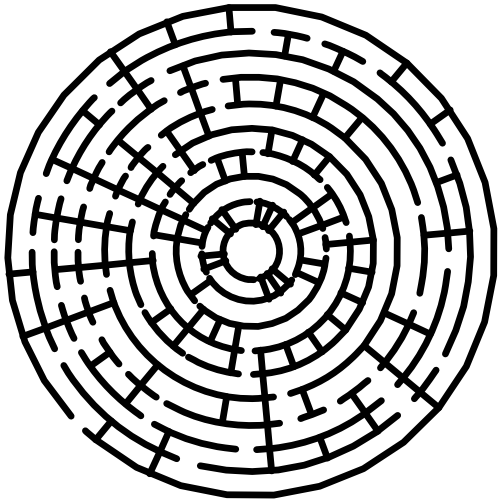
Who Pays?



Taking the *MAZE* Out of Funding

Minnesota Children & Youth with Special Health Needs

MINNESOTA MDH DEPARTMENT OF HEALTH

651-201-3650 OR 1-800-728-5420

www.health.state.mn.us/mcyshn

MCYSHN-9/10
IC 141-1426

Who Pays? Taking the MAZE out of Funding

Goal
The goal of this training is to improve access to care and access to other resources for children, youth, young adults and their families.

Objectives
Maze trainings inform families and professionals about a wide range of potential funding sources using a training manual developed by Minnesota Children & Youth with Special Health Needs (MCYSHN) staff. Content covered in the training is geared towards children, youth and young adults, including, but not limited to, those with special health needs. "Family Stories" are used to illustrate potential situations faced by families when trying to access care and other resources. The objectives for the Maze training are to:

- Compare and contrast the major public and private funding programs including information on eligibility
- Increase awareness of what services and programs are available to individuals and families
- Utilize "Tools" to identify appropriate funding resources
- Learn strategies that will help families and providers obtain the services that are needed

Audience
Parents of children and youth and professionals who work with families are potential audience members. Professionals include: mental health providers, public health nurses, school nurses, social workers, educators, advocates, clinical staff in health care settings, child care providers, financial workers, etc.

Cost
No charge for participants
Participants are encouraged to bring a (3) ring binder to hold the training manual which is distributed at the training.

Length
Sessions may very from 1 hour to 3 ½ hours.
Shorter training updates are available for those who have attended previously.

Updates
The entire MAZE training manual is updated annually and is available on the MCYSHN web site. To receive automatic e-mail notices of any updates to the MAZE training manual, subscribe to the Minnesota Department of Health e-mail Subscription Services by going to www.health.state.mn.us/mcyshn Go to the upper left hand corner of your computer screen and click on, "Subscribe to MCYSHN News."

Contact
MCYSHN district staff provide training opportunities throughout the State. To schedule a training, call the MCYSHN toll free number (1-800-728-5429) or contact MCYSHN district staff directly. (See map with names and contact information).

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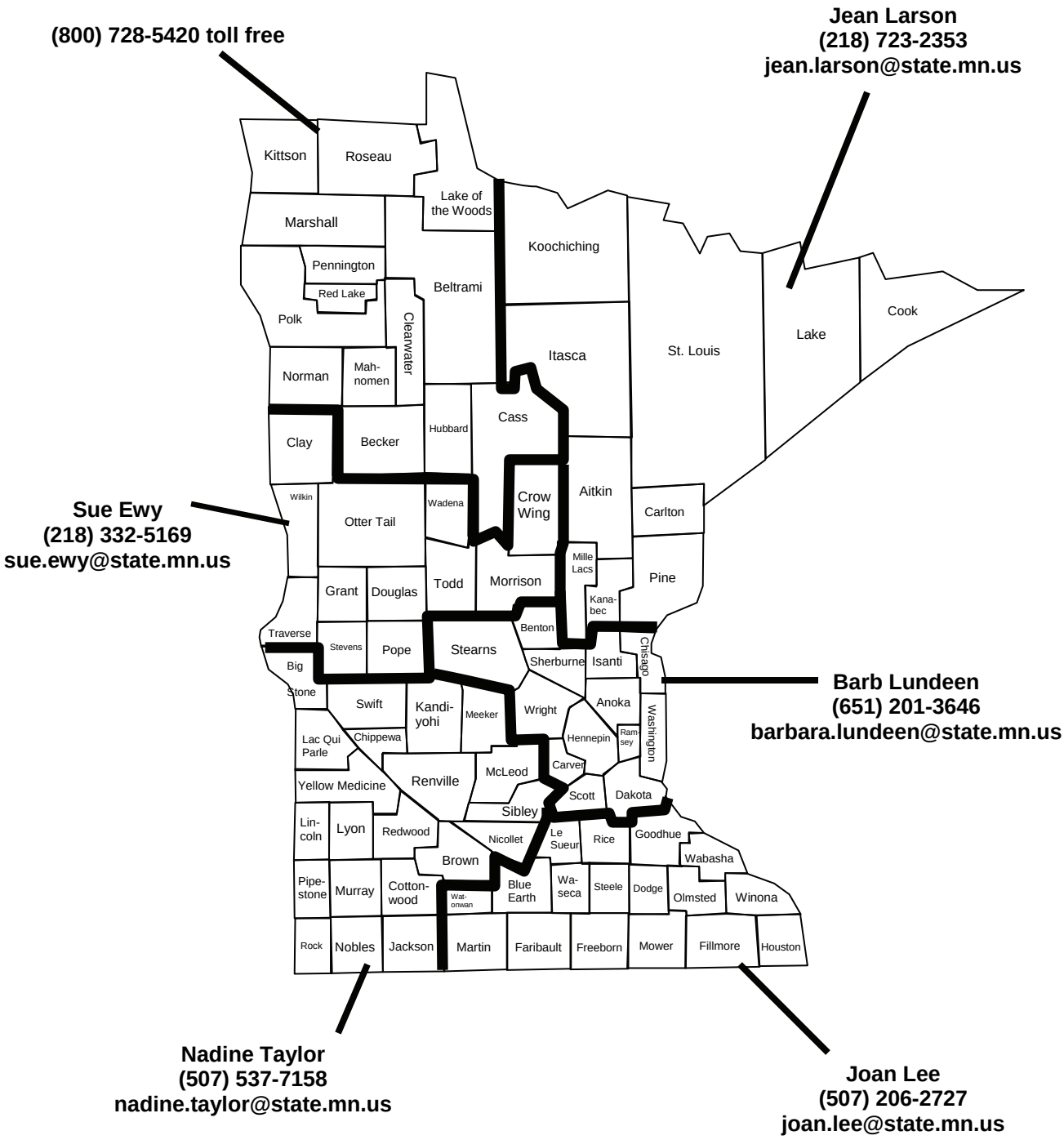
Minnesota Children and Youth with Special Health Needs (MCYSHN)

DISTRICT CONSULTANTS
MINNESOTA CHILDREN AND YOUTH WITH SPECIAL HEALTH NEEDS (MCSHN) STAFF



7/10

Minnesota Children & Youth with Special Health Needs

651-201-3650 or 1-800-728-5420

Who are Children & Youth with Special Health Needs?

Children and Youth with Special Health Care Needs are those children, ages birth to 21, who have or are at risk for chronic physical, developmental, behavioral or emotional conditions and who also require health and related services beyond those that are generally required by children.

In Minnesota, this includes nearly 200,000 children. One in every 5 families with children includes one or more children with special health needs.

Our Mission

To provide leadership through partnerships with families and other key stakeholders and improve the access to and quality of all systems impacting children and youth with special health needs and their families**.**

Programs and Services

For the most complete and up to date resources and information for all of Minnesota Children & Youth with Special Health Needs programs, please visit our website at www.health.state.mn.us/mcyshn

General Information and Assistance Line

Information is available for families, health care providers, public health nurses, teachers, social workers and others looking for help identifying and locating resources for children/youth with special health needs. The service is free and confidential. Knowledgeable staff will return calls during normal business hours.
(800) 728-5420 or (651) 201-3650
health.mcyshn@state.mn.us

District Consultants

District Consultants at Minnesota Children & Youth with Special Health Needs are located throughout the state and are available to assist in assuring access to and quality of services to children and their families. Because they live in the areas they serve, they understand local strengths and needs, and are readily available to help identify resources and problem solve in partnership with agencies and families.

Help Me Grow

Help Me Grow is Minnesota's early intervention program for children ages birth through five who have developmental delays or disabilities. Early childhood specialists will work with eligible children and families to plan the services and supports they need.

Follow Along Program

The Follow Along Program provides free, periodic screening of infants and toddlers to ensure early identification of those at risk for health issues and/or development delays. The program enhances a family's understanding of their child's development so they can meet the needs of their infants and toddlers, as well as know when to ask for help.

Newborn Screening Follow Up

Hospitals in Minnesota and the Minnesota Department of Health partner to screen all babies for rare and serious conditions. Almost every day, a baby is born in Minnesota with a hidden, rare disorder that can be found by newborn screening. These babies seem healthy at birth, but need early medical care in order to prevent complications of the condition such as serious medical issues, developmental delays, or even death if the disorder is not found and managed early.

Newborn hearing screening can find babies before they show delays in speech and language development. Minnesota Children & Youth with Special Health Needs assures that newborns identified through hearing and blood spot screening are connected to the resources their families need.

Suicide Prevention

The Suicide Prevention Program is educational in nature and is part of MDH's public health approach to mental health. The Suicide Prevention Coordinator monitors suicide trends, provides expertise about best practices in suicide prevention, serves as a resource to individuals seeking information, and offers technical assistance with local program development.

Tools

How to apply for Minnesota Health Care Programs (MHCP)

There are three steps to apply for Minnesota Health Care Programs:

- Fill out the application
- Gather the required documents and proofs (see below for more information on these)
- Mail or take your application and proofs to your county office or if you are applying for MinnesotaCare the state office. County and MinnesotaCare addresses and phone numbers are listed in the application.

Where can I get an application?

- Print out an application at the Department of Human Services (DHS) website www.dhs.state.mn.us use search function to find application forms, scroll down to MHCP application. You cannot submit your application on-line.
- Call or go to your county human services office
- Call the Minnesota Health Care Programs Member Help Desk at (651) 431-2670 or (800) 657-3739 and ask to have one mailed to you.

Where can I get help filling out the application?

- Your county office or the MinnesotaCare office in St. Paul (651) 297-3862
- A community organization in your area – a list can be found at: http://edocs.dhs.state.mn.us/lfserver/Public/DHS-5475-ENG
- A family member or friend who can act on your behalf.

What if I am not sure what health care program I should apply for? You can apply even if you are not sure that you are eligible. If you or your child are not sure about your eligibility, you should apply for all programs. You can do this by checking the box "All health care programs" on page 1 of the application. If your child has a chronic health condition check that box on page 3 question #9. Also indicate in this same question if you need help paying for medical bills from the past three months.

Does it matter when I apply? Yes, get your application in as soon as you can or while you are working on the application write your county social service agency regarding your intent to apply, which could be used as the coverage start date. The date your application is received affects when your coverage can start. After you are approved, coverage may:

- Go back to the date your application is received, or
- For Medical Assistance, if you request, it can go back three months from the date your application is received, or
- Begin the month after you are approved, or pay your first premium, if you have one, for the MinnesotaCare program.

What documents and proofs will I need to provide?

- U.S. citizenship and identity
- Immigration status if you are not a U.S. citizen
- Income – pay stubs for all employed family members for the last 30 days and/or your most recent tax form
- Assets if you are applying for family members over age 21

- Other health insurance that you have or could get
- Pregnancy (DHS will give you a form for your doctor to fill out).

What happens after I turn in my application? A worker will review it. Sometimes they may need more information to decide if you are eligible and get coverage for MA or MinnesotaCare. You will get a notice in the mail asking for specific information. If your financial worker needs something be sure to respond as quickly as possible if a time limit is given in the letter.

How will I know if I can get coverage? You will get a notice in the mail telling you:

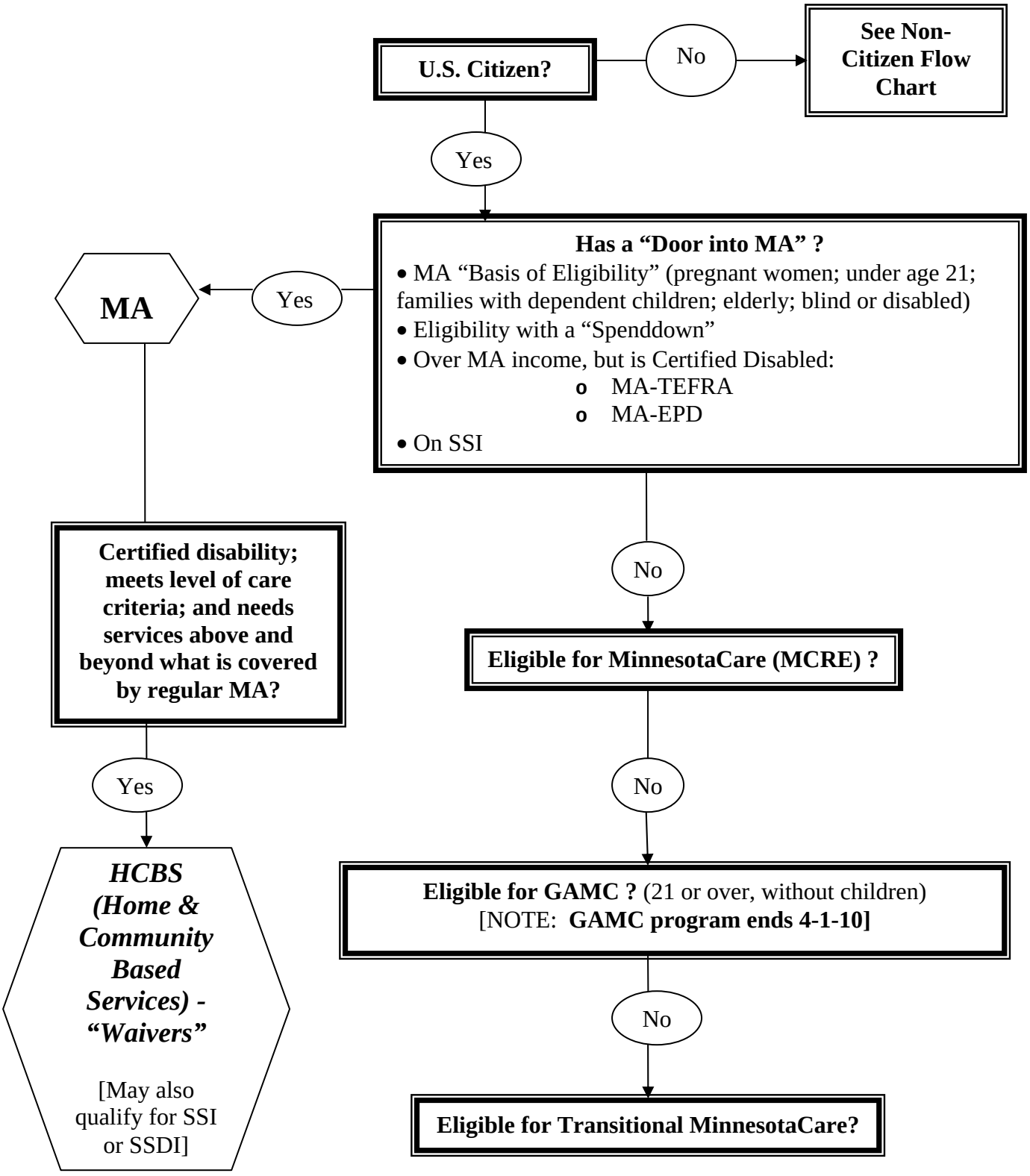
- If you can get coverage and if you will have to pay anything for it.
- If you or any household members cannot get coverage.
- How you can ask for a review of the decision(s) if you do not agree with it.
- If your application is for Medical Assistance (MA) your county agency will let you know if you are eligible for assistance within 45 days (60 days if they need a disability certification; 15 days for pregnant women). If a decision is not made in that time, the county agency will explain why in writing.

Do I need to reapply?

- If you are found eligible for MA the county financial worker will review your situation every six months to see if you are still eligible for health care assistance. You must complete, sign, date and return all forms sent to you by your county agency or you could lose your MA coverage.
- If you are found eligible for MinnesotaCare your eligibility must be renewed every 12 months. When you reapply you will need to account for any changes in circumstances that impact eligibility and premium amount such as income changes, pregnancy or change in the number in the household.

Information from the Minnesota DHS website regarding frequently asked questions about applying for MHCP

FUNDING FLOW CHART



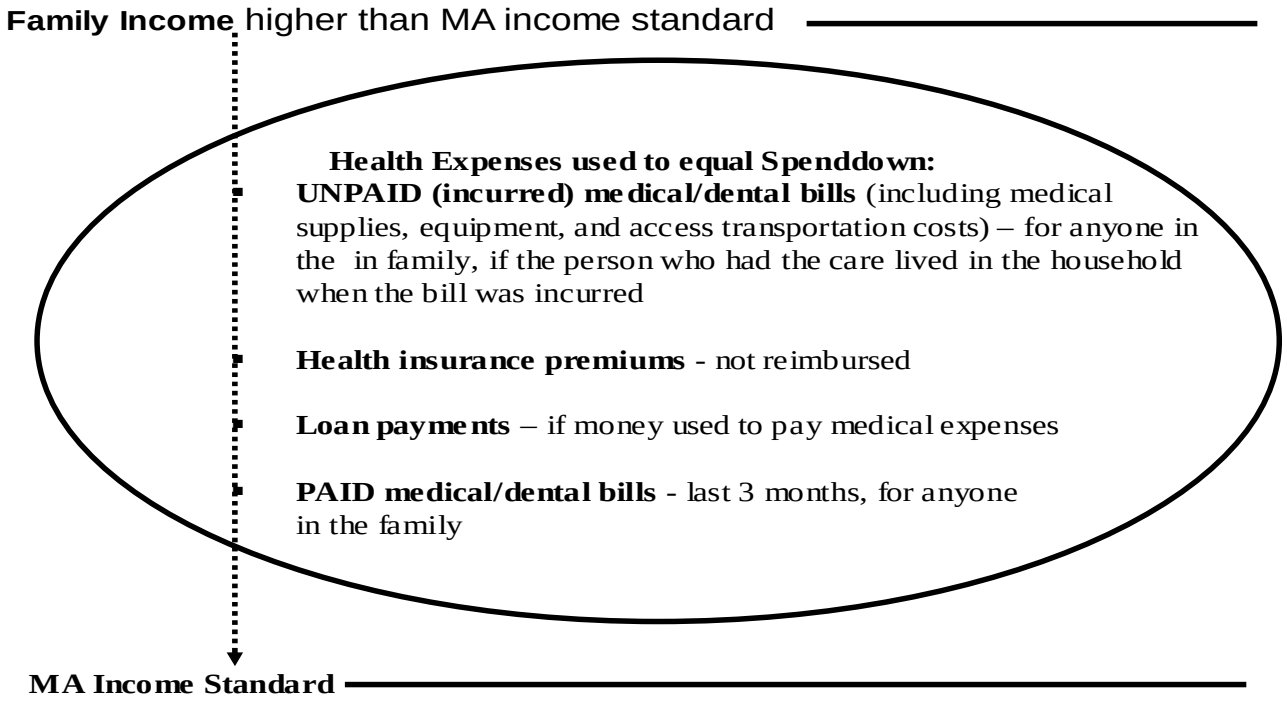
See "Other Resources" Handout

SPENDDOWN

A spenddown is a cost-sharing approach that allows MA (Medical Assistance) eligibility for people whose net income exceeds MA income standards, which are based on the Federal Poverty Guidelines (FPG). **The spenddown amount is the difference between the person's net income and the appropriate MA spenddown income standard.** People with a "families & children" MA basis of eligibility need to spend down to 100% of the FPG. People with a blind, disabled, or elderly basis of eligibility need to spend down to 75% FPG.

The spenddown allows persons to deduct certain health care expenses from their income. A spenddown is like an insurance deductible. The enrollee is responsible to pay the spenddown amount (called the "Recipient amount") to the provider(s). However, **the enrollee does NOT have to have paid the spenddown amount before MA starts coverage**. MA starts to pay on the day the enrollee incurs health care expenses that are equal to or greater than their spenddown amount (called the "Satisfaction date").

Each member of the household may have a different spenddown amount, depending on that member's net income and their Federal Poverty Guideline (FPG) eligibility limit. Some of the same health care expenses may be used to meet each household member's spenddown.



Net health care expenses (not paid by a third party) are used to meet a spenddown. The expense may be used to meet a future spenddown if eligibility for the entire certification period was denied. Any health care expenses the provider writes off or absorbs can NOT be used.

Allowable health care expenses include:

1. **UNPAID health/dental bills** (old bills, including those in collection), past or present, for the client or other allowable family members. These include therapies and medical equipment/supplies, such as wheelchairs. Unpaid bills for services received outside a managed care health plan network, prior to the current MA certification period, are allowable expenses for a spendown. "Allowable family members" include:
   - Client's spouse (if the spouse's income is used to determine the client's eligibility);

- Client's legal dependents (if they are included in the client's household size or would have been included when the bills were incurred).

  ***Example**: Susan applies for MA for herself and Sarah, her 16-year-old daughter. Susan still has a four-year-old unpaid medical bill for her other daughter (Mary, age 19), who has since moved out of the house. Susan can use Mary's unpaid bill toward meeting her spenddown because Mary lived in the household when the bill was incurred.*

- Client's siblings, half-siblings, and step-siblings who are included in the client's household size.
- Parents/stepparents who live with the client if their income is used to determine the client's eligibility or they are included in the client's household size. The family members do not have to be applying or eligible for MA for the client to use their health care expenses to meet a spenddown.

2. **Health Insurance Expenses** (non-reimbursed), 3 months prior to the MA application, including: Private/employer health, dental & long-term care premiums; Indemnity policy premiums; Medicare premiums; MCRE premiums; MA-EPD premiums; deductibles and co-pays.

3. **Loan payments** (owed to a person, financial institution, or credit company) for bills in active collection, for which the money from the loan was specifically paid to a medical provider. [The client may have set up a credit card account only for payment of specific health care expenses.] Only the medical expense portion of the loan can be used (not accumulated interest, late fees, or other related charges.

4. **PAID health/dental bills**, for anyone in the family, incurred during the current certification period (including 3 months prior to application), including out-of-pocket targeted case management expenses and health care access expenses such as transportation to and from a covered MHCP service.

5. **Non covered MinnesotaCare (MCRE) expenses** may be applied to an MA spenddown, if either:
   a) MCRE enrollee with a $10,000 inpatient hospitalization limit, who has an MA basis of eligibility, may be eligible for MA with a spenddown. The amount not covered by MCRE can be applied to an MA spenddown. Or
   b) Clients with an MA spenddown when another household member receives state-funded MCRE. The MCRE premium or managed care capitation amount and health care expenses not paid by MCRE can be used toward the MA spenddown. [State-funded MCRE is for legal guardians/foster parents, non-pregnant adults without children, and certain noncitizens.]

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There are **2 types of spenddowns** (If persons are eligible for more than one type of spenddown, the county will determine which spenddown type allows for MA to pay for more of the household health care.)

1. **6-month spenddown type** – This is the difference between the client's net income for a 6-month period and the applicable FPG for a 6-month period. **The 6-month spenddown is used when both**:
   a) the client's net 6-month income total exceeds the 6-month income standard; and
   b) the client already has health care expenses that equal or exceed the 6-month spenddown amount.

   Applicants must meet the spenddown amount by the end of the application month or the date the application is processed, whichever is later. After the client meets the 6-month spenddown amount, MA can cover care for the remaining portion of the 6-month certification period. If MA covers care 3 months prior to the application date, the coverage goes forward 3 months past the application date, for a total of 6 months (the certification period).

   ***Example**: Joan applies for MA in November. Her income is $100 over the 6-month FPG spenddown standard. To become MA income eligible, Joan will need to have at least $100 in health care expenses*

to meet the spenddown. Joan submits the following medical expenses: July 12th - $10 pharmacy; November 2 - $40 physical therapy (PT) visit; November 3rd - $45 pharmacy; November 5th - $50 PT visit; November 6th - $200 doctor visit Joan's medical bills total $345 (more than enough health care expenses to meet her $100 spenddown). Joan's expenses equaled (exceeded) her spenddown amount at her November 5th PT visit. Joan would be responsible for the following: July 12th pharmacy bill ($10), the November 2nd PT bill ($40), the November 3rd pharmacy bill ($45) and only $5 of the PT visit on November 5th. MA will pay the remaining amount ($45) of the November 5th PT visit, the $200 clinic visit on November 6th, and any other MA covered benefits for the remainder of her 6 month certification period. At the end of the 6 month certification period, Joan will need to reapply.

2. **Monthly spenddown type** – This is the difference between the total net income a client receives in a month and the applicable FPG standard for a single month. This spenddown amount is applied to each month of the certification period when the monthly income exceeds the FPG standard in a given month. **The monthly spenddown is used when both**:

   a) the client can't meet a 6-month spenddown or chooses not to use a 6-month spenddown; and
   b) the client can meet the spenddown in at least one month during the application processing period, including any retroactive month, the application month, or a subsequent month that falls within the processing period.

   There is no "Satisfaction date" for a monthly spenddown. MA will pay all other claims for that month, submitted by providers, once the recipient amount is met for that month. [If the client does not have anticipated medical bills to meet the monthly spenddown in the next certification period consider MinnesotaCare eligibility.]

   ***Example**: Jerome is on RSDI due to a disability. His medical expenses include a 4-month old unpaid doctor bill ($50), a monthly health insurance premium ($50), monthly prescription cost ($200/month), and a prescription cost of $175 every other month. Jerome's monthly spenddown amount is $400 (he doesn't have enough allowable health care expenses to meet a 6-month spenddown, but he does have enough in recurring health care expenses to meet his monthly spenddown, for at least one month of the certification period). Jerome will have a recipient amount (what he is responsible for) of $200 for the 1st month of the certification period and $250 for the remainder of the certification period. He will be responsible for the $50 health insurance premiums monthly, and the 4-month old unpaid ($50) doctor bill. He meets the spenddown in the months he fills the $175 prescription (every other month).*

A form ("Medical Expenses Request", DHS #1844) is available from your county financial worker to help you organize the required health care expenses. You will need to verify the expenses reported on the form, using copies of bills from your provider(s), or copies of your Explanation of Benefits (EOB) from third party payors, or in some cases, the county financial worker can contact the provider directly. Once persons have met their spenddown amount, the county financial worker sends an Explanation of Medical Benefits (EOMB) to the enrollee. The EOMB lists health care expenses submitted by providers, which medical bills were used to meet the spenddown amount and which bills the enrollee is responsible to pay.

Some programs DO NOT have a spenddown option, including, but are not limited to:

1) MA-EPD (MA for Employed Persons with Disabilities);
2) MA for "automatic newborns" (they have no income limit);
3) MinnesotaCare (MCRE);
4) GAMC (General Assistance Medical Care).

Minnesota Department of **Human Services**

Minnesota Health Care Programs
Income and Asset Guidelines Effective 4/1/10 through 6/30/11

MAXIS Standard					****				K*****		G***		E		E		C*		E**	
	MinnesotaCare $48 Annual Premium		MinnesotaCare Adults without Children		MinnesotaCare Children to Age 21 and Families with Children		MinnesotaCare Covered Services No $10,000 Inpatient Cap for Parents		MA Infants under Age 2		MA Children – Age 2 through 18		MA Children – Age 19 and 20		MA Adults with Children		MA Pregnant Woman		MA Elderly, Blind, Disabled (No spenddown)	
Family Size	*150% FPG*		*250% FPG*		*275% FPG*		*215% FPG*		*280% FPG*		*150% FPG*		*100% FPG*		*100% FPG*		*275% FPG*		*100% FPG*	
	Monthly	Annually	Monthly	Annually	Monthly	Annually	Monthly	Annually	Monthly	Annually	Monthly	Annually	Monthly	Annually	Monthly	Annually	Monthly	Annually	Monthly	Annually
1	1,354	16,248	2,257	27,084	2,482	29,784	1,941	23,292	2,527	30,324	1,354	16,248	903	10,836	903	10,836	NA	NA	903	10,836
2	1,822	21,864	3,037	36,444	3,340	40,080	2,612	31,344	3,400	40,800	1,822	21,864	1,215	14,580	1,215	14,580	3,340	40,080	1,215	14,580
3	2,290	27,480	Not Eligible		4,198	50,376	3,283	39,396	4,273	51,276	2,290	27,480	1,527	18,324	1,527	18,324	4,198	50,376	1,527	18,324
4	2,758	33,096	Not Eligible		5,056	60,672	3,954	47,448	5,146	61,752	2,758	33,096	1,839	22,068	1,839	22,068	5,056	60,672	1,839	22,068
5	3,226	38,712	Not Eligible		5,914	70,968	4,625	55,500	6,019	72,228	3,226	38,712	2,151	25,812	2,151	25,812	5,914	70,968	2,151	25,812
6	3,694	44,328	Not Eligible		6,772	81,264	5,296	63,552	6,892	82,704	3,694	44,328	2,463	29,556	2,463	29,556	6,772	81,264	2,463	29,556
7	4,162	49,944	Not Eligible		7,630	91,560	5,967	71,604	7,765	93,180	4,162	49,944	2,775	33,300	2,775	33,300	7,630	91,560	2,775	33,300
8	4,630	55,560	Not Eligible		8,488	101,856	6,638	79,656	8,638	103,656	4,630	55,560	3,087	37,044	3,087	37,044	8,488	101,856	3,087	37,044
9	5,098	61,176	Not Eligible		9,346	112,152	7,309	87,708	9,511	114,132	5,098	61,176	3,399	40,788	3,399	40,788	9,346	112,152	3,399	40,788
10	5,566	66,792	Not Eligible		10,204	122,448	7,980	95,760	10,384	124,608	5,566	66,792	3,711	44,532	3,711	44,532	10,204	122,448	3,711	44,532
Add'l	468	5,616	Not Eligible		858	10,296	671	8,052	873	10,476	468	5,616	312	3,744	312	3,744	858	10,296	312	3,744
Asset Test	No asset test for children.		No asset test for pregnant women and children. $10,000 for household of one. $20,000 for household of more than one.						None		None		None		• Adults with children: $10,000 for hh of 1 • $20,000 for hh of more than 1		None		• $3,000 for a single person • $6,000 for hh of 2, plus $200 for each dependent	

FPG = Federal Poverty Guidelines
* Pregnant Woman – Minimum household size of 2.
** Persons with income over 100% FPG must spend down to 75% FPG.
*** Children 2–18 with income over 150% FPG must spend down to 100% FPG.
**** Parents with income over $50,000 are ineligible for MinnesotaCare.
***** Infants under age 2 with income over 280% must spenddown to 100% FPG.

Note: Income and asset guidelines change. Use this chart for general reference only. Refer to the Minnesota Health Care Programs Manual for the most current information.

Next →

Minnesota Health Care Programs Income and Asset Guidelines Effective 4/1/10 through 6/30/11

MAXIS Standard	F		U******		Q******		W******		S******		H		H				
	Transition Year MA		MA Qualifying Individuals (QI)		MA Qualified Medicare Beneficiaries (QMB)		MA Qualified Working Disabled Individuals (QWD)		MA Service Limited Medicare Beneficiaries (SLMB)		MA Elderly, Blind, Disabled (with a Spenddown)		GAMC		Family Planning Program		MA for Employed Person with Disabilities (MA-EPD)
Family Size	*185% FPG*		*135% FPG*		*100% FPG*		*200% FPG*		*120% FPG*		*75% FPG*		*75% FPG*		*200% FPG*		To qualify for MA-EPD, an individual must: • Be certified disabled by the Social Security Administration (SSA) or the State Medical Review Team (SMRT). • Be 16 to 65 years of age. • Be employed and have required taxes withheld or paid from earned income. • Have monthly earnings of more than $65. • Meet the MA-EPD asset limit of $20,000 per enrollee. • Pay a premium and • Pay an unearned income obligation, if required.
	Monthly	Annually	Monthly	Annually	Monthly	Annually	Monthly	Annually	Monthly	Annually	Monthly	Annually	Monthly	Annually	Monthly	Annually	
1	1,670	20,040	1,239	14,868	923	11,076	1,825	21,900	1,103	13,236	677	8,124	677	8,124	1,805	21,660	
2	2,247	26,964	1,660	19,920	1,235	14,820	2,449	29,388	1,477	17,724	911	10,932	911	10,932	2,429	29,148	
3	2,824	33,888	2,081	24,972	1,547	18,564	3,073	36,876	1,851	22,212	1,145	13,740	1,145	13,740	3,053	36,636	
4	3,401	40,812	2,502	30,024	1,859	22,308	3,697	44,364	2,225	26,700	1,379	16,548	1,379	16,548	3,677	44,124	
5	3,978	47,736	2,923	35,076	2,171	26,052	4,321	51,852	2,599	31,188	1,613	19,356	1,613	19,356	4,301	51,612	
6	4,555	54,660	3,344	40,128	2,483	29,796	4,945	59,340	2,973	35,676	1,847	22,164	1,847	22,164	4,925	59,100	
7	5,132	61,584	3,765	45,180	2,795	33,540	5,569	66,828	3,347	40,164	2,081	24,972	2,081	24,972	5,549	66,588	
8	5,709	68,508	4,186	50,232	3,107	37,284	6,193	74,316	3,721	44,652	2,315	27,780	2,315	27,780	6,173	74,076	
9	6,286	75,432	4,607	55,284	3,419	41,028	6,817	81,804	4,095	49,140	2,549	30,588	2,549	30,588	6,797	81,564	
10	6,863	82,356	5,028	60,336	3,731	44,772	7,441	89,292	4,469	53,628	2,783	33,396	2,783	33,396	7,421	89,052	
Add'l	577	6,924	421	5,052	312	3,744	624	7,488	374	4,488	234	2,808	234	2,808	624	7,488	
Asset Test	None		• $10,000 for a single person • $18,000 for hh of 2		• $10,000 for a single person • $18,000 for hh of 2		• $4,000 for a single person • $6,000 for hh of 2		• $10,000 for a single person • $18,000 for hh of 2		• $3,000 for a single person • $6,000 for hh of 2, plus $200 for each dependent		• $1,000 per household		None		• $20,000 per enrollee

****** $20 disregard is included in totals

ADA3 (5-09)

This information is available in alternative formats to individuals with disabilities by calling (651) 431-2670 or (800) 657-3739. TTY users can call through Minnesota Relay at (800) 627-3529. For Speech-to-Speech, call (877) 627-3848. For additional assistance with legal rights and protections for equal access to human services programs, contact your agency's ADA coordinator.

MEDICAL FUNDING SUMMARY – Medical Assistance (MA)

Age	• Must meet an MA "basis of eligibility" – one of the following: Under age 21; Pregnant women; Parent with dependent children under age 19 in the home; Age 19 and 20; Elderly (≥ 65); Blind or disabled. [NOTE: If no biological parent lives in the home, one non-parent relative in the home can have a Relative Caretaker "basis".] • "Automatic newborn" eligibility for infant, until age 1year., if born to mother on MA (& other MHCPs) at birth.
Household / Income / Assets	• **Household size - Includes: 1)** all persons living together, with a parental (biological or adoptive), marital, or sibling relationship; and **2)** people temporarily away from home (ex: college; military service). Pregnant woman = 2 persons (or more, depending on the number of fetuses) for household size. • **Income:** Counts gross income (& some unearned income) of natural/adoptive parents of children (under 21), the last 30 days, minus MA deductions/disregards (such as work expenses, court-ordered child support payments, childcare costs, income/assets set aside for a PASS ***)**. Self-employed use last year's federal income tax, or projected income if income is expected to be less than last year. **Doesn't count** [not a complete list]: **1)** Stepparent income toward a child, if biological/adoptive parent lives in the home; **2)** Parent or Spouse income of disabled or blind person (age 18-21), regardless of whether disabled person lives with his/her parents; **4)** Certain cash gift lump sum income (ex: if used for a non-covered prosthetic device); **4)** Grandparent or other non-parent relative caretaker income to a child; **4)** Income for MA-BC (Breast Cancer) enrollees; **5)** Adoption assistance; **6)** Food Support Program payments; **7)** WIC; **9)** SSI received for children < 21; **10)** Student financial aid (unless required to work for the aid) • Income standard varies, based on the person's "basis of eligibility". Income standards are based on Federal Poverty Guidelines (FPG). • Persons over income may still be MA eligible with a **"spenddown"**, using paid and unpaid health care expenses (some can be older than 3 months) for anyone in the family; medical insurance premiums; and loan payments (if money from load was used to directly pay health care providers). **Assets**: Under $10,000 for 1; $20,000 for 2 or more; Self-employed parent's net capital & operating assets $200,000. **[Exception: No asset limit** for pregnant women & children under 21.]
Resident/Citizenship	• Minn. resident (date physically present), & intend to stay in Minn.; doesn't require a fixed or permanent address. • Must be a U.S. Citizen or a noncitizen lawfully residing in the U.S. Non-citizen eligibility depends on status, date of U.S. entry, & possibly sponsor's income/assets. Refugees are eligible for RMA (Refugee MA) for the 1st 8 months in the U.S. [For more information about immigration statuses eligible for MA, see "Noncitizens and Minnesota Health Care Programs", and "Noncitizen Information" in this packet. DHS also has a document "Health Care Eligibility for Noncitizens" (June 2008) found on the DHS Website www.dhs.state.mn.us] •Most nonimmigrants (visitors, tourists, or foreign students) and undocumented persons are only eligible for EMA Emergency Medical Assistance) or CHIP-funded MA (for pregnant women prenatal through 60 days postpartum). • Only persons in the family applying to be covered by benefits need to provide proof of their status.]
Condition	• Pregnancy is a basis of eligibility. Enrollees with a "Disabled" basis of eligibility must be certified disabled by the State Medical Review team (SMRT) or the Social Security Administration (SSA). • MA eligibility can go back 3 months prior to the date of application & cover past unpaid medical bills. • For pregnant women, county human services must process a completed MA application within 15 days. • From 7-1-09 to 12-31-10, people ≤ age 65 may get MA while being treated for colorectal cancer if they were screened by Minn.Dept. of Health's Sage Scopes prevention project & are not otherwise eligible for MHCP or other coverage.
Insurance	• Can have other insurance (private, employer, TRICARE, or COBRA); other insurance pays before MA pays. • MA may pay the other insurance premium, if determined "cost effective". [**Exception**: MA does not pay MCHA (Minnesota Comprehensive Health Association) premiums.] Adult enrollees who have insurance or access to insurance must cooperate to determine if payment of the premiums by MA is cost-effective. • Children remain eligible even if parents don't cooperate with medical support requirement.
Family	• **Spenddown:** May be responsible for a "spenddown" (like an insurance deductible). [NOTE: MinnesotaCare may be a better program for some – compare MA spenddown amount with MinnesotaCare premium] • **Co-pays** (an amount you are responsible for) on some services [Exception: **No co-pays for**: pregnant women and children under 21; or persons on Refugee Medical Assistance (RMA)].

