

LONG-TERM SUPPORT MODULE

COMMUNITY OPTIONS PROGRAM

The Community Options Program (COP) is Wisconsin's state funded nursing home preadmission screening and diversion program. In each county, the program is administered by a lead agency. The lead agency can be a human services department, a department of social services, a department of community programs or a joint department of community programs - department of social services, and aging departments.

MA COMMUNITY WAIVERS

The Medicaid Home and Community Based Services waivers permit the use of Medicaid funding to provide home and community based services not ordinarily allowed as state plan services under Wisconsin's Medical Assistance Program (WMAP).

CIP II AND COP-W

CIP II and COP-W provide funding for community services for elderly and physically disabled persons who are relocated or diverted from nursing homes. Some developmentally disabled persons who do not require active treatment may also be served under these waivers.

COMMUNITY INTEGRATION PROGRAM 1A (CIP 1A)

CIP 1A provides funding for community services for persons with developmental disabilities who are relocated or diverted from any of Wisconsin's State Centers for the Developmentally Disabled.

COMMUNITY INTEGRATION PROGRAM 1B (CIP 1B)

CIP 1B provides funding for persons relocated or diverted from ICF/MR facilities other than State DD Centers or from any licensed general nursing home.

BRAIN INJURY WAIVER (BIW)

The Brain Injury Waiver (BIW) provides funding for persons with traumatic brain injuries who are relocated or diverted from nursing home or hospital units designated by the Wisconsin Medical Assistance Program (WMAP) as facilities for brain injury rehabilitation.

CHILDREN'S LONG-TERM SUPPORT WAIVERS (CLTS-W)

CLTS-W are three separate Home and Community Based Services intended to provide support to families with children that have needs associated with developmental disability, physical disabilities, or severe emotional disturbances/mental illness. Services are intended to support continued community living at home with natural families.

ICF-MR RESTRUCTURING INITIATIVE

This initiative allows counties to have access to the funds that pay for individuals with a developmental disability in an ICF-MR or nursing home. The county may use the funds available for an individual to continue their residence in the ICF-MR or they may choose to relocate him or her to the community. The county will access community services for the person through the CIP 1B Home and Community Based Waiver. The initiative also restricts admissions to private or county operated ICF-MR facilities.

COMMUNITY OPPORTUNITIES AND RECOVERY (COR) WAIVER

COR provides community services for persons with serious mental illness and co-occurring physical disabilities that are relocated from nursing homes.

COMMUNITY INTEGRATION PROGRAM CIP 1A AND 1B

The Community Integration Program 1A (CIP 1A) provides the option of living in the community and receiving community services. It serves individuals relocated or diverted from any of Wisconsin's three Centers for the Developmentally Disabled. CIP 1A allows the cost of covered home and community based services to be reimbursed by Medicaid. The program uses an individualized service planning process and promotes the integration of persons with developmental disabilities into the life of their communities. CIP 1A promotes the use of independent living arrangements or small residential settings and integrated work or educational sites as the preferred setting for services.

The Community Integration Program 1B (CIP 1B) provides the option of home and community based services to persons with developmental disabilities who would otherwise be served in any type of ICF-MR or nursing home excluding the State Centers for DD. Specifically, CIP 1B serves persons with a developmental disability who were residents of a Intermediate Care Facility for the Mentally Retarded (ICF-MR) other than the Centers for the Developmentally Disabled and relocate to the community or people who are eligible for admission to ICF/MR. CIP 1B is identical to CIP 1A in the types of services covered. Most of the administrative requirements of the program are the same as well.

An individual already living in the community may become a CIP 1A or 1B participant (with the approval of BDDS - Community Integration Specialists [CIS]), if they replace a CIP 1A or 1B participant previously living in the community, who left the program. In CIP 1B an individual living in the community may also enroll in CIP 1B if they receive approval/further service plan by State CIS.

Because CIP 1A and 1B must meet federal (as well as state) reporting requirements under the Medicaid program, the program participant (i.e., the Medicaid eligible individual for whom an individual service plan has been developed) must be reported on the HSRS.

CIP 1A/B also provide various options for waiver participants to manage their own services.

BRAIN INJURY WAIVER (BIW)

The Brain Injury Waiver (BIW) provides funding for the same home and community based services as CIP 1A and CIP 1B but serves only persons who have a brain injury as defined in 51.01(2)(g), Wis. Stats.

Brain injury is defined as any injury to the brain, regardless of age of onset, whether mechanical or infectious in origin, including brain trauma, brain damage and traumatic head injury. It includes injuries that are vascular in origin (CVA or aneurysm) if received by a person prior to his or her attaining the age of 22 years. Brain injury does not include alcoholism, Alzheimer's disease or other infirmities of aging.

In addition, persons must be receiving, or be eligible to receive, post acute rehabilitation services in a nursing home or hospital designated as a special unit for brain injury rehabilitation by the WMAP. The person has as a result of the injury significant physical, cognitive, emotional and/or behavioral impairments, which meet the level of care as defined in the WMAP, prior authorization for admission to a nursing home or hospital designated for brain injury rehabilitation, and which are expected to continue indefinitely. Persons meeting the above criteria will be eligible for the waiver if:

1. The person is in a nursing home or hospital designated as a facility for brain injury rehabilitation by the WMAP, is receiving services under the WMAP and further inpatient rehabilitation is not required, but the person needs a high level of intense and continuous rehabilitation (supervision and services) available under the waiver to reenter the community.

OR

2. The person has been referred for placement in such a facility is MA eligible and meets the level of care for admission, but intensive services under the waiver could be provided in the community in lieu of placement.

Level of care and prior authorization for admission are determined by the Division of Health, Bureau of Health Care Financing.

The BIW covers the same services as CIP 1A and CIP 1B. The BIW must meet federal and state reporting requirements under the Medicaid program and is to be reported on the HSRS.

CHILDREN'S LONG-TERM SUPPORT WAIVERS

Children with long-term support and special health care needs in Wisconsin have available to them a variety of program supports and services. The children's redesign initiative includes three federal home and community based services waivers, as well as coordination with other funding resources such as Family Support and Community Options Programs. There are also related administrative efforts for intake, referral, coordination and quality assurance with the intent to better coordinate supports for children with long-term support and special health care needs.

The new waivers include one for children with a developmental disability, one for children with a physical disability and one for children with severe emotional disturbances or mental illness. Within the DD and MH CLTS Waivers, children with autism have coverage for an intensive in-home autism service that was previously available through the Medicaid State Plan. A child will only be eligible for the specialized service for a three year period but then will be eligible for other ongoing waiver services up to the age of 22.

