve disputes among the agencies represented on the county FCFC or local cluster concerning the provision of services to children under jurisdiction of juvenile court or whose parents have requested assistance from the FCFC. 121.37(C)(9).

If an agency on the FCFC is dissatisfied with the results of the local dispute resolution process, the agency may initiate procedures outlined in RC 121.38. Under these procedures,

- A local decision maker defines a plan of care which allocates responsibility for services and/or funding among the member agencies; the decision make must ensure the child is eligible for services from the responsible agency;

- If the agency designated in the plan of care objects to the proposal, the agency may file an action in the juvenile court which has jurisdiction over the child;

- The juvenile court must issue an order "directing one or more agencies represented on the county council to provide services or funding for services to the child" based on the family service coordination plan and other evidence gathered in the process of review.

A family or custodian which is dissatisfied with the results of the FCFC process may initiate local dispute resolution procedures. The FCFC must issue a ruling within 60 days after initiation of the dispute resolution process. RC 121.381. Services or funding must continue during the dispute resolution process. RC 121.382. The statute does not cover appeals by a family to Juvenile Court.

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 adults with disabilities that have little or no income, as well as low-income parents raising minor children with disabilities. SSI benefits, sometimes called Title XVI benefits after the section of the Social Security Act, are designed to provide money to meet basic needs for food, shelter, and clothing, plus ease the financial burdens sometimes associated with special-needs children.

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)
20 CFR 416 & POMS (see info)

Services
Approved applicants receive a maximum of $710 a month (in 2013) in Supplemental Security Income for individuals (adults and children); $1066 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, are eligible for SSI benefits. Disabled minor children under 18 may qualify for Child's SSI if their parents have limited income and assets according to "deeming" rules, under which a parent's income and assets are deemed to be available to the child. Deeming rules also apply to couples where one spouse is disabled. Unlike under the Social Security Disability program, no SSI benefits are available to the minor children of a disabled parent who qualifies only for SSI.

Definitions

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

- meets a "listed impairment," a condition so severe as to deserve approval in short order; or
- 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.

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

Under the "Student Earned Income Exclusion," students under age 22 can exclude $1,700 per month (up to a total of $6,840 per year) for the purpose of qualifying for SSI.

Certain medical conditions are considered so limiting that SSI will make presumptive 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
- Down Syndrome
- Muscular Dystrophy or CP with marked difficulty walking, speaking, using hand and arm
- Severe Mental Retardation (Social Security still uses this term, but is on the verge of adopting "intellectual disability")
- Birth weight below two pounds, 10 ounces-low birthweight or severe prematurity in accordance with a chart.

Disabled adult means an individual who is age 18 or older and has a medically determinable physical or mental impairment which:

- Meets a "listed impairment"
- 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 $1,040 gross (before taxes) a month (for 2013) in the competitive work force. Impairment-related work expenses may reduce earnings below SGA.

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 for 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. Earned income is treated more favorably than unearned income. 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. A minor child's parent's income is deemed available, but an adult child's parent's income is not. At the same time, the SSI benefits of an adult child living in a parent's home may be subject to a reduction reflecting in-kind support and maintenance.

Resources include, but are not limited to, things such as:

- Cash, bank accounts, stocks, U.S. savings bonds
- Land
- Vehicles
- Personal property
- Life insurance
- 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
- Special Needs Trust (drafted and administered in accordance with SSI's rules at the time the trust is scrutinized)

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. Even slight excesses over the resource limit can generate months of overpaid benefits amounting to thousands of dollars. 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 those assets. 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.

Within three years before the SSI application, transferring assets by gift (as opposed to sale) can create a period of ineligibility unless they are transferred to an exempt trust.

Appeal Process

Determinations made by the Social Security Administration, such as benefit eligibility (medical and financial, initial or continuing) and overpayment issues, may be appealed by an established procedure. An applicant or recipient has several options in the disability appeals process which must be completed in the order below.

Reconsideration

- If an applicant disagrees with SSA's initial determination, they must appeal within 60 days by filing a Request for Reconsideration (Form SSA-561) in writing with the local Social Security office or online at www.ssa.gov.
- The Bureau of Disability Determination (BDD) will then gather additional evidence, which may include the report of a consultative examination performed by one of their own doctors, evaluate both old and new medical, educational, and vocational evidence, and make a determination. The applicant will be notified of their decision in writing, usually within three to six months.
- Occasionally, BDD will issue a partly favorable determination, with a disability onset date later than the one the individual claimed. Before automatically appealing such a partly favorable decision, consider this: Do you want to risk your ongoing benefits by filing an appeal? At the next level, the judge is free either to approve the earlier onset date and higher lump-sum of past-due benefits you seek, OR to find you not disabled and not deserving of benefits for any period.
- If an adverse medical determination is made as a result of a continuing disability review, along with the Request for Reconsideration (Form SSA-789), the recipient may wish to file a request for continuation of benefits within 10 days (not 60), so that benefits will continue until final adjudication of the issue at the Administrative Law Judge (ALJ) hearing level. (This option may not be available in cases involving financial issues.) An overpayment may be declared eventually if the individual is found not to be disabled, but they would still have the opportunity to file a Request for Waiver of Overpayment (SSA- 632) if it was not their fault they were overpaid *and* they cannot afford to repay the interim benefits they received while their case was pending.