***PASS** (Plan to Achieve Self Support): certain income and assets can be excluded for eligibility if Blind or Disabled basis of eligibility.

MCYSHN and DHS 8-11-10

MEDICAL FUNDING SUMMARY – MA-TEFRA

Age	• Under age 19 and living with at least one parent (biological or adoptive). • TEFRA is usually no longer needed at age 18, since parent income is not counted for persons ≥ age 18, with a Disabled "basis of eligibility", even if living at home). At age 18, refer to SSI *****.
Income/Assets	• **Household size:** Child with a disability is considered a household size of 1, even living with parents. • **Income:** Counts child's gross income, less deductions and disregards (such as work expenses, or P.A.S.S. income ******). **Doesn't count:** Parent's income, or child support received for or on behalf of the child, or RSDI payments received by or on behalf of child under age 18. • Children over income may still be eligible with a "spenddown" (spenddown to 100% of the FPG). • **Assets:** Not counted.
Resident/Citizen	• Minnesota resident (date physically present in Minn.), with intention to stay in Minn. [Does not require a fixed or permanent address.] • U.S. Citizen or noncitizens with a Lawful immigration status *******. • Only those in the household applying for coverage need to provide proof of immigration status. • If over MA income limits, the TEFRA option (doesn't count parent income) is a way for the noncitizen child with a disability and level of care need to become eligible for Emergency Medical Assistance (EMA), for the noncitizen child with a disability and level of care need (regardless of immigration status), of the child has a "medical emergency". [See the "Medical Funding Summary-EMA" in this packet]
Condition	• Certified as disabled by State Medical Review Team (SMRT) or Social Security Administration (SSA) and needs a level of care comparable to that provided in a hospital, nursing home, or an intermediate care facility for persons with mental retardation and related conditions ICF/MR). • Disability recertification is needed every 1 to 4 years (frequency is determined by the SMRT). • Cost to MA for home care can't be more than MA would pay for child's care in a facility/institution.
Insurance	• Can have other insurance, which must be used first before MA pays. • MA may pay your other insurance premium, if the premium is determined to be "cost effective". [**Exception:** MA does not pay Minnesota Comprehensive Health Association (MCHA) premiums.] • TEFRA enrollee's other health insurance policies are considered "cost effective" and do not require further review if the child's portion of the premium is $50 or less per month.
Cost	• Monthly parental fee, based on the family size and income • Parental fee starts the 1st month on MA, including any months of retro-active eligibility. • Before applying for TEFRA, the child's eligibility should first be determined counting the parent(s) income, using the MA "Children under 21" income limit (and if needed, look at the spenddown). There is no parental fee and no disability requirement for MA "Children under 21" basis).

*** Refer 18 yr. olds to SSI** (Supplemental Security Income) if their disability continues. MA is left open while the SSI determination is pending. If SSI determines there is no longer a disability, parental income is counted. [NOTE: SSI is under the federal government, Social Security Administration (SSA). For more SSA information see the Website: www.socialsecurity.gov). Also see the "SSA Overview" in this packet.]

**** P.A.S.S.** (Plan to Achieve Self Support) allows persons.(age ≥ 15), with a disability, to exclude some income &/or resources which would otherwise be counted when determining income MA eligibility (blind or disabled basis). The P.A.S.S. money you exclude must be tied to achieving a work goal and occupational objective. Examples include assistive technology, laptp computer, tuition and books, child care, tutoring or testing fees. A P.A.S.S. proposal is submitted to county Human Services for approval.

***.For more information about noncitizens, see the **"Noncitizens and MHCP**", in this packet. Also, the DHS website www.dhs.state.mn.us contains a document "Eligibility for Noncitizens" (June 30, 2008).

MEDICAL FUNDING SUMMARY - MA for Employed Persons With Disabilities (MA-EPD)*

Age	• Ages 16 to 65, and employed, and meeting disability criteria. • Not eligible for MA-EPD if on SSI (Supplemental Security Income).
Income / Assets	• **Household size:** Each person is a household size of 1. Married couples, both applying, are each considered a household size of 1, plus children, for each spouse. • **Income:** Counts only income of MA-EPD applicant. Counts gross earned income, or if self-employed, counts net income (gross minus business expenses). The income must be above $65/month; Medicare, Social Security & state & federal income taxes must be paid or withheld. Doesn't count spouse's income. There is NO maximum income [**Exception:** DOES count parent income for youth with disabilities, ages 16 or 17, living with a parent (both for income eligibility and for premium amount)] • An MA-EPD enrollee may be eligible without earnings for up to 4 months due to either: 1) job loss that was not caused by or attributed to the enrollee (ex: layoffs due to lack of work, business closing or plant shutdown); or b) a verified need for a medical leave due to a medical condition. • **Assets**: $20,000 per applicant. [**Exceptions:** Doesn't count: Assets for youth under age 21; or Spousal assets and share of jointly held assets; or Retirement accounts.]
Resident/Citizen	• Minn. resident (date physically present in Minn.), with intention to stay in Minn.. [Does not require a fixed or permanent address.] • U.S. Citizen or noncitizen maintaining a lawful immigration status. Noncitizen eligibility depends on status, date of entry into U.S., & possibly a sponsor's income & assets. • Most non-immigrants (visitors, tourists, & foreign students) and undocumented persons are **not** eligible. • Only those in the household applying for coverage need to provide proof of immigration status. • Cannot be on MA-EPD if on Refugee Medical Assistance (RMA).
Condition /Disability	• Must be certified disabled by State Medical Review Team (SMT) or Social Security Administration (SSA). Persons with no current disability certification should be referred to SMRT. This includes those whose SSI/RSDI application is pending or being appealed, or benefits are terminated, or persons with extended Medicare who are no longer receiving RSDI due to their income exceeding the RSDI "substantial gainful activity level". (Refer them to MA-EPD 2 months before their Medicare extension ends.) • MA-EPD enrollee may be eligible without earnings for up to 4 calendar months. • Persons certified disabled and eligible for MA with a spenddown, may qualify for MA-EPD if they go to work. • Can be on both a Home and Community Based Services ("Waiver") Program and MA-EPD.
Insurance	• Can have other insurance, which must be used first before MA pays. • MA may pay the enrollee's other insurance premium, if the premium is determined to be "cost effective" for MA. **[Exception:** MA does not pay for Minnesota Comprehensive Health Association (MCHA) insurance premiums.] Persons eligible for Medicare must enroll as a condition of MA-EPD eligibility, regardless of their income and the amount of the Part B premium. Part B premiums may sometimes be reimbursed by MA-EPD .
Costs	• Monthly premium, based on gross earned & unearned income, on a sliding scale, if income is greater than 100% of the FPG. Minimum premium is $35. There is no maximum premium. • Eligibility begins when 1st premium paid; can go back 3 mo. if premium paid for retroactive months. • Eligibility ends for non-payment of premium. If premiums paid later, MA-EPD can be restarted.

*** MA may be a better alternative than MA-EPD in some situations, such as:** (1) MA without a spenddown; (2) MA with a monthly spenddown amount lower than the MA-EPD premium; (3) MA with a spenddown greater than the MA-EPD premium, when the spenddown is satisfied with existing unpaid medical bills.

**** Lawful Immigration Status**: For more information about noncitizens, see the **"Noncitizens and MHCP"**, and the **"Noncitizen Information"** pieces in this packet. Also, see the DHS website www.dhs.state.mn.us for their document titled "Eligibility for Noncitizens" (June 30, 2008).

MEDICAL FUNDING SUMMARY – HCBS (Home and Community Based Services - "Waivers")

CAC - Community Alternative Care **CADI** - Community Alternatives for Disabled Individuals
DD - Developmental Disability **TBI** - Traumatic Brain Injury

	CAC	CADI	DD	TBI
Age	Under age 65, when waiver is opened	Under age 65, when waiver is opened	Any age	Under age 65, when waiver is opened
Condition or Disability	• Certified disabled; and • Chronically ill or medically fragile; and • Needs a hospital level of care (without the CAC services, person would require frequent or continuous hospitalizations over a 12 month period). Level of care must be certified by a primary physician.	• Certified disabled; and • Needs a Nursing Facility (NF) level of care	• Certified disabled; and • Has a developmental disability or a related condition; and • Needs an ICF/DD (intermediate care facility for persons with developmental disabilities) level of care.	• Certified disabled; and • Has a traumatic or acquired brain injury (not congenital), with severe or significant behavioral and cognitive issues from the brain injury; and • Needs a nursing facility or neurobehavioral hospital level of care
Income / Assets	• Must be on Medical Assistance (MA), either "regular" MA, or MA-TEFRA, or MA-EPD; and must have an assessed need for supports and services over and above those already provided by MA. • Counts only individual's income and assets (not the parents or spouses, even if the person lives with their parents or spouse). If married, a person may get waiver services while living at home with his/her spouse. • **Asset limit**: $3,000 for household of 1 [**Exception**: **No** asset limit for children under age 21]			
Citizenship/ Residency	• Minnesota resident (date physically present) and intends to stay in Minnesota. (A fixed/permanent address is not required). • Must be U.S. Citizen or a "Qualified noncitizen". Noncitizen eligibility depends on the person's immigration status, date of entry into the U.S. (and possibly a sponsor's income/assets). [See the "Noncitizens and Minnesota Health Care Programs" information for which noncitizens are considered "Qualified".] • Only the person in the family applying to be covered by benefits needs to provide proof of their status. • **Not eligible:** Non-immigrants (visitors, tourists, or foreign students) and undocumented persons.			
Other Insurance	• Can have other insurance (other insurance has to be billed first); • MA may be able to pay the other insurance premium, if determined to be cost-effective. • Persons with disabilities may be excluded from Managed Care, and continue to receive their services from "fee-for-service" providers.			
Cost to Family	• Parents may pay monthly a parental fee for HCBS enrollees under age 18. The parental feeis based on family size and income. • Adults may have to pay a "spenddown" in order to become income MA-eligible, if their income is over the MA limits.			

APPLY: Contact your county human services agency and ask to talk with a Disability Social Worker.

NOTE: HCBS are NOT an entitlement program. That means a person may qualify, but funding may not be available in the county due to a waiting list. (Counties keep a waiting list, based on severity of need). Persons eligible for the HCBS program are encouraged to apply and get on the waiting list in their county

MEDICAL FUNDING SUMMARY – MinnesotaCare (MCRE)*

Age	• Families with children < age 21 in home (including parents, stepparents, relative caretakers, guardians or foster parents), and adults without children. Relative caretakers, legal guardians, or foster parents (of children < 21 in the home) are considered "adults without children" if they are not including the children on the MCRE application, • "Automatic newborn" eligibility (until infant age 1 year) if mother was on MCRE at the time of the birth.
Income / Assets	• **Household size**: All persons with parental/marital relationship, including stepparents, & young adults < 21. Pregnant woman = 2. Household size of one if either: 1) under 21 & not living with parent/relative caretaker/foster parent/guardian; OR 2) single & ≥ age 21, even if living at home. [A relative caretaker or foster parent or guardian of child < 21 in home are an "adult without children" if not including children on their application.] • **Income:** Counts gross household (earned & unearned), including stepparent. Self-employed use adjusted gross from 1040 federal tax form, plus some depreciation. Income limit for non-pregnant parent (> 21): $50,000 or 275% FPG, whichever is less. **Doesn't count** [not complete list]**: 1)** Earned income of full/part-time student < age 19; **2)** Food Support Program; **3)** WIC; **4)** Retroactive SSI/SSDI; **5)** Undergraduate student financial aid; **6)** Grandparent (3-generation household), if counting grandparent income makes grandchild ineligible; **7)** Counts only the child's income to determine child's eligibility and premium amount if the relative caretaker or guardian or foster parent is applying for the children separately, not applying for the adult. • **Assets**: $10,000 (for 1); $20,000 (2 or more).[**Exception:** No asset limit for pregnant women and children < 21]
Resid/Citize	• Must **intent to live in Minnesota**, **and**: 1) **Preg. women & families with children < 21:** Resident on day of arrival in Minn.; 2) **Adults without children** must live in Minn. 180 days immediately before MCRE eligible. • U.S. Citizen, or noncitizen with a lawful immigration status***.** Noncitizen eligibility depends on immigration status, date of entry into U.S., & possibly sponsor's income/assets. **[**Only people in the family requesting coverage need to provide proof of their immigration status.] **Undocumented or nonimmigrant** noncitizens not eligible.
Condition	• **No** health condition, disability or level of care required for eligibility. • Households with enrollees on active military duty can re-enroll without penalty during/after active tour of duty. • Retroactive (30 days) MCRE, if person applies for MCRE within 30 days after their MA or GAMC ended. • NO $10,000 inpatient hospital limit for adults in families with children if income ≤ 215% FPG. Enrollees can apply for MA if they have inpatient expenses not covered by MCRE (use unpaid expenses for MA spenddown). • Certain disabled adults without children must apply for MA (Medical Assistance).
Insurance	• **Insurance barriers: 4-mo. wait –** Must be without insurance (including Medicare) for 4 mo**. 18 month wait** – If employee has current/past (in last 18 mo.) access to "Employer Subsidized Insurance" (ESI), where employer pays half the employee's premium cost. ESI is determined separately for the employee & for the dependents. [**NO insurance barriers for: a)** "Automatic" newborns; **or b)** "Underinsured"** child in family with income ≤ 150% FPG can keep/cancel other insurance for child without affecting child's MCRE eligibility. **NO 4-month wait: a)** Child with income ≤ 150% FPG; **or b)** Child < 21 meeting Children's Health Plan exception (continuously enrolled in CHP on or before 6-30-93) **or c)** If moving directly from MA or GAMC; **or d)** Had TRICARE (not considered other health insurance). **NO 18-month wait: a)** Dependents, if employer doesn't offer family coverage; **or b)** Lost ESI due to employer dropping benefits & on MCRE within the past 6 mo.**]**
Cost	• Premiums: a) Sliding scale (based on family size, income & number of people covered); or b) Fixed $4/mo.per enrolled child if family income ≤ 150% FPG. Coverage begins month after 1st premium is paid. Must wait 4 mo. to re-enroll if either premium isn't paid or person voluntarily ends MCRE (unless can prove "Good Cause" *******) [**Exceptions: a)** DHS pays premium for 12 mo. for **military member or family** (within 24 mo. of active duty); **b)** Pregnant woman (thru 60 days postpartum) & infant < 2 yr cannot be cancelled for nonpayment of premiums and premiums can be forgiven at the end of postpartum or when child turns 2 if not paid.

*** Lawful immigration status & MCRE programs: "Qualified" noncitizens: FF** for Parents/relative caretakers; **LL** for Children < 21 & pregnant women); **"Other lawfully present":** JJ for Guardians, foster parents & noncitizen parents/relative caretakers who don't qualify for federally funded MCRE; **BB** for Non-pregnant adults without children (regardless of citizenship).

**** "Underinsured" child**: **1)** No coverage in 2 or more: basic hospital/medical-surgical; major medical coverage; prescription drug coverage; preventive or comprehensive dental; preventive or comprehensive vision; **or 2)** ≥ $100 deductible per person per year; **or 3)** Excludes services for a particular diagnosis (child doesn't have to have the particular diagnosis), or excludes for a pre-existing condition (child must have the pre-existing condition)pre-existing condition; **or 4)** On Medicare.

***** "Good Cause"**: Circumstances beyond enrollee's control or enrollee could not reasonably foresee. Circumstances include, but are not limited to: serious physical/mental illness; regular income source not received; MCRE coverage was dropped due to belief the other health coverage was available, but the other coverage does not materialize; "Safe at Home" program participants.

MCYSHN & DHS 8-13-10

MEDICAL FUNDING SUMMARY - GAMC (General Assistance Medical Care) *

Age	• Non-pregnant adults, ages 21 to 65, with no dependent children in the home [Dependent child is under age 18, or age 18 and a full-time student expecting to graduate by age 19].
Income /Assets	• **Household** size includes all people living together with a parental or marital relationship. • **Income:** Counts income from the last 6 months. Counts income & assets of a person's spouse when spouse lives with the client. [There is no eligibility with a spenddown for GAMC.] **Re-apply every 6 months.** •**Asset Limits:** $1,000 for a family of any size (cash; checking & savings accounts; CDs, stocks & bonds; recreational vehicles; land/houses that you don't live on or in). **Assets NOT included:** Home you live in; household & personal goods (such as clothing, jewelry, furniture, appliances, tools & equipment used in the home); motor vehicle under certain conditions; capital & operating assets of a trade or business.
Residency/Citizens	• **Minnesota Resident** - 30 consecutive days & intend to stay (Staying in a battered woman's shelter counts toward the 30 days.) [**Exception**: The 30-day criteria doesn't apply if a household member has a medical emergency, or is a migrant agricultural worker who verifies the household earned at least $1,000 in Minnesota within 12 months before the month of application.] • Must be a U.S. citizen or a noncitizen lawfully residing in the U.S. [See "Noncitizens and Minnesota HealthCare Programs" in this packet, for more information on immigration status criteria.] • Undocumented and non-immigrants (visitors, tourists, foreign students) are NOT eligible.
Condition	• Coverage begins on the date of application or on the date all eligibility factors are met– renewal every 6 months.[Does **not** go back and pay past bills]. • People pursuing disability certification from the State Medical Review Team (SMRT) or the SSA (Social Security Administration) may get GAMC pending the disability determination If determined disabled, can be MA (Medical Assistance) under the disabled category, or MA-EPD(MA For Employed Persons with Disabilities).
Insurance	• Can have other health insurance (this includes private, employer, TRICARE and COBRA). **NOTE:** This will change on 11/1/10 – people with private insurance will not be eligible.
Cost	• Co-pays for some services. [NOTE: Co-pays for household members may be applied toward a spenddown for MA (Medical Assistance) eligibility for the client]

*** As of June 1, 2010, GAMC recipients may choose a hospital-based Coordinated Care Delivery System (CCDS) to receive health care services. Non-emergency services (except pharmacy services and chemical dependency treatment) that are not provided and coordinated by the CCDS are not covered, unless provided by a hospital receiving payment through the Uncompensated Care Pool for GAMC individuals not enrolled in a CCDS.** Four Twin Cities metro-area hospitals were participating as a CCDS, as of 6-1-10. GAMC enrollees must enroll in a CCDS to get health care services, unless it is an emergency. A CCDS provides and coordinates the following hospital and non-hospital health care services: Inpatient Hospital; Outpatient Hospital; Outpatient clinic (including primary care and some specialty care); Mental health; Emergency medical transportation; Physician-administered drugs. Services provided can be different at different CCDSs. If persons are enrolled in a CCDS, but receive non-emergency services at other clinics/providers outside the CCDS, or if persons are not enrolled in a CCDS and receive any services, the person may be billed for those services (except emergency services, which are billed to the CCDS or services billed to the Uncompensated Care Pool).

• **In addition, MHCP covers the following for all GAMC clients (whether enrolled in a CCDS or not)**: (1) Outpatient prescription drugs and medication therapy management services are available from any pharmacy that accepts MHCP coverage (The pharmacy bills MHCP on a fee-for-service basis.) Outpatient drug coverage does NOT include drugs administered in a clinic (always administered by a healthcare professional), medical equipment or medical supplies; and (2) Chemical dependency services (administered through the Consolidated Chemical Dependency Treatment Fund (CCDTF), available through the county DHS.

•**Persons on GAMC who are NOT enrolled in a CCDS:** (1) May be able to access some health care services through their local hospital or community clinic, including mental health. [NOTE: See the DHS Website (www.dhs.state.mn.us) for information about mental health services]. AND (2) May be billed by non-CCDS hospitals for inpatient & outpatients services provided (only if the hospital does not seek Uncompensated Care Pool (UCP) payment, through Feb. 28, 2011. [Non-hospital providers are not eligible to receive payment from the UCP.]

• **Beginning March 1, 2011** GAMC enrollees who did not sign up for a CCDS may no longer be able to get non-emergency care from non-CCDS hospitals.

MEDICAL FUNDING SUMMARY – EMA / RMA / NMED

EMA – Emergency Medical Assistance; RMA – Refugee Medical Assistance; NMED – Noncitizen Medical Assistance

	EMA [Federally-funded]	**RMA** [Federally-funded]	**NMED** [State-funded MA]
Age	• Needs an MA "basis" *****; • Noncitizen **disabled children under age 19, with a medical emergency,** may use the TEFRA option to become eligible (parent income is not counted under TEFRA)	• **Don't** need an MA "basis" * If has an MA basis, must first have ineligibility for MA determined. • CAN'T be a full-time student in an institution of higher learning unless enrollment is part of a state-approved plan	• Needs an MA "basis " ***** [**Exception:** CVT recipients don't need an MA "Basis" of eligibility] • Noncitizen **disabled children under age 19,** may use TEFRA option to become income eligible (parent income is not counted under TEFRA)
Income / Assets	• **MA income/asset limits.** No sponsor income/assets are counted. • No asset limit for pregnant women and children under age 21. "Automatic newborn"(infant born to woman on MA has "automatic" MA for 1 year) • If over income, may still qualify with a "spenddown".	• **Income/Asset limit**: 100% of FPG, after deductions; If over income, may still qualify with a "spenddown". **Asset limit**: $10,000 for 1; $20,000 for 2 • **Exception:** No asset limits if pregnant or child under age 21.	• **MA income/asset limits**. If over income, may still qualify with a "spenddown" • **Exception:** No income or asset limits if receiving CVT services
Citizenship/ Resident	• Minnesota resident (on day of arrival); intends to stay in Minn.; No fixed/permanent address required. • Covers noncitizens not eligible for MA solely due to their immigration status, including undocumented or non-immigrant persons; • Don't need Social Security number	• Minnesota resident (on day of arrival) & intends to stay in Minn. • In the U.S. 8 months or less; • **1 of the following**: Refugees, (including Asylee, Cuban/Haitian, Amerasian, and Afghan/Iraqi Special Immigrant); or Victim of trafficking	• Minn. resident (day of arrival); • Covers noncitizens not MA eligible solely due to their immigration status. [**No NMED if an undocumented or non-immigrant** child, pregnant, parent, single adult, elderly, blind, or disabled] • Persons on NMED who have a "medical emergency" are eligible for EMA. • Don't need Social Security number
Condition	• Must have **medical emergency**** • Possible 3-month retroactive coverage for chronic condition meeting the "emergency" definition.	• No health condition or disability requirement. • Possible 3 month retroactive eligibility	• Possible 3 month retroactive eligibility if getting CVT services
Insurance	• Can have other insurance • Other Insurance premium may be paid if "Cost Effective". • Excluded from Managed Care	• Can have other insurance • Other Insurance premium may be paid if "Cost Effective". • Excluded from Managed Care	• If have other health care insurance or a spenddown. • NMED enrollees with other insurance are excluded from Managed Care.
Cost	• May be responsible for a "spenddown"	• May have a "spenddown". • NO copays	• May be responsible for a "spenddown"

*** MA "Basis of eligibility":** Pregnant; Under age 21; Parent with child under age 18 in the home; 4) 65 or older; 5) Blind or disabled. [**NOTE**: Beginning July 1, 2010, all lawfully present noncitizen children under 21 and pregnant women are eligible for MA with FFP (Federal Financial Participation). Undocumented & other nonimmigrant pregnant women may be eligible for CHIP-funded MA through the 6-day postpartum period or EMA for labor & delivery only.]

**** EMA "Medical emergency"**: Either short-term, acute (including labor and delivery) or ongoing chronic medical or mental health condition. The emergency must meet criteria: in the absence of immediate medical attention or if left untreated, the condition could reasonably be expected to place the person's health in serious jeopardy or cause serious dysfunction or impairment to a bodily function, bodily organ or part. {Acute condition examples: stroke; heart attack; abscessed teeth; broken bones; ear infections. Chronic condition examples: insulin dependent diabetes; HIV positive with complications; cancer; kidney disease; tuberculosis.} For short-term emergencies, coverage is for the duration of the emergency only; for chronic conditions meeting the emergency definition, eligibility may continue indefinitely.

MCYSHN & DHS 8-5-10

NONCITIZENS and MINNESOTA HEALTH CARE PROGRAMS

MA = Medical Assistance**;** **EMA** = Emergency Medical Assistance**;** **GAMC** = General Assistance Medical Care; **MCRE** = MinnesotaCare**;** **NMED** = Noncitizen Medical (state-funded MA); **RMA** = Refugee Medical Assistance.

[**For more information**, in this packet see both the "Medical Funding Summaries" (eligibility information summarized for each program), and "Noncitizen Information" (immigration statuses described). Also, DHS has a document "Health Care Eligibility for Noncitizens" on their Website] (www.dhs.state.mn.us)]

Immigration Status	**Pregnant Women**	**Children (under 21)**	**Adults over age 21 (Parents, Blind, Disabled, or Elderly)**	**Adults over 21** (Not a parent, pregnant, blind, disabled, or elderly)
Qualified noncitizen: Including: Refugee; American Indian noncitizen; Asylee; Amerasian; Cuban/Haitian Entrant; Afghani/Iraqi Special Immigrant; Lawful Permanent Resident (LPR) > 5 years; Battered noncitizen > 5 years; Parolee > 5 year; Trafficking victim; Withholding of removal; Victim or witness of certain crimes; Military service in U.S. armed forces (including spouse and children)	• **MA with FFP** (Federal Financial Participation) • **RMA** • **MCRE** [program LL]	• **MA with FFP** • **TEFRA**.option for certain disabled children if ineligible due to parents' excess income • **RMA** • **MCRE** [program LL]	• **MA with FFP** • **RMA** • **MCRE** [program LL for parents or relative caretakers]	• **RMA** • **MCRE** [program BB] • **GAMC**
Other lawfully present noncitizen: Including, but not limited to: LPR < 5 yrs; Battered noncitizen < 5 yr; Parolee ≤ 1 yr; Parolee ≥ 1 yr. and < 5 yrs; Applicant for asylum; Deferred action; Deferred Enforced Departure; Family Unity Beneficiary; Lawful Temporary Resident; Pending immigration status; Temporary Protected Status; Marshall & Micronesian Islander; Republic of Palau citizen; Stays of deportation; Persons with an order of supervision; Granted work authorization under pending application for adjustment of status; Nonimmigrants legally admitted on a long term basis, such as those with K-Visas, V-Visas, U-Visas	• **MA with FFP** (Federal Financial Participation) • **MCRE** [program KK]	• **MA with FFP** (Federal Financial Participation) • **TEFRA** option for certain disabled children if ineligible due to parents' excess income • **MCRE** [program KK]	• **State-funded MA (NMED)** • **MCRE** [program JJ for parents or relative caretakers]	• **MCRE** [program BB] • **GAMC**
Undocumented & nonimmigrant noncitizen including temporary visitor, foreign student, and temporary worker.	• **CHIP-funded MA** if no insurance & no spenddown • **EMA** if has insurance or spenddown	• **EMA** (**TEFRA** option for certain disabled children with a medical emergency, if ineligible due to parents' income)	• **EMA**	**NOT eligible for any Minnesota Health Care Program**
People receiving services from the Center for Victims of Torture (CVT)	• **State-funded MA (NMED**) if not MA eligible without a spenddown	• **State-funded MA (NMED** if not MA eligible without a spenddown	• **State-funded MA (NMED**) if not MA eligible without a spenddown	• **State-funded MA (NMED**) if not MA eligible without a spenddown

[SOURCES (1) DHS Health Care Programs Manual; (2) DHS Bulletin #10-21-09 Legislative Changes to MA Eligibility for Certain Noncitizen Children and Pregnant Women (7-27-10).]

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NONCITIZEN INFORMATION

Immigration status is established by the U.S. Citizenship and Immigration Services (USCIS).

[**NOTE**: The DHS document "Health Care Eligibility For Noncitizens", on the DHS Website **www.dhs.state.mn.us** , contains much more information.]

Immigration Status is NOT considered in determining eligibility for the following:

- EMA (Emergency Medical Assistance).
- Persons receiving services from the CVT (Center for Victims of Torture)
- Other services and programs, such as non-cash emergency disaster relief, school lunch/breakfast programs, Public Health immunizations, testing and treatment for communicable diseases, Head Start, WIC (Women, Infants and Children) and some local or regional free/reduced fee clinics.

Afghan and Iraqi Special Immigrants - Status began 12-07, for Afghan and Iraqi translators employed by the U.S. military (including spouses and unmarried children under age 21). They are eligible for RMA (Refugee Medical Assistance) for the same period as refugees and for federally-funded MA (Medical Assistance) if they meet all other MA requirements.

American Indian Noncitizens - If 1 of the following: (1) Born in Canada and at least 50% American Indian blood (includes spouse and biological or adopted children also at least 50%). They are considered a LPR.; or (2) Member of a federally recognized Indian tribe (as defined in the Indian Self-Determination and Education Assistance Act) born in Canada.

Amerasian - Noncitizen children of Vietnamese mothers and U.S. citizen fathers who were born in Vietnam between 1/1/62 and 1/1/76. This includes their accompanying immediate relatives (spouses, children, parents or guardians). They are admitted to the U.S. as LPR (Lawful Permanent Resident). This group does not include Amerasians from Vietnam here as non-immigrant, or Amerasians from countries other than Vietnam.

Asylee (Status is set after entering the U.S) - Noncitizens already present and have been granted permission to remain in the U.S. Asylum is granted because of a well-founded fear of persecution if they return to their home country. They may apply for LPR (Lawful Permanent Resident) status after one year. Asylees who adjust their status to LPR are eligible as asylees for 7 years from the date granted asylum. **Applicants for Asylum** are allowed to remain in the U.S. with an employment authorization document or card while their applications for asylee status are pending with the USCIS.

"Battered immigrants" - Noncitizen spouse or child victim of domestic violence (battered or subjected to extreme cruelty) who are attempting to become a LPR (Lawful Permanent Resident). The domestic violence occurs in the U.S., by a U.S. citizen or LPR parent, spouse, or relative, who resided in the same household as the victim. The applicant must no longer live with the abuser and cannot have participated in the abuse of the child. The need for health care coverage must be "substantially connected" to the abuse. The immigration provisions of the 1994 Violence Against Women Act (VAWA) allow certain battered immigrants to file for immigration relief without the abuser's assistance or knowledge, in order to seek safety and independence from the abuser. USCIS determines the battery and/or cruelty and approves the petition for adjustment to LPR status. If the person doesn't have a legal immigration status, USCIS may place them in "deferred action" status at the time of the self-petition approval.

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Center for Victims of Torture (CVT) - State law allows those receiving "care and rehabilitation" services from a non-profit center established to serve victims of torture, to **not have to meet MA eligibility criteria** ("basis of eligibility", income, asset, or immigration requirements).

Conditional Entrant - Granted conditional entry into the U.S. because of fear of persecution in the home country due to race, religion, political opinion or because of a natural disaster. This status was used for refugees prior to the Refugee Act of 1980 and is no longer used by Federal Government.

Conditional Permanent Resident - Received LPR (Lawful Permanent Resident) status through marriage to a U.S. citizen if they have been married less than 2 years when the LPR status was granted. After 2 years, the couple or individual must file a petition for the removal of the condition during the 90 days before the second anniversary of the date the conditional resident status was obtained.

Cuban/Haitian - Nationals of Cuba or Haiti who meet 1 of the following: paroled into U.S.; or are subject to exclusion or removal proceedings; or who have an application for asylum pending. This status continues for those applying to stay in the U.S. through other than refugee, immigration, and tourist or business channels. Not all people from Cuba or Haiti have this status - some are admitted under other statuses, such as refugee or LPR (Lawful Permanent Resident).

Deferred Action - Granted by the USCIS or an immigration judge. Deferred action means the USCIS will not initiate removal proceedings against the person. This status may be granted to a self-petitioning battered spouse or child.

Deferred Enforced Departure (DED) - Granted to certain noncitizens by executive authorization of the President, offering protection from deportation for a period of 12 or 18 months because of political instability in the country of origin or other reasons.

Family Unity Beneficiary – Provides protection from deportation and employment authorization to the spouses and unmarried children (under age 21) of noncitizens who obtained legal status under the Immigration Reform and Control Act of 1986 (IRCA).

Honorably discharged U.S. veterans, or active duty U.S. military - Noncitizen veteran honorably discharged from the U.S. military (2 yrs. minimum active duty), or active duty personnel. This includes their spouses and unmarried dependent children. NOTE: Active duty includes Army, Navy, Air Force, Marine Corps, or Coast Guard - does NOT include National Guard service.

Lawful Permanent Resident (LPR) - Lawfully admitted to the U.S. as permanent residents under the Immigration and Nationality Act (INA). The spouse and children of the primary application may also be admitted at the same time. If they have a sponsor, the sponsor's income and assets may be counted [Exceptions: See "Sponsor-Deeming" for types of noncitizens where sponsor income and assets are NOT counted.] Lawful permanent residency can be generally obtained through one of the following:

(1) Family-based visa petition (filed by a U.S. citizen or an LPR who is a close family member);

(2) Employment-based visa petition (filed by an employer to immigrate a prospective

employee whose job skills are needed in the U.S.);
(3) Winning of the diversity visa lottery (for persons from certain countries);
(4) Adjustment of status from refugee and asylum status or from a temporary class of admission; or
.
(5) "Self-petitioning" for an immigrant visa (as a widow or widower of a U.S. citizen, or an abused spouse or child of a US citizen or LPR;
(6) Application for adjustment under special immigration laws

Lawful Temporary Resident (LTR) - Resided in the U.S. unlawfully since before 1/1/82 and were allowed to legalize their status under the 1986 IRCA. Most of these people now are LPRs.

Nonimmigrants - Some immigrants are admitted into the U.S. for a limited period of time and specific purpose (such as foreign students, tourists, temporary workers, visitors on business) and would not be eligible for Minnesota Health Care Programs. However, some immigrants are legally admitted to the U.S. on a long term basis and must follow certain requirements to adjust their status, such as nonimmigrants with a T or U visa. Other noncitizens are admitted as nonimmigrants and later adjust their status, for example to apply for asylum. Citizens of the former trust territories of Micronesia and the Marshall Islands are permanent non-immigrants (status doesn't expire; can live and work permanently in U.S).

Order of Supervision - Permanently living in U.S. Under Color of Law (PRUCOL), with the knowledge and permission of the USCIS, and are required to report to USCIS periodically. They are deportable, but factors exist which make it unlikely the USCIS would be able to remove them (ex: age, or physical condition, or humanitarian concerns, or the availability of a county to accept them).

"Other Lawfully Present" – Noncitizens here on a non-permanent, limited basis. They will most likely leave the U.S. when their status expires, or they will file a petition to adjust their status to LPR. This includes, but is not limited to:

- Applicants for Asylum
- Deferred Action
- Deferred Enforced Departure (DED)
- Family Unity Beneficiary
- Lawful Temporary Resident (LTR)
- Parollees for less than 1 year
- Pending application for Special Immigrant Juvenile status
- Pending immigration status
- Persons with an order of supervision
- Withholding of Removal
- Temporary Protected Status (TPS)
- Granted work authorization under a pending application for adjustment of status
- Citizens of Micronesia, the Marshall Islands, and Republic of Palau admitted as nonimmigrants & permitted to live permanently or indefinitely in the U.S.
- Other immigration categories of noncitizen lawfully present in the U.S. include, but are not limited to: Indefinite stay of deportation; Indefinite voluntary departure; Stays of deportation; or Filed application for adjustment of status and USCIS has accepted as "properly filed".