CLTS-W also provides various options for waiver participants to manage their own services.

REGISTER OF ELIGIBLE APPLICANTS

County agencies are required to register on the Human Services Reporting System applicants of any age who, based on a preliminary review of functional and financial eligibility, are likely to meet the functional and financial eligibility, are likely to meet the criteria for COP or Medicaid waivers participation but who are not yet receiving funding. The purpose of using HSRS to register these applicants is to build a statewide registry containing standardized information that may be used to do effective program planning.

Persons to be entered on this HSRS applicant registry include those who are:

- Currently in an institution and who request COP or Medicaid waivers services; or,
- Currently receiving **no** publicly funded community long-term care services; or,
- Currently receiving **some** publicly funded community long-term care services, but **not** from COP or a Medicaid waiver.

Note: Participants who are already receiving COP or Medicaid waiver funded services are **not** to be placed on this registry.

ICF-MR RESTRUCTURING INITIATIVE

The ICF/MR Restructuring Initiative applies to individuals who have a developmental disability level of care and who resided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or nursing home in 2004.

The ICF/MR Restructuring Initiative provides two fundamental changes: (1) New admission restrictions and corresponding changes in periodic review processes, and (2) Realignment of funding mechanisms and responsibilities, so that funding that currently supports a person in an ICF/MR can follow that person into the community.

COMMUNITY OPPORTUNITIES AND RECOVERY (COR) WAIVER

The Community Opportunities and Recovery (COR) Waiver offers adult persons with serious mental illness and co-occurring physical disabilities a choice of relocation from nursing homes to the community. The COR Waiver includes case management and a mix of recovery focused services appropriate to support this target group. Participant direction of services is a participant option included in four COR Waiver services. A comprehensive assessment will identify the needs of an individual. An individualized plan of care will determine the mix of waiver services to be provided. The plan will include agreed upon mental and physical health services. A backup plan will also be developed during the planning process to ensure supports are available for safety at times of high risk. The array of COR Waiver services are available to complement services available in the state Medicaid plan.

Eligibility for COR will be based on initial and continuing Long Term Care Functional Screen eligibility, a diagnosis of serious mental illness, and the interest and the ability of the individual to live in a community setting. The COR waiver uses the existing financial and functional eligibility processes in place for the Community Options Program Waiver (COP-W) participants. COR does not include those individuals seeking diversion from nursing home placement.

DEPARTMENT OF HEALTH SERVICES

Division of Enterprise Services
F-22018 (Rev. 12/2008)

STATE OF WISCONSIN

SOS Desk (608) 266-9198
Completion of this form meets the requirements of
the State / County contract specified under the
Wisconsin Statutes. S. 46.031(2g).
P.L. 97-35; Federal Regulations: 42 CFR 441

**HSRS LONG-TERM SUPPORT MODULE
MODULE TYPE A**

REGISTRATION - Screen L1 N/U/I/E (Module Key:)											
1 Worker ID		2a Last Name			2b First Name		2c Middle Name		2d Suffix	3 MA Number (10 digits) OR SSN (9 digits)	
4 Client ID		5 Birthdate (mm/dd/yyyy)		6 Sex <input type="checkbox"/> F <input type="checkbox"/> M	7a Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No		7b Race (Circle up to 5) <input type="checkbox"/> A=Asian <input type="checkbox"/> B=Black or African American <input type="checkbox"/> W=White <input type="checkbox"/> I=American Indian or Alaska Native <input type="checkbox"/> P=Native Hawaiian or Pacific Islander			8 Client Characteristics	
9 Level of Care	10 Marital Status	11 Living Arrangement Prior Current People		12 Natural Support Source	13 Type of Movement / Prior Location (Check 1) (Optional for COP assessment, plan, applicant register) <input type="checkbox"/> N=Relocated from general nursing home <input type="checkbox"/> D=Diverted from entering any type of institution <input type="checkbox"/> F=Relocated from ICF / MR facility <input type="checkbox"/> B=Relocated from brain injury rehab unit						
14 Special Project Status		15 County of Fiscal Responsibility	16 Court Ordered Placement <input type="checkbox"/> Y=Yes <input type="checkbox"/> N=No	17 MA Waiver Financial Eligibility Type <input type="checkbox"/> A=Categorically eligible <input type="checkbox"/> B=Categorically financially eligible - special income limit <input type="checkbox"/> C=Medically needy <input type="checkbox"/> D=COP eligible			18 Indicator for Waiver Mandate (Optional for COP assessment, plan, applicant register) <input type="checkbox"/> A=MA Waiver eligible <input type="checkbox"/> B=Not MA Waiver eligible <input type="checkbox"/> C=MA Waiver eligible but exempt				
SERVICES - Screen L2 U/I (Module Key:)											
19 Episode End Date		20 Closing Reason	CIP1A and CLTS-W Only			*Provider Number Required for SPCs: 102 Adult day care 202/01/02 Adult family home 506 CBRF 604 Supportive and service coordination (CIP1A, 1B, BIW, CLTS-W, COR) 711 Residential care apt. complex 896 ICF-MR/NH residents					
			21 Slot Number STATE USE ONLY	22 Start Date STATE USE ONLY	23 End Date						
PGM No	24 SPC/Subprogram	25 Target Group	26 LTS Code	27 Funding Source	28 SPC Start Date		29 SPC End Date		30 Provider Number * Required for some SPCs		31 SPC Review Date mm yyyy
OPTIONAL DATA - Screen 18											
NOTE: Street address, city, state, zip code and county are required for CIP 1A, 1B, BIW and CLTS-W.											
Street Address				City		State	Zip Code		County		Telephone ()
Case Review Date		Diagnosis		Family ID		Local Data		Shaded areas are optional.			

WORKER ID (Field 1)

OPTIONAL

DEFINITION: The worker collecting the Long-Term Support data on the participant.

CODES: Enter the ten digit code identifying the person collecting the data on the participant.

NOTES: Must be 10 numbers. Must be a valid number from the HSRS worker or provider file.

This field may be used for the sorting and distribution of output reports.

NAME - LAST, FIRST, MIDDLE, SUFFIX (Fields 2a-2d)

REQUIRED

DEFINITION: The full legal name of the client. Nicknames, abbreviations or other variations should not be used. Using only full legal name for all clients throughout the state will help to protect the integrity of the unique Client ID number.

CODES: Enter the full legal name of the client. If the client has no legal first name, then enter the word None. If no middle name and/or suffix, leave those fields blank. If more than one middle name, use the first middle name.