Hearing

- If an applicant disagrees with the Reconsideration Determination, they must appeal within 60 days by filing a Request for Hearing before an Administrative

Law Judge (HA-501) in writing with the local Social Security office or online at www.ssa.gov.

- If the claim is not granted early, "on the record" without a hearing, the Office of Disability Adjudication and Review (ODAR) will schedule a hearing before an Administrative Law Judge, now often within one year. This is intended to be a non-adversarial proceeding, and no lawyer appears representing the government to oppose the individual's claim. Because of the high volume of claims in our area, several new hearing offices have been opened (Akron & Toledo) and many Cleveland cases are assigned to judges at National Hearing Centers out of state. The NHC hearings take place via video teleconference, meaning the judge and claimant see each other on large TV screens. Medical advisors and vocational experts called to assist the ALJ may participate in person, by VTC, or by phone.
- A face- to-face meeting between the applicant and the judge may be arranged if the applicant so wishes, although such a request may delay the hearing. 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.
- Travel costs may be reimbursed for applicants traveling more than 75 miles one way.
- Most cases are completely electronic, all evidence is stored on a CD or at a secure website, and paper files are rare.
- Many representatives, whether attorneys or non-attorneys, will represent you on a contingent fee basis, 25% of past-due benefits, up to a maximum of $6,000 in 2013.
- SSI past-due benefits can reach back no further than the date of application, while SSD past-due benefits can reach back as far as one year prior.
- Any interim benefits received during the course of the case will stop if the judge issues an unfavorable decision, and an overpayment may be declared.

Appeals Council Review

- Although unlikely, the Appeals Council may reverse or remand a *favorable* ALJ decision in a process called own-motion review. Receiving a Notice of Award, funds by direct deposit, or notice from the local Social Security office about proving financial eligibility for SSI benefits after the hearing – are all signs that the Appeals Council has not disturbed the judge's finding in your favor that you are disabled.
- If an applicant disagrees with an *unfavorable* or partly favorable Administrative Law Judge decision, they must appeal within 60 days, filing a Request for Review of Decision/Order of Administrative Law Judge (Form HA-520) in writing with the local Social Security office. The form is available for downloading but you cannot yet complete this process online.

- The Appeals Council may consider new evidence and will issue a written decision affirming, remanding, or reversing the judge's decision. Again, in part-favorable situations, always ask whether you want to jeopardize the very benefits you just obtained.

Federal Court

- If the applicant disagrees with the Appeals Council's decision, they must appeal within 60 days. It is highly recommended an applicant have an attorney at this level of appeal, although you are permitted to proceed "pro se" on your own.
- 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 affirming, remanding, or reversing the Appeals Council's decision.

Social Security Disability Insurance (SSDI)

Summary

Social Security Disability Insurance (SSDI), sometimes called Title II benefits after the section of the Social Security Act, 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 USC 401-434
20 C.F.R. 404 – 411
POMS https://secure.ssa.gov/apps10/poms.nsf

Services

SSDI provides approved individuals, and in some cases a 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 $710 per month (in 2013), there is no fixed amount for SSDI payments. The average Social Security disability payment to a disabled worker is anticipated to be $1,132 in 2013; a disabled worker with a spouse and one child is expected to receive an average of $1,919. The maximum disability benefit in 2013 is $2,533. SSDI payments are usually 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 their first benefit month.

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 $1,160 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.

Minor children of a disabled wage-earner may, depending on how long and how much the worker contributed to the Social Security system ("family maximum"), receive auxiliary benefits equal to up to 50% of the wage-earner's benefit amount.

An adult who was disabled before the age of 22 may be eligible to collect Title II "child's benefits," formerly called DAC (Disabled Adult Child) benefits, now known as CDB (Childhood Disability Benefits), if a parent is deceased or begins receiving retirement or disability benefits. These benefits are considered "child'sbenefits" 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 Social Security benefits), must qualify as "disabled" under the SSA's definition of the word before age 22, regardless of when SSA actually makes that determination, and must not have substantial earnings ($1,040 gross per month as of 2013). The adult 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, educational, and vocational 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.

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 Crohn's disease so severe that, for example, a 5'7" person weighs 110 lbs.). Those who meet a listing should be granted benefits right away. A new program called "Compassionate Allowance" speeds the process for those with devastating disabilities.

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 who questions the decision or thinks SSA is missing information should contact the local Social Security office, contact 1-800-772-1213 or go online to www.ssa.gov to request an appeal.

The appeal process is the same for SSI and SSDI.