"Paroled" into U.S. - Noncitizens granted entry into the U.S. for humanitarian, medical, legal reasons, or for other reasons deemed to be of public interest.

Pending Immigration Status - Applicants for asylum, family unity and adjustment of status, who are already here and have a pending immigration status, are considered to be lawfully residing in the U.S. while their applications are still being processed. The process of establishing asylee status can take a year or longer.

"Public Charge" - A term used by USCIS to describe a noncitizen who has become, or is likely to become, primarily dependent on the government for subsistence. For health care programs, using MA (Medical Assistance), GAMC (General Assistance Medical Care) or other health care benefits will NOT affect "public charge" status, except for the use of long-term care (nursing homes). Refugees and asylees are NOT subject to public charge considerations. This pertains to a person who relies on cash assistance for their income (MFIP, SSI, MSA and GA), and it may harm a person's chances of adjusting their status and getting a green card.

"Qualified" noncitizens – Noncitizens who entered the U.S. on or after August 22, 1996, and live in the U.S. for at least 5 years in a "qualified" status may qualify for MA with FFP or MinnesotaCare back to the 1st day of the month in which they meet the five-year requirement. A person who meets one of the following immigration criteria: (1) LPR; (2) Refugee; (3) Granted asylum; (4) Removal is being withheld; (5) "Paroled" for at least 1 year; (6) Granted conditional entry; (7) Cuban/Haitian entrant; (8) Battered noncitizen with an approved or pending petition for immigration status.

Refugee (status set prior to entering the U.S.) - Have permission to enter and live in the U.S. because of a well-founded fear of persecution in their home county due to race, relation, membership in a particular social group, or due to political opinion. They can apply for LPR (Lawful Permanent Resident) status after 1 year. Once they adjust their status to LPR, they are eligible as refugees for 7 years from the date of U.S. entry. This status includes: Afghan/Iraqi Special Immigrant; Asylee; Cuban/Haitian, Amerasian; Victims of trafficking.

Pending Application for "Special Immigrant Juvenile" status - They have an "Other Lawfully Present" status, and if under age 21 or pregnant, can apply for MA (Medical Assistance) with FFP, or MinnesotaCare. "Special Immigrant Juvenile" is an immigrant who is present in the U.S. and who has been declared dependent on a juvenile court or who a court has legally committed to or placed under the custody of an agency or a department of state and who has been deemed eligible for long-term foster care due to abuse, neglect or abandonment.

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Sponsor-Deeming - A sponsor is a U.S. citizen or LPR who signs a USCIS legally enforceable written agreement ("Affidavit of Support") on behalf of a noncitizen, as a condition of the noncitizen's entry into the U.S. The USCIS determines whether a noncitizen needs a sponsor to enter the U.S. and if a person meets the criteria to become a sponsor for the noncitizen. A sponsor agrees to provide financial support to maintain an immigrant at 125% of the Federal Poverty Guideline (FPG). 100% of the sponsor's (and sponsor's spouse) income and assets are counted as income for the sponsored-immigrant. Sponsor-Deeming applies even if the sponsor never gives the noncitizen any money. The sponsor's family size and fixed debts are irrelevant. Sponsor-deeming applies only to family-based immigrants (arriving through a petition from a family member, the most common method of immigrating to the U.S). Sponsor-Deeming applies for MA, GAMC and MinnesotaCare. **Exceptions: Sponsor-deeming does NOT apply** for all of the following: (1) Pregnant women and children under age 21; (2) Refugees; (3) Asylees; (4) Diversity visa (visa lottery) recipients; (5) MA-BC (breast/cervical cancer) program; (6) EMA (Emergency Medical Assistance); (7) Immigrants

with Temporary Protected. Status (TPR); or (8) Indigence - when DHS determines without the benefit, the immigrant will go hungry or become homeless. Indigence exemption is up to 12 months, with possible 12-month renewal.

Temporary Protected Status (TPS) - Granted to people from counties designated by the Secretary of Homeland Security (counties were there is an ongoing armed conflict, an environmental disaster, or other extraordinary circumstances that pose a serious threat to the person's safety if they return to their home country). TPS does not lead to permanent resident status.

Trafficking Victim - Certified by the Office of Refugee Resettlement (ORR) or the U.S. Dept. of Health and Human Services (HHS), for persons forced into the international sex trade, prostitution, slavery, or forced labor coercion, threats of violence, psychological abuse, torture and imprisonment. Certification is for an 8-month period, with follow-up certification possible. Trafficking victims under age 18 are not required to be certified, but are issued letters of confirmation by the ORR.

Undocumented - Persons entering the U.S. without the necessary documents, avoided Bureau of Customs and Border Protection (BCBP) inspection at the border, or violated the terms of a nonimmigrant visa (after entering the U.S. legally) by not leaving the U.S. when their visa expired. Undocumented noncitizens can only apply for EMA;

"Unqualified" noncitizens – This includes the following: (1) Have no documentation; (2) Have expired documentation; (3) Came to the U.S. with a fiancé ("K"or "K-1"visa); (4) Have applied for suspension of deportation or cancellation of removal; (5) Have applications pending for adjustment or asylum; (6) Lawful temporary residents under an amnesty program; or (7) Non-immigrants (students, or visitors, or those with a temporary worker visa, or those with temporary protected status[TPS])

Withholding of Removal (formerly called "withholding of deportation") – This status is similar to asylees (deportation is withheld because of a threat to life/freedom in the person's home country due to race, religion, nationality, membership in a particular social group, or political opinion). Very few are given this status. They have NO direct path to becoming an LPR.

[Sources: (1) DHS Bulletin #10-21-09 (issued 7-27-10) "Legislative Changes to MA Eligibility for Certain Noncitizen Children and Pregnant Women"; (2) DHS Health Care Programs Manual (downloaded 8-1-10); (3) DHS "Health Care Eligibility for Noncitizens" 6-18-08; (4) "Public Benefits for Noncitizens" (Fall 2010), Mid-Minnesota Legal Assistance]

MHCP (Minnesota Health Care Programs)
Covered Services and Non-Covered Services, Supplies and Equipment

COVERED SERVICES

Service must be "Medically Necessary" to be covered and some need prior authorization. See the MCHP Provider Manual on the DHS Website (www.dhs.state.mn.us) for coverage details, including authorization information.
MA-Medical Assistance; **RMA**-Refugee Medical Assistance; **NMED**-Noncitizen Medical; **EMA**-Emergency Medical Assistance

[**NOTE:** ***Letters in bold and in parentheses behind some of the services*** on the list indicates there is more information about that service coverage on the pages following this table.]

SERVICES		MA; or RMA; or NMED	❖ MinnesotaCare (MCRE)		EMA
			Expanded Benefit Set	3 Basic "Plus" Benefit Sets	
Case Management/Service Coordination **{A}**		Yes	Yes	No	Yes
Chemical Dependency Treatment **{B}**		Yes	Yes	Yes	Yes
Child and Teen Checkups (C&TC)		Yes	Yes	No	No
Chiropractic **{C}**		Yes	Yes	Yes	Yes
Dental **{D}**		Yes	Yes	Yes	Yes
Emergency Room **{E}**		Yes	Yes	Yes	Yes
Eye Exams /Eyeglasses **{F}**		Yes	Yes	Yes	Yes
Family Planning **{G}**		Yes	Yes	Yes	No
Hearing Aids		Yes	Yes	Yes	No
Home Care **{H}**		Yes	Yes	Yes	Yes
Hospice Care		Yes	Yes	Yes	Yes
IEP (Individual Education Plan) Services **{I}**		Yes	Yes	No	Yes
Immunizations		Yes	Yes	Yes	No
Inpatient Hospitalization **{J}**		Yes	Yes	Yes	Yes
Insurance Premiums **{K}**		Yes	No	No	No
Interpreters (hearing and language) **{L}**		Yes	Yes	Yes	Yes
Medical Equipment and Supplies		Yes	Yes	Yes	Yes
Mental Health **{M}**		Yes	Yes	Yes	Yes
Nursing Home/ICF-DD		Yes	Yes	No	Yes
Outpatient Surgical Center		Yes	Yes	Yes	Yes
Physician and Clinic Visits **{N}**		Yes	Yes	Yes	Yes
Podiatrist **{O}**		Yes	Yes	Yes	Yes
Prescription Drugs **{P}**		Yes	Yes	Yes	Yes
Rehab. Therapies (PT, OT, Speech) **{Q}**		Yes	Yes	Yes	Yes
Transportation (Medical) **{R}**	Access	Yes	Yes	No	Yes
	Emergency or Special	Yes	Yes	Emergency only	Yes

- ❖ **MCRE Expanded =** Pregnant women and children (under 21); income at or below 275% of the FPG.
- ❖ **MCRE Basic Plus** = : Parents with children (under 21 in the home), with income above 175% of the FPG. Parent eligibility ends at family income of $50,000/year.
- ❖ **MCRE Basic Plus One** = Non-pregnant adults (21 & older), without children under 21 in their home, with income at or below 250% of the FPG.
- ❖ **MCRE Basic Plus Two** =: Parents with children (under 21) in their home; income at or below 175% of the FPG.

[**NOTE: GAMC -** As of June 1, 2010, GAMC recipients must choose a hospital-based Coordinated Care Delivery System (CCDS). Non-emergency services (except pharmacy services) that are not provided and coordinated by the CCDS are not covered. [For more GAMC information, see the "Medical Funding Summary-GAMC, in this packet.]

COPAYS

The copay amounts are set by the Minnesota Legislature, and the enrollee pays them directly to their provider. (For persons **on a MHCP with a "spenddown",** copays are billed by the provider to the enrollee only after their spenddown has been met.).

Some **persons have NO copays:**

- Pregnant women & children under 21; or
- Persons living/expecting to live for more than 30 days in a nursing home or ICF/DD; or
- Persons on Refugee Medical Assistance (RMA); or
- Persons in hospice car

Copay limits: One per day per treating provider for eye glasses, non-emergency visits to an ER (except drugs), and non-preventive visits (required because of the person's symptoms, diagnosis, or established illness). Monthly copays for MA enrollees with income at or below 100% of the FPG are capped at 5% of their monthly gross income (ranging from $0 up to a maximum of $7 per month). The copay monthly cap is based on monthly gross income and the number of adults in the household who qualify for limited copays.

If you are unable to pay a copay, a federal statute protects persons on federally-funded MA from denial of services based on inability to pay as long as you tell the provider you can't pay the copay. Providers cannot ask for proof that you cannot pay. However, the provider can still bill you for the copay amount. If the person is on federally-funded MA, the provider also cannot deny future or ongoing service to the recipient. [Exception: This federal statue does NOT apply to persons on state-funded MA (NMED for non-citizens) or state-funded MinnesotaCare. The services have to be provided for the current visit, but it if it the provider's standard office policy to refuse services to patients who have debt, these persons may be refused future ongoing services because of the inability to pay their copay.]

{A} Case Management /Service Coordination

- The terms **case management/service coordination** are often used interchangeably and include activities to help the recipient access a wide variety of needed services (health, social services, educational, vocational, advocacy, transportation, legal, volunteer and others), as they relate to the recipient's needs.. Case management includes assessment, development of a care plan; referral and related activities to obtain needed services; and monitor/follow-up activities. Persons need to meet the criteria for one of 6 types of case management: 1) Child Welfare Targeted Case Management; 2) Mental Health Targeted Case Management; 3) Relocation Service Coordination; 4) Rule 185 Case Management; 5) Targeted Case Management for Vulnerable Adults and Adults with Developmental Disabilities; and 6) Waiver Case Management. [See the DHS Disability Services Program Manual online (www.dhs.state.mn.us)].
- Managed Care Organizations (MCO) are responsible for assessing the need for and providing case management services for persons enrolled. County DHS determines eligibility if not MCO enrolled, with eligibility re-determined every 36 months.
- Effective on or after July 1, 2010, the **Health Care Homes** (HCH) program, authorized by the Minnesota Legislature in 2008, allows qualified MHCP-enrolled providers to receive HCH reimbursement for the delivery of care coordination services to MHCP recipients who have complex and chronic medical conditions. The development of the HCH initiative is a coordinated effort between the Minnesota Department of Health and the Department of Human Services. Clinics and clinicians must meet a set of standards and criteria in order to be certified as a health care home in Minnesota. Once providers are certified, they will be included on a list available on the DHS Website.(www.dhs.state.mn.us) .

{B} Chemical Dependency (outpatient and residential)

- Covered for all MHCP recipients who, after receiving a chemical use assessment, meet the criteria for chemical abuse (Level 2) or chemical dependency treatment (Level 3). Halfway house and extended care is paid fee-for-service. Outpatient CD treatment is covered.

- The Managed Care Organization (MCO) is responsible for Primary Residential Inpatient care (including the assessment, placement, and the provision or contracting of chemical dependency treatment services) for their MHCP enrollees. Recipients in MCOs who meet the criteria for extended rehabilitation or transitional rehabilitation must be referred by the MCO to the county DHS for placement under the Consolidated Chemical Dependency Treatment Fund (CCDTF).
- **GAMC:** Use the county CCDTF.

{C} Chiropractic - Covered services include manual manipulations of the spine for subluxation(s) and x-rays to diagnose subluxation(s).
- The **3 MCRE Basic Plus** benefit sets have a $3 copay

{D} Dental - There are no yearly dollar limits on dental services.
- **MCRE Expanded** coverage includes the full MA dental benefits. **Orthodontia** is covered for children in limited circumstance and only with prior authorization
- The 2009 Minnesota Legislature made significant limitation changes to MHCP dental coverage effective January 1, 2010. For all non-pregnant adults on MHCP, including **MCRE Basic Plus One, Basic Plus Two, and MCRE Basic Plus**, coverage consists of a limited benefit set:
    - Periodic exam once per calendar year
    - Limited examination
    - Comprehensive exam once per 5 years
    - Bitewing x-rays once per calendar year
    - Periapical x-rays
    - Panoramic x-rays once per 5 years (except when medically necessary for the diagnosis & follow up of oral & maxillofacial pathology & trauma. Panoramic x-rays may be taken once every 2 years for patients who cannot cooperate for intraoral film due to a developmental disability or medial condition that does not allow for intraoral film placement.
    - Cleaning once per year
    - Fluoride varnish once per year
    - Posterior & anterior fillings
    - Root canals limited to the anterior & premolar teeth only
    - Removable dentures & partials (each dental arch, one every 6 years)
    - Oral surgery limited to extractions, biopsies, & incision & drainage of abscesses
    - Palliative treatment & sedative fillings for the relief of pain
    - The following services are covered only if provided in an outpatient hospital setting or feestanding ambulatory surgical center as part of outpatient dental surgery: Periodontal scaling & root plaining once every 2 years; General anesthesia; and full mouth survey x-rays once every 5 years.
- **EMA:** Eligibility exists for the duration of the emergency only, and may begin or end mid-month. Cleanings, fluoride treatment/fluoride varnish, periodic oral exams, oral hygiene instructions, sealants, and routine x-rays are not covered..

{E} Emergency Room (ER)
- Copay for ER visit which was **not an emergency**: **MA** - $6**; EMA**-$6; **MCRE non-pregnant parents and adults without children**-$6; **GAMC** - $25.
- **Effective January 1, 2010** the copay for the non-emergency use of the emergency room is reduced from $6 to $3.50 for all MHCP enrollees.

{F} Eye exams/Eyeglasses/Contact lenses
- NO MHCP pays for eyeglass add-ons (ex: lens coating, special edge treatments, scratch resistant coating, anti-reflective lens coating), or upgraded lenses (ex: transition lenses, no-line bifocals, high-index plastic, more fashionable frames), or back-up glasses. The recipient must pay for the entire cost of the eyeglasses (including repairs) if they contain the non-covered add-ons or upgrades. Providers must tell the recipient

before providing the item that it isn't covered by MHCP. The provider can't bill the recipient for the difference between the MHCP covered product and the add-on or non-covered item.

- Copays do not apply if only the frames are dispensed, or only the lenses are dispensed, or for repair of eyeglasses.
- **Contact lenses** are covered without authorization if prescribed for aphakia, keratoconus, or aniseikonia and for bandage lenses. All other diagnoses/conditions requires authorization for contact lens services and supplies.
- **MA and MCRE Expanded:** No copays.. **3 MCRE Basic** benefit sets have $3 copay on eye exam & $25 copay on eyeglasses. **EMA:** doesn't cover vision screening or eyeglasses. **GAMC:** Does NOT cover eyeglasses. A CCDS (Coordinated Care Delivery System) may cover eye exams. [Each CCDS can decide what services they cover.]

{G} Family Planning - All MHCP recipients, who have this as a covered service, have free choice of qualified family planning providers, including those outside of their provider network. The **3 MCRE Basic** benefit sets have $3 copay for family planning services.

{H} Home Care [See the DHS topic packet in this manual for more "Home Care" information]

- MHCPs do NOT cover a home visit if more than one visit (for a particular type of home health service by a home health agency), per recipient per day - (Exception: respiratory therapy visits or skilled nurse visits as specified in the recipient's plan of care).
- **MCRE Expanded:** covers Private Duty Nursing and PCA. The **3 MCRE Basic** benefit sets do NOT include Private duty nursing and PCA. **EMA:** Covers home care only for acute conditions (not chronic conditions). EMA does not cover Public Health Nurse (PHN) health promotion and counseling visits.

{I} IEP Services: Paid fee-for-service. [See "School" topic packet for more information on IEP coverage]

{J} Inpatient Hospitalization

- **MCRE Basic Plus:** No copay; and no $10,000 annual limit if income at or below 215% FPG. **MCRE Basic Plus One:** $10,000 yearly limit and a 10% copay (up to $1,000). [NOTE: If the $10,000 inpatient hospital limit has been reached, the enrollee is responsible for the balance of the hospital bill, unless the enrollee is eligible for MA.] **EMA:** Doesn't cover organ transplants.

{K} Insurance Premiums

- **MA** may be able to pay your other health insurance premium if DHS determines it to be "cost effective". This includes both if you are paying the premium for private insurance yourself, or the coverage is available through current or former employment and the insurance premium is at some cost to you. Policies that cover children on TEFRA are considered cost effective and don't require further review if the child's portion of premium is $50 or less per month.
- Medicare supplement (also known as "Medigap" policies) and Medicare Advantage (Medicare part C) are never considered cost-effective. MA does not reimburse Minnesota Comprehensive Health Association (MCHA) insurance premiums.
- Persons with insurance or access to insurance must cooperate to determine if payment of the premiums is cost effective and must enroll in the plan at the earliest possible date or remain enrolled in the plan if it is approved as cost effective. Adult members of a case are ineligible for MHCPs if they fail to cooperate with the cost effective health insurance requirements.

{L} Interpreter Services (including hearing impaired and foreign language)

- Agencies getting state or federal funds must provide a free interpreter to people with limited English skills (including most government offices, schools, courts, hospitals, police and fire departments, and

non-profits). Interpreter services are considered "access" or "enabling" services and are covered by MHCP, so the enrollee can get medically necessary health care.

- MHCP providers with at least **15 employees and Prepaid Health Plans** must provide these interpreter services if the enrollee needs them to receive medical services. If the MHCP provider has **fewer than 15 employees**, the County DHS agency and MinnesotaCare Operations are responsible for providing these interpreter services not covered by the Prepaid HealthPlan, for MHCP enrollees on MA, or MCRE pregnant women and children under age 21.
- All MHCP enrollees eligible for access services are to be given written information about their county DHS access plan requirements. To get an interpreter, ask for one. If the agency refuses, tell them the law says they must provide an interpreter. Complain in writing and keep a copy. Getting an interpreter should not take so long that you lose a benefit or miss a deadline. It is illegal for an agency to ask you to bring an interpreter (you can bring your own if you want, but an agency may choose to use its own interpreter). Children/minors should not be interpreters[2].

{M} Mental Health (MH) - There are NO copays for mental health visits. Some services require persons meet criteria and/or functional limitations based on their diagnosis. [NOTE: See the "Mental Health" topic packet for more info. on children's mental health. Also, see the DHS MHCP Provider Manual (Chapter 14) for specific mental health details: www.dhs.state.mn.us].

- For children's residential MH treatment services, both the Managed Care Organization (MCO) and county DHS have a role in authorizing, paying for and monitoring the services.
- For MH-Targeted Case Management (MH-TCM), Managed Care Organizations are responsible for both determining eligibility and providing the services, either directly or through contracted providers. Persons eligible for and who accept the offer of MH-TCM services should have timely access to the services ("wait lists" can not established to access MH-TCM). Acceptance of MH-TCM cannot be a requirement for consumers to access other services. **The 3 MCRE Basic benefit sets do not cover Adult MH-TCM.**
- **GAMC -** Access to mental health services is the same as access to other health care services - if enrolled in a CCDS, they should go to their CCDS. The CCDS determines coverage for non-emergency mental health services (such as MH-TCM) and for Intensive Residential Service Treatment (IRTS). If persons on GAMC are not enrolled in a CCDS, there is no coverage for MH-TCM, IRTS and other non-emergency mental health services. (However, there may be some free or low-cost services available through local providers.)

{N} Physicians/Clinics/Lab/X-ray

- **MA and all the MCRE** benefit sets cover non-preventive visits and preventive visits Preventive visits = routine physical exams, screenings, prenatal and postnatal care, and counseling/risk factor reductions visits.) The **3 MCRE Basic** benefit sets have a $3 copay for non-preventive visits, and visits with diagnostics only (ex: colonoscopies). **EMA** doesn't cover organ tranplants, preventive visits or screening tests (hearing screenings, mammograms, lab, x-rays, etc.), or preventive physician and clinic services. **GAMC –** No copays if services are received through the CCDS. If not enrolled in a CCDS, the recipient can be billed.
- Preventive visits not covered by MHCPs include services that are only for vocational or educational purposed that are not health related; and services that deal with external social, or environmental factors that do not directly address the recipient's physical or mental health.]

{O} Podiatrist – The 3 MCRE Basic benefit sets have a $3 copay for non-preventive visits.

{P} Prescription Drugs - There are **no copays** for certain mental health drugs or for contraceptive drugs.

- All of the Over-The–Counter drugs must be dispensed in the manufacturer's original, unopened container. (Except Sorbitol may be re-packaged.)

- Two rescue inhalers (ex: albuterol) can be dispensed if one is needed for home and one for school/work.
- **MA, GAMC and EMA**: all have $3 copay on brand names and $1 copay on generic, with $7/month maximum co-pay. The **3 MCRE Basic** benefit sets have a $3 copay, with no monthly copay maximum.
- Prescription drugs **NOT covered by MHCP** includes: (1) drugs for erectile dysfunction; (2) Minixidol for male pattern baldness; (3) Herbal or homeopathic products drugs dispensed after their expiration date; (4) Nutritional supplements, except as specifically allowed in the DHS Provider Manual or provider updates; (5) the cost of shipping or delivering a drug; (6) drugs lost in shipping or delivery; (7) Compounded drugs, except as allowed in the Provider Manual; (8) drugs determined to be less-than-effective (DESI) by the FDA and drugs identified as identical, related or similar to DESI drugs; (9) drugs from manufacturers without a rebate agreement with CMS; (10) drugs which are limited or excluded by the state as allowed by federal law (OBRA 90); (11) drugs requiring prior authorization and for which criteria wasn't met. In addition, **GAMC** doesn't cover anti-rejection drugs. Also, **EMA** doesn't cover vitamins/minerals, organ transplant anti-rejection drugs, drugs treating impotence of organic origin, acne medication, contraception, smoking deterrents, fertility drugs, hydroquinone cream, antihyperlipemia drugs, weight loss drugs, ADHD drugs, growth hormone, Drysol, or Antabuse.

{Q} Rehabilitation Therapies - Physical Therapy (PT), Occupational Therapy (OT), Speech Language Pathology (SLP) and Audiology.

- For **GAMC:** All rehab services must be coordinated through the recipient's CCDS.

{R} Transportation - Medical transportation is to and from a covered MHCP appointment.

- Enrollees in a Managed Care Organization (MCO) should contact their MCO for transportation procedure requirements; otherwise, contact your county DHS for transportation procedures.

- The **3 types of medical transportation** include:
  1. **"Access" ("common carrier") transportation services (ATS)** includes bus, taxi, private car/contract, or direct mileage reimbursement to the recipient or the recipient's volunteer driver. This may include the cost of parking, and in some cases also lodging, meals and airfare. Common carrier (bus, taxi) or volunteer driver mileage reimbursement is paid through the Managed Care Organization for plan enrollees. Personal mileage reimbursement is through the County DHS or through MNET (Minnesota Non emergency Transportation), depending on county of residence. Contact county DHS for ATS policies.
  2. **Ambulance** includes emergency and non-emergency ambulance services.
  3. **Special Transportation Services (STS)** is for persons unable to use common transportation (e.g., a bus, taxi or volunteer driver) because of physical or mental impairment which requires the transportation driver to provide direct assistance to the recipient. STS is required to enable the recipient to obtain covered medical services. Direct driver assistance for the recipient is required in the residence/pick up location to exit/enter and at the medical facility to enter/exit to/from the appropriate medical appointment desk (station-to-station/door through door); the driver must obtain a signature from the provider. STS to a health service destination outside of the recipient's local trade area must be ordered by the recipient's attending physician and must be the nearest available provider capable of providing the medical service.. All MHCP recipients are responsible for selecting and contacting an STS provider and scheduling their own STS trips, after getting an approved level of need assessment from MNET (Minnesota Non Emergency Transportation).

- **MA and MCRE Expanded** benefit sets cover all transportation types. (For MCRE Expanded**,** common carrier costs and personal mileage reimbursement is available through the MCRE division.) The **3 MCRE Basic** benefit sets cover ATS and emergency, but not special transportation. **EMA** doesn't cover non-emergency transportation for routine or preventive care. **GAMC** enrollees signed up with a CCDS receive the emergency transportation services provided by their CCDS.

COVERED EQUIPMENT/SUPPLIES (This is not a complete list)

- Apnea monitors, memory monitors and Trend Event Recording
- Alternating pressure pads, mattresses and lamb's wool pads
- Ambulatory uterine monitoring devices
- Assistive technology and Augmentative communication devices
- Bath lifts
- Bathtub chairs and seats
- Bedpans
- BIPAP
- Bilirubin lights
- Blood glucose monitors
- Bone growth stimulators
- Breast pumps (power and manual) and supplies
- Bronchial drainage vests
- Canes, crutches, walkers
- Car seats (specialized)
- Chest compression vest systems
- Commodes
- Continuous passive motion devices
- CPAP and Bi-PAP devices (for obstructive sleep apnea)
- Cranial electrotherapy stimulator (CES)
- Disposable diapers, Undergarments, liners/pads, and underpads
- Enteral nutritional products and administration equipment
- "Formula" (specialized products for child with specific medical needs)
- Eyeglasses
- Gait trainers
- Gloves
- Hearing aids
- Heating pads, heat lamps and steam packs
- Hospital beds, mattresses and side rails
- Infusion pumps
- IPPB machines
- Lymphedema pumps
- Nebulizers with compressor
- Orthopedic footwear (foot deformities, or other medical conditions)
- Ostomy supplies
- Oxygen and oxygen supplies, including oxygen humidifiers
- Patient lifts
- Peak flow meters
- Pneumogram recording equipment
- Portable paraffin bath units
- Postural drainage boards
- Pressure reducing support surfaces
- Prosthetics and orthotics
- Raised toilet seats
- Rent for durable medical equipment (for 10 mo. or to purchase price)
- Repairs/Service to durable medical equipment
- Respiratory Assist Devices (suitable for 12 hrs. or less per day)
- SAD lights
- Seat lift mechanisms
- Seating and positioning devices
- Self-administered injection supplies
- Sitz baths
- Standers
- Suction pumps (respiratory)
- Topical products defined as drugs (including skin care products for specified conditions)
- Tracheostomy supplies
- Traction equipment and trapeze bars
- Transcutaneous electrical nerve stimulators (TENS)
- Ultraviolet cabinet
- Vaporizers
- Ventilators
- Wheelchairs (manual and motorized)
- Wigs (for diagnosis of alopecia areata)
- Wound care supplies/Wound therapy (specialized)

NON-COVERED SERVICES, EQUIPMENT, and SUPPLIES

[Note: Some may be covered under Home & Community-Based Services program]

- Adaptive furniture
- Air conditioners
- Amplifiers for TV, telephone, etc.
- Appliances
- Artificial insemination
- Autopsies
- Bathroom scales
- Bed baths
- Bedboards
- Beds (oscillating and lounge beds), bed boards, bed tables and other bed accessories)
- Bicycles
- Blankets
- Blood glucose analyzers (reflectance colorimeter)
- Body-worn speech amplifying systems, such as “Speechmaker”
- Bottle washers
- Car seats (standard use)
- Cell phones
- Cervical roll or pillow
- Circumcisions, unless medically necessary
- Clothing
- Computers (personal computers & printers)
- Control units and battery device adapters
- Diathermy machines
- Disinfectants
- Disposable ice packs/disposable heat wraps
- Disposable wipes (including Attends wash cloths)
- Ear piercing
- Electric toothbrushes/water picks
- Energy drinks
- Enuresis or bed-wetting alarms
- Environmental products, such as hypoallergenic bedding and linens, air filters and purification systems, humidifiers and dehumidifiers (central or room)
- Exercise equipment
- Eyeglasses or lenses for occupational/educational needs, unless it is the recipient’s only pair & is necessary for vision correction.
- Facilitated communication
- Feeding instruments, tableware and eating utensils
- Food blenders
- Food thickeners
- Formula (standard) for healthy infants under age 1yr. of age
- Grocery store products
- Hair analysis and transplants
- Health club memberships
- Health services: (a) when doctor order is required but not obtained; or (b) not documented in recipient’s medical record, plan of care, treatment plan, IEP, or individual services plan; or (c) paid for by recipient or other source, except when payment is made for services incurred during recipient’s retroactive eligibility period; or (d) not containing documentation of required supervision; or (e) provided [other than emergency health services] without the full knowledge & consent of the person or their legal guardian.
- Heat and massage foam cushion pads
- Herbal or homeopathic products
- Home modifications (ex: grab bars, handrails, elevators, stair lifts, doorways widening, bathroom modifications, ramps)
- Home security systems
- Hot tubs
- Hygiene supplies and equipment (ex: hand-held shower units and shower trays, dental care supplies & equipment, disposable wipes)
- Hypnotist services, other than hypno-psychotherapy
- Incontinence undergarments (includes pants to wear with pads)
- Instructional materials (e.g. pamphlets and books)
- Isolation gowns
- Jet injectors (hypodermic jet pressure powered)
- Karate lessons
- Lotion

[Non-covered continued]

- Magnifying glasses
- Massage devices and masseuse services
- Medical identification bracelets and response systems
- Menses products (sanitary pads)
- Mobility devices, if: a) requested to meet behavioral needs rather than mobility needs; or b) requested solely for use in a public school if the device can be covered through an IEP; or c) designed for sports/recreational purposes; or d) wheelchairs with stair climbing ability; or e) options/accessories to convert a manual chair to a power chair.
- Missed appointments (MHCP recipients may not be billed)
- Non-prescription over-the-counter ointment/creams/ lubricants
- Nutritional products: 1) for health newborns; or 2) for which the need is nutritional rather than medical, or is related to an unwillingness to consume solid or pureed foods; or 3) for a convenient alternative to preparing/consuming regular food; or 4) because of an inability to afford regular foods or supplements
- Orthopedic mattresses
- Orthopedic shoes (stock orthopedic shoes, except when attached to a leg brace or for a diabetic)
- Paternity tests
- "Potty" chair/seats for toilet training children
- Power mobility devices requested solely for the purpose of community outings such as attending social activities.
- Pulse tachometers
- Reachers
- Reading glasses
- Reversal of voluntary sterilizations
- Saline or other solutions for the care of contact lenses
- Sport shakes
- Surgical masks/gowns
- Surgery primarily for cosmetic purposes
- Surrogate pregnancy and related services
- Swimming lessons
- Switches, except on power operated wheelchairs or augmentative communication devices
- Table foods
- Tape recorders
- Tattoos
- Telephones, telephone alert systems, telephone arms, and answering machines
- Tennis/gym shoes
- Therapeutic tables
- Thermometer covers
- Toothbrushes and toothettes
- Toys
- Trampolines
- Transfer boards
- Treadmills
- Tricycles, chain-driven or otherwise
- Underwear
- Utensils
- Vehicle modifications: adapted seating, door handle replacements, door widening, motorized lifts, wheelchair lifts, wheelchair securing devices
- Video recorders
- Vocational or educational services, including functional evaluations or employment physicals, except as provided under IEP-related services
- Waterbeds
- Weight loss program enrollment
- White canes for the blind

[SOURCES: 1) DHS MHCP Provider Manual (downloaded 7-19-10); 2) Your Right to an Interpreter (Fall'08); Minneapolis Legal Aid Society.]

Social Security Administration (SSA) Overview

When Social Security Administration (SSA) decides a child/adult is disabled they pay benefits under two programs:

- Supplemental Security Income (SSI) for people with little or no income and resources and pays benefits based on financial need.
- Social Security Disability Insurance (SSDI) pays benefits to adults and certain members of their family if the adult is "insured" meaning they worked long enough and paid Social Security taxes.

Supplemental Security Income (SSI)

Children as well as adults may qualify for SSI disability payments. The child must have a physical or mental condition(s) that very seriously limits his/her activities; AND the condition(s) must have lasted, or be expected to last, at least 1 year or result in death. SSI counts the family's household income and most assets. [Exception example: your house and car usually are not counted as resources.] NOTE: This "Tools" packet contains the SSI income and disability guidelines for children (under age 18). Adults (over age 18) should check with their SSA office or call the SSI toll free to check on income eligibility. Adult disability criteria are at: www.socialsecurity.gov/disability/professionals/bluebook (Part A criteria in the "Bluebook")

SSI is monthly cash payments to people with low incomes and few resources, who are blind or disabled, or age 65 or older or children as defined above. You do not have to have worked to get SSI payments. (SSI payments are financed through general tax revenues, not through Social Security taxes.) Some refugees and other noncitizens may qualify for SSI. If you are a noncitizen and want to apply for SSI benefits, it is best to contact SSA to see if you are in one of certain categories of eligible non-citizens (aliens). Social Security provides free interpreter services to persons to conduct their Social Security business. NOTE: You **cannot** apply online for SSI. To apply for benefits call SSA at 1-800-772-1213 (or if you are deaf or hard of hearing at TTY 1-800-325-0778) and make an appointment to apply for SSI benefits. At the appointment, a representative will help you apply for benefits by interviewing you and completing the forms with information you give to them. In Minnesota, children who get SSI payments do not automatically qualify for Medicaid. The family will need to apply for MA.

SSA has many publications available, including, but not limited to: "Supplemental Security Income (SSI)"; and "Benefits for Children With Disabilities". The "Disability Starter Kits" and publications are available online at the SSA Website: www.socialsecurity.gov ; or call **toll-free, 1-800-772-1213 (TTY number 1-800-325-0778);** or visit your local Social Security Administration office. [**NOTE**: Generally, people who get SSI also can get Medical Assistance (MA), food stamps and other assistance from the Department of Human Services (DHS)].

It takes about three to five months for SSA to decide a person's SSI disability claim. You can speed up the decision by being prepared for the disability interview at your local SSA office. The SSA Website has online "Disability Starter Kits", specific for adults, children and noncitizens. The kits include checklists and worksheets to help you gather the information you'll need for the disability interview. **NOTE:** People should appeal if their initial disability determination is denied. About 60% of all SSI and SSDI disability determinations are initially denied. [See the "Appeals" topic packet in these training materials for more information on appealing SSI disability determinations.] SSI and SSDI benefits can be paid retroactively up to one year from the time of official disability.

There is a new Compassionate Allowance Conditions list that describes medical conditions that are considered so severe that they automatically mean that you are disabled as defined by law. Impairments considered severe enough to prevent an individual from doing any gainful activity (or in the case of children under age 18 applying for SSI, severe enough to cause marked and severe functional limitations). Most of the listed impairments are permanent or expected to result in death. The list is at www.socialsecurity.gov/compassionate allowances/

Social Security Disability Insurance (SSDI)

SSDI provides monthly cash payments based on the individual's earning record, which is on file at the SSA. SSDI is not based on financial need. It is available both to certain people who have never worked and those who have worked enough to earn sufficient "work credits". In certain situations SSDI can be based on a deceased spouse's earnings, or it may be based on a parent's earnings. For example, when a parent starts receiving Social Security retirement or disability benefits, other family members also may be eligible for payments.

Benefits can be paid to "adult children" (age 18 or older) who are severely disabled. It is not necessary that the adult child ever worked because benefits are paid on the parent's earning record. These individuals, eligible for what is called "Disabled Adult Child" (DAC) benefits, are eligible as an adult, but they were disabled as a child. For an "adult child" (at least age 18), to receive benefits on their parent's work record, the following rules apply:

- The child's disabling impairment must have started before age 22; and
- She or he must meet the definition of disability for adults; and
- She or he must be unmarried (or married and meet certain requirements); and
- The parent, who paid into Social Security, must be entitled to disability or retirement benefits or be deceased (and be insured for Social Security) for the disabled adult child to receive benefits.