NOTES: Must be all letters. Last name limited to 35 letters. First name limited to 25 letters. Middle name limited to 25 letters or blank. Suffix limited to 10 letters or blank. No apostrophes, hyphens, slashes, dashes, spaces between letters within the name, or any other punctuation marks are accepted. Hyphenated names should be written without a hyphen or space between the names.

MA OR SOCIAL SECURITY NUMBER (Field 3)

MA NUMBER REQUIRED IF APPLICABLE

OPTIONAL - SOCIAL SECURITY NUMBER

DEFINITION: The medical assistance identification number or social security number which has been assigned to this client.

CODES: Enter the client's 10 digit medical assistance number, or the 9 digit social security number.

CLIENT ID (Field 4)
REQUIRED - COMPUTER GENERATED

DEFINITION: A unique computer generated identifier for each individual reported on HSRS. Three elements, full legal name, birthdate, and sex produce a fourteen character identifier which bears no resemblance to the client's name.

CODES: Leave blank if none is known to exist for this person.

The ID will be generated and returned to you on the terminal screen. Copy it down or print out the screen. Once the ID number is generated, use it on all future input.

OR

If the ID is already generated, enter the 14 character HSRS Client Identification number - one letter followed by 13 numbers.

NOTES: If a person receiving a LONG-TERM SUPPORT service is already registered on HSRS (on CORE or another Module), you should enter the client ID and skip name, birthdate, sex, Hispanic/Latino indicator and race.

BIRTHDATE (Field 5)
REQUIRED

DEFINITION: Birthdate of the client.

CODES: Enter the 8 digit birthdate of the client using month/day/full year format. Example: June 3, 1980 is 06031980.

NOTES: Must be 8 numbers. Must be prior to the current date. Year must be later than or equal to 1860.

SEX (Field 6)
REQUIRED

DEFINITION: Gender of the client.

CODES: F = Female
M = Male

HISPANIC/LATINO (Field 7a)

REQUIRED

DEFINITION: All persons of Mexican, Puerto Rican, Cuban, Central or South American, or another Spanish culture or origin, regardless of race.

CODES: Y = Yes
N = No

RACE (Field 7b)

REQUIRED

DEFINITION: The race of the client as determined by the participant. Code as many as apply up to all five.

CODES: A = Asian
B = Black or African American
W = White
P = Native Hawaiian or Pacific Islander
I = American Indian or Alaska Native

Asian: All persons having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African American: All persons having origins in any of the black racial groups of Africa.

White: All persons having origins in any of the original peoples of Europe, North Africa or the Middle East.

Native Hawaiian or Pacific Islander: All persons having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. (The term Native Hawaiian does not include individuals who are native to the State of Hawaii by virtue of being born there.)

American Indian or Alaska Native: All persons having origins in any of the original peoples of North, South and Central America.

CLIENT CHARACTERISTICS (Field 8)
REQUIRED

DEFINITION: Describes the client according to selected personal, social and demographic factors that are of interest to the agency. Code as many as apply up to three. Code definitions are in Appendix I.

CODES: Enter up to three codes from the list below that best describe the client.

- 02 Mental illness (excluding SPMI)
- 03 Severe and persistent mental illness (SPMI)
- 04 Alcohol client
- 05 Drug client
- 07 Blind/visually impaired
- 08 Hard of hearing
- 32 Blind/deaf
- 79 Deaf
- 09 Physical disability/mobility impaired
- 10 Chronic alcoholic
- 12 Alcohol and other drug client
- 18 Alzheimer's disease/related dementia**
- 23 Developmental disability - cerebral palsy
- 25 Developmental disability - autism spectrum
- 26 Developmental disability - mental retardation
- 27 Developmental disability - epilepsy
- 28 Developmental disability - other or unknown
- 34 Developmental disability - brain injury - occurred at age 21 or earlier
- 35 Developmental disability - brain injury - occurred after age 21*
- 36 Other handicap
- 37 Fragile/frail medical condition - not for use as first client characteristic
- 55 Frail elderly
- 57 Abused/neglected adults/elder
- 77 Challenging behavior - not for use as first client characteristic
- 86 Severe emotional disturbance
- 87 Prader Willi
- 88 Asperger Syndrome
- 89 Pervasive developmental disorder
- 91 Hurricane Katrina evacuee
- 92 Hurricane Rita evacuee
- 93 Chapter 54/55 adults/elder

For COP, COP-W, and locally matched CIP 1B, the first Client Characteristic is used for monitoring significant proportions.

* For COP purposes, code 35 clients are counted as physical disability.

** For COP purposes, code 18 clients under 65 are counted as physical disability, clients 65 and over are counted as elderly.

**LEVEL OF CARE (Field 9)
REQUIRED**

DEFINITION: The person's level of care as determined from either: a) the rating assigned by the Division of Health to a completed Physician's Plan of Care (PPOC) form; or b) the person's highest eligibility level as determined from the COP functional screen.

CODES:

- 1 = Highest functional screen eligibility is Level I.
- 2 = Highest functional screen eligibility is Level IIA.
- 3 = Highest functional screen eligibility is Level IIB.
- *4 = Meets functional screen special eligibility Level III only. Has physician's diagnosis of Alzheimer's disease or a related disorder.
- *5 = Meets functional screen special eligibility Level III only – special SPMI level or referred from an IMD or does not meet functional Screen Levels I or II.
- *6 = Meets functional screen special eligibility Level III only. Is referred under Interdivisional Agreement 1.67 or has lost level of care eligibility under the waivers.
- 7 = Functional screen Level IV - does not meet any of the above Levels of Care or is grandfathered in with ICF 3, 4 or ICF-MR 4-level of care determination prior to 11/1/83.
- *8 = Has been ongoing COP recipient prior to 1/1/86 and is therefore COP eligible without a level of care determination.
- *9 = Has not had a level of care assigned as yet - level of care will be determined **PRIOR** to service provisions.
- B = Brain Injury.
- **M = DD1A - DD people whose health status is fragile, unstable or Relatively unstable.
- **N = DD1B - DD people requiring considerable guidance and supervision.
- **O = DD2 - Moderately retarded adults with emphasis on skills training.
- **P = DD3 - Mildly retarded with emphasis on refinement of social skills and attainment of domestic and vocational skills.
- R = DD1 - Children
- S = Psychiatric hospital - children
- T = Nursing home - children
- U = Hospital - children

NOTES:

- * Codes 4, 5, 6, 8 and 9 are not waiver eligible codes. Codes M, N, O, and P are for use with LTS codes (Field 26) 1, 4, 8, and R. Codes R, S, T, and U are for use with Children's Waivers only.
- ** Detailed definitions may be found in MA Waiver Manual Appendix G.

MARITAL STATUS (Field 10)

REQUIRED

DEFINITION: The marital status of the client.