Bureau for Children with Medical Handicaps (BCMH)

Summary

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 listed in the rules. Autism and developmental disabilities are not covered medical conditions.

Financial Eligibility

A child may be financially eligible for BCMH treatment services if the family's adjusted gross income is equal to or below 185% of the federal poverty level ($43, 567.50 for a family of four as of 2013) 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.

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 form and 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. Covered diagnostic procedures include:

    - 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
    - Community nutrition consults

- ***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
        - Cystic Fibrosis
        - Diabetes
    - Hearing Loss
    - Heart defects
    - Sickle Cell Disease
    - Spina Bifida

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

    - 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

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.

Special Needs Trusts

A Special Needs Trust ("SNT") is used when the beneficiary or beneficiaries may need to be financially eligible for means-tested public benefits, e.g., Medicaid or SSI, and/or situations when the beneficiary is unable to manage his or her own finances. SNTs have restrictions on what its funds may pay for in exchange for those funds not counting as income or resources for means-tested public benefits.

The type of SNT depends on whether the assets funding the trust are first-party funds, i.e., assets belonging to the disabled beneficiary, or third-party funds, i.e., assets that never were available to the disabled beneficiary.

The trust may be funded with the beneficiary's own savings, inheritance, personal injury settlement, Social Security backpayment (Medicaid exempts SS backpayments for 6 months; SSI allows for 9 months exemption), wages, gifts, etc.

The trust may also be funded with assets that are owned by anyone other than the beneficiary, such as a parent, other family member, godparent, or friend. The trust may be named as the beneficiary of life insurance, bank accounts, or other assets.

Definitions

"Settlor" or "Grantor" establishes the trust.

- Can be the beneficiary if competent adult, but the only type of special needs trust that is available is the pooled trust.
- If not competent adult, parent/grandparent can apply for pooled trust or appointed guardian can apply to probate court for authorization to establish SNT.

"Beneficiary" is the person who benefits from the trust.

"Trustee" is the person responsible for managing the trust.

- Can be person (a relative, friend, or attorney) or establishment (bank); the beneficiary cannot serve as his or her own trustee.
- Trustee has a fiduciary responsibility to maintain records, provide regular accountings (may be required for SSA, DJFS, or probate court), and act in best interest of beneficiary.
- Disbursement records should include payee, date, and purpose; keep cancelled checks and receipts.

If the SNT pays for food or specific shelter items, then it is likely the beneficiary will be penalized by ODJFS (Medicaid) and SSA (SSI). The payment of food or shelter by a third-party, including a trust, is similar to giving the beneficiary cash, which is unearned income. This is the concept of "in-kind support and maintenance". There are, however, situations where it may be in the beneficiary's best interest to allow the trust to make such payments in exchange for the beneficiary being assessed a spend-down for Medicaid or a reduction of SSI benefits.

First-Party SNT

A person under 65 with a disability who wishes to place his or her assets in trust generally has two options: a Medicaid payback trust or a **pooled** Medicaid payback trust.

A Medicaid payback trust must include a Medicaid payback provision. This type of trust is also known as a d4A, which is a reference to the federal law that provides for this type of trust. It can only be established by a parent, grandparent, guardian, or court.

When the beneficiary dies, the state(s) that provided him or her medical assistance through the state Medicaid program is entitled to be reimbursed from any assets remaining at the beneficiary's death, regardless of the beneficiary's age at the date of death. The trust agreement dictates where any remaining trust assets are distributed. This is different than Ohio's Estate Recovery program, which allows for Medicaid reimbursement from an Ohio Medicaid recipient's estate but only if the decedent is 55 or older.

A pooled Medicaid payback trust, also known as a d4C, is an existing partnership between a non-profit and a corporate trustee. The trust assets are pooled with the assets of other similarly-situated individuals for investment purposes, although each sub-trust is assigned its own account number. It can be established by a parent, grandparent, guardian, court, or competent person with a disability.

When the beneficiary dies, the state(s) that provided him or her medical assistance through the state Medicaid program is entitled to be reimbursed from any assets remaining at the beneficiary's death, regardless of the beneficiary's age at the date of death. The person establishing the pooled trust may name a beneficiary to receive any assets remaining after the death of the beneficiary and repayment to the state(s). A pooled trust can offer the second option of allowing the pooled trust to retain all of the assets upon the beneficiary's death without repaying the state(s) for use by the pooled trust.

Third-Party Special Needs Trust

A special needs trust that contains third-party assets, i.e., assets owned by someone other than the beneficiary, like a parent, grandparent, friend, godparent, sibling, or aunt, is not required to include a Medicaid payback provision. The trust agreement will dictate where the assets are distributed at the beneficiary's death.

It can be established by anyone other than the beneficiary with the disability.

Regardless of the type of trust, the trustee must be aware of general fiduciary rules, state-specific trust codes, Medicaid rules, and Social Security regulations in order to properly administer a trust for a person with a disability.

See Chart 1.

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.

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.