The "child's" benefit is based on the parent's Social Security benefit amount. (The "child" includes a biological child, an adopted child, or in some cases also a stepchild, or a dependent grandchild of a person already receiving Retirement Benefits or SSDI, or who died while covered by Social Security.) A person receiving only DAC benefits can have unlimited assets and so can receive an inheritance without affecting DAC benefits. **SSDI example**: A 38yr old man has cerebral palsy since birth. His father retires and starts collecting Social security retirements benefits at age 62. The son may be able to start collecting a disabled "child's" benefit on his father's Social Security record. **NOTE:** An adult child already receiving SSI benefits should still check to see if benefits may be payable on a parent's earnings record (possibility of higher benefits and entitlement to Medicare).

For more information in general, go to: www.socialsecurity.gov Information about applying for disability benefits is at: www.socialsecurity.gov/applyfordisability/ or call the toll-free number, **1-800-772-1213**, to make an appointment to file a disability claim at your local Social Security office or to set up an appointment for someone to take your claim over the telephone. The disability claims interview lasts about one hour. If you are deaf or hard of hearing, you may call our toll-free TTY number, **1-800-325-0778**, between 7 a.m. and 7 p.m. on business days. It can take a long time to process an application for disability benefits (three to five months).

People receive SSDI payments after five full months of disability and the person will be entitled to Medicare coverage 24 months after the entitlement date (when you become eligible for payments). See the MA-Employed Persons with Disabilities (MA-EPD) section of this manual for more information on MA coverage prior to the Medicare coverage begins. Note: It is possible to be on both SSI and SSDI at the same time, although recipients receive just one check.

BEST (Benefit Eligibility Screening Tool)

BEST is a tool found on the Social Security Website for finding out if you could be eligible for benefits from any of the programs Social Security administers. (If you already get any of those benefits, BEST will not screen for those again, but it will screen for the other benefits.)

- Medicare
- Social Security Retirement
- Special Veterans
- Social Security Disability
- Social Security Survivors
- Supplemental Security Income (SSI)

BEST gives you eligibility information based on your answers to their questions. You need to answer all of the questions. If you're answering the questions on behalf of someone else, (including a child), the term "you" applies to that person. Answer the questions as they apply to the person you are helping.) Based on your answers, BEST will tell you **all** the programs you for which you may qualify. Example: It will ask for your (and your spouse's) date of birth, date of marriage(s), and earnings and personal finance information to determine if you could be eligible for SSI or qualify for help with your Medicare premium. If you don't understand a question, click the questions mark icon to

view help text for that question. It takes approximately 5 to 10 minutes to answer all the questions. BEST is **not** an application. You must contact Social Security to file an application. BEST will **not** give you an estimate of benefit amounts. BEST **doesn't know or ask** for your name or Social Security number and **does not** access your personal Social Security records. No one else will see the answers you give. When you leave BEST, all of your answers will be erased. Social Security **will not** keep any record of your answers. In fact, you may want to print a copy of each page for your own records as you go through the questions. After you complete the questions and see the results, if you decide that you would like to apply for any of the benefits, you must contact Social Security to file an application.

Work Incentive Programs

Many young people who get SSI disability benefits want to work. Your local Social Security office can provide more information about two programs not covered in this overview: Benefits Planning, Assistance and Outreach (BPAO) program; and the Protection and Advocacy for Beneficiaries of Social Security (PABSS) program. Below is more information about PASS and Ticket To Work.

PASS (Plan for Achieving Self Support) Is an SSI provision to help individuals with disabilities return to work.

How does a PASS help someone return to work?

- SSI eligibility and payment amount are based on income and resources (things of value that an individual owns).
- PASS lets disabled individual set aside money and/or things he or she owns to pay for items or services needed to achieve a specific work goal.

How does PASS work?

- Applicant finds out what training, items or services needed to reach work goal.
- Can include supplies to start business, school expenses, equipment and tools, transportation and uniform requests.
- Applicant finds out how much these items and services will cost.
- PASS can help person save to pay these costs. PASS lets person set aside money for installment payments as well as a down payment for things like a vehicle, wheelchair or computer if needed to reach work goal.

How do you set up a PASS?

- Decide on work goal and determining items and services necessary to achieve.
- Can get help in setting up plan from a vocational rehabilitation (VR) counselor; an organization that helps people with disabilities; Benefits Specialists or Protection and Advocacy organizations who have contracts with SSA; Employment Networks involved in the Ticket to Work program; the local Social Security office or anyone else willing to help him or her.
- Contact local SSA office; SSA work site or some third parties shown above to get a PASS form (SSA-545-BK) to complete.
- Bring or mail it to the Social Security office.
- SSA usually approves plans prepared by VR
- If goal is self-employment, there must also be a business plan

What happens to the PASS?

- SSA sends PASS to SSA employees who are trained to work with PASS.
- PASS expert works directly with the applicant. PASS expert looks over the plan to see if work goal is reasonable
- SSA reviews plan to make sure that items and services listed on PASS needed to achieve the work goal and reasonably priced.

- If changes needed, the PASS expert discusses with the applicant.
- If PASS not approved, can appeal the decision.

Ticket to Work Program -Under this program, SSI & SSDI beneficiaries (starting at age 18) can get help with training and other services they need to go to work **at no cost to them.** Most beneficiaries will receive a "ticket" (a paper document) sent by the Social Security Administration in the mail, along with a notice and a booklet explaining the Ticket Program. (Tickets can be replaced if lost/destroyed). The beneficiary can take the "ticket" to an Employment Network. The Employment Networks are private organizations or public agencies, that have agreed to work with Social Security to provide services under the program. The services provided by the Employment Network support the person to help them get the kind of services they need to go to work and achieve their employment goals. The Ticket program is voluntary; persons with Tickets do not have to use them. For more information go to www.socialsecurity.gov/work . Social Security has a publication, *Your Ticket To Work* [Publication No. 05-10061.] To find out more about the Employment Networks in your area, contact MAXIMUS, Inc. (toll-free 1-866-968-7842 or TTY 1-866-833-2967); or visit their Website at www.yourtickettowork.com (The SSA contracts with MAXIMUS, Inc. to serve as the Operations Support Manager and administer the Ticket program.)

The Red Book – A Guide to Work Incentives

The Red Book is a general reference source about the employment-related provisions of Social Security Disability Insurance (SSDI) and the Supplemental Security Income (SSI) Programs. It is a resource for educators, advocates, rehabilitation professionals, and counselors who serve people with disability. It is downloadable in both English and Spanish at http://www.ssa.gov/redbook/ There is also other Social Security Administration information online for persons getting disability benefits and are interested in working. For example, there is a publication "Working While Disabled – How We Can Help" [SSA Publication No.05-10095].

ADAPTED FROM: Social Security Administration publications/websites: (1) "Understanding The Benefits" [1-10]; (2) "The Appeals Process [01-08] (3) "A Snapshot" [5-09]; (4) "Disability Benefits" [8-09]; (5) "Benefits for Children with Disabilities" [10-07]; (6) Adults Disabled Before Age 22 ; (7) Filing for social security disability benefits http://www.essortment.com/all/filingforsocia_pjb.htm (8) "The Red Book – A Guide to Work Incentives 2010" www.socialsecurity.gov/redbook; (9) SSA Website information: www.socialsecurity.gov [5-10]; and (10) "Social Security Disability vs. Supplemental Security Income and Subsequent Entitlements Publication" No. 4, 7/2007 http://www.patientadvocate.org

SSI INCOME GUIDELINES 1/1/10 – 12/31/10

Parental income and assets affect SSI payment for the disabled child living with them. The income table below shows parental **(monthly) incomes above which SSI eligibility ceases**, when the child/youth (under age 18) is no longer income eligible for SSI. **The table is a guideline only**. This chart does not apply when the family has a combination of earned and unearned income. The SSA (Social Security Administration) office does income determination for families. **TO USE THIS INCOME TABLE: First** consider the far left column, "# of ineligible siblings" – this is the number of other siblings in the family who are NOT disabled. **Second**, consider the number of parents in the family and whether the income is earned or unearned. If there are more than 6 ineligible children, add $337 for each additional ineligible child.

# of ineligible siblings	All income is **earned**		All income is **unearned**	
	One parent in household	Two parents in household	One parent in household	Two parents in household
0	$ 2,821	$ 3,495	$ 1,388	$ 1,725
1	$ 3,158	$ 3,832	$ 1,725	$ 2,062
2	$ 3,495	$ 4,169	$ 2,062	$ 2,399
3	$ 3,832	$ 4,506	$ 2,399	$ 2,736
4	$ 4,169	$ 4,843	$ 2,736	$ 3,073
5	$ 4,506	$ 5,180	$ 3,073	$ 3,410
6	$ 4,843	$ 5,517	$ 3,410	$ 3,747

INCOME / ASSETS:
Earned Income - wages (gross) or self-employment (net) income

Unearned Income - interest, dividends, unemployment, social security, gifts, child and spousal support payments, inheritances, etc. MFIP (Minn. Family Investment Program) and other payments based on need may be affected by SSI and are treated differently.

Assets - cash, investments, property, etc. There is a $2,000 limit for the eligible child. Parental assets of over $2,000 for a single parent, $3,000 for two parents in the household are deemed to the child. Resources that do NOT count include: home (residence); most household and personal items; one vehicle; most parental retirement funds; WIC; Food Stamps; business assets used for self support; items under a Plan for Achieving Self Support; burial plots; burial space item contracts and accrued interest; life insurance and/or burial contract up to $1,500 ($2,000 in Minn. if irrevocable), plus accrued interest (term insurance alone has no limit).

CITIZENSHIP / RESIDENCY
A **disabled person** living in one of the 50 states, Washington, DC or the Northern Mariana Islands, who is **one** of the following:

- U.S. Citizen or national; or
- Lawful permanent resident who was lawfully residing in the US on 8/22/96; or
- Lawful permanent resident with 40 qualifying work credits (can be earned on parent, spouse, or own record); or
- Certain noncitizens with a military service connections; or
- Certain refugee or asylee noncitizens during the first 7 years of U.S. residency.

INDEX FOR THE SSI DISABILITY GUIDELINES

If a condition is not listed below, look in the disability guidelines beginning on the next page. NOTE: Eligibility may also be determined by reviewing the functional limitation of a condition or groups of conditions.

SSI MEDICAL EVALUATION GUIDELINES - Part B (children less than age 18 yrs.)

This summary covers children less than age 18years (called Part B). In some instances, adult (age 18 & older) criteria are used for children. The website includes detailed explanations of the disability criteria. **Adult (age 18 & older) criteria, called Part A and the full Part B explanations can be found in the "Blue Book", on the Social Security Website: www.socialsecurity.gov/disability/professionals/bluebook**
[Source: Disability Evaluation From Social Security "Blue Book" (as of January 4, 2010)]

PREMATURITY & LOW BIRTH WEIGHT (25216.001)

(Disability at least until the chronological age of 12 months) for 1 of the following:

1. Infant weighing less than 1200 grams (about 2 lb. 10 oz.) at birth; OR
2. Infant weighing at least 1200 grams but less than 2000 grams (about 4 lb. 6 oz.) at birth AND is small for gestational age (birth weight ≥ 2 S.D. below the mean or < the 3rd percentile for gestational age).

GROWTH IMPAIRMENT (100.00)

Criteria are applicable only until closure of major epiphyses. Determination of growth impairment should be based upon the comparison of current height with at least 3 previous determinations, including length at birth, if available.
• **RELATED to additional medical impairment** (100.02) **– Either a** fall of greater than 15 percentiles in **height** which is sustained**; or a** fall to, or persistence of **height** below the 3rd percentile**.**
• **NOT RELATED to additional medical impairment** (100.03) - **Both a** fall of greater than 25 percentiles in **height** which is sustained**; AND Bone age** greater than 2 S.D. below the mean for chronological age**.**

MUSCULOSKELETAL (101.00)

Major dysfunction of a joint(s), due to any cause (101.02)	**Characterized by gross anatomical** deformity (e.g. subluxation, contracture, bony or fibrous ankylosis, instability) **and chronic joint pain and stiffness** with signs of limitation of motion or other abnormal motion of the affected joint(s), **and findings on appropriate medically acceptable imaging** of joint space narrowing, bony destruction, or ankylosis of the affected joint(s), with **EITHER A or B:** **A. Involvement of one major peripheral weight-bearing joint** (i.e. hip, knee, or ankle), resulting in inability to ambulate effectively; or **B. Involvement of one major peripheral joint in each upper extremity** (i.e. shoulder, elbow, or wrist-hand), resulting in ability to perform fine and gross movements effectively.
Reconstructive surgery or surgical arthrodesis (101.03)	**Of a major weight-bearing joint,** with inability to ambulate effectively, and return to effective ambulation didn't occur, or is not expected to occur, within 12 months of onset.
Disorders of the spine (101.04)	**(e.g., lysosomal disorders, metabolic disorders, vertebral osteomyelitis, vertebral fracture, achondroplasia):** Resulting in compromise of a nerve root (including the cauda equina) or the spinal cord, with evidence of nerve root compression characterized by neuro-anatomic distribution of pain, limitation of motion of the spine, motor loss (atrophy with associated muscle weakness) accompanied by sensory or reflex loss & , if there is involvement of the lower back, positive straight-leg raising test (sitting & supine).
Amputation (due to any cause) (101.05)	**With 1 of the following:** **A. Both hands; OR** **B. One or both lower extremities at or above the tarsal region, with stump complications** resulting in medical inability to use a prosthetic device to ambulate effectively, which have lasted or are expected to last for at least 12 months; **OR** **C. Hemipelvectomy or hip disarticulation; OR** **D. One hand & one lower extremity at or above tarsal region,** with inability to ambulate effectively**.**
Fracture(s) (femur, tibia, pelvis, ≥ 1 tarsal) (101.06)	**Fractures of femur, tibia, pelvis, or one or more tarsal bones, with BOTH of the following:** **A. Solid union not evident** on appropriate medically acceptable imaging, and not clinically solid; **AND** **B. Inability to ambulate effectively**, and return to effective ambulation did not occur or is not expected to occur within 12 months of onset.
Upper extremity fracture (101.07)	**With nonunion of a fracture of the shaft of the humerus, radius, or ulna**, under continuing surgical management, directed toward restoration of functional use of the extremity, and such function was not restored or expected to be restored within 12 months of onset.

Soft tissue injury (101.08)	**(e.g. burns) of an upper or lower extremity, trunk, or face and head,** under continuing surgical management, directed toward the salvage or restoration of major function, and such major function was not restored or expected to be restored within 12 months of onset.
SPECIAL SENSES and SPEECH (102.00)	
Loss of visual acuity (102.02)	**With 1 of the following:** **A. Remaining vision in better eye** after best correction is 20/200 or less; **OR** **B. Inability to participate in testing using Snellen methodology or other comparable visual acuity testing** & clinical findings that fixation & visual-following behavior are absent in the better eye, **and 1 of the following:** 1. Abnormal anatomical findings indicating a visual acuity of 20/200 or less in the better eye; or 2. Abnormal neuroimaging documenting damage to the cerebral cortex which would be expected to prevent the development of a visual acuity better than 20/200 in the better eye; or 3. Abnormal electroretinogram documenting the presence of Leber's congenital amaurosis or achromatopsia; or 4. An absent response to VER testing in the better eye
Contraction of visual field in the better eye (102.03)	**With 1 of the following:** **A. The widest diameter subtending an angle around the point of fixation** no greater than 20 degrees**; OR** **B. A mean deviation** of -22 or worse, determined by automated static threshold perimetry**; OR** **C. A visual field efficiency** of 20 percent or less as determined by kinetic perimetry**.**
Loss of Visual efficiency (102.04)	**Visual efficiency of the better eye of 20 percent or less** after best correction
Hearing (102.08)	**With 1 of the following** (select appropriate age group, based on age at the time of the decision): **Below age 5 years -** inability to hear air conduction thresholds at an average of ≥ 40 db in better ear**.** **5 years & above - 1 of the following:** 1. Inability to hear air conduction thresholds at an average of ≥ 70 db in better ear; or 2. Speech discrimination ≤ 40% in better ear; or 3. Inability to hear air conduction thresholds at average of ≥ 40 db in better ear, & a speech & language disorder significantly affecting speech clarity and content and is attributable to hearing impairment.
RESPIRATORY (103.00)	
Chronic pulmonary insufficiency (103.02)	**With 1 of the following:** **A. Chronic obstructive pulmonary disease** due to any cause with $FEV_1 \leq$ value in **Table I** (below); **OR** **B. Chronic restrictive ventilatory disease,** due to any cause, with FVC ≤ value in **Table II** (below); **OR** **C. Frequent need for 1 of the following:** 1.Mechanical ventilation; or 2.Nocturnal supplemental oxygen as required by persistent or recurrent hypoxemia**; OR** **D. Presence of a tracheostomy** in a child less than 3 years old; **OR**

Height Without Shoes (cm/inches)	TABLE I $FEV_1 \leq$	TABLE II $FVC_1 \leq$
≤119/ ≤46	**0.65**	**0.65**
120-129/47-50	**0.75**	**0.85**
130-139/51-54	**0.95**	**1.05**
140-149/55-58	**1.15**	**1.25**
150-159/59-62	**1.35**	**1.45**
160-164/63-64	**1.45**	**1.65**
165-169/65-66	**1.55**	**1.75**
≥170/≥67	**1.65**	**2.05**

OR (continued next page)

Chronic pulmonary insufficiency (103.02)

Continued

E. Bronchopulmonary dysplasia, characterized by **2 of the following:**
1. Prolonged expirations; or
2. Retractions, flaring and tachypnea indicating intermittent wheezing or increased respiratory effort; or
3. Hyperinflation and scarring on chest x-ray or other appropriate imaging technique; or
4. Bronchodilator or diuretic dependence; or
5. Frequent requirement for nocturnal supplemental oxygen; or
6. Weight disturbance persisting for $\geq$ 2 months, with an involuntary weight loss (or failure to gain weight at an appropriate rate of age) resulting in a fall from the established growth curve of either 15 percentiles or to below the 3rd percentile; **OR**

F. 2 required hospital admissions (each longer than 24 hr.) within a 6-month period for recurrent lower respiratory tract infections or acute respiratory distress associated **with either:**
1. chronic wheezing or chronic respiratory distress; or
2. weight disturbance (as described above under Bronchopulmonary Dysplasia weight disturbance); **OR**

G. Chronic hypoventilation ($PaCO_2$ > 45 mm Hg) **or chronic cor pulmonale** (see Chronic Heart Failure 104.02); **OR**

H. Growth impairment (100.00).

Asthma (103.03)

With 1 of the following:

A. FEV_1 $\leq$ value specified in Table I (see 103.02 on page 2); **OR**

B. Attacks in spite of prescribed treatment & requiring physician intervention, occurring at least once every 2 months or at least 6 times/year. Each inpatient hospitalization for longer than 24 hr for control of asthma counts as 2 attacks, & an evaluation period of at least 12 consecutive months must be used to determine the frequency of attacks. (Attacks are defined as prolonged symptomatic episodes lasting 1 day & requiring intensive treatment, such as IV bronchodilator or antibiotic or prolonged inhalation therapy in a hospital, or equivalent setting.) **OR**

C. Growth impairment (100.00); OR

D. Persistent low-grade wheezing between attacks or absence of extended symptom-free periods requiring daytime and nocturnal use of sympathomimetic bronchodilators **with 1 of the following:**
1. Persistent prolonged expiration with x-ray or other appropriate imaging techniques evidence of pulmonary hyperinflation or peribronchial disease; or
2. Short courses of corticosteroids; average > 5 days/mo. for at least 3 mo., during a 12-mo. period.

Cystic fibrosis (103.04)

With 1 of the following:

A. FEV_1 $\leq$ values in Table III

TABLE III

Height Without Shoes (cm/inches)	$FEV_1 \leq$
≤ 119/≤46	**0.75**
120-129/47-50	**0.85**
130-139/51-54	**1.05**
140-149/55-58	**1.35**
150-159/59-62	**1.55**
160-164/63-64	**1.85**
165-169/65-66	**2.05**
≥170/67	**2.25**

OR

B. For Child unable to perform ventilatory function testing - 2 of the following:
1. History of dyspnea on exertion or accumulation of secretions as manifested by repetitive coughing or cyanosis; or
2. Persistent bilateral rales and rhonchi or substantial reduction of breath sounds related to mucus plugging of trachea or bronchi; or
3. Appropriate medically acceptable evidence of extensive disease, such as thickening of proximal bronchial airways or persistence of bilateral peribronchial infiltration**; OR**

<table>
<tr><td>Cystic fibrosis (103.04) continued</td><td>C. Persistent pulmonary infection accompanied by superimposed, recurrent, symptomatic episodes of increased bacterial infection occurring at least once every 6 months and requiring intravenous or nebulization antimicrobial treatment; OR
D. Episodes of bronchitis or pneumonia or hemoptysis (more than blood-streaked sputum) or respiratory failure, requiring physician intervention, occurring once every 2 mo. or 6 times/yr. Each inpatient hospitalization for longer than 24 hours for treatment counts as 2 episodes, and an evaluation period of at least 12 consecutive months must be used to determine frequency of episodes; OR
E. Growth impairment (100.00).</td></tr>
<tr><td>Lung transplant (103.05)</td><td>Consider under a disability for 12 months following the date of surgery; thereafter, evaluate the residual impairment(s)</td></tr>
<tr><td colspan="2">CARDIOVASCULAR (104.00)</td></tr>
<tr><td>Chronic heart failure (104.02)</td><td>While on a regime of prescribed treatment, but still have 1 of the following:
A. Persistent tachycardia at rest (see Table I); OR
B. Persistent tachypnea at rest (see Table II); or markedly decreased exercise tolerance; OR
C. Growth disturbance with involuntary wt. loss or failure to gain wt. at appropriate rate for age, with either a fall of 15 percentiles or a fall to below the 3rd percentile (persisting for 2 months).

TABLE I-TACHYCARDIA AT REST
<table><tr><th>Age</th><th>(apical heart beats/minute)</th></tr><tr><td>Under 1 year</td><td>150</td></tr><tr><td>1 through 3 years</td><td>130</td></tr><tr><td>4 through 9 years</td><td>120</td></tr><tr><td>10 through 15 years</td><td>110</td></tr><tr><td>Over 15 years</td><td>100</td></tr></table>
TABLE II-TACHYPNEA AT REST
<table><tr><th>Age</th><th>(respiratory rate per minute over)</th></tr><tr><td>Under 1 year</td><td>40</td></tr><tr><td>1 through 5 years</td><td>35</td></tr><tr><td>6 through 9 years</td><td>30</td></tr><tr><td>Over 9 years</td><td>25</td></tr></table></td></tr>
<tr><td>Recurrent Arrhyth-mias (104.05)</td><td>Not related to reversible causes such as electrolyte abnormalities or digitalis glycoside or antiarrhythmic drug toxicity, resulting in uncontrolled, recurrent episodes of cardiac syncope or near syncope, despite prescribed treatment, and documented by resting or ambulatory (Holter) electrocardiagraphy, or by other appropriate medically acceptable testing, coincident with the occurrence of syncope or near syncope.</td></tr>
<tr><td>Congenital heart disease (104.06)</td><td>With 1 of the following:
A. Cyanotic heart disease, with persistent chronic hypoxemia, as manifested by 1 of the following:
1. Hematocrit 55% or greater on 2 evaluations. 3 or more months apart within a consecutive 12-month period; or
2. Arterial O_2 saturation of less than 90% in room air, or resting PO_2 of 60 Torr or less; or
3. Hypercyanotic spells, syncope, characteristic squatting, or other incapacitating symptoms directly related to documented cyanotic heart disease; or
4. Exercise intolerance with increased hypoxemia on exertion; OR
B. Secondary pulmonary vascular obstructive disease with a mean pulmonary arterial systolic pressure elevated to at least 70% of the systemic arterial systolic pressure; OR
C. Symptomatic acyanotic heart disease, with ventricular dysfunction interfering very seriously with the ability to independently initiate, sustain, or complete activities; OR
D. For infants over 12 months of age at the time of filing, with life-threatening congenital heart impairment that will require or already has required surgical treatment in first year of life, and the impairment is expected to be disabling (because of residual impairment following surgery, or the recovery time required, or both) until the attainment of at least 1 yr. of age. Infant considered disabled until attainment of at least age 1; thereafter, evaluate impairment severity with reference to the appropriate listing.</td></tr>
<tr><td>Heart Transplant (104.09)</td><td>Consider under a disability for 1 year following surgery; thereafter, evaluate residual impairment under the appropriate listing.</td></tr>
<tr><td>Rheumatic heart disease (104.13)</td><td>With persistence of rheumatic fever activity with significant murmur(s), cardiac enlargement or ventricular dysfunction, & other associated abnormal lab findings (ex: elevated sedimentation rate or ECG findings) for 6 mo. or more (within 12-mo. period). Disabled for 18 mo. then evaluate residual impairment</td></tr>
</table>

DIGESTIVE (105.00)	
Gastroin-testinal Hemor-rhaging (105.02)	**Gastrointestinal hemorrhaging from any cause,** requiring blood transfusion (with or without hospitalization) of at least 10 cc of blood/kg of body weight, & occurring at least 3 times during a consecutive 6-month period. Transfusions must be at least 30 days apart within the 6-month period. Consider a disability for 1 year following last documented transfusion; thereafter, evaluate the residual impairment(s).
Chronic Liver Disease (105.05)	**With 1 of the following:** **A. Hemorrhaging from esophageal, gastric, or ectopic varices or from portal hypertensive gastropathy,** demonstrated by endoscopy, x-ray, or other appropriate medically acceptable imaging, resulting in hemodynamic instability, & requiring hospitalization for transfusion of at least 10 cc of blood/kg of body wt. Consider a disability for 1 year following last documented transfusion; thereafter, evaluate the residual impairment(s); **OR** **B. Ascites or hydrothorax** not attributable to other causes, despite continuing treatment as prescribed, present on at least 2 evaluations at least 60 days apart within a consecutive 6-month period; **each evaluation documented by 1 of the following:** 1. Paracentesis or thoracentesis; or 2. Appropriate medically acceptable imaging or physical exam and **1 of the following** a) Serum albumin of 3.0 g/dL or less; or b) International Normalized Ratio (INR) of at least 1.5**; OR** **C. Spontaneous bacterial peritonitis** with peritoneal fluid containing an absolute neutrophil count of at least 250 cells/mm^3; **OR** **D. Hepatorenal syndrome, with 1 of the following;** 1. Serum creatinine elevation of at least 2 mg/dL; or 2. Oliguria with 24-hr. urine output less than 1 mL/kg/hr; or 3. Sodium retention with urine sodium less than 10 mEq per liter;**OR** **E. Hepatopulmonary syndrome , with 1 of the following:** 1. Arterial oxygenation (P_a0_2) on room air of **1 of the following:** a) 60 mm Hg or less, at tests sites less than 3,000 ft. above sea level, or b) 55 mm Hg or less, at test sites from 3,000 to 6,000 ft. above sea level, or c) 50 mm Hg or less, at test sites above 6,000 ft.; **OR** 2. Documentation of intrapulmonary arteriovenous shunting by contrast-enhanced echocardiography or macroaggregated albumin lung perfusion scan. **OR** **F. Hepatic encephalopathy, WITH #1 below AND EITHER # 2 or # 3 below**: 1. Documentation **of abnormal behavior, cognitive dysfunction, changes in mental status, or altered state of consciousness (**for ex: confusion, delirium, stupor, or coma), present on at least 2 evaluations at least 60 days apart within a consecutive 6-month period; AND 2. History of transjugular intrahepatic portosynstemic shunt **(TIPS)** or any surgical portosystematic shunt; or 3. **1 of the following** occurring on at least 2 evaluations at least 60 days apart within the same consecutive 6-month period as in Hepatic encephalopathy #1 above (under Hepatic encephalopathy): a) Asterixis or other fluctuating physical neurological abnormalities; or b) Electroencephalogram (EEG) demonstrating triphasic slow wave activity; or c) Serum albumin of 3.0 g/dL or less; or d) International Normalized Ratio (INR) of 1.5 or greater. **OR** **G. End Stage Liver Disease, with** (select appropriate age group)**:** **For children 12 years or older,** SSA CLD scores of 22 or greater**.** Consider a disability from at least the date of the first score. **For children under age 12years,** SSA CLD-P scores of 11 or greater. Consider under a disability from at least the date of the first score. **H. Extrahepatic biliary atresia as diagnosed on liver biopsy or intraoperative cholangiogram.** Consider disabled for 1 year following the diagnosis; thereafter, evaluate the residual liver function.

Inflammatory bowel disease (IBD) (105.06)	**Documented by endoscopy, biopsy, appropriate medically acceptable imaging, or operative findings, with 1 of the following:** **A. Obstruction of stenotic areas** (not adhesions) in the small intestine or colon with proximal dilation, confirmed by appropriate medically acceptable imaging or in surgery, requiring hospitalization of intestinal decompression or for surgery, and occurring on at least 2 occasions at least 60 days apart within a consecutive 6-month period; **OR** **B. 2 of the following,** despite continuing treatment as prescribed and occurring within the same consecutive 6 month period: 1. Anemia with hemoglobin less than 10.0 g/dL, present on at least 2 evaluations at least 60 days apart; or 2. Serum albumin of 3.0 g/dL or less, present on at least 2 evaluations at least 60 days apart; OR 3. Clinically documented tender abdominal mass palpable on physical exam with abdominal pain or cramping that is not completely controlled by prescribed narcotic medication, present on at least 2 evaluations at least 60 days apart; or 4. Perineal disease with a draining abscess or fistula, with pain that is not completely controlled by prescribed narcotic medication, present on at least 2 evaluations at least 60 days part; or 5. Need for supplemental daily enteral nutrition via a gastrostomy or daily parenteral nutrition via a central venous catheter (See 105.10 for children under age 3 years.)
Short bowel syndrome (105.07)	**Due to surgical resection of more than one-half of the small intestine,** with dependence on daily parenteral nutrition via a central venous catheter
Malnutrition (105.08)	**Due to any digestive disorder, with BOTH of the following:** **A. Chronic nutritional deficiency** despite continuing treatment as prescribed, present on at least 2 evaluations at least 60 days apart within a consecutive 6-month period, **and documented by 1 of the following:** 1. Anemia with hemoglobin less than 10.0 g/dL; or 2. Serum albumin of 3.0 g/dL or less; or 3. Fat-soluble vitamin, mineral, or trace mineral deficiency; **AND** **B. Growth retardation** documented by (select appropriate age group): **For children under age 2 years**: Multiple weight-for-length measurements that are less than the 3rd percentile, documented at least 3 times within a consecutive 6-month period; or **For children age 2 and older**: Multiple Body Mass Index (BMI)-for age-measurements that are less than the 3rd percentile, documented at least 3 times within a consecutive 6-month period.
Liver Transplant (105.09)	Consider a disability for 1 yr. following the date of transplantation**;** thereafter, evaluate the residual impairment(s).
Gastrostomy Feedings (105.10)	**Need for supplemental daily enteral feeding** via a gastrostomy due to any cause, for children who have not attained age 3 years; evaluate the residual impairment(s).
GENITO-URINARY (106.00)	
Impairment of renal function (106.02)	**Due to any chronic renal disease** that has lasted or can be expected to last for a continuous period of at least 12 months; **with 1 of the following:** **A. Chronic hemodialysis or peritoneal dialysis**; **OR** **B. Kidney transplant** (consider a disability for 12 months following surgery; thereafter, evaluate the residual impairment); **OR** **C.** Persistent elevation of **serum creatinine** to greater than or equal to 3 mg/dL, over at least 3 months; **OR** **D.** Reduction of **creatinine clearance** to 30 ml per minute (43 liters/24hr) per 1.73 m^2 of body surface area over at least 3 months.
Nephrotic syndrome (106.06)	**With anasarca (edema), persisting at least 3 mo, despite prescribed therapy; with 1 of the following:** **A. Serum albumin** less than or equal to 2.0 g/dL (100 ml); **OR** **B. Proteinuria** greater than or equal to 40 mg/m^2/hr. (May also evaluate complications of the nephrotic syndrome, such as orthostatic hypotension, recurrent infections, or venous thromboses, under the appropriate listing for the resultant impairment.)

Congenital Genito-urinary (106.07)	**Resulting in 1 of the following** occurring at least 3 times in a consecutive 12-month period: **A.** Repeated **urologic surgical procedures**; OR **B.** Documented episodes of **systemic infection** requiring an initial course of parenteral antibiotics; OR **C.** Hospitalization for episodes of **electrolyte disturbance**.
HEMATOLOGICAL (107.00)	
Hemolytic anemia (107.03)	**Due to any cause** and manifested by persistent hematocrit less than or equal to 26 percent despite prescribed therapy, and reticulocyte count of 4 percent or greater.
Sickle cell disease (107.05)	**With 1 of the following:** **A.** Recent, recurrent severe **vaso-occlusive crises** (musculoskeletal, vertebral, abdominal); **OR** **B.** Major **visceral complication** in 12 months prior to application; **OR** **C. Hyperhemolytic or aplastic crisis** within 12 months prior to application; **OR** **D.** Chronic, severe **anemia** with persistent hematocrit of 26 percent or less; **OR** **E. Congestive heart failure** (104.02), **cerebrovascular damage** (111.00), or **emotional disorder** (112.00).
Thrombo-cytopenia purpura of childhood (107.06)	**Chronic idiopathic thrombocytopenia purpura of childhood,** with purpura and thrombocytopenia of less than or equal to 40,000 platelets/cu mm despite prescribed therapy or recurrent upon withdrawal of treatment.
Inherited coagulation (107.08)	**Inherited coagulation disorder, with EITHER:** **A.** Repeated spontaneous or inappropriate **bleeding**; **OR** **B. Hemarthrosis** with joint deformity.
SKIN CONDITIONS (108.00)	
Ichthyosis (108.02)	**With extensive skin lesions** that persist for at least 3 months despite continuing treatment as prescribed.
Bullous disease (108.03)	**(Ex: pemphigus, erythema multiforme bullosum, epidermolysis bullosa, bullous pemphigoid, dermatitis herpetiformis),** with extensive lesions skin lesions persisting at least 3 months despite continuing prescribed treatment.
Skin or mucous membrane infections (108.04)	**Chronic** infections with extensive fungating, or extensive ulcerating skin lesions that persist for at least 3 months despite continuing treatment as prescribed.
Dermatitis (108.05)	**(Ex: psoriasis, dyshidrosis, atopic dermatitis, exfoliative dermatitis, allergic contact dermatitis),** with extensive skin lesions that persist for at least 3 months despite continuing treatment as prescribed.
Hidradenitis suppurative (108.06)	**With extensive lesions** involving both axillae, both inguinal areas, or the perineum that persists for at least 3 months despite continuing treatment as prescribed
Genetic photosensi-tivity disorders (108.07)	Established by clinical and laboratory findings: **A. <u>Xeroderma pigmentosum</u>** – Consider the individual disabled from birth. **B. Other genetic photensitivity disorders**, **with 1 of the following**: 1. Extensive skin lesions lasting or can be expected to last a continuous period of at least 12 months; or 2. Inability to function outside a highly protective environment for a continuous period of at least 12 months.
Burns (108.08)	**With extensive skin lesions** that have lasted or can be expected to last for a continuous period of at least 12 months.
ENDOCRINE (109.00)	
Thyroid disorders (109.02)	**A. Hyperthyroidism,** with clinical manifestations despite prescribed therapy**, with 1 of the following:** 1. Increased **serum thyroxine** (T4) and either increased free T4 or resin T3 uptake; or 2. Increased **thyroid uptake of radioiodine**; or 3. Increased **serum triiodothyronine** (T_3).