CODES:

- 1 = Married
- 2 = Divorced
- 3 = Separated
- 4 = Widow/widower
- 5 = Never married
- 6 = Legally separated
- 9 = Unknown/other

LIVING ARRANGEMENT – PRIOR, CURRENT, PEOPLE (Field 11)

REQUIRED

DEFINITION: **PRIOR AND CURRENT** - The place where the program participant generally resides or resided prior to and during their placement in a long-term support program.

PEOPLE - The relationship of the people who share a dwelling with the program participant during their placement in a long-term support program.

CODES:

PRIOR AND CURRENT

- 06 State mental health institute - not a current living arrangement – may be used for COP assessment, plan, and applicant register
- 07 ICF/MR: not state center - not a current living arrangement - may be used for COP assessment, plan, and applicant register
- 21 Adoptive home
- 22 Foster home - nonrelative
- 23 Foster home - relative
- 24 Treatment foster home
- 27 Shelter care facility
- 30 Person's home or apartment
- 32 State center for developmental disabilities - not a current living arrangement - may be used for COP assessment, plan, and applicant register
- 33 Nursing home - not a current living arrangement - may be used for COP assessment, plan, and applicant register
- 37 Adult family home 1-2 beds
- 38 Adult family home 3-4 beds
- 43 Child group home
- 44 Residential care center (children)

LIVING ARRANGEMENT - PRIOR, CURRENT, PEOPLE (Field 11) – continued

- 50 Brain injury rehab unit - hospital
- 51 Brain injury rehab unit - nursing home
- 60 Supervised community living - not valid for CIP 1, BIW, CLTS-W
- 61 CBRF 5-8 beds
- 63 CBRF independent apartment - not a current living arrangement for CIP 1, BIW, and CLTS-W
- 64 CBRF 9-16 beds - not a current living arrangement for CIP 1, BIW, and CLTS-W
- 65 CBRF 17-20 beds - not a current living arrangement for CIP 1, BIW, and CLTS-W
- 66 CBRF 21-50 beds - not a current living arrangement for CIP 1, and BIW, and CLTS-W. Need department approval for COP, COP-W, CIP II.
- 67 CBRF 51-100 beds - not a current living arrangement for CIP 1, and BIW and CLTS-W. Need department approval for COP, COP-W, CIP II.
- 68 CBRF over 100 beds - not a current living arrangement for CIP 1, BIW, and CLTS-W. Need department approval for COP, COP-W, CIP II.
- 70 Residential care apartment complex - only for COP-W and CIP II participants - may be used for COP assessment, plan, and applicant register
- 98 Other living arrangement - only for COP assessment, plan, and applicant register

PEOPLE

- 05 Living alone
- 09 Living alone with attendant care
- 10 Living with immediate family
- 11 Living with immediate family with live-in attendant care
- 15 Living with extended family
- 16 Living with extended family with live-in attendant care
- 18 Living with others
- 19 Living with others with live-in attendant care
- 90 Transient housing situation

NATURAL SUPPORT SOURCE (Field 12)

REQUIRED

DEFINITION: The social network available to a waiver participant to support them in functioning successfully in the community.

CODES:

- 1 Parent
- 2 Spouse
- 3 Child
- 4 Other relative
- 5 Nonrelative
- 6 None

TYPE OF MOVEMENT/PRIOR LOCATION (Field 13)

REQUIRED - OPTIONAL FOR COP ASSESSMENT, PLAN, AND APPLICANT REGISTER

DEFINITION: Indicates two separate facts about the program participant:

- (1) whether or not the participant was:
 - a. actually a resident of some type of nursing home immediately prior to the start date in the LTS program and moved out of it to reside in the community (relocation); or
 - b. eligible for nursing home admission, was not a recent resident of a nursing home and is reentering the LTS program from the community; and
- (2) for relocation participants only, the type of nursing home or ICF/MR from which the participant initially moved. Do not change this code if the participant merely switches between different waivers. This second factor does not apply to diverted clients.

CODES:

N = The person has been **relocated from a general nursing home** licensed under HFS 132. Do not enter an N if the person was **diverted** from any type of licensed nursing home. (Allowable for COP, COP-W, and CIP2.)

F = The person was **relocated from an ICF/MR facility** licensed under HFS 134 rules also known as a Facility for the developmentally Disabled (FDD).

D = The person was **diverted from entering any type of institution.**

B = The person was **relocated from a brain injury rehabilitation unit** of a hospital or nursing home.

NOTES: ICF/MR facilities are also known as Facilities for the Developmentally Disabled (FDD) and are all licensed under HFS 134. They include the state centers for the developmentally disabled and a distinct ICF/MR unit of a general nursing home.

Nursing homes licensed under HFS 132 rules are general nursing homes. This field is optional for COP Assessment and Plan. It must be entered before COP SPCs can be reported.

SPECIAL PROJECT STATUS (Field 14)

REQUIRED IF APPLICABLE

DEFINITION: Indicates whether the participant is enrolled in one of the programs listed below.

CODES: I = ICF-MR initiative
L = Recipient of a CIP II loan slot

COUNTY OF FISCAL RESPONSIBILITY (Field 15)

REQUIRED

DEFINITION: The county that has financial responsibility for the client.

CODES:

01 Adams	25 Iowa	49 Portage
02 Ashland	26 Iron	50 Price
03 Barron	27 Jackson	51 Racine
04 Bayfield	28 Jefferson	52 Richland
05 Brown	29 Juneau	53 Rock
06 Buffalo	30 Kenosha	54 Rusk
07 Burnett	31 Kewaunee	55 St Croix
08 Calumet	32 La Crosse	56 Sauk
09 Chippewa	33 Lafayette	57 Sawyer
10 Clark	34 Langlade	58 Shawano
11 Columbia	35 Lincoln	59 Sheboygan
12 Crawford	36 Manitowoc	60 Taylor
13 Dane	37 Marathon61	Trempealeau
14 Dodge	38 Marinette	62 Vernon
15 Door	39 Marquette	63 Vilas
16 Douglas	40 Milwaukee	64 Walworth
17 Dunn	41 Monroe	65 Washburn
18 Eau Claire	42 Oconto	66 Washington
19 Florence	43 Oneida	67 Waukesha
20 Fond du Lac	44 Outagamie	68 Waupaca
21 Forest	45 Ozaukee	69 Waushara
22 Grant	46 Pepin	70 Winnebago
23 Green	47 Pierce	71 Wood
24 Green Lake	48 Polk	72 Menominee
		84 Menominee Tribe
		92 Oneida Tribe

COURT ORDERED PLACEMENT (Field 16)
REQUIRED

DEFINITION: Indicates whether or not the client's community placement and initial participation is the result of, and was made pursuant to, a court order under s. 55.06 of Wisconsin Statutes.