Thyroid disorders (109.02) Continued	**B. Hypothyroidism,** despite prescribed therapy**, with 1 of the following:** 1. **IQ** less than or equal to 70; or 2. **Growth impairment** (100.02); or 3. **Precocious puberty**.
Hyperpara-thyroidism (109.03)	**With 1 of the following:** **A.** Repeated increased total or ionized **serum calcium; OR** **B.** Increased **serum parathyroid hormone.**
Hypo- or Pseudohypo -para-thyroidism (109.04)	**With 1 of the following:** **A. Severe recurrent tetany or convulsions** which are unresponsive to prescribed therapy; **OR** **B. Growth retardation** (100.02).
Diabetes insipidus (109.05)	Documented by pathologic hypertonic saline or water deprivation test**, and 1 of the following:** **A. Intracranial space-occupying lesion**, before or after surgery; **OR** **B.** Unresponsiveness to **Pitressin**; **OR** **C. Growth** retardation (100.02); **OR** **D.** Unresponsive **hypothalmic** thirst center with chronic or recurrent hypernatremia; **OR** **E.** Decreased **visual fields** attributable to pituitary lesion
Hyper-function of adrenal cortex (109.06)	**Primary or secondary, with BOTH of the following:** **A.** Increased **urinary 17 -hydroxycorticosteroids** (or 17-ketogenic steroids); **AND** **B.** Unresponsiveness to low-dose **dexamethasone** suppression.
Adrenal cortical insufficiency (109.07)	**Adrenal cortical insufficiency** with recent, recurrent episodes of circulatory collapse.
Juvenile Diabetes mellitus (109.08)	**Requiring parenteral insulin, with 1 of the following,** despite prescribed therapy: **A.** Recent, recurrent **hospitalizations with acidosis; OR** **B.** Recent, recurrent episodes of **hypoglycemia; OR** **C. Growth retardation (100.02); OR** **D.** Impaired **renal function (106.00).**
Iatrogenic hypercor-ticoid state (109.09)	**With chronic glucocorticoid therapy resulting in 1 of the following:** **A. Osteoporosis; OR** **B. Growth retardation** (100.02**); OR** **C. Diabetes mellitus** (109.08); **OR** **D. Myopathy** (111.06); **OR** **E. Emotional disorder** (112.00).
Pituitary dwarfism (109.10)	**With documented growth hormone deficiency and growth impairment** (100.02).
Adreno-genital syndrome (109.11)	**With 1 of the following:** **A.** Recent, recurrent **salt-losing episodes** despite prescribed treatment; **OR** **B.** Inadequate replacement therapy manifested by **accelerated bone age and virilization; OR** **C. Growth impairment (100.02).**
Hypogly-cemia (109.12)	**With recent, recurrent hypoglycemic episodes producing convulsions or coma.**
Turner's syndrome (109.13)	**(Gonadal Dysgenesis)** Chromosomally proven. Evaluate resulting impairment under the criteria for the appropriate body system.

MULTIPLE BODY SYSTEMS (110.00)

Impairments that commonly affect multiple body systems and are significant enough to result in marked & severe functional limitations. In addition to the listings below, many impairments can cause deviation from, or interruption of the normal function of the body or interfere with development (ex: congenital anomalies, chromosomal

disorders, dysmorphic syndromes, metabolic disorders, & perinatal infections diseases). The functional limitations & the progression of these limitations are more variable than with the catastrophic congenital abnormalities & diseases included in 110.06 – 110.08, so the specific effects on the child are evaluated under the listing criteria in the affected body system(s) and are evaluated on an individual basis. [Examples: Triple X syndrome; Fragile X syndrome; PKU; Caudal Regression Syndrome; Fetal Alcohol Syndrome.]	
Non-mosaic Downs syndrome (110.06)	**Considered disabled from birth** & established by definitive chromosomal analysis (karyotype analysis), or evidence from an acceptable medical source, includes a clinical description of the diagnostic physical features of the impairment & that is persuasive that a positive diagnosis has been confirmed by definitive chromosomal analysis at some time prior to this evaluation. (Report must be consistent with other evidence (ex: showing limitation in adaptive functioning or signs of a mental disorder that can be associated with non-mosaic Down syndrome; educational history; or psychological testing results, etc.)
Mosaic Downs syndrome (110.07)	**There is a wide range in the level of severity of this impairment – it can be profound and disabling , but it can also be so slight as to be undetected clinically**. It is evaluated for disability under the listing criteria in any affected body system(s) on an individual case basis.
Catastrophic congenital abnormality or disease (110.08)	**These are present at birth, although they may not be apparent immediately. With 1 of the following:** **A. Death** usually is expected within the 1st months of life, and the **rare individuals who survive longer are profoundly impaired** (for example, anencephaly, trisomy 13 or 18, cyclopia); **OR** **B.** That **interferes very seriously with development**; for example, cri du chat syndrome (deletion 5p syndrome) or Tay-Sachs disease (acute infantile form).
NEUROLOGICAL (111.00)	
Major motor seizure disorder (111.02)	**A. Convulsive epilepsy:** More than 1 major motor seizure per month despite 3 months of prescribed treatment, **with 1 of the following**: 1. **Daytime episodes** (loss of consciousness and convulsive seizures); or. 2. **Night time episodes** with residuals interfering with activity during the day. **B. Convulsive epilepsy syndrome: At least 1 major motor seizure in the year prior to application,** despite 3 months of prescribed treatment; **AND with 1 of the following**: 1. **IQ** less than or equal to 70;or 2. Significant interference with **communication** due to speech, hearing, or vision defect; or 3. Significant **mental disorder**; or 4. Where significant **adverse effects of medication** interfere with major daily activities.
Nonconvul-sive epilepsy (111.03)	**Greater than one minor motor seizure per week,** with alteration of awareness or loss of consciousness, despite 3 months of prescribed treatment.
Benign brain tumor (111.05)	**Evaluate under 111.02, 111.03, 111.06, 111.09 or the criteria of the affected body system.**
Motor dysfunction (111.06)	**(Due to any neurological disorder)** Persistent disorganization or deficit of motor function for age involving 2 extremities, which (despite prescribed therapy) interferes with age-appropriate major daily activities & results in disruption of **EITHER** fine and gross movements; **OR** gait and station.
Cerebral palsy (111.07)	**With 1 of the following:** **A. Motor dysfunction** (101.02 or 111.06); **OR** **B. Less severe motor dysfunction** (but more than slight) **and with 1 of the following**: 1. **IQ** less than or equal to 70; or 2. **Seizure disorder**, with at least one major motor seizure in year prior to application; or 3. Significant interference with **communication** due to speech, hearing, or vision defect; or 4. Significant **emotional disorder**.
Meningo-myelocele (& related disorders) (111.08)	**With 1 of the following (despite prescribed treatment):** **A. Motor** dysfunction (101.02 or 111.06); **OR** **B. Less severe motor** dysfunction (but more than slight**) and either** urinary/fecal incontinence inappropriate for age; or IQ less than or equal to 70; **OR** (continued next page)

	C. Four extremity involvement; **OR** **D.** Noncompensated **hydrocephalus** producing interference with mental/motor developmental progression.
Communica-tion impairment (111.09)	**Associated with documented neurological disorder; and with 1 of following:** **A.** Documented **speech** deficit which significantly affects the clarity and content of the speech; OR **B.** Documented **comprehension** deficit resulting in ineffective verbal communication for age; OR **C. Hearing** impairment (102.08).
MENTAL DISORDERS (112.00)	
Organic mental disorders (112.02)	**Abnormalities in perception, cognition, affect, or behavior associated with brain dysfunction, with Both A and B:** **A.** Medically documented persistence of **1 of following:** 1. Developmental arrest, delay, or regression; or 2. Disorientation to time and place; or 3. Memory impairment, either short-term (inability to learn new information); intermediate, or long-term (inability to remember information that was known in past); or 4. Perceptual or thinking disturbance (hallucinations, delusions, illusions, or paranoid thinking); or 5. Disturbance in personality (e.g., apathy, hostility); or 6. Disturbance in mood (e.g., mania, depression); or 7. Emotional lability (e.g., sudden crying); or 8. Impairment of impulse control (e.g., disinhibited social behavior, explosive temper outbursts); or 9. Impairment of cognitive function (clinically timed standardized psychological testing); or 10. Disturbance of concentration, attention, or judgment**. AND** **B. (Select** appropriate age group): 1. **Age 1 to 3 years – with 1 of following:** a. **Gross motor/fine motor** development at a level generally acquired by children no more than ½ the child's chronological age; or b. **Cognitive/communicative** function at a level generally acquired by children no more than ½ the child's chronological age (including medical findings of equivalent abnormality such as inability to use simple verbal/nonverbal behavior to communicate basic needs/concepts); or c. **Social function** at level generally acquired by children no more than ½ child's chronological age, (including medical findings of an equivalent abnormality exemplified by serious inability to achieve age-appropriate autonomy as manifested by excessive clinging/extreme separation anxiety); or d. **Attainment of development/function** generally acquired by children no more than 2/3 of child's chronological age in 2 or more areas (GM, FM, cognitive, communicative, or social). 2. **Age 3 to 18 years - marked impairment in at least 2 of following:** a. Age appropriate **cognitive/communicative** function; or b. Age appropriate **social functioning**; or c. Age appropriate **personal functioning**; or d. Marked difficulties in **maintaining concentration, persistence, or pace.**
Schizo-prenic, Delusional (paranoid); Schizo-affective, and other psychotic disorders (112.03)	**Onset of psychotic features,** characterized by a marked disturbance of thinking, feeling, and behavior, with deterioration from a previous level of functioning or failure to achieve the expected level of social functioning. and **with BOTH A AND B**: **A. 1 of following** (persistence for at least 6 months, either continuous or intermittent): 1. Delusions or hallucinations; or 2. Catatonic, bizarre, or other grossly disorganized behavior; or 3. Incoherence, loosening of associations, illogical thinking, or poverty of content of speech; or 4. Flat, blunt, or inappropriate affect; or 5. Emotional withdrawal, apathy, or isolation. **AND** **B.** (Select appropriate age group): **Age 1 to 3 years** - at least 1 criteria in B1 of 112.02. **Age 3 to 18 years** - at least 2 criteria in B2 of 112.02.
Mood disorders (112.04)	**Characterized by a disturbance of mood** (referring to a prolonged emotion that colors the whole psychic life, generally involving either depression or elation), **accompanied by a full or partial manic or depressive syndrome, with BOTH A AND B:** (continued on next page)

Mood disorders (112.04) continued	**A. 1 of following (**persisting, either continuous or intermittent): 1. **Major depressive syndrome with at least 5 of following** (which must include either depressed or irritable mood or markedly diminished interest or pleasure): a. Depressed or irritable mood; or b. Markedly diminished interest or pleasures in almost all activities; or c. Appetite or weight increase or decrease, or failure to make expected weight gains; or d. Sleep disturbance; or e. Psychomotor agitation or retardation; or f. Fatigue or loss of energy; or g. Feelings of worthlessness or guilt; or h. Difficulty thinking or concentrating; or i. Suicidal thoughts or acts; or j. Hallucinations, delusions or paranoid thinking. **OR** 2. **Manic syndrome (**elevated, expansive or irritable mood), **and 3 of following:** a. Increased activity or psychomotor agitation; or b. Increased talkativeness or pressure of speech; or c. Flight of ideas or subjectively experienced racing thoughts; or d. Inflated self-esteem or grandiosity; or e. Increased need for sleep; or f. Easy distractibility; or g. Involvement in activities with high potential of painful consequences which are not recognized; or h. Hallucinations, delusions/paranoid thinking; **OR** 3. **Bipolar or cyclothymic syndrome** with history of episodic periods manifested by full symptomatic picture of both manic and depressive syndromes (and currently or most recently characterized by full or partial symptomatic picture of either or both syndromes); **AND** **B.** (Select appropriate age group): **Age 1 to 3 years** - at least 1 criteria in B1 of 112.02. **Age 3 to 18 years** - at least 2 criteria in B2 of 112.02.
Mental retardation (112.05)	**Characterized by significantly sub average general intellectual functioning** with deficits in adaptive functioning **and with 1 of following (A through F):** **A.** (Select appropriate age group): **Age 1 to 3 years** - At least 1 criteria in B1 of 112.02. **Age 3 to 18 years** - At least 2 criteria in B2 of 112.02**; OR;** **B. Mental incapacity** - dependence upon others for personal needs (grossly in excess of age appropriate dependence) & inability to follow directions such that use of standardized test is precluded; **OR** **C.** Verbal, performance, or full scale **IQ** less than or equal to 59**; OR** **D.** Verbal, performance, or full scale **IQ of 60 through 70 and a physical or other mental impairment** imposing additional and significant limitation of function; **OR** **E.** Verbal, performance, or full scale **IQ** of 60 through 70**, AND** (select appropriate group): **Age 1 to 3 years –** Attainment of developmental or function generally acquired by children no more than 2/3 of child's chronological age in either gross motor or fine motor (see B1a or B1c of 112.02). **Age 3 to 18 years** - Marked impairment in at least one of B2b or B2c or B2d of 112.02**; OR** **F.** (Select appropriate age group): **Age 1 to 3 years** - Cognitive/communicative function at 2/3 of child's chronological age in B1b of 112.02 & a physical/other mental impairment imposing an additional & significant functional limitation **3 to 18 years –** Meets **criteria of social functioning (see 112.02 B2a), and a physical or other mental impairment imposing an additional and significant limitation of function.**
Anxiety disorders (112.06)	**Either the predominant disturbance or is experienced if the individual attempts to master symptoms** (e.g. confronting the dreaded object or situation in a phobic disorder, attempting to go to school in a separation anxiety disorder, resisting the obsessions or compulsions in an obsessive compulsive disorder, or confronting strangers/peers in avoidant disorders). **With BOTH A and B:** **A. 1 of following:** 1. Excessive anxiety (when child separated/separation is threatened, from parent/parent surrogate; or

Anxiety disorders (112.06) continued	2. Excessive and persistent avoidance of strangers; OR 3. Persistent unrealistic or excessive anxiety and worry (apprehensive expectation), accompanied by motor tension, autonomic hyperactivity, or vigilance and scanning; OR 4. Persistent irrational fear of specific object, activity or situation resulting in compelling desire to avoid dreaded object, activity or situation; OR [list continued] 5. Avg. of once a week recurrent severe panic attacks, manifested by sudden unpredictable onset of intense apprehension, fear or terror, often with a sense of impending doom; OR 6. Recurrent and intrusive recollections of traumatic experience, including dreams, which are a sense of marked distress; or 7. Recurrent obsessions or compulsions, which are a source of marked distress**. AND** **B.** (Select appropriate age group): **Age 1 to 3 years - a**t least 1 criteria in B1 of 112.02**.** **Age 3 to 18 years - at least 2 criteria in B2 of 112.02.**
Somato-form eating & Tic disorders (112.07)	**Physical symptoms** for which there are no demonstrable organic findings or known physiologic mechanisms; **or eating and tic disorders with physical manifestations, with BOTH A AND B:** **A. 1 of following:** 1. **Unrealistic fear and perception of fatness** despite being underweight, and persistent refusal to maintain a body weight which is greater than 85% of average weight for height and age; **OR** 2. **Persistent and recurrent involuntary, repetitive, rapid, purposeless motor movements** affecting multiple muscle groups with multiple vocal tics; **OR** 3. **Persistent nonorganic disturbance of 1 of the following:** a. Vision; or b. Speech; or c. Hearing; or d. Use of a limb; or e. Movement and its control (coordination disturbance, psychogenic seizures); or f. Sensation (diminished or heightened); or g. Digestion or elimination; or 4. **Preoccupation with belief that one has serious disease/injury. AND** **B.** (Select appropriate age group): **Age 1 to 3 years** - at least 1 criteria in B1 of 112.02. **Age 3 to 18 years** - at least 2 criteria in B2 of 112.02.
Personality disorders (112.08)	**Pervasive, inflexible and maladaptive personality traits** typical of child's long-term functioning and not limited to discrete episodes of illness**, with BOTH A AND B:** **A. Deeply ingrained, maladaptive patterns of behavior, associated with 1 of following:** 1. Seclusiveness or autistic thinking; or 2. Pathologically inappropriate suspiciousness or hostility; or 3. Oddities of thought, perception, speech, and behavior; or 4. Persistent disturbances of mood or affect; or 5. Pathological dependence, passivity, or aggressiveness; or 6. Intense and unstable interpersonal relationships and impulsive and exploitive behavior; or 7. Pathological perfectionism and inflexibility. **AND** **B.** (Select appropriate age group): **Age 1 to 3 years** - at least 1 of the criteria in B1 of 112.02**.** **Age 3 to 18 years** - at least 2 of the criteria in B2 of 112.02.
Psycho-active substance dependence disorders (112.09)	**Manifested by cluster of cognitive, behavioral, & physiologic symptoms** indicating impaired control of psychoactive substance use & continued substance use despite adverse consequences, **with BOTH A & B:** **A. With 4 of the following:** 1. Substance taken in larger amounts or over a longer period than intended & a great deal of time is spent in recovering from its effects; or 2. 2 or more unsuccessful efforts to cut down or control use; or 3. Frequent intoxication or withdrawal symptoms interfering with major role obligations; or 4. Continued use despite persistent or recurring social, psychological, or physical problems; or

Psycho-active substance dependence disorders (112.09) continued	5. Tolerance, as characterized by requirement for markedly increased amounts of substance in order to achieve intoxication; or 6. Substance taken to relieve or avoid withdrawal symptoms**; AND** **B. (Select appropriate age group):** **Age 1 to 3 years** – at least 1 of the criteria in B1 of 112.02. **Age 3 to 18 years** – at least 2 of the criteria in B2 of 112.02.
Autism and other Pervasive Develop-mental disorders (112.10)	**Characterized by qualitative deficits in the development of reciprocal social interaction, verbal & nonverbal communication skills & in imaginative activity.** Often, a markedly restricted repertoire of activities and interests, which frequently are stereotyped and repetitive, **with BOTH A AND B:** **A. For autistic disorders: all of following:** 1. Qualitative deficits in development of reciprocal social interaction; and 2. Qualitative deficits in verbal and nonverbal communication and in imaginary activity; and 3. Markedly restricted repertoire of activities and interests. **A. For other pervasive development disorders: both of following:** 1. Qualitative deficits in development of reciprocal social interaction; and 2. Qualitative deficits in verbal and nonverbal communication and in imaginary activity**. AND** **B. (Select appropriate age group):** **Age 1 to 3 years** - at least 1 of the criteria in B1 of 112.02. **Age 3 to 18 years** - at least 2 of the criteria in B2 of 112.02.
ADHD (112.11)	Manifested by developmentally inappropriate degrees of inattention, impulsiveness, & hyperactivity; **with BOTH A AND B:** **A. All 3 of the following:** 1. Marked inattention; and 2. Marked impulsiveness; and 3. Marked hyperactivity; **AND** **B**. (**Select appropriate age group):** **Age 1 to 3 years** - at least 1 criteria in 112.02B for this age group. **Age 3 to 18 years** - at least 2 criteria in 112.02B for this age group.
Develop-mental and emotional disorders of newborn and younger infants (Birth to Age 1) (112.12)	May be related to either organic or functional factors or to a combination of these factors**; with 1 of following (A thru E):** **A. Cognitive/communicative functioning** acquired by children no more than ½ of child's chronological age (e.g. in infants 0 to 6 months, markedly variation in the production or imitation of sounds and severe feeding abnormality, such as problems with sucking, swallowing, or chewing); **OR** **B. Motor development** ½ of child's chronological age; **OR** **C. Apathy, over-excitability, or fearfulness**, demonstrated by absent or grossly excessive response to on of the following stimulations: visual; or auditory; or tactile; **OR** **D. Failure to sustain social interaction on an ongoing, reciprocal basis as evidenced by 1 of following:** 1. Inability by 6 months to participate in vocal, visual, and motoric exchanges (including facial expressions); or 2. Failure by 9 months to communicate basic emotional responses, such as cuddling or exhibiting protest or anger; or 3. Failure to attend to caregiver's voice or face or to explore an inanimate object for period of time appropriate to infant's age**; OR** **E. Attainment of development or function** generally acquired by children no more than **2/3 of child's chronological age in 2 or more areas** (cognitive, communicative, motor, or social).
MALIGNANT NEOPLASTIC DISEASE (113.00)	
Malignant solid tumors (113.03)	• **Consider a disability for 2 years from time of initial diagnosis.** Thereafter, evaluate any residual impairments(s) under the criteria for the affected body system; **OR** • **Consider a disability for 2 years from the date of recurrence of active disease.** Thereafter, evaluate any residual impairments(s) under the criteria for the affected body system.

Lymphoma (113.05)	**Excluding T-cell lymphoblastic lymphoma; with 1 of the following:** **A. Non-Hodgkins lymphoma,** including Burkitt's and anaplastic large cell. Persistent or recurrent following initial antineoplastic therapy; **OR** **B. Hodgkin's disease** with failure to achieve clinically complete remission, or recurrent disease within 12 months of completing initial antineoplastic therapy; **OR** **C. Bone marrow or stem cell transplantation** (a disability until at least 12 months from date of transplantation. Thereafter, evaluate residual impairment(s) under criteria of affected body system.
Leukemia (113.06)	**With 1 of the following:** **A. Acute leukemia [including T-cell lymphoblastic lymphoma and juvenile chronic myelogenous leukemia (JCML)] (**a disability until at least 24 months from the date of diagnosis or relapse, or at least 12 months from the date of bone marrow or stem cell transplantation, whichever is later. Thereafter, evaluate any residual impairments(s) under the criteria for the affected body system)**; OR** **B. Chronic myelogenous leukemia (except JCML), with 1 of the following:** 1. Accelerated or blast phase. Consider under a disability until at least 24 months from the date of diagnosis or relapse, or at least 12 months from the date of bone marrow or stem cell transplantation, whichever is later. Thereafter, evaluate any residual impairments(s) under the criteria for the affected body system; or 2. Chronic phase, as described in **a or b**: a. A disability until at least 12 mo. from bone marrow/stem cell transplantation date. Thereafter, evaluate any residual impairment(s) under the criteria for the affected body system; or b. Progressive disease following initial antineoplastic therapy.
Thyroid gland (113.09)	**With 1 of the following:** **A. Anaplastic (undifferentiated) carcinoma; OR** **B. Carcinoma with metastases** beyond regional lymph nodes progressive despite radioactive iodine therapy; **OR** **C. Medullary carcinoma with metastases** beyond the regional lymph nodes.
Retino-blastoma (113.12)	**With 1 of the following:** **A. With extension beyond the orbit; OR** **B. Persistent or recurrent** following initial antineoplastic therapy**; OR** **C. With regional or distant metastases.**
Brain tumors (113.13)	**Highly malignant tumors,** such as medulloblastoma or other primitive neuroectodermal tumors (PNETs) with documented metastases, grades III and IV astrocytomas, glioblastoma multiforme, ependymoblastoma, , diffuse intrinsic brain stem gliomas, or primary sarcomas.
Neuro-blastoma (113.21)	**With 1 of the following:** **A. With extension across the midline; OR** **B. With distant metastasis; OR** **C. Recurrent; OR** **D. With onset at age 1 year or older.**
IMMUNE SYSTEM (114.00)	
Systemic lupus erythema-tosus (114.02)	**With EITHER A or B:** **A**. Involvement of **2 or more organs/body systems, with BOTH:** 1. One of the organs/body systems involved to at least a moderate level of severity; AND 2. At least 2 constitutional symptoms & signs (severe fatigue, fever, malaise, or involuntary weight loss); **OR** **B**. Any **other manifestation(s) of SLE resulting in one of the following** (select appropriate age group): **Birth to age 1 year** - at least 1of the criteria in 112. 12; or **Age 1 to age 3 years** - at least 1 of the appropriate age-group criteria in paragraph B1 of 112. 02; or **Age 3 to age 18** – at least 2 of the appropriate age-group criteria in paragraph B2 of 112.02.
Systemic vasculitis (114.03)	**With EITHER A or B:** **A**. Involvement of **2 or more organs/body systems, with BOTH:** 1. One of the organs/body systems involved to at least a moderate level of severity; AND 2. At least 2 constitutional symptoms & signs (severe fatigue, fever, malaise, or involuntary weight loss); **OR** **B.** Any **other manifestation(s) of systems vasculitis resulting in 1 of the following** (select appropriate

Systemic Vasculitis, continued	age group): **Birth to age 1 year** - at least 1of the criteria in paragraphs A-E of 112. 12; or **Age 1 to age 3 years** - at least 1 of the appropriate age-group criteria in paragraph B1 of 112. 02; or **Age 3 to age 18** – at least 2 of the appropriate age-group criteria in paragraph B2 of 112.02.
Systemic sclerosis (sclero-derma) (114.04)	**With 1 of the following:** **A.** Involvement of **2 or more organs/body systems, with both:** 1. One of the organs/body systems involved to at least a moderate level of severity; **and** 2. At least 2 constitutional symptoms & signs (severe fatigue, fever, malaise, or involuntary weight loss); **OR** **B.** With **1 of the following**: 1. Toe contractures or fixed deformity of 1 or both feet; resulting in the inability to ambulate effectively; or 2. Finger contractures or fixed deformity in both hands, resulting in the inability to perform gross motor and fine motor movements effectively; or 3. Atrophy with irreversible damage in 1 or both lower extremities, resulting in the inability to ambulate effectively; or 4. Atrophy with irreversible damage in both upper extremities, resulting in the inability ro perform fine and gross movements effectively. **OR** **C. Raynaud's phenomenon**, characterized by **either**: 1. Gangrene involving at least 2 extremities; or 2. Ischemia with ulcerations of toes or fingers, resulting in the inability to ambulate effectively or to perform fine and gross movements effectively; OR **D.** Any other manifestation(s) of systemic sclerosis (scleroderma) resulting in 1 of the following (select appropriate age group): **Birth to age 1 year** - at least 1of the criteria in paragraphs A-E of 112.12; or **Age 1 to age 3 years** - at least 1 of the appropriate age-group criteria in paragraph B1 of 112. 02; or **Age 3 to age 18 years –** at least 2 of the appropriate age-group criteria in paragraph B2 of 112.02.
Polymyo-sitis & dermato-mysitis (114.05)	**With 1 of the following:** **A. Proximal limb-girdle (pelvic or shoulder) muscle weakness**, resulting in inability to ambulate effectively or inability to perform fine and gross movements effectively; **OR** **B. Impaired swallowing** (dysphagia) with aspiration due to muscle weakness; **OR** **C. Impaired respiration due to intercostal & diaphragmatic muscle weakness; OR** **D. Diffuse calcinosis** with limitation of joint mobility or intestinal motility; **OR** **E. Any other manifestation(s) of polymyositis or dermatomyositis** resulting in 1 of the following (select appropriate age group): **Birth to age 1 year** - at least 1of the criteria in paragraphs A-E of 112.12; or **Age 1 to age 3 years** - at least 1 of the appropriate age-group criteria in paragraph B1 of 112. 02; or **Age 3 to age 18 years** – at least 2 of the appropriate age-group criteria in paragraph B2 of 112.02.
Undifferen-tiated & mixed connective tissue disease (114.06)	**With EITHER A or B:** **A. Involvement of 2 or more organs/body systems**, **with both** 1. One of the organs/body systems involved to at least a moderate level of severity; and 2. At least 2 of the constitutional symptoms and signs (severe fatigue, fever, malaise, or involuntary weight loss); **OR** **B.** Any other manifestation(s) of undifferentiated or mixed connective tissue disease resulting in 1 of the following (select appropriate age group): **Birth to age 1 year** - at least 1of the criteria in paragraphs A-E of 112.12; or **Age 1 to age 3 years** - at least 1 of the appropriate age-group criteria in paragraph B1 of 112. 02; or **Age 3 to age 18 years** – at least 2 of the appropriate age-group criteria in paragraph B2 of 112.02
Immune deficiency disorders, excluding HIV (114.07)	**With EITHER A, B, or C:** **A. 1 or more of following infections**, resistant to treatment or requiring hospitalization or intravenous treatment 3 or more times in a 12-month period: 1. Sepsis; or 2. Meningitis; or 3. Pneumonia; or

Immune deficiency disorders, excluding HIV infection (114.07) (continued)	4. Septic arthritis; or (continued next page) 5. Endocarditis; or 6. Sinusitis documented by appropriate medically acceptable imaging**; OR** **B. Stem cell transplantation** (considered disabled until at least 12 months after the date of transplantation, Thereafter, evaluate any residual impairment(s) under the criteria for the affected body system. **OR** **C. Any other manifestation(s) of an immune deficiency disorder resulting in 1 of the following** (select appropriate age group)**:** **Birth to age 1 year** - at least 1of the criteria in paragraphs A-E of 112.12; or **Age 1 to age 3 years** - at least 1 of the appropriate age-group criteria in paragraph B1 of 112. 02; or **Age 3 to age 18 years** – at least 2 of the appropriate age-group criteria in paragraph B2 of 112.02.
HIV (114.08)	**With 1 of the following (A through O):** **A. Bacterial Infections**: **1 of the following**: 1. Mycobacterial infection (e.g. caused y M. avium-intracellulare, M. kansasii, or M. tuberculosis) at site other than the lungs, skin, or cervical or hilar lymph nodes; or pulmonary tuberculosis resistant to treatment; or 2. Nocardiosis; or 3. Salmonella bacteremia, recurrent non-typhoid; or 4. **In a child less than 13 yrs old**., multiple or recurrent pyogenic bacterial infections (sepsis, pneumonia, meningitis, bone or joint infection, or abscess of an internal organ or body cavity, but not otitis media or superficial skin or mucosal abscesses) occurring 2 or more times in 2 years. **For children age 13 & older**, may have an impairment that medically equals this listing if the circumstances of the case warrant (ex: delayed puberty, or they would evaluate pelvic inflammatory disease in older girls) 5. Other multiple or recurrent bacterial infection(s), including pelvic inflammatory disease, requiring hospitalization or intravenous antibiotic treatment 3 or more times in a 12-month period. **OR** **B. Fungal infections: 1 of the following**: 1. Aspergillosis; or 2. Candidiasis - involving the esophagus, trachea, bronchi, or lungs, or at a site other than the skin, urinary tract, intestinal tract, or oral or vulvovaginal mucous membranes; or 3. Coccidioidomycosis, at site other than lungs or lymph nodes; or 4. Cryptococcosis, at a site other than lungs (eg, cryptococcal meningitis); or 5. Histoplasmosis, at a site other than lungs or lymph nodes; or 6. Mucorrmycosis; or 7. Pneumocystis pneumonia or extrapulmonary Pneumocystis infection. **OR** **C. Protozoan or helminthic infections: 1 of the following**: 1. Cryptosporidiosis, isosporiasis, or microsporidiosis, with diarrhea lasting for 1 month or longer; or 2. Strongyloidiasis, extra-intestinal; or 3. Toxoplasmosis of an organ other than liver, spleen, or lymph nodes. **OR** **D. Viral infections: 1 of the following:** 1. Cytomegalovirus disease (CMV) at a site other than the liver, spleen or lymph nodes; or 2. Herpes simplex virus causing 1 of the following: a. Mucocutaneous infection (ex: oral, genital, perianal) lasting 1 month or longer; or b. Infection at site other than skin or mucous membranes (e.g., bronchitis, pneumonitis, esophagitis, or encephalitis); or c. Disseminated infection; or 3. Herpes zoster, either disseminated or with multidermatomal eruptions resistant to treatment; or 4. Progressive multifocal leukoencephalopathy. **OR** **E. Malignant neoplasms: 1 of the following**: 1. Carcinoma of cervix, invasive, FIGO stage II and beyond; or 2. Karposi's sarcoma, with either: extensive oral lesions;or Involvement of the gastrointestinal tract, lungs, or other visceral organs; or 3. Lymphoma (ex: primary lymphoma of the brain, Burkitt's lymphoma, immunoblastic sarcoma, other non-Hodgkin's lymphoma, Hodgkin's disease); or 4. Squamous cell carcinoma of anal canal or anal margin. **OR** **F. Conditions of skin/mucous membranes** (other than described in B2, D2, or D3 above), with extensive

HIV (114.08) Continued	fungating or ulcerating lesions not responding to treatment (ex: dermatological conditions such as eczema or psoriasis, vulvovaginal or other mucosal Candida, condyloma caused by human papillomavirus, genital ulcerative disease). **OR** **G. Neurological manifestations of** HIV (ex, HIV encephalopathy, peripheral neuropathy) **resulting in 1 of the following:** 1. Loss of previously acquired, or marked delay in achieving, developmental milestones or intellectual ability (including sudden acquisition of a new learning disability); or 2. Impaired brain growth (acquired microcephaly or brain atrophy); or 3. Progressive motor dysfunction affecting gait and station or fine and gross motor skills**. OR** **H. Growth disturbance, with 1 of the following:** 1. Involuntary weight loss (or failure to gain weight at appropriate rate for age), resulting in either a fall of 15 percentiles, or a fall to below the 3rd percentile, that persists for 2 months or longer; or 2. Involuntary weight loss of 10 percent or more of baseline (computed based on pounds, kilograms, or body mass index (BMI) that persists for 2 months or longer; **OR** **I. Diarrhea, lasting for 1 month or longer**, resistant to treatment and requiring intravenous hydration or alimentation, or tube feeding; **OR** **J. Lymphoid interstitial pneumonia/pulmonary lymphoid hyperplasia (LIP/PLH complex),** with respiratory symptoms that significantly interfere with age-appropriate activities, and that cannot be controlled by prescribed treatment; **OR** **K.** One or more of the following infections (other than described in A-J above), resistant to treatment or require hospitalization or intravenous treatment 3 or more times in a 12-month period: Sepsis; Meningitis; Pneumonia; Septic arthritis; Endocarditis; or Sinusitis documented by appropriate medically acceptable imaging. **OR** **L**. **Any other manifestation(s) of HIV infection**, including any listed in 114.08 A through K, but without the requisite findings (ex: oral candidiasis not meeting the criteria in 114.08F, diarrhea not meeting the criteria in 114.08I), or any other manifestation(s) (ex: oral hairy leukoplakia, hepatomegaly), resulting in 1 of following (select appropriate age group): **Birth to 1 year**, at least one of the criteria in paragraphs A through E of 112.12; or **1 year to 3 years,** at least one of the age-appropriate age group criteria in paragraph B1 of 112.12; or **3 years to 18 years,** at least 2 of the appropriate age group criteria in paragraph B2 of 112.02**.**
Inflam-matory Arthritis (114.09)	**With 1 of the following:** **A. Persistent inflammation or persistent deformity of either:** 1 or more major peripheral weight-bearing joints resulting in the inability to ambulate effectively; **or** 1 or more peripheral joints in each upper extremity resulting in the inability to perform fine or gross motor movements effectively. **OR** **B. Inflammation or deformity in 1 or more major peripheral joints with both** involvement of 2 or more organs/body systems with 1 of the organs/body systems involved to at least a moderate; and at least 2 constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary wt. loss). **OR** **C. Ankylosing spondylitis or other spondyloarthropathy, with** ankylosis (fixation) of the dorsolumbar or cervical spine at **either** 45 degrees or more of flexion measured from the vertical position (zero degrees; **or** at 30 degrees or more of flexion (but less than 45 degrees) and involvement of 2 or more organs/body systems involved to at least a moderate level of severity. **OR** **D. Any other manifestation(s) of inflammatory arthritis** resulting in (select appropriate age group): **Birth to 1 year**, at least one of the criteria in paragraphs A through E of 112.12; or **1 year to 3 years,** at least one of the age-appropriate age group criteria in paragraph B1 of 112.12; or **3 years to 18 years**, at least 2 of the appropriate age group criteria in paragraph B2 of 112.02**.**
Sjogren's syndrome (114.10)	**With EITHER A or B:** **A. Involvement of 2 or more organs/body systems** with **both** 1 of the organs/body systems involved to at least a moderate level of severity; **and** at least 2 of the constitutional symptoms & signs (severe fatigue, fever, malaise, or involuntary weight loss: **OR** **B. Any other manifestation(s) of Sjogren's syndrome resulting in** (select appropriate age group): **Birth to 1 year**, at least one of the criteria in paragraphs A through E of 112.12; or **1 year to 3 years,** at least one of the age-appropriate age group criteria in paragraph B1 of 112.12; or **3 years to 18 years,** at least 2 of the appropriate age group criteria in paragraph B2 of 112.02.

Additional Resources

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Child Care

Center for Inclusive Child Care (CCIC)

The CICC is a statewide network, funded by the MN Departments of Education and Human Services, which promotes and supports inclusive early childhood and school age programs and professionals. It provides training and consultation to child care professionals around a wide variety of inclusion support topic areas, including behavior challenges, disability perceptions, and specific disabilities. The website contains links to hundreds of disability specific sites and is a central resource for materials, products and information that promote and support inclusive care. It helps educators, trainers, and parent's access information about early intervention, disability law, and state and national resources. The page is available in: Spanish, French, German, Italian, Portuguese, Chinese, Japanese, and Korean. Mailing address: CCIC, Concordia University, 275 North Syndicate Street, St. Paul, MN 55104. Phone 651-603-6265. www.inclusivechildcare.org

Child Care Assistance Programs (CCAP)

Minnesota's CCAP can help income-eligible families pay child care costs for children up to age 12 and for children with special needs up to age 14. These costs may be paid for qualifying families while to go to work, look for work, or attend school. Child Care assistance may be available to: 1) Families participating Minnesota Family Investment Program (MFIP); 2) Families that had an MFIP case close within the last 12 months; 3) Low-income families that may be eligible for the Basic Sliding Fee program. To qualify for CCAP, families must comply with child support enforcement if applicable for all children in the family. Care must be provided by a legal child care provider over the age of 18. All families will have a copayment based on their gross income and family size.