CODES: Y = Yes
N = No

MA WAIVER FINANCIAL ELIGIBILITY TYPE (Field 17)
REQUIRED

DEFINITION: The basis of a client's financial eligibility for Medical Assistance.

CODES: A = Categorically eligible
B = Categorically financially eligible - special income limit
C = Medically needy
D = COP eligible (required for applicant register)
N = Non nursing home level of care - not eligible for COP/MA Waiver funds

NOTES: Code D - COP eligible must be used for the applicant register, and must be updated when applicant begins waiver services

INDICATOR FOR WAIVER MANDATE (Field 18)
REQUIRED - OPTIONAL FOR COP ASSESSMENT, PLAN, AND APPLICANT REGISTER

DEFINITION: Documents that a client's eligibility has been reviewed and complied with COP-MA Waiver mandate.

CODES: A = MA Waiver eligible
B = Not MA Waiver eligible
C = MA Waiver eligible but exempt

NOTES: Medicaid Waiver Funds **must** be used in lieu of COP funds to provide services to an individual if that individual is determined to be eligible for waiver services.

EPISODE END DATE (Field 19)
REQUIRED WHEN SERVICES END

DEFINITION: The date on which the person terminated the program and last received services. This date should be entered only if the person's participation in the Long-Term Support Program has terminated.

CODES: Enter an 8 digit date in the format of month/day/full year (mm/dd/yyyy).

CLOSING REASON (Field 20)
REQUIRED WHEN SERVICES END

DEFINITION: The reason why the participant will no longer receive services.

CODES: Enter the two digit code of the appropriate reason for terminating the client's participation.

- 05 Moved out of state
- 06 Died
- 09 Service not available
- 11 Not or no longer income/asset eligible
- 14 Not or no longer level of care eligible
- 21 Services arranged without agency involvement
- 24 Insufficient funds in COP to provide services
- 32 Rejected individual service plan (ISP)
- 35 Private pay/other public funding sources used to pay for service
- 38 Voluntarily declined or terminated services
- 39 Transferred to or preferred nursing home care
- * 41 Transfer to joint lead agency
- 43 Ineligible living arrangement
- 44 Moved out of county/closed on LTS
- 45 Moved out of county/still open on LTS
- 46 Refused to supply needed financial documentation
- 47 Transfer to Pace Program
- 48 Transfer to Partnership Program
- 50 Not eligible - residency requirement (COP only)
- 51 Declined further services due to estate recovery
- 52 Moved to and now resides in DD Center
- 53 Moved to and now resides in ICF-MR
- 54 Moved to and now resides in IMD
- 55 Cannot support safe care plan/behavioral challenges
- 56 Cannot support safe care plan/medical issues
- 57 No formal/informal supports available in community
- 58 County has exceeded CBRF cap
- **60 Transferred to IRIS or Managed Care/Family Care

*Code 41 is used when a county closes an existing wait list client transferred to an ADRC.

**Code 60 is used when an ADRC closes a wait list client.

SLOT NUMBER (Field 21)

STATE ENTERED FOR CIP IA AND CLTS-W

DEFINITION: The unique number for each CIP IA or CLTS-W slot.

CODES: The first four numbers are the reporting unit code. The last four numbers are assigned by the Bureau of Long Term Support - Developmental Disabilities Services.

NOTES: The slot number is assigned and entered by the Bureau of Long Term Support - Developmental Disabilities Services (BLTS-DD).

SLOT START DATE (Field 22)

STATE ENTERED FOR CIP IA AND CLTS-W

DEFINITION: The date the slot is first used by a client who occupies slot.

CODES: Date will be entered by the Bureau of Long Term Support - Developmental Disabilities Services.

SLOT END DATE (Field 23)

REQUIRED FOR CIP IA AND CLTS-W

DEFINITION: The date the slot could no longer be used.

CODES: Enter an 8 digit number in the format of month/day/full year.

NOTES: All waiver SPCs must be closed before slot end date is entered. If the client is moving from one slot to another, the SPC end date should be the same as the new start date. This will assure that no days will be lost because days are calculated by counting the day in but not the day out.

STANDARD PROGRAM CATEGORY/SUBPROGRAM (Field 24)
REQUIRED MONTHLY FOR EACH SERVICE DELIVERED TO THE PARTICIPANT

DEFINITION: The specific program (SPC) which is provided to the client. The subprogram relates to narrower program initiatives if appropriate. Refer to the Medicaid Waivers Manual and DDES numbered memos for what is allowable and definitions. Most are a variation of the HSRS SPC definitions.

NOTE: Certain HIPAA service codes will also be acceptable in place of the SPC code, if you so desire. The HIPAA service code is 5 positions long. The first 3 positions of the HIPAA code should be reported in the SPC field, and the last 2 positions reported in the SPC subcode field. If the HIPAA service code can be cross walked to ONE SPC, we will accept that HIPAA code.

If you are reporting an SPC, then report the unit type for that SPC. Conversely, if you are reporting a HIPAA service code, then report the HIPAA units type. For example: HIPAA code T1002 crosswalks to SPC 710, but the unit type for T1002 is 15 minutes and unit type for SPC 710 is hours. If you report SPC 710, then units should be reported in hours. If you report T1002, then units should be reported in 15 minute increments (e.g., 2 units would be 1/2 hour).

CODES: Enter the 3 digit code and the 2 digit subprogram code if applicable.

COP CODES:

SPC/SUBPROGR CODE	STANDARD PROGRAM CATEGORY NAME	UNITS TO BE REPORTED
095 01	Participant cost share	None
095 02	Refunds, voluntary contributions	None
101	Child day care	Days
102	Adult day care	Hours
103 22	Respite care residential	Hours
103 24	Respite care institutional	Hours
103 26	Respite care home based	Hours
103 99	Respite care other	Hours
104 10	Supportive home care - days	Days
104 11	SHC - personal care/days	Days
104 12	SHC - supervision services/days	Days
104 13	SHC - routine home care services/days	Days
104 14	SHC - chore services/days	Days

STANDARD PROGRAM CATEGORY/SUBPROGRAM (Field 24) – continued

COP CODES – continued

SPC/SUBPROGR CODE	STANDARD PROGRAM CATEGORY NAME	UNITS TO BE REPORTED	
104	20	Supportive home care - hours	Hours
104	21	SHC - personal care/hours	Hours
104	22	SHC - supervision services/hours	Hours
104	23	SHC - routine home care services/hours	Hours
104	24	SHC - chore services/hours	Hours
106	01	Energy assistance	None
106	02	Housing assistance	None
106	03	Housing start-up	None
107	30	Specialized transportation and escort - trips	One way trips
107	40	Specialized transportation and escort - miles	Miles
107	50	Transportation, specialized	Items
108		Prevocational services	Hours
110		Daily living skills training	Hours
112	46	Personal emergency response systems	None
112	47	Communication aids	Items
112	55	Specialized medical supplies	Items
112	56	Home modifications	Projects
112	57	Adaptive aids - vehicles	Items
112	99	Adaptive aids - other	Items
113		Consumer education and training	Hours
114		Vocational futures planning	Hours
202	01	Adult family home 1-2 beds	Days
202	02	Adult family home 3-4 beds	Days
203		Children's foster/treatment home	Days
204		Group home	Days
205		Shelter care	Days
301		Court intake and studies	Hours
401		Congregate meals	Meals
402		Home delivered meals	Meals
403	01	Recreational activities	Hours
403	02	Alternative activities	Hours
403	03	Alternative/other	Items
406		Protective payments/guardianship	None
503		Inpatient stay	None**
506	61	CBRF 5-8 licensed beds	Days
506	63	CBRF independent apartment	Days
506	64	CBRF 9-16 beds	Days
506	65	CBRF 17-20 beds	Days

STANDARD PROGRAM CATEGORY/SUBPROGRAM (Field 24) - continued

COP CODES – continued

SPC/SUBPROGR CODE	STANDARD PROGRAM CATEGORY NAME	UNITS TO BE REPORTED	
506	66	CBRF 21-50 beds - need department approval	Days
506	67	CBRF 51-100 beds -need department approval	Days
506	68	CBRF over 100 beds-need department approv	Days
507	03	Counseling and therapeutic resources - hours	Hours
507	04	Counseling and therapeutic resources-items/se	Items/services
509		Community support	None
510		Comprehensive community services	Days
603	01	COP assessment	Hours
603	02	COP plan	Hours
604		Case management	Hours
605		Advocacy and defense resources	Hours
606		Health screening and accessibility	Hours
610		Housing counseling	Hours
615		Supported employment	Hours
619		Financial management services	Hours
704		Day treatment - medical	Days
705		Detoxification - social setting	None
706		Day services treatment	Hours
710		Skilled nursing services	Hours

** The system calculates the days of service by counting the SPC Start Date, but not the SPC End Date.

NOTES: Provider Number (Field 30) is required for SPCs:
 102 Adult day care
 202/01 Adult family home - 1-2 beds
 202/02 Adult family home - 3-4 beds
 506 CBRF

A reassessment or plan update for ongoing (COP or MA Waiver funded) service participants should be charged to ongoing case management per COP guidelines. COP clients must have an assessment (603/01) and plan (603/02) SPC entered before other service SPCs are reported.

STANDARD PROGRAM CATEGORY/SUBPROGRAM (Field 24) - continued

CIP 1A, 1B, 1B-ICFMR, AND BIW CODES:

SPC/SUBPROGR CODE	STANDARD PROGRAM CATEGORY NAME	UNITS TO BE REPORTED
095 01	Participant cost share	None
102	Adult day care	Hours
103 22	Respite care residential	Hours
103 24	Respite care institutional	Hours
103 26	Respite care home based	Hours
103 99	Respite care other	Hours
104 10	Supportive home care - days	Days
104 11	SHC - Personal care/days (optional)	Days
104 12	SHC - Supervision services/days (optional)	Days
104 20	Supportive home care - hours	Hours
104 21	SHC - Personal care/hours (optional)	Hours
104 22	SHC - Supervision services/hours (optional)	Hours
104 88	Supportive home care - worker room and board	None
106 03	Housing start-up	None
107 30	Specialized transportation and escort - trips	One way trips
107 40	Specialized transportation and escort - miles	Miles
107 50	Transportation specialized	Items
108	Prevocational services	Hours
110	Daily living skills training	Hours
112 46	Personal emergency response systems	None
112 47	Communication aids	Items
112 55	Specialized medical and therapeutic supplies	Items
112 56	Home modifications	Projects
112 57	Adaptive aids - vehicles	Items
112 99	Adaptive aids - other	Items
113	Consumer education and training	Hours
202 01	Adult family home 1-2 beds	Days
202 02	Adult family home 3-4 beds	Days
203	Children's foster/treatment home	Days
402	Home delivered meals	Meals
503*	Inpatient ICF/MR stay	None**
506 61	CBRF 5-8 licensed beds	Days
507 03	Counseling and therapeutic services	Hours
507 04	Counseling and therapeutic services	Consults
604	Support and service coordination/case management	Hours
604 01	Support and service coordination/case management - face-to-face contact (optional)	Hours

STANDARD PROGRAM CATEGORY/SUBPROGRAM (Field 24) - continued

CIP 1A, 1B, 1B-ICFMR, AND BIW CODES:

SPC/SUBPROGR CODE	STANDARD PROGRAM CATEGORY NAME	UNITS TO BE REPORTED
604 02	Support and service coordination/case management - collateral contact (optional)	Hours
604 03	Support and service coordination/case management - face-to-face home contact (opt)	Hours
604 04	Support and service coordination/case management - other contact (optional)	Hours
609*** 10	Consumer directed supports	Days
610	Housing counseling	Hours
615	Supported employment	Hours
619	Financial management services	Hours
706 10	Day services - adult	Hours
706 20	Day services - children	Hours
710	Nursing services	Hours

NOTES:

Provider Number (Field 30) is required for SPCs:

- 102 Adult day care
- 202/01 Adult family home - 1-2 beds
- 202/02 Adult family home - 3-4 beds
- 506 Community based residential facility
- 604 Support and service coordination/case management

- * Inpatient stays exceeding 30 days require closing of all waiver SPCs. If episode contains only waiver SPCs (no COP), then the episode should also be closed. If the client returns for services, reopen the episode by zeroing out the Episode End Date and Closing Reason, and open new SPCs.
- ** The system calculates the days of service by counting the SPC Start Date, but not the SPC End Date.
- *** Only used by county agencies that have an approved Memorandum of Understanding (MOU) with BLTS.