Families should fill out an application to find out if they qualify for help with their child care costs. Contact your county's Department of Human Services (DHS) or the Child Care Resources and Referral (CCRR) Agency in your area to begin the application process. There is a fact sheet called "Do You Need Help Paying for Daycare (DHS-3551) on the DHS Website www.dhs.state.mn.us

Child Care Financial Aide Website

The Child Care Financial Aid website offers more information or help with child care for parents, employers and child care providers. Parents can use the Web site to estimate eligibility for tax credits, fee subsidies, scholarships and program options. It can also connect parents to tools for finding child care providers and learn about options for parenting education. There is also information on Head Start and Early Head Start. These are comprehensive child development programs that serve children from birth to age 5, pregnant women, and their families. They are child-focused programs and are aimed at increasing the school readiness of young children in low-income families. Employers can find information about offering child care benefits. www.childcarefinancialaid.org

Dependent Care Assistance Programs (DCAPs)

These are accounts set up by an employer allowing employees to contribute money through payroll deductions to pay for child care costs. The deduction lowers your taxable income. The maximum amount you can deduct per year is $5,000 per family. It is important to carefully estimate child care expenses when deciding the annual amount to you direct to a DCAP, since any money you do no use by the end of the year is forfeited to the employer to offset administrative expenses. Minnesota Child CareResource & Referal Network; 380 Lafayette Road, Suite 103; St. Paul MN 55107. To connect to your local Resource and Referral Agency: 888-291-9811; Twin Cities Area: 651-665-0150 http://mnchildcare.org/businesses/dependent.php

Minnesota Child Care Resource and Referral Network

The Minnesota Child Care Resource and Referral Agencies helps parents find and select quality childcare that fits their individual needs. They also support quality child care in the state by offering comprehensive training to child care professionals. To find out more about child care in your county, contact the Minnesota Child Care Resources and Referral Network, Statewide Information and Referral Line (888-291-9811; Metro area: 651-665-0150) or go online at: http://www.mnchildcare.org

Post-Secondary Child Care Grant Program
This helps students who do not get MFIP (Minnesota Family Investment Program) with child care costs so parents can attend public colleges and universities, technical and community colleges, private colleges and some vocational schools. For more information, check with your school's financial aid office. http://www.mheso.state.mn.us/mPg.cfm?pageID=348 Minnesota Office of Higher Education; 1450 Energy Park Drive, Suite 350; St. Paul, MN 55108-5227; 651-642-0567; 800-657-3866.

Child Support

"Child Support Services" – from Dept. of Human Services
This site offers important information about child support hearings. It includes information on what to expect, what you must bring to the hearing, notification of hearings, how to request special needs and interpreters, how to prepare for the hearing, and additional information to help with this process. There is also a Minnesota Child Support Online site (requires a pin number) for accessing court information. Click on this site and do a search for "Child Support Services." www.dhs.state.mn.us

Disability Information

The DBTAC Great Lakes ADA Center: A Disability & Business Technical Assistance Center
The Great Lakes ADA Center staffs a toll-free information line providing informal guidance on the Americans with Disabilities Act (ADA) and other related disability laws. Spanish is also available on this site. University of Illinois at Chicago, Institute on Disability & Human Development (MC 728), 1640 West Roosevelt Road, Room 405, Chicago, IL 60608, 312-413-1407 (V/TTY), or 800-949-4232 (V/TTY), Email: gldbtac@uic.edu www.adagreatlakes.org

Disability Information
Disability.gov offers clear information about how to apply for Social Security and veterans benefits, as well as disability benefits for children. There is also information for people thinking about returning to work while receiving disability benefits. For information about more than 1,000 benefit and assistance programs, including many that can benefit people with disabilities visit: www.disability.gov

Disability Linkage Line
Do you have a disability? Are you on Medicare? If so, you may be able to save hundreds of dollars every year by enrolling in the Medicare Savings Programs. That's money you can use for medical bills, utilities, groceries or other necessities. The Disability Linkage Line is a free, statewide, information, referral and assistance service to help people with disabilities, chronic illnesses and their representatives connect to community services. Disability Linkage Line TM Resource Specialists will provide one-to-one assistance to help people learn about their options and connect with the supports and services they choose. To ask how to apply, call 1-866-333-2466. Further information on this site is available at www.dhs.state.mn.us

Disability Minnesota
The purpose of this website is to provide a single entry point to over 100 Minnesota state agency programs, products, and services that are devoted to the range of disability issues. This website also provides access to laws, statutes, and regulations in pertinent disability-related areas. www.disability.gov/state/minnesota/benefits

Disability Scoop
Disability Scoop is the premier source for developmental disability news. It provides a central, reliable source for news, information and resources, including original content and series, taking an in-depth look at the day's news as it pertain to developmental disabilities. www.disabilityscoop.com

Disability Specialists, Inc.
Disability Specialists, Inc. works with Social Security Disability Claimants at no cost. They offer complete assistance from application to subsequent appeals, including all paperwork and forms required by the Social Security Administration. 1-800 642-6393 (toll-free) 218-666-3136 (fax) www.disabilityspecialist.net/

Family Village
Family Village is a global community that integrates information, resources, and communication opportunities on the Internet for persons with cognitive and other disabilities, for their families, and for those that provide services and support. Their global community includes informational resources on specific diagnoses, communication connections, adaptive products and technology, adaptive recreational activities, education, worship, health issues, disability-related media and literature, and much more. Address: Family Village, Waisman Center, University of Wisconsin-Madison, 1500 Highland Avenue, Madison, WI 53705 www.familyvillage.wisc.edu/index.htmlx

Minnesota Organization on Fetal Alcohol Syndrome (MOFAS)
MOFAS is a state affiliate of the National Organization on Fetal Alcohol Syndrome (NOFAS), an organization that strives to eliminate birth defects from alcohol consumption during pregnancy and to improve the quality of life for those individuals and families affected with a fetal alcohol spectrum disorder. They sponsor community awareness events, trainings for professionals about diagnosing a fetal alcohol spectrum disorder, and a variety of trainings for families, professionals and providers about advocacy and effective interventions/supports for individuals with a fetal alcohol spectrum disorder. The website offers information about their FASD Community Grant Program, MN Regional Resource Coordinators and Resource Directory as well as links to FASD journal articles, handouts and other organizations. MOFAS 1885 University Avenue, Suite 395, St. Paul, MN 55104. 651-917-2370 or 1-866-90-MOFAS www.mofas.org

NORD, National Organization for Rare Diseases, Inc.
NORD is committed to the identification, treatment, and cure of rare disorders through programs of education, advocacy, research, and service. NORD has an excellent Rare Disease Database and works closely with humanitarian-minded pharmaceutical and biotechnology companies to ensure that certain vital medications are available to those individuals whose income is too high to qualify for Medicaid but too low to pay for their prescribed medications. **The National Organization for Rare Disorders (NORD) Medical Foods Assistance Program** for Patients with Phenylketonuria (PKU) is now accepting applications for financial support. The program is a new safety net that provides financial support for PKU patients without benefit coverage to obtain their preferred medical food. (203) 744-0100 (800) 999-6673 (voicemail only) http://www.rarediseases.org/

Equipment

CCR is a volunteer organization that assists people with disabilities (hearing, vision or physical) to purchase adaptive equipment. Eligibility is individually determined and based on the CCR Board's decision. They do not pay for the purchase of vans (new or used) but may be able to assist with van adaptations such as hand brakes or a lift. They also do not pay for computers, software or computer adaptations. They may provide funding for hearing aids, glasses, & wheelchairs for example. They encourage collaborative funding from a variety of resources. For an application or more information contact Anne Marie Hennen, 5742 Rhode Island Ave. North Minneapolis, MN 55428 Phone: 763-550-0176. Further information on this program may be obtained on the Minnesota Star Program site: www.mnplan.state.mn.us/star/program.html?Id=7

Used Equipment Referral Service (UERS)
This website offers a nation wide list of agencies by state that offer used equipment services, Loan Closets and rental equipment. http://www.uiowa.edu/infotech/Otheruse.doc
Examples of some Minnesota agencies with used equipment information include:
Complete Mobility Systems (accessible vans). 1-800-570-0236. www.imedmobility.com
Telephone Equipment Distribution Program 1-800-657-3663. www.tedprogram.org
Goodwill Industries/Easter Seals Loan Closet 1-800-669-6719.

Kuehn Motor Company (accessible vans) 877-672-0774.
PACER Center 1-800-537-2237. www.pacer.org/STC/ email: pacer@pacer.org
Southeast Minnesota Center for Independent Living 507-285-1815 www.semcil.org

Family Support and Advocacy

The ARC of Minnesota

The Arc of Minnesota is a private, non-profit, statewide voluntary organization; local chapters of The Arc span the state of Minnesota. The Arc serves people of all ages with many kinds of developmental disabilities including, but not limited to, intellectual disabilities, Down Syndrome, autism, cerebral palsy, and Fetal Alcohol Spectrum Disorder. ARC is concerned with the total life of an individual, from birth to death, and with all services or needs an individual and his or her family may have. ARC provides crucial information for people with developmental disabilities and their families, connects them with resources, and stands with them when they need an advocate. Workshops, information and referral, one-on-one advocacy for families and their children with developmental disabilities, public policy advocacy, and support services are provided across the state by The Arc of Minnesota or local affiliated chapters of The Arc. The Arc fights for persons with developmental disabilities so they can reach for a brighter, more inclusive future.

Contact: The Arc of Minnesota, 770 Transfer Road, Suite 7A, St. Paul, MN 55114. Phone: 651-523-0823 or 1-800-582-5256. Website: www.thearcofminnesota.org or e-mail: mail@arcmn.org

Catholic Charities

It is one of the Twin Cities' largest private providers of social services, working to strengthen families, reduce poverty and build stronger communities in the Minneapolis and St. Paul metropolitan area through their advocacy efforts. They serve those most in need through four divisions: Children, Families, Housing, & Emergency Services and Advocacy. St. Joseph's Home for Children specializes in assessment, crisis intervention and residential programming, especially for children with severe emotional and behavioral problems. Offer supports and services for children, families, and the homeless. 651-664-8500. www.cctwincities.org

Community Action Agency

Offices are located throughout the state, with varying names. They often know what is available in the area for a variety of resources, including emergency food shelves, housing, and energy assistance, Head Start, low-cost medical care, county offices, and more. You can find a Community Action Agencies in your area by going to their Website at http://www.mncaa.org/ or 100 Empire Drive, Suite 202; St. Paul, MN 55103. 651-645-7425

Community Services Locator

The Community Services Locator is an online directory for finding services for children and families in the communities in which they live. The locator, produced by the MCH Library, may be used by service providers and families to find available health, mental health, family support, parenting, child care, and other services. Topics include education and special needs, health and wellness, mental health and well-being, family support, parenting, child care and early childhood education, and financial support. A new A-Z Resources and Services Index offers another avenue for navigating the locator and the library's Web site. The locator along with all appropriate 1/800 numbers for all agencies is available at
www.mchlibrary.info/KnowledgePaths/kp_community.html

Family Voices

Family Voices of Minnesota is a grass roots network of families whose children, youth and young adults have special health care needs and/or disabilities. Family Voices mission is to achieve family-centered care for all children and youth with special health care needs and/or disabilities. Through our state and national networks, we provide families tools to make informed decisions, advocate for improved public and private policies, build partnerships among professionals and families, and serve as a trusted resource on health care. Family Voices of MN includes a web-site: www.familyvoicesofminnesota.org an e-mail network through which local, state and national information is exchanged and there are occasional mailings. For more information contact the network

coordinators via e-mail: network@familyvoicesofminnesota.org or the national organization at www.familyvoices.org/

MinnesotaHelp.info is a centralized Internet entry point that contains information about services provided by both public and private entities throughout the state. The site is easy to use for both the beginner and the more experienced internet-savvy consumer or professional. The site contains information links for all ages. Information on many topics is available by County and may be accessed by zip codes or city and state. It includes shelters, crisis nurseries and vouchers for lodging. There is a Spanish information page and access to Minnesota Northstar government website. www.minnesotahelp.info

The Minnesota State Council on Disability (MSCOD)
MSCOD is an agency that collaborates, advocates, advises and provides information to expand opportunities, increase the quality of life and empower all persons with disabilities. Services are provided to individuals with disabilities and their families, the Governor and Legislature, government and private agencies, employees, and the general public. Services include: (1) Review of disability issues, programs and policies and advise the Governor, Legislature and State agencies; (2) Promote coordinated, collaborative, interagency efforts. (3) Provide information and referrals regarding disability issues, services and policies. (4) Collect, conduct and make disability related research and statistics available. (5) Advocate for policies and programs that promote the quality of life for people with disabilities. Address: The Minnesota State Council on Disability (MSCOD), 121 East Seventh Place, Suite 107, St. Paul, MN 55101. Phone: 651-361-7800 or 1-800-945-8913 (Voice or TTY) www.disability.state.mn.us

National Dissemination Center for Children with Disabilities (NICHCY)
This is the national information center that provides information on disabilities and disability-related issues. Anyone can use our services—families, educators, administrators, journalists, and students. Our special focus is children and youth (birth to age 22). NICHCY shares information about disabilities in children and youth. You can explore their Website, read their publications and share them with others, let them connect you with resources in your state and in the United States, and call them free of charge to talk with their information staff about your special concerns. They're bilingual, too! Address: NICHCY, 1825 Connecticut Avenue NW, Suite 700, Washington, DC 20009. Phone: 1-800-695-0285 (Voice or TTY). http://nichcy.org

PACER Center, Inc. (Parents'Advocacy Coalition for Education Rights)
Pacer's Health Information and Advocacy Center project provides a central source for families of children and young adults with disabilities to obtain support, advocacy and information about the health care system. Some of the information provided includes understanding insurance and filing insurance appeals, communicating with health care providers, making informed choices about health care providers, and general health resources. PACER offers workshops for parents and professionals, links with parent-to-parent support programs, puppet shows on disability sensitivity and preventing child abuse. They have many free publications. Address: PACER Center, Inc., 8161 Normandale Boulevard, Minneapolis, MN 55437. Phone: 952-838-9000 or 1-800-537-2237 (Voice) 952-838-0190 (TTY). www.pacer.org

PACER's Simon Technology Center
The Simon Technology Center, a project of PACER, provides numerous assistive technology services and programs for children, families, consumers, and professionals. Free assistive technology consultations for children and adults; A statewide loan library of software, devices, adapted toys, books and videos; Information and referral; A free online listing service for used assistive technology; Trainings on assistive technology for parents and professionals; A monthly electronic newsletter and a bi-annual print newsletter; An early childhood technology training program; Creation Station, a creative activities program for children with disabilities and their friends and family members; E.X.I.T.E. Camp, a day camp for middle school girls with disabilities that fosters interest in science and technology. Simon Technology Center, PACER Center, 8161 Normandale Blvd., Minneapolis, MN 55437-1044; Voice: 952-838-9000, Toll free 1-800-537-2237; TTY: 952-838-0190; FAX: 952-838-0199. For more information, visit www.pacer.org/stc

What does it mean to be an advocate? How and when should you advocate for yourself? This fact sheet by PACER Center has many helpful tips about self-advocacy.
http://www.pacer.org/parent/php/PHP-c116.pdf

Patient Advocate Foundation
The Patient Advocate Foundation is a national non-profit organization that seeks to safeguard patients through effective mediation assuring access to care, maintenance of employment and preservation of their financial stability relative to their diagnosis of life threatening or debilitating diseases. The **"Fundraising Ideas for Patients"** is located thru the 'The Patient Pal' tab at the top of the Patient Advocate Foundation website.
www.patientadvocate.org

Respite Care
www.childneurologyfoundation.org/ "Our Family: A Respite Workbook for Families and Care-Providers" is available at the Child Neurology Foundation. This workbook is to be completed by families to provide all personal health information for temporary caregivers to ensure the best care for your child while in respite care. Copies are available from on this site under "Advocacy," or call Toll Free: 1-800-263-5430.

Fatherhood Resources

"Fathers to the Forefront "
This action plan was written in 2007 and seeks to engage all fathers, especially fathers who are facing multiple barriers, so that they may become healthy assets for the development of their children, their families, and their communities. The authors of this action plan aim to increase levels of healthy father involvement in Minnesota's urban, suburban, rural, and tribal communities by working in tandem with organizations that support healthy women and children. www.mnfathers.org/FathersToTheForefront.pdf

Minnesota Father's and Families Network enhances healthy father-child relationships by promoting initiatives that inform public policy and further develop the field of fatherhood practitioners statewide. (651) 222-7432 http://www.mnfathers.org/

National Responsible Fatherhood Clearinghouse
The National Responsible Fatherhood Clearinghouse is designed to help you as a father or family member learn about the importance of being actively involved with your children and to learn creative and effective strategies for getting involved and staying involved in the lives of your children. http://www.fatherhood.gov/father/

Financial Information

Children's Defense Fund and Children's Defense Fund--Minnesota
The Children's Defense Fund (CDF) is a private, nonprofit, nonpartisan research and advocacy organization supported by foundations, corporate grants and individual donations. They do not accept government funds. Using research and data, CDF focuses on educating others about the needs of the poor, of minority children and those with special needs. They encourage preventive investment before children get sick or into trouble, drop out of school, or suffer family breakdown. Their website has many informative resources including Minnesota county data, Minnesota Census Data and a Minnesota Legislative Scorecard. You can sign up to receive their newsletter or join their E-Advocacy Network. 651-227-6121 www.cdf-mn.org

Federal Earned Income Credit and the Minnesota Working Family Credit
The Earned Income Credit (EIC) is a special credit for low income working families that reduces the amount of federal tax you owe (if any). The credit is subtracted from the amount of tax you owe, so you pay less tax or get money back from the government. Even if you do not owe any tax liability, you might still get some money back. You must meet certain eligibility requirements in order to claim the credit. Taxpayers who qualify for the

federal EIC qualify for the Minnesota Working Family Credit. For more information on federal tax credits and refunds and to see if you are eligible, call (800) 829-1040. For information on state tax credits, call 651-296-3781.

The Minnesota Governor's Council on Developmental Disabilities
The Minnesota Governor's Council on Developmental Disabilities works toward assuring that people with developmental disabilities receive the necessary support to achieve independence, self determination, productivity, integration and inclusion into the community. One program that was created by this Council is the Partners in Policymaking leadership training program for adults with disabilities and parents of young children with developmental disabilities. The purpose of the program is twofold: To teach best practices in disability, and the competencies of influencing public officials. For more information go to www.partnersinpolicymaking.com Address: Minnesota Governor's Council on Developmental Disabilities; 370 Centennial Office Building, 658 Cedar Street, St. Paul, MN 55155. Phone: 651-296-4018 or 1-877-348-0505. www.mnddc.org

Minnesota Supplemental Aid (MSA)
MSA pays people with low incomes who are elderly, blind, or disabled to bring their income to a set amount. Many people on MSA get SSI. MSA uses Social Security disability criteria. MSA has income and asset limits and applications must be made through your local county human services agency. The best way to find more information on MSA is to use Google and type in Minnesota Supplemental Aid. www.dhs.state.mn.us/main and look under "Economic Supports."

Food Support

Angel Food Ministries
By buying food from first rate suppliers at substantial volume discounts, Angel Food Ministries is able to provide families with approximately $65 worth of quality nutritious food for $30. http://www.angelfoodministries.com/

Bridge to Benefits
Bridge to Benefits is a multi-state project by Children's Defense Fund Minnesota to improve the well-being of families and individuals by linking them to public work support programs and tax credits. A section is included on the School Meal Program (Free/Reduced-Price School Breakfast & Lunch) explaining who is eligible for free/reduced school breakfast and lunch: Children attending public and private schools grades K-12. All foster children can get free meals. If your family is getting help from Food Support (stamps), MFIP, or FDPIR (Food Distribution Program on Indian Reservations), you can get free meals. Otherwise, if you are not on these programs, your family has to have an income below the limits to get help. Some families can get free meals and others can get a reduced (lower) price on their meals. The most you currently pay for a reduced-price lunch is 40 cents. You may also be eligible for busing, field trips, after school enrichment classes, athletics and summer programs sponsored by the school district. www.mn.bridgetobenefits.org

Emergency Foodshelf Network
The mission of the Emergency Foodshelf Network is to provide high quality food and essential support services to hunger relief programs in the community. Search by county. www.emergencyfoodshelf.org/

FARE For All (formerly Fare Share)
Fare For All stands for **F**ood **A**nd **R**esource **E**xchange and is a non-profit volunteer-based cooperative food-buying program that allows people to stretch their food purchasing power. Two hours of community service, benefiting someone else or your community entitles you to purchase a monthly food package consisting of fresh meats, fruits and vegetables and other grocery items. The savings is up to 40% to 50% one would pay at their local grocery store. This program is in several states. There are no income requirements. Phone: 763-450-3880 or 1-800-582-4291. www.fareforall.org

Food Coop
The Coop Directory Service is an online source of information about natural food co-ops www.coopdirectory.org/

Food Support (Previously called food stamp program)
Food support is a program that helps people with lower incomes pay for nutritious food, which helps kids to grow up strong and helps adults to stay healthy. Food Support does not pay for all the food that a person or a family needs each month, just some of it. The Food Support program is administered by the Minnesota Department of Human Services but eligibility and case management is done by county human services departments. Food Support is the name of Food Stamps in Minnesota. We don't call the program "Food Stamps" anymore because you don't get stamps to buy food. You get a card. As of October 1, 2008, Supplemental Nutrition Assistance Program (SNAP) is the new name for the federal Food Stamp Program.

Food Shelves
On the top of the page is a path "Click Here to Find Emergency Food." This will take you to Hunger Solutions: A Statewide Partnership of Organizations Fighting Hunger. www.mnhungerpartners.org/

You can look up locations of Foodshelf, Meals on Wheels, Summer Feeding, Food Support Office, WIC. Use the search criteria to find a location near you. www.hungersolutions.org/find Phone: 651-486-9860

Minnesota Food Helpline
Launched in June 2009 by Hunger Solutions Minnesota (HSM), the Minnesota Food Helpline provides a vital service to Minnesotans at risk for hunger. The multilingual staff will help enroll low-income Minnesotans in the Food Support (Food Stamps) program and help callers find emergency food assistance in their area. No one in Minnesota should go hungry. If you, your family or someone you know are having difficulty making ends meet, please call the helpline at 1-888-711-1151. www.hungersolutions.org/

Women, Infants and Children (WIC)
The WIC Program is a supplemental food and nutrition program for low-income pregnant, breastfeeding, and postpartum women, and infants and young children who are at nutritional risk. The purpose of the WIC Program is to prevent health problems and to improve the health of program participants during critical times of growth and development. The WIC Program provides nutrition education, access to health services, referrals to health and other human services and vouchers for supplemental foods. To locate your nearest WIC office, contact them at 651-201-5000 or for Minnesota callers outside the metro area toll-free 1-888-345-0823 or visit the website: http://www.health.state.mn.us/divs/fh/wic

Free or Low-Cost Dental Care Resources in Minnesota

Children's Defense Fund-Minnesota (CDF-MN)
CDF-MN provides a low-cost health care directory including dental care that is available at **www.cdf-mn.org** click on "low-cost health care directory" on the left side of the home page. **NOTE**: The low-cost health care directory is being revised at the time of this printing. Please check back later for a full listing. Call 489-CARE to be referred to affordable medical, dental or mental health services in Minnesota for people who are uninsured or underinsured.

Children's Dental Services
Providing low-cost or free dental care to pregnant women and children 0-18 years whose families cannot pay for dental care or have no insurance. Clinic staff assists families in completing applications for public assistance programs. Children with challenging behaviors or needing emergency care are also seen. Clinic staff is multilingual, speaking at least 13 languages. There are 13 clinic sites throughout the metro area available to people living anywhere in Minnesota or the United States. 612-746-1530 for scheduling.
www.childrensdentalservices.org

National Foundation of Dentistry for the Handicapped
There are dentists in Minnesota who have volunteered to provide comprehensive dental care to people of all ages, who, because of a serious disability, advanced age or medical problems, lack adequate income to pay for needed care. 888-471-6334; (direct) 866-242-6290. **www.nfdh.org**

University of MN Pediatric Dental School
The University dental school provides care for children 16 years old and younger; including general anesthesia or sedated dentistry as needed for special needs children; 24 hour emergency care is available; treatment is provided by two year fellows and graduate dental students, under the supervision of the dental faculty. 888-749-8108.

Hibbing Community College: pediatric through adult dental care is provided by UH dental students. For more information or appointments, call 218-263-2916 or 1-888-749-8108.

Rice Regional Dental Clinic in Willmar: located in Wilmar is also staffed by UH dental students, under the supervision of an experienced dentist and will pediatric through adult dental care is provided by UH dental students. For more information call 320-235-4543.

Give Kids A Smile Day
The first Saturday of February each year, all dentists across the state are asked to provide free dental care to children. An appointment needs to be scheduled by calling the University of Minnesota at 612-625-4967.

Free or Low-Cost Health Care Resources in Minnesota

Bridge to Benefits Minnesota
This is a multi-state project by Children's Defense Fund Minnesota to improve the well-being of families and individuals by linking them to public work support programs and tax credits. By clicking on the link below, a person can use the Eligibility Screening Tool to see what services they may be eligible for. 555 Park Street, Suite 410; St. Paul, MN 55103; Phone: 651-227-6121; Fax: 651-227-2553. www2.bridgetobenefits.org/

Children's Defense Fund Minnesota / Minnesota Low Cost Health Care Directory
This directory was compiled to help uninsured or underinsured families understand what health care options are available to them. Low-cost health care options are listed by County**.** **www.cdf-mn.org** **NOTE:** The low-cost health care directory is being revised at the time of this printing. Please check back later for a full listing. Call 489-CARE to be referred to affordable medical, dental or mental health services in Minnesota for people who are uninsured or underinsured.

Find a Health Center
The U.S. Department of Health and Human Services, Health Resource and Services Administration (HRSA) has a web based tool called, **Find a Health Center**, which lists federally-funded health centers providing care for people, even if they have no health insurance. Individuals pay what they can afford, based on there income. Health centers provide a wide range of services including: checkups for individuals who are well or sick, pregnancy care, immunizations, dental care, and mental health and substance abuse care. Health centers are in most cities and many rural areas. **findahealthcenter.hrsa.gov/**

MinnesotaHelp.info
This is an easy-to-use, centralized Internet entry point that contains information about services provided by both public and private entities throughout the state. This English/Spanish site contains information links for all ages. Use the Search feature to find free and reduced health care services by County. **www.minnesotahelp.info**

The Neighborhood Health Care Network
This is a health care consortium of community clinics in Ramsey, Hennepin and Washington Counties serving economically and ethnically diverse populations such as immigrants and refugees or others who have limited

incomes and may not have health insurance. Callers are directed to affordable primary health care centers in their area, are screened for possible eligibility for Minnesota State Health Care Programs, and offered assistance completing applications. Interpreters are available. **Call 651 489-CARE (2273), or 1-866-489-4899 (toll free). www.nhcn.org**

Portico Health Net
This program helps individuals and families **living in Ramsey, Washington, or Dakota county** to connect with a health care program. It helps people fill out applications for Minnesota Health Care Programs (such as MinnesotaCare, Medical Assistance, or General Assistance Medical Care). It also has provided its own health access program for people without health insurance. It also can help identify other community resources that may be helpful for you. To find out if you may be eligible for a low cost or even free health care program call (651) 603-5100 or 866-430-5111. You can also check out their website at: For a fact sheet describing the Portico Health net coverage program, go to: http://www.porticohealthnet.org/docs/fact-sheet.pdf; **www.porticohealthnet.org.**

Shriner's Hospital for Children Twin Cities
A 40-bed children's hospital facility providing high quality pediatric orthopedic care. The hospital provides comprehensive medical, surgical and rehabilitative care for children with orthopedic conditions. Children up to age 18 are eligible for care if, in the opinion of Shriner's Hospital physicians, there is a reasonable possibility they can benefit from the specialized services available. There is no charge for any care or services provided within Shriners Hospitals for Children facilities. Twin Cities Shriner's Hospital, 2025 East River Parkway, Minneapolis, MN 55414. Metro Phone: 612-596-6100; 888-293-2832, extension 6105.
http://www.shrinershq.org/hospitals/TwinCities For a listing of all Shriner's hospitals and services in the U.S.: http://www.shrinershq.org/Hospitals/Main

Free or Low-Cost Women's Health Care Resources in Minnesota

The Minnesota Family Planning Program (MFPP)
Family planning and related health care services for people who are NOT enrolled in Minnesota Health Care Programs. Check the site for services offered. This program is administered by the Department of Human Services. For more information call the Minnesota Family Planning Hotline 800-783-2287 or visit the website www.dhs.state.mn.us/familyplanning

Primary Care Resources
A list of providers who serve persons even if they do not have insurance. These providers may charge a fee based on a persons ability to pay. This list was updated as of **July 2009**. It is organized by County and may or may not include all of the providers in a specific County.
edocs.dhs.state.mn.us/lfserver/legacy/DHS-4741-ENG

Health Care Services

Courage Center
The mission of Courage Center is to empower people with physical disabilities to reach for their full potential in every aspect of life. They are guided by the vision that one day, all people will live, work, learn and play in a community based on abilities not disabilities. They provide rehabilitation services for people with physical disabilities and/or sensory impairments, parent support groups, recreational and camping programs, and transitional rehabilitation programs. Their Website lists classes, tips, publications and more. Address: Courage Center, 3915 Golden Valley Road, Golden Valley, MN. Phone: 763-588-0811 or 1-888-846-8253. www.courage.org

My Health Minnesota → Go Local
A free, online directory of health care services and providers throughout Minnesota, including clinics, hospitals, nursing homes, assisted living facilities, health screening programs, and more. All 87 counties in Minnesota are covered. **My Health Minnesota → Go Local** is a joint project of the National Library of Medicine and the Health Sciences Libraries of the University of Minnesota, the Mayo Clinic Libraries, and the MINITEX Library Information Network. You can access this resource at: www.medlineplus.gov/minnesota

Shriners Hospitals for Children
Shriners Hospitals is an international health care system for children to the age of 18. It provides specialty pediatric care, innovative research and outstanding teaching programs for children with orthopedic conditions, burns, spinal cord injuries and cleft lip and palate. Eligible children receive care in a family-centered environment at no financial obligation to patients or families. In the U.S.: 1-800-237-5055.
http://www.shrinershq.org/Hospitals/Main

"Uncompensated Care"
Some large clinics &/or hospitals may have internal "charity" funds to help some families reduce their outstanding payments. Families should contact the business office or social services office at the clinic/hospital to discuss past due bills, or "holds" on getting future appointments due to the outstanding bill. The decision is often based on a combination of family circumstances (making it difficult to pay the bills - not just because they just don't want to pay) and the type of care the patient needs. If families have a new funding source (ex: just became eligible for a Minn. Health Care Program such as Medical Assistance), the business office may "reconsider" what was due before that eligibility began, to help reduce the outstanding balance. The business office often has a "financial questionnaire" for families to complete, regarding income coming into the family, expenses going out, and assets. Sometimes families can talk with their doctor, nurse, or a social worker at the clinic/hospital where they are receiving the care. These people may be able to help as "advocates" for families in working with the business office.

Hearing

The Deaf and Hard of Hearing Services Division (DHHSD) at the Department of Human Services offers information about hearing loss, available referral services including interpreters and legal services, assistive technology, publications and other resources for individuals, families and professionals. Their website www.dhhsd.org. This web site also provides information on alternative communication accessibility options including Sign language interpreters, CART services, Cued language transliteration, services for deaf and blind consumers, and information on job coaches fluent in sign language for deaf and hard of hearing employees. 651-431-5940 (Voice) 1-888-206-6513 (TTY).

Hearing Aids
Minnesota law requires a health plan, including those issued by Health Maintenance Organizations, to cover hearing aids for children age 18 or younger for hearing loss due to functional congenital malformation of the ears that is not correctable by other covered procedures. Coverage is limited to one hearing aid per ear every three years. A plan may apply deductibles, coinsurance, and copayments generally applicable to other covered services to the hearing aid coverage (Minn. Stat. Ann. §§ 62Q. 675 and 62A. 011). This bill does not apply to employers who are self-insured [ERISA]. Contact your employer's Human Resource Department to determine if your health plan is self-insured. For assistance with coverage under an ERISA plan, call the Minnesota Department of Commerce at 651-296-2488 or 1-800-657-3602.

The Lions Infant Hearing Program established a hearing instrument loaner bank for Minnesota's newly identified infants and young children with hearing loss. New and reconditioned behind-the-ear hearing aids are available to loan for a six-month period of time. The loan period is designed to provide families with adequate time to investigate and purchase amplification for their child without delaying intervention. Each device will carry a warranty. However, audiological services, batteries and ear molds will need to be obtained through the dispensing audiologist at the families' expense.

To request a hearing aid list and request form, the audiologist should contact the Lions Infant Hearing Screening Program. Upon receipt, complete the request form and return via fax or mail. The instrument(s) will be mailed to you within one week and may be used for a maximum of six months. Please email or phone if you have any questions about the Lions Infant Hearing Program Loaner Hearing Instruments Bank. Email: lionsear@umn.edu Fax: 612-625-8901 Phone: 612-626-0946

Financial Resources for Parents with Deaf and Hard of Hearing Children
If your insurance company is not responsible for providing hearing aids for your child under legislation enacted in 2003, you can get a list of organizations to determine eligibility for assistance at:
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs_id_018498

Minnesota DeafBlind Technical Assistance Project
The Minnesota DeafBlind Technical Assistance Project is federally funded under the Individuals with Disabilities, Education Act (IDEA). The Project provides technical assistance which supports Minnesota children and youth, birth to 21 years, who have BOTH a vision and hearing impairment. These services are in addition to those provided by schools, and other state and local agencies. Minnesota DeafBlind Technical Assistance Project; 3055 Old Highway 8, Suite 302, St. Anthony MN.55418. Telephone: 612.638.1525 or 1526; Fax: 612.706.0811; Toll Free: 800.848.4905; TTY: 612.706.0808. www.dbproject.mn.org

Minnesota Hands & Voices – Life Track Resources
Minnesota Hands and Voices is a state-wide organization that provides parent-to-parent support to families of children who are deaf or hard of hearing. Services include speech, occupational, and physical therapies, deaf mentors, educational workshops, seminars and social events. For more information, call 651-227-8471 (voice), 651-227-3779 (TTY) or go to: www.lifetrackresources.org

Newborn Hearing Screening – is now mandated in the state of Minnesota. For more information on the mandate and other hearing resources for children, go to the MDH web site at:
www.health.state.mn.us/newbornscreening

Housing and Housing Issues

The Arc of Minnesota Housing Opportunities Program
Persons with developmental disabilities (DD) and their families or representatives are offered help with minor or major housing issues. Support is offered through three programs:

Housing Counseling:
Counseling help with housing questions, information and referrals. Topics can cover any housing issue but generally cover items such as: ownership, rental, social service supports, trusts, licensing, maintenance, roommates, and many other residential issues. Also, counseling help with home financing and other residential costs. This involves finding financial assistance through mortgage programs, grants and other sources for the purchase, construction, repair, accessibility, remodeling, etc. of a home.

Housing Access Coordination (HAC):
HAC is an approved service within the MR/RC Waiver. The cost for this service is paid by the Waiver. HAC service allows an authorized consultant to provide direct housing support to a client or his or her representatives, to assist them with housing decisions or the implementation of their housing plans. For example, this service might help with: 1) seeking subsidized rental programs; 2) locating an available apartment: 3) obtaining mortgage financing; 4) finding a home to purchase; 5) constructing a home; 6) deciding on house mates; 7) maintenance planning; 8) and much, much more.

Demonstration Housing Programs:
The Arc of Minnesota plays a major role in several trial housing programs designed to improve or expand housing opportunities for persons with DD. Currently The Arc of Minnesota is a part of the HomeChoice program (a mortgage program for people with disabilities) and the Landlord Partnership Program (coordinating Hennepin County and the Section 8 program). (For more details contact Dennis Collins at 651-523-0823 or 1-800-582-5256, ext. 111, email: dennisC@arcmn.org website: www.arcofminnesota.org

Catholic Charities offers a variety of housing and emergency services for the homeless and those in need of food. http://www.ccspm.org/ Phone: (612)-664-8500.

Centers for Independent Living (CIL)
Minnesota's eight Centers for Independent Living (Centers or CIL) are non-residential, consumer-controlled non-profit organizations serving people of all ages with physical, sensory, mental or other disabilities. The philosophy guiding all Centers and CIL services is people with disabilities have the right to control their own lives and fully participate in all areas and aspects of society. The services offered by Minnesota's Centers are designed to assist individuals with disabilities to live with greater independence, to contribute their talents and creativity, to expand their options and secure their basic rights in areas such as housing, transportation, education and employment. Centers are located in St. Cloud, Rochester, Mankato, East Grand Forks, Marshall, Moorhead, Hibbing and St. Paul.

Consumer control is the key element of the Independent Living (IL) philosophy. A majority of every Center's governing board, managers and staff are people with disabilities. Each CIL in Minnesota offers differing ancillary services. All of Minnesota's Centers, however, are mandated to provide the following services: IL Skills Evaluation and Training, Peer Counseling, Advocacy, and Information and Referral.