STANDARD PROGRAM CATEGORY/SUBPROGRAM (Field 24) - continued

CIP II, COP-W, AND COMMUNITY RELOCATION INITIATIVE CODES:

SPC/SUBPROGR CODE	STANDARD PROGRAM CATEGORY NAME	UNITS TO BE REPORTED
095 01	Participant cost share/spend down	None
095 02	Refunds, voluntary contributions	None
102	Adult day care	Hours
103 22	Residential respite	Hours
103 24	Institutional respite	Hours
103 26	Respite care home based	Hours
103 99	Respite - other	Hours
104 10	Supportive home care - days	Days
104 11	SHC - personal care/days (optional)	Days
104 12	SHC - supervision services/days (optional)	Days
104 13	SHC - routine home care services/days (opt)	Days
104 14	SHC - chore services/days (optional)	Days
104 20	Supportive home care - hours	Hours
104 21	SHC - personal care/hours (optional)	Hours
104 22	SHC - supervision services/hours (optional)	Hours
104 23	SHC - routine home care services/hours (opt)	Hours
104 24	SHC - chore services/hours (optional)	Hours
106 01***	Energy assistance - when relocating from nursing home	None
106 03***	Housing start-up - when relocating from nursing home	None
107 30	Specialized transportation and escort - trips	One way trips
107 40	Specialized transportation and escort - miles	Miles
107 50	Specialized transportation	Items
110	Daily living skills training	Hours
112 46	Personal emergency response systems	None
112 47	Communication aids	Items
112 55	Specialized medical supplies	Items
112 56	Home modifications	Projects
112 57	Adaptive aids - vehicles	Items
112 99	Adaptive aids - other	Items
114	Vocational futures planning	Hours
202 01	Adult family home 1-2 beds	Days
202 02	Adult family home 3-4 beds	Days
402	Home delivered meals	Meals
503*	Inpatient stay	None**
506 61	CBRF 5-8 licensed beds	Days

STANDARD PROGRAM CATEGORY/SUBPROGRAM (Field 24) - continued

CIP II, COP-W, AND COMMUNITY RELOCATION INITIATIVE CODES:

SPC/SUBPROGR CODE	STANDARD PROGRAM CATEGORY NAME	UNITS TO BE REPORTED
506 63	CBRF independent apartment	Days
506 64	CBRF 9-16 beds	Days
506 65	CBRF 17-20 beds	Days
506 66	CBRF 21-50 beds - need department approval	Days
506 67	CBRF 51-100 beds - need department approval	Days
506 68	CBRF over 100 beds - need department approval	Days
507 03	Counseling and therapeutic resources - hours	Hours
507 04	Counseling and therapeutic resources	Items/services
604	Case management	Hours
604 04	Case management - other contact (optional)	Hours
619	Financial management services	Hours
706	Day services treatment	Hours
710	Skilled nursing services	Hours
711	Residential care apartment complex	Days

NOTES: Refer to the Medicaid Community Waivers Manual for SPC definitions. Most are a variation of the HSRS SPC definitions.

Provider Number (Field 30) is required for SPCs:

- 102 Adult day care
- 202/01 Adult family home - 1-2 beds
- 202/02 Adult family home - 3-4 beds
- 506 CBRF
- 604 Case management
- 711 Residential care apartment complex

- * Inpatient stays exceeding 30 days require closing of all waiver SPCs. If episode contains only waiver SPCs (no COP), then the episode should also be closed. If the client returns for services, reopen the episode by zeroing out the Episode End Date and Closing Reason and open new SPCs.
- ** The system calculates the days of service by counting the SPC Start Date, but not the SPC End Date.
- *** SPC 106/01 and 106/03 are only allowed when Field 13 Type of Movement/Prior Location is coded N - relocated from a general nursing home.

STANDARD PROGRAM CATEGORY/SUBPROGRAM (Field 24) - continued

CHILDREN'S WAIVER CODES:

SPC/SUBPROGR CODE	STANDARD PROGRAM CATEGORY NAME	UNITS TO BE REPORTED	
095	01	Participant cost share	None
103	22	Residential respite	Hours
103	24	Institutional respite	Hours
103	26	Home based respite	Hours
103	99	Respite - other	Hours
104	10	Supportive home care - days	Days
104	11	SHC - personal care/days (optional)	Days
104	12	SHC - supervision services/days (optional)	Days
104	20	Supportive home care - hours	Hours
104	21	SHC - personal care/hours (optional)	Hours
104	22	SHC - supervision services/hours (optional)	Hours
104	88	Supportive home care - worker room and board	None
106	03	Housing start up	None
107	30	Specialized transportation and escort - trips	1 way trips
107	40	Specialized transportation and escort - miles	Miles
107	50	Transportation specialized	Items
110		Daily living skills training	Hours
112	46	Personal emergency response systems	None
112	47	Communication aids	Items
112	55	Special medical and therapeutic supplies	Items
112	56	Home modifications	Projects
112	57	Adaptive aids - vehicles	Items
112	99	Adaptive aids - other	Items
113		Consumer education and training	Hours
202	01	Adult family home 1-2 beds	Days
202	02	Adult family home 3-4 beds	Days
203		Children's foster/treatment home	Days
503*		Inpatient stay	None**
507	03	Counseling and therapeutic services	Hours
507	04	Counseling and therapeutic services	Items/services
512		Intensive in-home autism services	Hours
604		Support and service coordination	Hours
604	01	Support and service coordination/case management - face-to-face contact (opt)	Hours
604	02	Support and service coordination/case management - collateral contact (optional)	Hours
604	03	Support and service coordination/case management - face-to-face home contact (opt)	Hours
604	04	Support and service coordination/case management - other contact (optional)	Hours

STANDARD PROGRAM CATEGORY/SUBPROGRAM (Field 24) - continued

609	20	Consumer and family directed supports	Days
610		Housing counseling	Hours
615		Supported employment	Hours
619		Financial management services	Hours
706	20	Day services - children	Hours
710		Nursing services	Hours

NOTES: Provider ID (Field 30) is required for SPC 604.

* Inpatient stays exceeding 30 days require closing of all waiver SPCs. If episode contains only waiver SPCs (no COP), then the episode should also be closed. If the client returns for services, reopen the episode by zeroing out the Episode End Date and Closing Reason, and open new SPCs.

3** The system calculates the days of service by counting the SPC Start Date, but not the SPC End Date.

REGISTER OF ELIGIBLE APPLICANTS CODES: (Applies to COP and all Medicaid home - community based Waivers)

SPC/SUBPROGR CODE	STANDARD PROGRAM CATEGORY NAME	UNITS TO BE REPORTED
897	Institutional resident	None
898	Receiving no publicly funded ongoing service that is intended to meet the long-term care needs of the individual	None
899	Receiving some publicly funded ongoing service but no COP or Waiver service	None

NOTES: For SPCs 897, 898 or 899 Target Group is optional; LTS Code is not allowed; SPC Start Date is required; and SPC End Date is required when applicant begins COP or Waiver service, or when applicant's name is removed from the county's register. LOC is required for Register of Eligible Applicants SPCs.

ICF-MR RESTRUCTURING INITIATIVE

896	ICF-MR/NH resident	None
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NOTES: Provider Number (Field 30) is required.

STANDARD PROGRAM CATEGORY/SUBPROGRAM (Field 24) - continued

COMMUNITY OPPORTUNITIES & RECOVERY (COR) WAIVER CODES:

SPC/SUBPROGR CODE	STANDARD PROGRAM CATEGORY NAME	UNITS TO BE REPORTED
507 04	Counseling and therapeutic resources	Items/services
604	Case management	Hours
605 01	Benefit counseling	Hours
609 20	Consumer and family directed supports	Days
609 30	Consumer and family directed support	Hours
610	Housing counseling	Hours
619	Financial management services	Hours
706	Day services treatment	Hours
710	Skilled nursing services	Hours
711	Residential care apartment complex	Days

NOTES: Refer to the Medicaid Community Waivers Manual for SPC definitions. Most are a variation of the HSRS SPC definitions.

Funding source MF allowed.

Type of Movement/Prior Location must be coded N.

Provider Number (Field 30) is required for SPCs:

- 102 Adult day care
- 202/01 Adult family home - 1-2 beds
- 202/02 Adult family home - 3-4 beds
- 506 CBRF
- 604 Case management
- 711 Residential care apartment complex

Target Group must be coded 31 for COR SPCs.

TARGET GROUP (Field 25)

REQUIRED

DEFINITION: Indicates the need and/or problem that best explains the primary reason the program participant is receiving this service. Target Group describes why this service is being delivered to the program participant.

CODES: 01 = Developmental disability
 31 = Mental health
 18 = Alcohol and other drug abuse
 57 = Physical or sensory disability
 58 = Adults and elderly (age 65 and over)

NOTES: Only codes 01, 31, and 57 are allowed for children's waivers.

LONG-TERM SUPPORT CODE (Field 26)
REQUIRED

DEFINITION: The long-term support program and/or match source which is funding this service.

CODES:

- 1 = CIP IA
- 2 = CIP II
- 3 = COP waiver
- 4 = CIP IB
- 6 = BIW
- 7 = COP
- 8 = CIP IB - locally matched slot
- B = BIW - locally matched slot
- F = Children's autism - DD
- G = Children's autism - MH
- P = Children's autism PD
- H = Children's long-term support - DD state match
- I = Children's long-term support - DD local match
- J = Children's long-term support - MH state match
- K = Children's long-term support - MH local match
- L = Children's long-term support - PD state match
- M = Children's long-term support - PD local match
- N = Community relocation initiative
- R = CIP 1B - ICFMR
- S = Transfer - sending county cost
- T = COR Community Opportunities and Recovery waiver

NOTES: LTS code S is used by counties who transfer a waiver participant to another county but who retain the obligation to fund some of the person's expenses. Code S will not be allowed with any other active LTS code and will not require a slot assignment. Any costs associated with this code will not be counted as expenditures that result in repayment by the state and will not appear on the L-300. Only the receiving county will report 100% of the waiver expenditures to claim the federal match. The sending county will report only the amount of match that is sent to the receiving county.

FUNDING SOURCE (Field 27)

REQUIRED FOR LTS CODES 8, B, I, K, M

DEFINITION: The source of any non federal funds used to match part or all of the cost of funding waiver covered services.

CODES: CP = COP match funding
CA =Community aids match funding
FS =Family support match funding
RO= Conditional release
FC = ACT-405
AZ = Alzheimer's funding (only allowed with SPC 899)
LO = County tax levy or sales tax
FT = Family Care transfer (only allowed with LTS codes 2, 4)
ND = Nursing home diversion (only allowed with LTS code 2)
MF = Money follows the person (only for LTS codes 1, N, R, T)

SPC START DATE (Field 28)

REQUIRED

DEFINITION: The date service in an SPC was begun.

CODES: Enter the 8 digit date in the format month/day/full year.

SPC END DATE (Field 29)

REQUIRED

DEFINITION: The date service in an SPC was terminated.

CODES: Enter the 8 digit date in the format month/day/full year.

PROVIDER NUMBER (Field 30)

REQUIRED FOR SPCS 102 ADULT DAY CARE, 202/01, 202/20 ADULT FAMILY HOME, 506 CBRF, 604 SUPPORT AND SERVICE COORDINATION (CIP 1A, 1B, BIW, CLTS-W, COR ONLY), 711 RESIDENTIAL CARE APARTMENT COMPLEX (CIP II, COP-W ONLY), AND 896 ICF-MR/NH RESIDENT.

DEFINITION: The number assigned to identify the provider that has delivered the service to the waiver participant.

CODES: Enter the 10 digit HSRS code identifying the provider of the specific SPC. May be either a HSRS provider or worker number.

SPC REVIEW DATE (Field 31)

OPTIONAL

DEFINITION: The date when the next SPC review is due to take place.

CODES: Enter the 6 digit date in the format of month/full year.

UNITS (Field 32)

REQUIRED MONTHLY

DEFINITION: The number of units of service the provider delivered to the client in a specific SPC during the month being reported.

CODES: Enter the 3 digit whole number and 1 decimal place which corresponds to the number of units of service delivered to the client during the time period.

NOTES: The unit measurement corresponds to the unit for the specific SPC. (e.g., Respite Care = Hours.)

COSTS (Field 33)

REQUIRED MONTHLY

DEFINITION: The total expenses of providing specific SPC services to the client during the month being reported.

CODES: Enter up to six whole numbers and two decimal places representing the dollar amount expended for services in the specific SPC.

NOTES: Accurate and timely reporting is necessary as these reports are official audit documentation for federal reimbursement. These data are submitted to the Federal Health Care Financing Administration annually. Monthly reports are also used to make payments to the county agencies.

Monthly costs up to \$9,999.99 are allowed except for the following:
LTS codes 1, 4, 6, 8, B, F, G, H, I, J, K, L, M, P, and R will accept up to \$99,999.99 per month for the following SPCs: 103/24, 103/99, 104/10, 104/11, 104/12, 104/20, 104/21, 104/22, 106/03, 107/30, 107/40, 110, 112/56, 112/57, 112/99, 202/01, 202/02, 203, 506/61 and 609/10.

LTS codes 2, 3, and N will accept up to \$99,999.99 per month for SPCs 112/56 and 112/57.

Costs not allowed for SPCs 503, 896, 897, 898, and 899.

DELIVERY MONTH/YEAR (Field 34)
REQUIRED

DEFINITION: The month and year during which units of an SPC were delivered or costs reported.

CODES: Enter a 6 digit number in the format month/full year.