For additional information on Minnesota's Centers and/or State IL Services, please contact David Sherwood-Gabrielson, Department of Employment and Economic Development at 1-800-328-9095, or 651-259-7350, or TTY 651-296-3900. http://www.macil.org/

Heat Share (1-800-842-7279)
Heat Share is a statewide energy assistance program available through the Salvation Army. Families call the 800 number and enter their zip code to be transferred to the Heat Share office closest to them. This is a program of "last resort" (i.e.: the household has received a shut off notice). There are income guidelines. Families must first apply for emergency assistance through their county and to the Energy Assistance Program and show proof of these program acceptances or denials. Heat Share pays the electric or heat provider directly. The link below lists phone numbers specific to your service area: www.thesalarmy.com

HousingLink provides affordable-housing, waiting list, and section 8 voucher information to the Twin Cities metropolitan area and selected regions of Greater Minnesota. **612-522-2500;** http://www.housinglink.org

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Housing Resources ToolBox
The Housing Resources ToolBox provides information on: 1) housing options in Minnesota; 2) services to help keep you in your home; 3) affordable housing programs; and 4) searchable databases for locating housing.

Individuals and their families, county staff, and housing and services providers may access information to address the unique needs of older adults, refugees, people with disabilities, and the homeless. Included are descriptions of living arrangements, homelessness prevention and programs, housing information for refugees, information and resources on housing rights, innovative housing options for people with disabilities, resources for relocation/nursing home transition, services and programs to keep individuals in their own homes, vacancies lists and public housing waiting list information, and web resources to locate housing services. www.dhs.state.mn.us and click on the Economic Supports tab.

Minnesota Energy Assistance Programs
Minnesota Department of Commerce (MDC) This website is dedicated to Minnesota energy information. The Energy Info Center, Utility Information and Energy Assistance information are all included on this site. 1-800-657-3710 (MN only) http://www.energy.mn.gov

Minnesota Help Info
The website contains searchable databases and up-to-date lists for locating housing and service providers in Minnesota according to zip codes or city and state. Includes shelters, crisis nurseries and vouchers for lodging. www.minnesotahelp.info

Minnesota Housing Finance Agency (MHFA)
Financial and advance affordable housing opportunities for low and moderate income Minnesotans. www.mnhousing.gov/ Address: MHFA, Home Improvement Division, 400 Sibley St., Suite 300, St. Paul, MN 55101. Phone: 651-296-7608 or 1-800-657-3769 outside Metro area.

National Association of Hospital Hospitality Houses, Inc
A caring association of more than 150 nonprofit organizations located throughout the U.S. that provide family-centered lodging and support services to families and their loved ones who are receiving medical treatment far from their home communities. 800-542-9730
http://www.nahhh.org/about_history.php

Rebuilding Together – Twin Cities
An affiliate of the national non-profit Rebuilding Together organization, Rebuilding Together Twin Cities works with volunteers and partners in the metro area to preserve and revitalize low-income homes.
www.rebuildingtogether-twincities.org

Information and Referral Resources

2-1-1
These community services provide information and referral regarding a broad variety of community resources. You will receive confidential, anonymous information about health education, education, legal services, counseling, food &/or clothing shelves, diapers, formula and more. Help is available to individuals, families and agencies at no charge, by telephone (Twin Cities metro area, call 2-1-1 anytime, 24 hr/day, or 651-291-0211, outside the metro area, call 1-800-543-7709) www.211.org

The Beehive
The Beehive is an online place to go for information and resources around the things that matter in our lives: money, health, jobs, school and family. http://www.thebeehive.org/

Family Planning Program
The Minnesota Family Planning Program (MFPP) provides coverage of family planning and related health care services for people who are NOT enrolled in Minnesota Health Care Programs. Eligible persons are Minnesota residents who are not pregnant, between the ages of 15 and 50 with income at or below 200 percent of the federal

poverty guidelines and a US citizen or a noncitizen qualified to participate in federally funded programs. Covered services include office visits and family planning education, testing and treatment for sexually transmitted diseases found during a family planning visit, birth control and sterilizations. Services NOT covered include abortion services, infertility treatments, treatment for HIA/AIDS and inpatient family planning services. This program is administered by the Department of Human Services. For more information call 651-431-3480 (metro) or 1-888-702-9968 toll free. www.dhs.state.mn.us/familyplanning

GovBenefits.gov
GovBenefits.gov will help you discover if there are government benefit programs available to help you. Our online screening tool is free, easy-to-use, and completely confidential. It does not require your name, phone number, Social Security number, or any other identifying information. You answer a series of questions about yourself, and GovBenefits.gov returns a list of government benefit programs you may be eligible to receive along with information about how you can apply. Whether it's a direct payment, a loan, insurance, training, or other services - there may be programs available to help you. To get started, go to www.govbenefits.gov and select "Start here."

Minnesota Children and Youth with Special Health Needs (MCYSHN) Information and Assistance Line
The MCYSHN Information and Assistance Line is for families, health care providers, teachers, social workers and anyone who needs help identifying and locating resources for children with special health needs. A staff person will discuss services and resources provided by public and private agencies. Both national and state information is available. Call 651-201-3650 or toll free 1-800-728-5420 weekdays from 8 a.m. to 4:30 p.m.
www.health.state.mn.us/mcshn

Minnesota Department of Commerce Links to information on Federal Agencies, Energy Companies, Energy Assistance, MN power companies, Telecom Companies, Non-Profit Organizations, Insurance, etc.
www.commerce.state.mn.us

Public Health
Public Health Nurses can be valuable resources in the care of a child with special needs. They may provide information and referral to resources (including information on health services & other resources in the county, health and developmental screening, Child and Teen Check-ups, Women, Infants and Children (WIC), and in general, address a wide range of health and medical needs of the community. Some county public health agencies also provide home care services. To locate the nearest Public Health agency, go to:
http://www.health.state.mn.us/divs/cfh/ophp/index.html Call # 651-201-3880 or email health.ophp@state.mn.us

Social Services (Department of Human Service)
Human Service Agencies are responsible for administering social services, child support services, and financial assistance programs under state supervision. They are responsible for providing protective services to vulnerable adults and children, helping the elderly and disabled to achieve their highest level of independence, providing child support services to custodial and non-custodial parents, and assisting indigent and low-income families and individuals to meet their basic needs or to become self-sufficient. To locate the nearest human service agency, go to: http://www.dhs.state.mn.us and click on Counties/Regional offices (left side of page).

Spanish Language Government Services
The government's new Spanish-language information web portal links visitors to the entire spectrum of Spanish-language websites and web pages available from federal and state governments.
http://firstgov.gov/Espanol/index.shtml

Special Education Mediation Service
Minnesota Special Education Mediation Service (MNSEMS) provides a method of settling disagreements about a student's educational needs among parents, schools, and agency personnel. It is used to resolve issues such as: conflicts concerning the identification, evaluation, and educational placement; provision of a free appropriate public education; and the payment for such services. Additionally, MNSEMS offers facilitated IEP meetings. For more information, contact the Minnesota Department of Education at 651-582-8222. Further information can be found at www.education.state.mn.us

Insurance

Consolidated Omnibus Budget Reconciliation Act (COBRA)

Cobra is an option offered to employees who have been terminated or had work hours decreased, to buy group insurance coverage for a limited period of time (maximum 18 months). Employers with 2 or more permanent employees must offer COBRA (including the employee and dependents). To be eligible for the federal COBRA subsidy, an individual must: 1) be involuntarily terminated from employment between September 1, 2008, and May 31, 2010; and 2) be eligible for COBRA coverage as a result of that termination. The coverage must be the same as provided prior to termination. Premiums usually are quite costly. **COBRA Premium Subsidy –** The federal government's American Recovery and Reinvestment Act of 2009 (ARRA) subsidizes 65% of the COBRA premium for individuals. **Minnesota has an additional state COBRA premium subsidy**, which covers the remaining 35% portion of the premiums. The eligibility period for the Minn. COBRA Premium Subsidy is the number of months the enrollee meets eligibility criteria and receives the federal COBRA subsidy. To be eligible for the Minn. COBRA Premium Subsidy, an individual must: 1) elect COBRA coverage; and 2) receive the federal COBRA subsidy; and 3) be a Minn. resident and otherwise eligible for a Minnesota Health Care Program (MHCP). [Persons must be within the MinnesotaCare income limits.] Once their COBRA coverage ends, state law exempts former enrollees of the Minn. COBRA Premium Subsidy from the MinnesotaCare four-month waiting rule. The 2010 Minnesota Legislature extended the Minnesota COBRA premium subsidy until Feb. 28, 2011. [NOTE: Payments made by the Minn. COBRA Premium Subsidy can be counted toward a household member's medical "Spenddown" for Medical Assistance (MA). Individuals on MA generally do not need the Minn. COBRA Premium Subsidy since their share of COBRA premiums may be reimbursed as cost effective health care coverage.]

Employee Benefits Security Administration (EBSA)

The website offers a great deal of valuable information in both English and Spanish. EBSA is an agency whose mission is to protect the integrity of pensions, health plans, and other employee benefits for people. There are some exemptions where MHPA does not apply; such as for small employer group plans with 2-50 employees. This law does not apply to benefits for substance abuse or chemical dependency. Toll-free hotline: 1-866-444-EBSA. www.dol.gov/ebsa

HealthCare.gov is a new consumer web site that provides transparency into the health care marketplace. Through HealthCare.gov, individuals will have more control over their health care as informed and empowered consumers. The easy to use website provides one stop shopping access to a wealth of information, including new consumer rights and benefits under the Affordable Care Act, a timeline of when new programs under the new law will come online and a new insurance finder that makes it easy to find both private and public health insurance options. http://www.healthcare.gov/

Insurance - "A Consumer's Guide to Getting and Keeping Health Insurance in Minnesota"

Written in January 2006 by the Georgetown University Health Policy Institute, this 36 page guide describes your protections as a Minnesota resident when you seek to buy, keep or switch your health insurance, even if you or a family member has a serious health condition. It describes your protections under group health plans, individual health insurance and as a small employer or self-employed person. There is a 3-page summary of numerous state and federal laws (including the Health Insurance Portability and Accountability Act or HIPAA) and a chapter on Financial Assistance for Minnesota residents who cannot afford to buy health insurance.
http://healthinsuranceinfo.net/

Minnesota Disability Health Options (MnDHO)

This is a program for people with physical disabilities who are eligible for Medical Assistance (MA) or Medicare. This program is there for you 24 hours a day, seven days a week. People with physical disabilities can choose to join MnDHO or stay in their current MA program. There is no additional cost to join MnDHO. To be eligible for MN DHO you must: 1) be between 18 and 65 years old; 2) have a physical disability; 3) be eligible for MA (including MA for Employed Persons with Disabilities) or both MA and Medicare; and 4) live in one of the following counties: Hennepin, Ramsey, Anoka, Dakota, Carver, Scott, or Washington. The program is

administered by DHS along with UCare Complete (a health plan) and AXIS Healthcare (a care management organization for people with physical disabilities). AXIS Healthcare is a partnership between Sister Kenny Institute and the Courage Center. The health plan assigns a health care coordinator to each enrollee to help with paperwork and getting health care and support services. MnDHO offers all MA and Medicare services (if you also have Medicare). The health plan also may offer services that are normally not covered by MA or Medicare, such as modifications to the home or vehicle, extended personal care attendant services, and others. To enroll in MnDHO, contact UCare Complete at 612.676.3554. You can also contact your county Department of Human Services (only in one of the seven counties listed above). www.dhs.state.mn.us

Job Resources

Access to Telework
This is a finance program supporting employment for people with disabilities. This project will support the purchase of employment equipment and support to establish or expand home based self employment. Website: www.atmn.org Email: info@atmn.org Phone: 763-479-8239, Toll Free 866-535-8239, Minnesota Relay service 1-800-627-3529.

AmeriCorps and ServeMinnesota
People with disabilities who have a desire to give back to the community, gain career skills & experience and earn financial support for education are urged to consider joining AmeriCorps. ServeMinnesota, is the nonprofit agency that administers the AmeriCorps program in Minnesota. Often referred to as the "domestic Peace Corps," AmeriCorps offers opportunities for people age 17 and older from all walks of life to serve their communities. Minnesota is recognized as a national leader in its efforts to include people with disabilities in AmeriCorps. Currently, 23 percent of Minnesota AmeriCorps members report having a disability. AmeriCorps members are serving community needs from building affordable housing and tutoring children to securing employment for individuals with disabilities and mentoring at-risk teens. Some funds are set aside to provide reasonable accommodations to help provide equal access to AmeriCorps service positions. Individuals who join AmeriCorps commit to part-time or full-time service for one or two years. AmeriCorps is open to U.S. citizens, nationals or lawful permanent residents. AmeriCorps members receive a modest living allowance. At the successful completion of their term of service, they are awarded an Education Award, which may be used to pay future education costs or repay qualified college loans. To learn more about AmeriCorps or ServeMinnesota call (612) 333-7740 or go to their website at: www.serveminnesota.org

Job Accommodation Network (JAN)
JAN's mission is to facilitate the employment and retention of workers with disabilities by providing employers, employment providers, people with disabilities, their family members and other interested parties with information on job accommodations, self-employment and small business opportunities and related subjects. JAN's efforts are in support of the employment, including self-employment and small business ownership, of people with disabilities. JAN represents the most comprehensive resource for job accommodations available. 800-526-7234 (Voice); 877-781-9403 (TTY) http://janweb.icdi.wvu.edu/

Minnesota Work Incentives Connection
It helps people with disabilities understand how work affects their government benefits. Services provided include: a hotline to answer questions about how work affects government benefits and benefits analysis. Specifically, the Minnesota Work Incentives Connection can help you understand how work effects SSI - Supplemental Security Income, SSDI - Social Security Disability Insurance, Health Insurance - Medical Assistance, Medicare, other health programs, Food Support , Subsidized housing and Other Government benefits. Appointments are necessary. Minnesota Work Incentives Connection, (800) 976-6728 or (651) 632-5113, TTY (651) 632-5110 or MN Relay - 711 www.mnworkincentives.com

Legal

Citizenship
There is information pertaining to becoming a U.S. citizen available from Minneapolis Legal Aide. www.LawHelpMN.org or www.midmnlegal.org

"Getting Child Support Metro Office: Mid Minnesota Legal Assistance; 430 First Avenue North, Suite 300, Minneapolis, MN 55401-1780; 612-332-1441. Information on all the state offices is listed on this site. This particular fact sheet requires a little bit of exploring. **"** www.midmnlegal.org

LawHelp Minnesota
Information for low income Minnesotans to solve civil legal problems. The website is available in English and Spanish with services in several other languages and can help you answer to legal questions, find a legal aid office and get court information. Topics include issues related to housing, education, public benefits, family and juveniles, employment and others. There is also a wide variety of important **Fact Sheets**, such "MFIP for Parents Under Age 18," "Unemployment Benefits," "Becoming a US Citizen," "Public Benefits for Non-citizens" and "Guardianships and Conservatorship." The website has links to several publications regarding domestic violence, such as: "How Do I Apply for Immigration Benefits as a Battered Spouse or Child" (from the U.S. Citizenship and Immigration Services) These documents can be accessed by going to: www.LawHelpMN.org, then click on Immigration/Immigrants, then click on Battered Women / Domestic Violence

Minnesota Disability Law Center (MDLC)
MDLC is a statewide project of the Legal Aid Society of Minneapolis. It addresses the unique needs of people with disabilities in Minnesota and provides legal assistance and advocacy on disability-related matters. Address: Minnesota Disability Law Center, 430 First Avenue North, Suite 300, Minneapolis, MN 55401. Phone: 612-332-1441 or 1-800-292-4150. http://www.lawhelp.org/Program/2393/index.cfm
The Fact sheets can be found at www.mylegalaid.org/mdlc/mdlc-publications

Minnesota Legal Services Coalition (MLSC)
Founded in 1981, The Minnesota Legal Services Coalition (MLSC) is an association of seven Minnesota regional legal services programs. Formed to enhance cooperation and coordination, MLSC supports the regional programs that help low-income Minnesotans with a broad range of civil legal matters. Minnesota Legal Services Coalition; Midtown Commons - Suite #101B; 2324 University Avenue West, St. Paul, MN 55114; Telephone: 651-228-9105 http://www.mnlegalservices.org

Minnesota Organizations Offering Pro Bono Services to Clients
From the American Bar Association Directory. Click on "find legal help" or use the interactive map.
http://www.abanet.org/legalservices/probono/directory.html

Medication/Prescription Drugs

Free Medicine Program
Most drug manufacturers help people in financial need, regardless of their age. However, in order to qualify you need to meet the following three basic requirements: (1) You do not currently have insurance coverage for outpatient prescription medicines; and (2) Your income is at a level that causes hardship when prescription medicines are purchased at retail price; and (3) You do not qualify for a government or third party programs that provides for prescription medicine coverage. www.freemedicineprogram.com

Medication Therapy Management for People Who Suffer from Chronic Health Conditions and Are on a State Health Care Program This is a new service provided by pharmacists for people enrolled in State Health Care Programs (MA, MinnesotaCare, Home & Community Based Waivers, etc.) Local pharmacists, enrolled with the Department of Human Services (DHS), will provide individualized, face-to-face health care and medication

advice. Clients who are taking four or more prescriptions to treat or prevent two or more chronic conditions such as asthma, diabetes, or cardiovascular disease can qualify to receive the service. Pharmacists give the client an individualized medication plan that can identify unneeded medications as well as opportunities to select less expensive alternatives or new medications. Important information on the proper use of medications and other advice on lifestyle choices from diet to exercise are also offered.
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_145798

Minnesota Rx Connect
This website provides Minnesotans information on issues related to prescription medicine, safety and cost-saving tips, and programs to help low-income Minnesotans pay for prescription drugs. This site also provides Minnesotans with information about accessing lower-cost prescription medication from Canada. RxConnect at 1-800-333-2433 www.minnesotarxconnect.com

Partnership for Prescription Assistance (PPA)
This is a nationwide program (with a Minnesota Chapter) bringing together pharmaceutical companies, doctors, other health care providers, patient advocacy organizations and others to help qualifying patients who lack prescription get the medicines they need through the public or private programs that are right for them. Each patient assistance program has its own eligibility criteria. To contact PPA, call toll free at 1-888-477-2669. www.pparx.org or the Minnesota Chapter at www.pparxmn.org

Mental Health

American Academy of Child & Adolescent Psychiatry
This website offers information for families including: 1.) Up-to-date information on issues affecting children, teenagers and their families. 2.)Definitions of major mental disorders in easily understandable language along with a resource list, 3.) The latest information on children and psychiatric medications. www.aacap.org

Children's Mental Health Collaboratives
Children with emotional disorders and their families frequently seek services from many agencies because no one agency offers all the services they need. Children's Mental Health Collaboratives strive to be a local, integrated system of care providing a cohesive array of services. Communities bring together representatives from at least one county, school or special education cooperative, corrections and local mental health organization. Parents and representatives from other agencies are also typically part of their local Children's Mental Health Collaborative. You will find a list of contacts by county at: http://edocs.dhs.state.mn.us/lfserver/legacy/DHS-4069-ENG

Children's Mental Health Network: Minnesota Statewide Family Network (MSFN)
MSFN is a statewide non-profit parent-directed organization in Minnesota, whose mission is to expand opportunities and enhance the lives of children with mental health disorders and their families. MSFN helps connect parents with other parents and resources. It provides individual advocacy, workshops on a variety of topics (including accessing the children's mental health system, Positive Behavior Intervention and understanding the special education system for children with mental health needs), written materials and a website with children's mental health information and links to other related sites. A unique part of this organization is the Youth Advisory Board, whose mission is to create a youth leadership presence in Minnesota as self-advocates, share ideas on existing services, present at conferences and maintain a web site specific to adolescents and teens with a mental health need. Address: 8161 Normandale Blvd, Minneapolis, MN 55437. Voice: 952-838-1360 Toll-free for MN parents: 866-204-1360 www.cmhn.org

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Involuntary Commitment and Court-Ordered Treatment
Office of the Ombudsman for Mental Health and Developmental Disabilities; 121 7th Place East, Suite 420; St. Paul, Minnesota 55101-2117; 651-757-1800 or 1-800-657-35066 (Voice) TTY/voice-Minnesota Relay Service 711. www.ombudmhmr.state.mn.us

Minnesota Association for Children's Mental Health (MACMH)
MACMH provides information, education, advocacy and materials for families with children with emotional/behavioral disorders and mental health needs. Address: MACMH, 165 Western Avenue, St. Paul, MN 55102. Phone: 651-644-7333 or 1-800-528-4511. This site includes a Spanish language information site. www.macmh.org

Minnesota Parent Leadership Network (MPLN)
The Minnesota Parent Leadership Network (MPLN) is a parent driven organization made up of parents of children with mental health needs. The structure of the network consists of a Board of Directors, regional and ethnic community representatives, and our parent leaders from across the state. Beyond the structure of this grassroots organization, it is the passion, dedication and commitment to the work before us in developing a strong voice for children in our mental health system of care. For more information MPLN; 369 Wendell Street; Paynesville, MN 56362; phone: 1-866-837-3393 or www.mpln.org

National Alliance on Mental Illness (NAMI)
NAMI is the nation's largest grassroots mental health organization dedicated to improving the lives of persons living with serious mental illness and their families. NAMI offers support, education and legislative advocacy. There are NAMI organizations in every state and in over 1100 local communities across the country. There are 21 affiliates in Minnesota (see State website). NAMI, 2107 Wilson Boulevard, Suite 300, Arlington, VA 22201-3042; Main: (703) 524-7600; Information Helpline: 800-950-NAMI (6264). National website: www.nami.org (the national website is offered in English and Spanish and the toll free line offers more than 150 languages). Minnesota phone number: 651-645-2948 or 1-888-626-4435 and website: www.namimn.org

Office of the Ombudsman for Mental Health and Developmental Disabilities
An ombudsperson is an official who is designated to assist you to overcome the delay, injustice or impersonal delivery of services. The Minnesota Ombudsman for Mental Health and Developmental Disabilities performs in the following three areas: (1) client services (or general ombudsman services); (2) medical review (death and serious injury reporting); and (3) civil commitment training. Call for culturally specific ombudsperson. For more information you can go to**:** http://www.ombudmhmr.state.mn.us or call 651-757-1800 or 1-800-657-3506. Office of the Ombudsman for Mental Health and Developmental Disabilities; 121 7th Place E, Ste 420, Metro Square Bldg, St. Paul, MN 55101

www.wilder.org/research The Wilder Research Report titled "Immigrant and Refugee Mental Health" can be found on the Wilder Research website. Click on "Find a Report" and type in "immigrant" or the entire title to access this document.

Military

Child Care Programs for Military Families

There are a number of child care programs for military families, some specific to a branch of service, others for all branches of services. These programs include: Military Child Care In Your Neighborhood; Operation Child Care; Operation Military Child Care; and Quality Family Child Care. For more information contact the Child Care Aware hotline at (800) 424-2246 or go online for help with applying for the subsidy and location help. http://www.childcareaware.org

www.daddydolls.com To provide the family with quality products that will ease the stresses of separation due to deployments, business trips, hospitalizations, or living far from loved ones.

www.deploymentkids.com This is a site for kids to help work through a parent's deployment; where is my parent? How far away is that? How can I keep in touch? etc.

www.guardfamily.org This is the National Guard Bureau Family Program website and opens to the Minnesota National Guard Family Program site. Information is offered on the six-step Family Program model. The purpose of the program is to keep "serving families" informed of programs, benefits, resources, etc. and include family, youth and community outreach initiatives, national-level calendar events, and basically support, educate, refer, and assist in any way necessary.

www.health.state.mn.us/military/ Military/Veterans Resources listed on the Minnesota Department of Health's resource page for military members, veterans and their families. It includes the military County Reference Guide (PDF:768KB/204 pages) Updated September 2007.

www.militaryonesource.com Military OneSource is a 24/7 (365 days) online service for Military Members, including National Guard, and their families. 1.800.342.9647 is the telephone number for the U.S., but the site has telephone numbers for most countries. This site supplements existing installation services, provides free help and information by phone with professionally trained consultants on a wide range of issues that affect you and your family, from budgeting and investing to relationships and deployments.

www.ourmilitarykids.org This organization provides support for the National Guard and Reserve families one child at a time.

www.minnesotanationalguard.org
This is the Minnesota National Guard website. The Minnesota National Guard has pioneered a program in hopes of changing how Soldiers and Airmen are reintegrated back to their communities. Called Beyond the Yellow Ribbon, the program is named as a reminder that the support of Soldiers cannot end when they return from deployment and the yellow ribbons are untied.

www.naccrra.org/militaryprograms/
The National Association of Child Care Resource & Referral Agencies working with the U.S. Military Service to provide Operation: Military Child Care. They provide a subsidy for service members on active duty who have children in state licenses childcare. With questions, call Child Care Aware at 1-800-424-2246.

www.mngyc.com National Guard Youth and Teen Camp (ages 7-17). The Minnesota National Guard Youth and Team Camp is for dependents, nieces, nephews, brothers, sisters, and grandchildren of Minnesota Guard members. They spend seven days exploring Camp Ripley and the surrounding environment during the one-week camp session. For further information, contact the Minnesota National Guard Youth Camps/Teen Camps; 211 North McCarrons Boulevard; Roseville, MN 55113; Telephone: 763-670-1251; Fax: 651-558-2340.

www.myarmyonesource.com Information for both military personnel and their families.

www.nmfa.org Operation Purple Camp (ages 7-17) National Military Family Association. NMFA is an organization dedicated to serving military families. They recognized the need for more resources to support military children. The Operation Purple Program was created as a way to help military children struggling with the stresses of war. These free, week-long, overnight camps are open to all military children ages 7-17 and aims to help military kids experience carefree fun while also learning coping skills to deal with deployment-related stress and fostering relationships with other children who know what they are going through.

Suicide: A Veterans hotline is part of a specialized effort by the Department of Veterans Affairs to reduce suicide by enabling counselors to instantly check a veteran's medical records and then combine emergency response with local follow up services. 800-723-TALK (8255).

www.va.gov/kids This is a part of the Veterans Affairs site. It includes information on VA Kids – K-5th grade, VA Kids – 6th-12th grade, and teachers. It has games, information on the VA and veterans, VA volunteers and scholarships, and other links.

Out of Home Placement

American Association of Retired Persons (AARP)

AARP has a wealth of information on this websites for grandparents raising grandchildren.
http://www.aarp.org/relationships/grandparenting/

The GrandCare Support Locator, a service of AARP Foundation connects grandparents with national, state, and local groups, programs, resources and services that support grandparents or other relative caregivers as well as grandparents facing visitation issues
http://www.giclocalsupport.org/pages/gic_db_home.cfm

Adoption Assistance
Adoption Assistance is provided by the Minnesota Department of Human Services (DHS) making adoption possible for children from the foster care system with special needs who may otherwise not be adopted without such assistance. The program reimburses families for the costs of non-medical items and provides adoptive parents with financial assistance to assist with the care of the child's special needs. A child eligible for adoption assistance is also eligible for the medical assistance program in the state in which the adoptive family resides. In conjunction with the adoptive families' private health insurance, Minnesota's medical assistance program may supplement medical coverage for the child.

For further information, write or call the: Adoption Assistance Program, Family and Children's Services Division, Minn. Dept. of Human Services, PO Box 64944, St. Paul, MN 55164-0944. Telephone: 651-431-4656. For further information search "adoption - publications." on the DHS website www.dhs.state.mn.us

American Bar Association
The American Bar Association (ABA) Center on Children and the Law is a program of the Young Lawyers Division, aiming to improve children's lives through advances in law, justice, knowledge, practice and public policy. Areas of expertise include child abuse and neglect, child welfare and protective services system enhancement, foster care, family preservation, termination of parental rights, parental substance abuse, adolescent health and domestic violence. This site has information on the *"Fostering Connections to Success and Adoptions Act of 2008"* including a question and answer segment *"New Help for Children Raised by Grandparents and Other Relatives."* abanet.org/child/home.html

"Answers to Grandparents' Questions about Child Support"
This Department of Human Services brochure answers some frequently asked questions grandparents have about child support. http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-3393B-ENG

Children's Home Society and Family Services
Since 1889, Children's Home Society & Family Services (CHSFS) has met the needs of children and families through our adoption, child abuse and neglect prevention, early childhood education, and comprehensive family counseling and support services. As a statewide non-profit 501(c)(3) organization, CHSFS is committed to help children thrive and to build, strengthen and sustain individual, family and community life. For more information please log on to www.chsfs.org or call 651-646-7771 or 1-800-952-9302.

Education and Training Voucher (ETV)
This program is federally funded through the Chafee Foster Care Independence Act, which was enacted to help provide opportunities for youth who age out of the foster care system to attend post-secondary education and training programs. ETV awards can be up to $5,000 per school year to pay for tuition, fees, books, housing, transportation and other school-related costs.

All ETV applicants must be both:

- under age 21 at the time of the application deadline and
- accepted into an accredited post-secondary or training program (college, vocational, technical or trade school).

In addition, applicants must meet at least **one** of the following:

- in foster care on or after their 16th birthday and continue to be in foster care up to or beyond their 18th birthday;
- adopted from foster care after their 16th birthday;
- in foster care on or after their 16th birthday when a relative/kin accepted a transfer of permanent legal and physical custody through a juvenile court order; and/or
- were under state guardianship (also known as "state wards").

Forgotten Children's Fund
This fund was established by the American Legion Auxiliary and is administrated by the Minnesota Department of Human Services (DHS). It provides up to $300 per child per year so foster families can purchase special items and services. For example, it allows families to pay for things such as bikes, class rings, art supplies, sports equipment, driver's education, graduation expenses or camp registrations and fees for their foster children. Contact Thom Campbell at the Minnesota Department of Human Services, P.O. Box 0934, St. Paul, Minnesota 55164-0934, or email: thom.campbell@state.mn.us
http://www.dhs.state.mn.us/main/groups/children/documents/pub/dhs16_139938.pdf

Fostering Connections
The *Fostering Connections to Success and Increasing Adoptions Act of 2008* (*Fostering Connections*) made critically important changes to improve the lives of children, youth, and families affected by the nation's child welfare system. The new law aims to promote permanency and improved outcomes for children in foster care. The fostering connections resource center's website is a one-stop-shop for a range of online tools and technical support on all aspects of the law, including a transition planning toolkit to help youth transition from foster care successfully. http://www.fosteringconnections.org/

The Fostering Connections Kinship Toolkit: http://www.fosteringconnections.org/resources?id=0002

Grandfamilies of America
The mission of Grandfamilies of America is to provide grandparents and relatives caregivers of relative children, with the necessary tools to navigate the complex systems they come in contact with. 1-866-203-8926
http://grandfamiliesofamerica.com/index.html

Generations United
Generations United (GU) is the national membership organization focused solely on improving the lives of children, youth, and older people through intergenerational strategies, programs, and public policies. One initiative of GU is to improve the circumstances of grand families. There are Fact Sheets such as "Grandfacts: Data, interpretation, and implications for caregivers." 202-289-3979 http://www.gu.org/

Lutheran Social Services
Since the early 1990s, Lutheran Social Service has provided support and education to grandparents and others who are raising relative children. They serve Hennepin, Ramsey, Anoka, Dakota and Washington counties. Grandparents and others often take on this role of parenting for the following reasons: drugs, mental illness, incarceration, death, and child abuse or neglect related to drug addiction and mental illness. Their services include individual consultation, support groups throughout the metro, educational workgroups about raising relative children, recreational activities and a GrandFamily Connection newsletter. You can also find "*Legal Steps Getting Started Raising Relatives' Children*" on this website. 1-800-582-5260 or 612-879-5307 http://www.lssmn.org/grandfamilies/default.htm

Minnesota Department of Human Services
A wealth of information on foster care and out of home placement. Go to the DHS website, click on "A-Z Topics" and the "F" for Foster Care. www.dhs.state.mn.us

Minnesota Kinship Caregivers Association (MKCA)
A not-for-profit organization that advocates for, supports, and provides information and resources to people raising their grandchildren or children of other kin and friends. MKCA reaches out to people throughout Minnesota through "relative as parents" (RAP) programs. Check the website for further information, including numerous helpful hints, Legal Steps 2008 and links to other resources. Minnesota Kinship Caregivers Association, 161 St. Anthony Ave., Suite 940, St. Paul MN 55103. Phone: 651-917-4640 or 1-877-917-4640 www.mkca.org

National Foster Parent Association
The National Foster Parent Association (NFPA) offers scholarships for foster youth who wish to further their education beyond high school including college or university studies, vocational and job training, and correspondence courses, GED. Scholarships are also available for birth and adopted youth in foster homes. Also, available on this website are many additional links to other financial aid resources. NFPA; 2313 Tacoma Avenue South, Tacoma WA 98402. Phone: 1-800-557-5238 www.nfpainc.org

National Indian Child Welfare Association
The National Indian Child Welfare Association can connect inquiries to local areas for assistance regarding children of American Indian tribal affiliation. www.ncwa.org

"Paths to Permanency: Information for Minnesota Foster Families"
A discussion of the key differences between adoption and transfer of permanent legal custody. http://www.mnadopt.org/Downloads/DHS-4907-ENGpathsperm2007.pdf

Relative Custody Assistance
A Department of Human Services program providing help for people who accept custody of a child through juvenile court. Relative custody transfers permanent legal and physical custody of a child to a relative (a person linked to the child through blood, marriage, adoption or important friendship). With this transfer of authority, the relative becomes the child's custodian able to make decisions for the child as if the child were born to them, including the protection, education and care of the child. The court may order the birth parents to pay child support. Two types of financial help are available to legal custodians: (1) Minnesota Family Investment Plan (MFIP) Child Only Grant. (***http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-5561-ENG***) This grant is based on the child's income. Through this, they may receive a monthly MFIP grant, a food subsidy and the child will, also, receive Medical Assistance (MA). (2) Relative Custody Assistance (RCA) ***http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4769-ENG*** which is limited to families with a gross annual income three times more than the federal poverty guidelines and where custody of a child was received through a

Minnesota juvenile court. Eligibility is determined by the county. With RCA and MFIP together, the child receives the same monthly financial help as the child would receive from Adoption Assistance through DHS. For more information go to the DHS website ***www.dhs.state.mn.us*** (Click "Children" and "Foster Care.") or Minnesota Kinship Caregivers Association at 651-917-4642 for your regional contact. ***www.mkca.org***

Recreation

Access Tours
A non-profit organization packaging all-accessible tours of the American West, including national parks, etc. Access Tours is a service of the Access Institute. For more information contact Access Tours at 1-800-929-4811 or www.accesstours.org

Disabled Travelers
This site offers a comprehensive listing of businesses specializing in disability travel, including travel agents, accessible cruises, accessible van rentals and equipment, access guides and more. www.disabledtravelers.com

The Guided Tour, Inc.
This organization offers supervised travel and vacation programs in the US and overseas for individuals with developmental and physical challenges. They accommodate individuals, ages 17 and up and it is staffed by professionals who have experience working in the field of mental retardation and developmental disabilities. For more information call 1-800-783-5841 or www.guidedtour.com

Family Village
Special needs camps listed by state for the entire U.S.
www.familyvillage.wisc.edu/Leisure/camps.html#Minnesota

The Open Directory Project
The Open Directory Project is a volunteer-edited directory on the internet with a large volume of information, including camps nationwide for handicapped children. www.dmoz.org/

Wilderness Inquiry (WI)
This is a non-profit organization that focuses on getting people from all walks of life to personally experience the natural world through outdoor adventures in a variety of geographic locations such as the Boundary Waters Canoe Adventure, Mexico's Cooper Canyon or the Kenyan Safari Adventure. The trips are integrated to include older people, younger people, people with and without disabilities, physicians, veterans, accountants and people who live in large cities and in the country. WI staff are skilled wilderness guides and also come from a variety of professional backgrounds. WI also conducts a variety of activities including community events, research, equipment designs and trail and facility assessments. www.wildernessinquiry.org

Service Organizations

Most communities have a variety of services clubs that may contribute funds or organize a fund-raiser for individuals who live in their areas. Examples of service organizations include:
Lions Club http://www.lions5m1.org/lionnetmn/ (list of clubs in MN), Kiwanis Club www.mndak-kiwanis.org/public_district/index.aspx the Rotary, the Knights of Columbus www.mnknights.org the American Legion www.mnlegion.org and Legion Auxiliary, Moose Club, Masons www.mn-masons.org Sertoma Club, etc. Contact your local Chamber of Commerce for a listing of the service organization in the area and the contact person. The area's Community Action Agency may also know. The contact person from the service club will know what type of request the group considers and how to bring a request before them.

Technology

Alternate Finance Program (AFP), Managed by Assistive Technology of Minnesota (ATMn*) ATMn provides low interest loans to consumers, their families, and employers for the purchase of assistive technology devices and services. Federal funding is now available to assist ATMn* with the restructuring of it AFP. The current model is being restructured by adding a revolving loan program and a loan guarantee to increase the options available for individuals with disabilities in need of financial support, thus providing funding opportunities for people who previously were ineligible for a traditional loan.

The STAR Program, Minnesota's AT Act Project will oversee the project through its contractual arrangement with ATMn*. Contact ATMn* for more information" ATMn*, P.O. Box 310, Maple Plain MN 55359-0310, 763-479-8239, Toll Free: 866-535-8239, Minnesota Relay Service: 1-800-627-3529; email: info@atmn.org;
Web site: www.atmn.org

The Family Center on Technology and Disability (FCTD)
"The Family Center is a resource designed to support organizations and programs that work with families of children and youth with disabilities. FCTD offers a range of information and services on the subject of assistive technologies." FCTD has a regular newsletter called "News and Notes", which can be found at: www.fctd.info
Phone: 202-884-8068.

Assistive Technology and Modifications Toolkit
The toolkit from the Department of Human Services contains products, services and a list of organizations and resources people may use to plan independent lives. Twice a year, the Disability Services Division updates the resources to reflect newly identified products, services and organizations. http://www.atmn.org/atmodtoolkit.pdf

"Really Useful" (Technology for Students with Learning Disabilities"):
This downloadable 30 page booklet contains brief descriptions of software and assistive technology devices that have been successfully used by students of all ages with learning disabilities. Type in "Really Useful" at www.pacer.org/publications/stc.asp

System of Technology to Achieve Results (STAR) Program
A System of Technology to Achieve Results (STAR) is Minnesota's Assistive Technology Act program. STAR publishes a Directory of Funding Resources for Assistive Technology. This directory lists national and state funding resources, as well as, provides a 10-step Funding Strategy Plan. An online version of this directory is available in English and Spanish at www.starprogram.state.mn.us. To request a free copy of the directory, call 651-201-2640, Minnesota Relay Service at 7-1-1 or 1-800-627-3529 or email star.program@state.mn.us.

Telephone Assistance

Minnesota Telephone Equipment Distribution Program (TED)
This program can provide telephone equipment at NO CHARGE to Minnesota residents of all ages. Eligibility requirements do apply. The equipment includes amplified (corded or cordless) phones, speakerphones, captioned telephones, telephone ring signalers, deafblind equipment and other special equipment. To learn more, visit their web site at www.tedprogram.org or contact them at 1-800-657-3663, 1-888-206-6555 TTY

Telephone Assistance
Minnesota local service providers are authorized to provide two federally-funded and one state-funded telephone service discount programs. The Link-Up program provides a discount on new service connection charges when installing new telephone service. The Lifeline and Telephone Assistance Plan programs provide a monthly discount on your local telephone service. To be eligible, the telephone service must be in your name and you must participate in at least one of the qualifying public assistance programs (such as Medical Assistance, Food Support, SSI, etc.) or one of the qualifying programs for persons living on a reservation (such as Bureau of Indian Affairs

General Assistance) or be below 135% of the federal poverty guidelines to be eligible. To apply go to the website for an application to complete. Mail the application, along with proof you are on one of the qualifying programs or proof of your income, to your local phone company. www.puc.state.mn.us (Click on Consumer Info, and go to Consumer Assistance on the left, scroll down and click on Telephone Service Discounts). Consumer Assistance: 651-296-0406

Twin Cities Community Voice Mail (TCCVM)
Twin City Community Voice Mail is a program to provide free voice mail for up to 6 months for people who are looking for a job, looking for a place to live, are in an abusive situation, or need a way for their medical contacts to leave messages for them. To learn more about TCCVM call 651-643-0883 or http://www.tccvm.org/

Vision

Minnesota Vision Project
Program is available on a year-round, state-wide basis. The program can be accessed by contacting Louise Simmons, Salvation Army Headquarters, 651-746-3400. The program will cover eye exams by selected optometrists as well as provide glasses for children whose families meet the criteria listed below: 1) someone in the family needs to be employed; 2) the child/adult cannot be eligible for medical Assistance or MinnesotaCare; 3) if the family has insurance, it cannot cover either eye exams or glasses; 4) the child/adult cannot have had an eye exam with the previous two years (24 months); and 5) the family's income must meet criteria based on Federal Poverty Guidelines.

The National Eye Institute www.nei.nih.gov/health/financialaid.asp
The National Eye Institute (NEI) is a part of the federal government's National Institutes of Health. NEI's purpose is to conduct and support research and training, to disseminate information pertaining to eye diseases, disorders and the special health problems and requirements of the blind.

State Services for the Blind & Visually Handicapped
State Services for the Blind is a division of the Minn. Dept. of Employment and Economic Development and is a partner in Minnesota's WorkForce Center System. This division provides services/resources for children, youth, working adults, seniors, etc. It can lead you to an array of informative resources, including: internet sites, books, audio tapes, service provider and community links, kinds of assistive technology available, and a child newsletter. Address: 2200 University Ave. West #240, St. Paul, MN 55114-1840. Phone: 651-642-0500 or Toll free 1-800-652-9000. http://www.mnssb.org/

Young Children / B-3

The Center for Early Education and Development (CEED)
CEED is located at the University of Minnesota and has spent over 30 years helping children from infancy through age eight learn and develop to the best of their abilities. They are a valuable resource for early childhood teachers including Head Start and special education, home visitors, child care workers, psychologists and social workers. CEED strives to improve developmental outcomes for children by applied research to identify pressing community needs and conducting focused, high-impact studies to solve the problems. They also identify experiences and program options that promote young children's development. CEED provides research-based training to current and future early childhood professionals and utilizes a variety of outreach strategies to share their knowledge to support early childhood program and policy development. They publish newsletter, offer onsite and online courses, as well as chairing groups for supervisors, social workers and practitioners working with young children. CEED publishes training manuals for trainers of early childhood professionals and parents. Special projects are also created which integrate STEEP parenting support services and high quality child care and blending technology and technical assistance. CEED also produces many training videos, CD-ROMS and Tip Sheets. http://cehd.umn.edu/CEED/ Phone: 612-625-3058 Fax: 612-625-2093

Directory of Resources for Children and Families in Minnesota
This directory provides information on resources that may help families, providers and others working with families and children. Users are able to search for resources by specific counties or school districts (Help Me Grow - Early Intervention only). There is also information included within each search that provides statewide resources and programs available to Minnesota families. The directory is available at the following web address: **http://www.health.state.mn.us/mcyshn** For those who do not have Internet access, please contact the Minnesota Children and Youth with Special Health Needs Information and Assistance Line at: 651-201-3650 or 1-800-728-5420 for assistance in locating services or resources.

Help Me Grow
If your child has problems or difficulties with development or if you are concerned about your child's development, there is one number to call in every community. Parents and professionals work together to plan the services your child and family need. For children under the age of three, you can call one number to help you decide if your child would benefit from early intervention services. To locate your nearest Local Early Intervention contact, call your local school district or the Minnesota Department of Education at 1-866-693-4769.

Minnesota Parents Know
Minnesota Parents Know is a resource filled with convenient and trusted child development, health and parenting information. The Minnesota Parents Know Website is founded on the belief that parents are the first and most important teacher in a child's life. Parents are likely to benefit, however, from the aid and support of experts' information on child health, development, nutrition and safety in raising strong and healthy children. The site has been developed for parents with extensive input of parents and provides up-to-date research-based information on children from birth through grade 12, strategies to support children's learning, newsletters, expert tips, an interactive early childhood and child care search, connections to Minnesota services and resources, video clips, a parent Web literacy tutorial and a customized search function of high quality, non-commercial child development and health websites. Minnesota Department of Education (MDE), 1500 Highway 36 West, Roseville, Minnesota 55113 www.parentsknow.state.mn.us

Youth

Children, Youth and Family Consortium
Information & resources about children and families. McNamara Alumni Center, Suite 270A; 200 Oak Street SE; Minneapolis, MN 55455; 612-625-7849 http://www.cyfc.umn.edu/

Office of Youth Development
The Office of Youth Development is located within the Minnesota Department of Employment and Economic Development. It provides funding for a wide array of employment and training services for economically disadvantaged and at-risk youth. Other programs include more recent initiatives to expand employment and training opportunities for youth with disabilities and young adults with barriers to employment. In addition to general information about programs offered through the Office of Youth Development, a significant amount of resource material, policy information and technical documents are available for practitioners and others interested in learning more about these programs which include. The website offers a "Find a Youth Employment Program", by your county. Phone: 651-259-7555 www.deed.state.mn.us/youth

Miscellaneous

Domestic Violence
Minnesota Specific Resources by county
www.aardvarc.org/dv/states/minndv.shtml

The Minnesota Department of Human Services
DHS has a brochure titled **"***Domestic Violence Information"* (DHS-3477) which describes the domestic violence waivers. If you are eligible for public assistance and you experience domestic violence, certain program requirement may be temporarily waived, meaning they may not apply in your situation. Waivers are available for the following programs: Food Support, General Assistance, General Assistance Medical Care, Diversionary Work Program, Minnesota Family Investment Program, Medical Assistance, and MinnesotaCare. www.dhs.state.mn.us

Migrant and Seasonal Farmworker Program (Intercambio de información para trabajadores migrantes)
The Minnesota Department of Employment and Economic Development offers a Migrant and Seasonal Farmworker (MSFW) Program in designated WorkForce Centers. This program specializes in providing assistance to employees and employers seeking to obtain work or workers in agricultural and nonagricultural employment. Located in these "designated" WorkForce Centers is a Migrant Labor Representative. This person is bilingual (Spanish/English) and available to assist Migrant and Seasonal Farmworkers in obtaining employment and referring them to other services in the community such as education, training, health and legal services. There is also a link to Minnesota government benefits on their website. For additional information, contact the State Monitor Advocate/Consumer Affairs Specialist (Se habla espanol; 1st National Bank Building; 332 Minnesota Street, Suite E200; Saint Paul, MN 55101-1351; 651-259-7513 http://www.deed.state.mn.us/migrant/index.htm

National Center for Complementary and Alternative Medicine
CAMBASICS http://nccam.nih.gov/
The National Center for Complementary and Alternative Medicine (NCCAM) is the Federal Government's lead agency for scientific research on complementary and alternative medicine (CAM). They are 1 of the 27 institutes and centers that make up the National Institutes of Health (NIH) within the U.S. Department of Health and Human Services.

National Patient Air Transport HELPLLINE (1-800-296-1217)
This provides information about all forms of charitable, long-distance medical air transportation and provides referrals to all appropriate sources of help available in the national charitable medical air transportation network. Parents can learn how they can obtain travel help for repeated trips back & forth to distant specialized care. Patients may make multiple trips and there is no age limit. In virtually all cases, when a patient reaches the charitable medical air transportation program that is best suited to meet their needs, they will be asked to verify financial hardship and the patient's primary physician will be asked to sign a form indicating that the travel is for essential and necessary medical care. www.patienttravel.org

Service Animals
Helping Paws
Helping Paws is an accredited member of Assistance Dogs International, a nonprofit organization whose purpose is to improve the areas of training, placement, and utilization of Assistance Dogs. Helping Paws service dogs promote self-sufficiency and empower people with physical disabilities. Any adult with a physical disability, other than sight or hearing impairments, may apply for a Helping Paws service dog. The dogs are provided at no charge to applicants. There is a minimal application fee and an equipment fee for the applicant.
www.helpingpaws.org/

Assistance Dog United Campaign

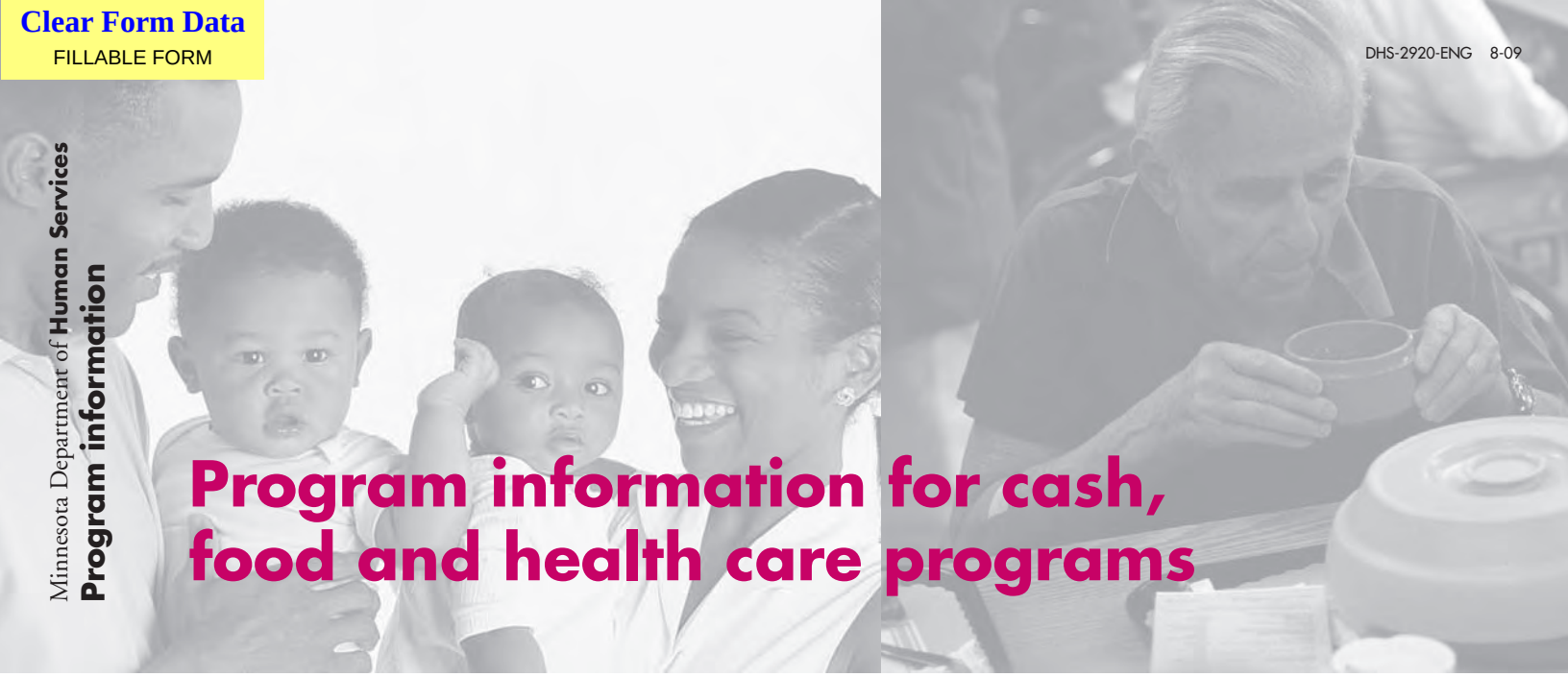
The ADUC is a health and human welfare organization providing financial assistance to individuals who have the need for an assistance dog but have difficulty in raising the necessary funds and to people and programs whose purpose is to provide assistance dogs to people with disabilities. Assistance dogs provide a very serious and meaningful service to people with disabilities or disabling conditions. The ADUC Board of Directors raises funds for assistance dog placements, for grants to support industry research, development efforts, and for scholarships for individuals attending the Bergin University of Canine Studies in pursuit of an Associate of Science degree in Assistance Dog Education. ADUC's funding for assistance dog placements is unique in that seventy percent of the donations are earmarked as vouchers. These vouchers are provided to the assistance dog user applicant who can then choose whichever ADUC member provider program they wish to enroll in. This unique disbursement method was designed to place some fiscal empowerment in the hands of the assistance dog user applicant, thereby ensuring that the provider program be accountable to the applicant for quality service.
www.assistancedogunitedcampaign.org

You may use the voucher system to obtain an assistance dog from any of the ADUC member programs listed on www.assistancedogunitedcampaign.org/programlist.html. If you do not see the name of a program you are interested in, have them contact ADUC or visit our website to get information regarding membership.

Department of Human Services (DHS)

Clear Form Data
FILLABLE FORM

DHS-2920-ENG 8-09



Minnesota Department of **Human Services**
Program information

Program information for cash, food and health care programs

How do you apply for help?

Ask for help from state and county cash, food and health care programs by mail, by phone or in person. You must fill out an application form. You must mail it or bring it in person to your county human services agency. (MinnesotaCare applications must go to either the county agency or the MinnesotaCare office in St. Paul.) The amount of help you can get the first month may depend on the date the county agency gets your application form.

If you are applying for cash assistance or food support benefits, you need an interview with a county worker to go over the forms. You will need to bring proof of:

- Who you are
- Where you live
- What family members live with you
- What your income is
- What you own.

You must contact your county agency for a new appointment if you miss your interview.

Whether or not you can get help and how much you get may depend on:

- How long you have lived in Minnesota
- How many people live with you
- How much income you and these people get each month
- How much money you have.

Each program has different rules.

What are cash benefit programs?

Cash benefit programs provide Minnesotans with low income help with their monthly expenses. It helps you when your income does not cover your expenses. Cash programs include:

- Diversionary Work Program (DWP)
- Minnesota Family Investment Program (MFIP)
- General Assistance (GA)
- Minnesota Supplemental Aid (MSA)
- Group Residential Housing (GRH)
- Refugee Cash Assistance (RCA)
- Work Benefit Program (WB)

DWP is a *short-term* work program that provides job counseling services and basic living costs to eligible families. DWP is for families who are working or looking for work, but need help with basic living expenses.

MFIP is a *monthly* cash assistance program for low-income families and pregnant women. MFIP is for:

- Families who have one or more children under age 19
- Women who are pregnant.

WB is a *monthly* benefit of $50 for families who are going off DWP or MFIP. WB is for families whose:

- Caregiver is working the required number of hours
- Gross family income is less than 200% of FPG.

GA is a *monthly* cash payment. It helps with interim money for housing and other basic needs. GA is for adults who are unable to work who:

- Have little or no income and
- Will soon return to work, or
- Are waiting to get help from other state or federal programs.

MSA is a small extra *monthly* cash payment. It helps adults who are eligible for federal Supplemental Security Income (SSI).

GRH is a *monthly* payment. It pays room and board for some people who cannot live in their own home. GRH is for people who are:

- Age 65 or older
- Disabled and age 18 or older
- Blind
- Unable to work.

RCA is a *monthly* cash payment for refugees and asylees. RCA is for people who:

- Have been in the United States eight months or less and
- Have refugee or asylee status.

What are health care programs?

Minnesota has several health care programs for low income Minnesotans. These programs may pay for all or part of your medical bills. They can help pay for health care your family and you need. Health care programs include:

- Medical Assistance (MA)
- MinnesotaCare
- General Assistance Medical Care (GAMC)
- Refugee Medical Assistance (RMA)
- Minnesota Family Planning Program

Most people who get cash assistance can also get health care coverage from one of the Minnesota health care programs.

MA is for people who are:

- Under age 21
- Age 65 or older
- Parents or caretakers of a child under age 18. In some cases, parents or caretakers of a chid under age 19.
- Pregnant
- Blind
- Disabled

MinnesotaCare helps people who do not have other health insurance. You must pay a premium to get coverage. MinnesotaCare is for people who do not:

- Get MA or GAMC
- Have other health insurance. Some children can still get MinnesotaCare even if they have other health insurance.

GAMC is for adults who:

- Cannot get MA, and
- Are age 21 or older
- Are under 65.

RMA is for people who:

- Cannot get MA, and
- Have been in the United States eight months or less.

Minnesota Family Planning Program is a health care program that covers only family planning services and related supplies.

What is child care assistance?

Minnesota's Child Care Assistance Program makes quality child care affordable for families with low incomes. Help is available from the following programs:

- **MFIP Child Care** is for families who receive assistance from DWP or MFIP.
- **Transition Year Child Care** may be available to families for up to 12 consecutive months after their DWP or MFIP case closes.
- **Basic Sliding Fee Child Care** is for other families with low incomes.

What is Food Support?

Food Support is a federal program that helps Minnesotans with low income buy food. Food support benefits are available through electronic benefits transfer (EBT) cards that can be used like money. Food support benefits are for:

- Single people
- Families with or without children.

Your income and the size of your household determines how much you get.

Your right to file a complaint

If you feel the county or the Minnesota Department of Human Services treated you differently in the handling of your public assistance application or benefits because of race, color, national origin, political beliefs, religion, creed, sex, sexual orientation, public assistance status, age or disability, including physical access to government buildings, you may file a complaint with your county agency or any of the following agencies.

Minnesota Department of Human Services
Office for Equal Opportunity
PO Box 64997
St. Paul, MN 55164-0997
(651) 431-3040 (Voice)
(866) 786-3945 (TTY)

Minnesota Department of Human Rights
190 East 5th Street, Suite 700
St. Paul, MN 55101
(800) 657-3704 (Voice)
(651) 296-1283 (TTY)

U.S. Department of Health and Human Services
Office for Civil Rights, Region V
233 North Michigan Avenue, Suite 240
Chicago, IL 60601
(312) 886-2359 (Voice)
(312) 353-5693 (TTY)

U.S. Department of Agriculture
Director, Office of Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410
(800) 795-3272 (Voice)
(202) 720-6382 (TTY)

Attention. If you want free help translating this information, ask your worker or call the number below for your language.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاسأل مساعدك في مكتب الخدمة الاجتماعية أو اتصل على الرقم 1-800-358-0377.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែពត៌មាននេះដោយមិនគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿងរបស់អ្នក ឬ ទូរស័ព្ទទៅលេខ 1-888-468-3787 ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, pitajte vašeg radnika ili nazovite 1-888-234-3785.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, nug koj tus neeg lis dej num (worker) lossis hu 1-888-486-8377.

ໂປຼດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງຖາມນຳພນັກງານຊ່ວຍວຽກຂອງທ່ານຫຼືໂທຣ໌ຫາຕາມເລກໂທຣ໌ 1-888-487-8251.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta’e, hojjataa kee gaafaddhu ykn lakkoofsa kana bilbili 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в переводе этой информации, обратитесь к своему социальному работнику или позвоните по следующему телефону: 1-888-562-5877.

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjamadda macluumaadkani oo lacag la’aan ah, weydii hawl-wadeenkaaga ama wac lambarkan 1-888-547-8829.

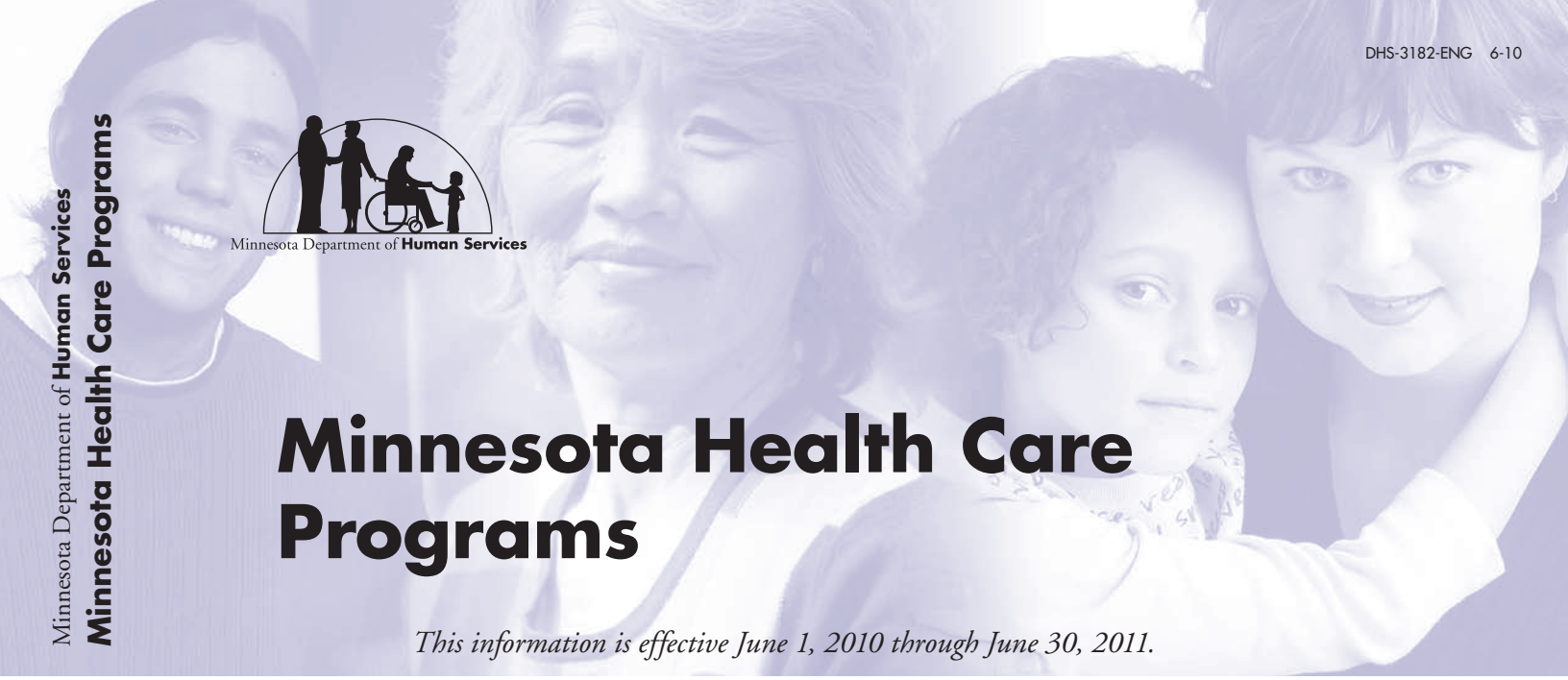
Atención. Si desea recibir asistencia gratuita para traducir esta información, consulte a su trabajador o llame al 1-888-428-3438.

Chú Ý. Nếu quý vị cần dịch thông-tin nầy miễn phí, xin gọi nhân-viên xã-hội của quý vị hoặc gọi số 1-888-554-8759.

LB2-0001 (1-08)

This information is available in alternative formats to individuals with disabilities by calling your county worker. TTY users can call through Minnesota Relay at (800) 627-3529. For Speech-to-Speech, call (877) 627-3848. For additional assistance with legal rights and protections for equal access to human services benefits, contact your agency’s ADA coordinator.

(agency)



Minnesota Department of Human Services

Minnesota Department of **Human Services**
Minnesota Health Care Programs

Minnesota Health Care Programs

This information is effective June 1, 2010 through June 30, 2011.

Minnesota offers several health care programs to people who qualify. You can apply for any of these programs with the same application—the Minnesota Health Care Programs Application.

Contact any of the agencies listed below for more information or to get an application:

- Your county human or social services office.
- MinnesotaCare at (651) 297-3862 or (800) 657-3739 (this toll-free number is only available to people that need to call long distance to reach MinnesotaCare).
- Department of Human Services at (651) 431-2670 or (800) 657-3739.
- The website at www.dhs.state.mn.us/healthcare.

To get health care program coverage, you must meet the program guidelines and be within the income and asset limits. If your income is more than the limit, you may still qualify and you should apply.

Assets that are counted include cash, bank accounts, stocks, bonds, certain vehicles and property where you do not live. Assets that are not counted include the home where you live, personal property and household goods.

Minnesota's health care programs may cover the following medical services:

- Doctor visits
- Dental visits
- Hospital care
- Prescriptions and immunizations
- Eye exams and eye glasses
- Chiropractic care
- Family planning
- Hearing aids
- Mental health services
- Medical equipment and supplies

You may have to pay a small copayment toward some medical costs.

Medical Assistance (MA)

MA may pay for medical bills going back three months from the month you turn in your application. MA also pays for current and future medical bills.

To get MA, you must:

- Live in Minnesota
- Meet income and asset limits
- Be one of the following:
  - Under age 21
  - A parent of a minor child
  - Pregnant
  - Age 65 or older
  - Blind or disabled.

Over →

MA Monthly Income Limits

Family size	1	2	3
Infants under age 2	$2,527	$3,400	$4,273
Children ages 2 through 18	1,354	1,822	2,290
Children ages 19 and 20	903	1,215	1,527
Pregnant woman	--	3,340	4,198
Adults with children	903	1,215	1,527
People who are blind or have a disability	903	1,215	1,527
Adults age 65 and over	903	1,215	1,527

MA Asset Limits

There is no asset limit for pregnant women and for children under age 21. Asset limits apply to the following people.

Family size	1	2 or more
Adults with children	$10,000	$20,000
People who are blind or have a disability	3,000	6,000*
Adults age 65 and over	3,000	6,000*

**For each dependent add $200.*

For people who are self-employed, net capital and operating assets are excluded up to $200,000 for MA for families.

What if I am disabled and working?

If you are disabled and have a job, you may qualify for Medical Assistance for Employed Persons with Disabilities (MA-EPD). You will have to pay a monthly premium. The amount is based on your monthly income.

MA-EPD Asset Limits

The asset limit for MA-EPD is $20,000 per enrollee. Some items are not counted for MA-EPD, such as your retirement account and your spouse's assets.

MinnesotaCare

MinnesotaCare is available for people who do not have health insurance. Some children may get MinnesotaCare even if they have insurance or access to insurance through an employer.

You will have to pay a monthly premium for MinnesotaCare. The cost depends on your family size and income. When you pay your first MinnesotaCare premium, coverage will begin on the first of the next month.

To get MinnesotaCare, you must:

- Live in Minnesota. Adults without children must live in Minnesota for 180 days.
- Be a U.S. citizen or a qualifying noncitizen.
- Have had no health insurance and no Medicare for the last four months.
- Meet income and asset limits.

You cannot enroll in MinnesotaCare if:

- Your current employer offers health insurance and pays half or more of the monthly cost of the insurance.
- Your employer offered health insurance, paid half or more of the monthly cost, and stopped insurance within the last 18 months.
- You are a parent, legal guardian, foster parent or relative caretaker, and your gross household income is over the limit for your family size or is $50,000 or more.

MinnesotaCare Monthly Income Limits

Family size	2	3
Families with children under age 21	$3,340	$4,198

MinnesotaCare Asset Limits

There is no asset limit for pregnant women and for children under age 21.

Adults with children have the following asset limits:

Family size	1	2 or more
Adults with children	$10,000	$20,000

For people who are self-employed, net capital and operating assets are excluded up to $200,000.

Should I apply for MinnesotaCare or MA?

The information below will help you decide if MA or MinnesotaCare is right for you.

MinnesotaCare

- You must pay a monthly premium if you and your family members qualify for MinnesotaCare.
- The first premium must be paid before coverage can start.
- Coverage begins in the month after you pay your premium. If you pay the premium in May, your coverage starts on June 1.

- You must pay the premium every month or your coverage will end. If your MinnesotaCare ends, you cannot enroll again for four months if you meet all program rules.
- Coverage cannot go back to previous months, unless your MA or GAMC just ended.
- MinnesotaCare requires that you and your family members be without other insurance coverage for four months before you can qualify. There are some exceptions to this rule for children.
- You and your family members will not qualify for MinnesotaCare if your employer offers health insurance and pays 50% or more of the premium. This rule may not apply to children, depending on the amount of household income.

Medical Assistance (MA)

- You will not have to pay a monthly premium for MA.
- MA coverage may go back three months from when you turn in your application, if you have medical expenses for those prior months.
- You can have other health insurance, even if it is through an employer, and still qualify for MA.
- If you have other health insurance, MA may pay your health insurance premiums.
- If MA ends, you can get coverage again whenever you meet the program rules.

General Assistance Medical Care (GAMC)

GAMC pays for some current and future medical services. GAMC eligibility only goes back to the date you turn in your application or a written request for health care. To get certain services, you will need to enroll in a Coordinated Care Delivery System (CCDS).

To qualify, you must:

- Live in Minnesota for at least 30 days
- Intend to stay in Minnesota. This may not apply if you have a medical emergency
- Be a U.S. citizen or a qualifying non-citizen
- Not be eligible for MA
- Meet income limits
- Meet asset limits.

GAMC Monthly Income Limits

Family Size		
1	2	3
$677	$911	$1,145

Medicare Savings Programs

If you are enrolled or eligible to enroll in Medicare, and your assets are below $10,000 for one person or $18,000 for two people, you may qualify for one of the following programs:

- Qualified Medicare Beneficiary (QMB)
- Service Limited Medicare Beneficiary (SLMB)
- Qualified Individuals (QI)

Qualified Medicare Beneficiary (QMB)

QMB pays monthly Medicare premiums, deductibles, copayment and co-insurance.

QMB Monthly Income Limits

Family size		
1	2	3
$923	$1,235	$1,547

Service Limited Medicare Beneficiary (SLMB)

SLMB pays monthly Medicare Part B premiums.

SLMB Monthly Income Limits

Family Size		
1	2	3
$1,103	$1,477	$1,851

Qualified Individual (QI) Program

QI pays monthly Medicare Part B premiums.

QI Monthly Income Limits

Family Size		
1	2	3
$1,239	$1,660	$2,081

Qualified Working Disabled (QWD)

QWD pays for Medicare Part A premiums if you cannot get free Medicare Part A.

The asset limit is $4,000 for one person and $6,000 for two people.

QWD Monthly Income Limits

Family Size		
1	2	3
$1,825	$2,449	$3,073

Attention. If you want free help translating this information, ask your worker or call the number below for your language.

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កំណាត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែពត៌មានេះដោយមិនគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿងរបស់អ្នក ឬ ទូរស័ព្ទទៅលេខ 1-888-468-3787 ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, pitajte vašeg radnika ili nazovite 1-888-234-3785.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, nug koj tus neeg lis dej num (worker) lossis hu 1-888-486-8377.

ໂປດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງຖາມນຳພນັກງານຊ່ວຍວຽກ ຂອງທ່ານຫຼືໂທຣ໌ຫາຕາມເລກໂທຣ໌ 1-888-487-8251.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, hojjataa kee gaafaddhu ykn lakkoofsa kana bilbili 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в переводе этой информации, обратитесь к своему социальному работнику или позвоните по следующему телефону: 1-888-562-5877.

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjamadda macluumaadkani oo lacag la'aan ah, weydii hawl-wadeenkaaga ama wac lambarkan 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para traducir esta información, consulte a su trabajador o llame al 1-888-428-3438.

Chú Ý. Nếu quý vị cần dịch thông tin nầy miễn phí, xin gọi nhân-viên xã-hội của quý vị hoặc gọi số 1-888-554-8759.

LB2-00001 (10-09)

ADA3 (5-09)

This information is available in alternative formats to individuals with disabilities by calling (651) 431-2670 or (800) 657-3739. TTY users can call through Minnesota Relay at (800) 627-3529. For Speech-to-Speech, call (877) 627-3848. For additional assistance with legal rights and protections for equal access to human services programs, contact your agency's ADA coordinator.

DHS-3532-ENG 4-08

Minnesota Department of Human Services

Medical Assistance For Employed Persons with Disabilities (MA-EPD)

Background

Medical Assistance for Employed Persons with Disabilities (MA-EPD) promotes competitive employment and the economic self-sufficiency of people with disabilities. It does this by assuring continued access to Medical Assistance (MA) for necessary health care services.

MA-EPD allows working people with disabilities to qualify for MA with no upper income limit and higher asset limits than regular MA. The goal of the program is to encourage people with disabilities to work and enjoy the benefits of being employed.

Who qualifies for MA-EPD?

To qualify for MA-EPD, a person must:

- Be certified disabled by either the Social Security Administration (SSA) or the State Medical Review Team (SMRT)
- Be at least 16 but less than 65 years of age
- Be employed and have required taxes withheld or paid from earned income
- Have monthly earnings of more than $65
- Not be eligible for MA under other, more beneficial categories
- Meet the asset limit*
- Pay a premium**
- Pay an "unearned income obligation," if required. **

What is the MA-EPD asset limit*?

The asset limit for MA-EPD is $20,000. Some assets that do not count towards the limit are:

- Spouse's assets
- Homestead property
- Retirement accounts
- Medical expense accounts set up through an employer
- One motor vehicle, under certain conditions
- Household goods, clothing and personal items
- Burial fund (up to $1,500).

What is the MA-EPD premium and unearned income obligation**?

Premiums:

Participants in the program must pay a monthly premium to be on MA-EPD. Premiums are based on a sliding fee scale or a minimum of $35, whichever is greater. Income and household size are used to calculate the premium. There is no maximum income limit or maximum premium amount for MA-EPD.

Unearned Income Obligation:

In addition to the monthly MA-EPD premium, people who have unearned income, such as Social Security Disability, must pay one-half percent of their unearned income. To calculate the monthly unearned income obligation, multiply the total unearned income amount by .005.

The Department of Human Services has developed a Web site that will assist in estimating MA-EPD premium cost. The Web site is located at http://www.dhs.state.mn.us/maepdpremium

This information is available in alternative formats to individuals with disabilities by calling your agency at (651) 431-2400 or (800) 747-5484. TTY users can call through Minnesota Relay at (800) 627-3529. For Speech-to-Speech, call (877) 627-3848. For additional assistance with legal rights and protections for equal access to human services benefits, contact your agency's ADA coordinator.

Medical Assistance For Employed Persons with Disabilities (MA-EPD)

What if a person loses their job or can't work because of a medical condition?

Job Loss:
People on MA-EPD who lose their job through no fault of their own (they didn't quit or get fired) may stay on MA-EPD for up to four months while looking for another job. If they do not have a job at the end of four months they cannot remain on MA-EPD.

Medical Leave:
People on MA-EPD who become unable to work because of a medical condition may stay on MA-EPD for up to four months. They must have a written, signed doctor's statement that says they are expected to return to work within four months. If they cannot return to work within four months, they cannot be on MA-EPD.

What services does MA-EPD cover?

MA-EPD pays for the same services as regular Medical Assistance, including:

- Home care services
- Inpatient hospital services
- Mental health services
- Medical equipment and supplies
- Personal assistance services
- Physical, occupational and speech therapy
- Physician and health clinic visits.

There are co-pays for some services such as non-preventive care visits and eyeglasses. In certain circumstances, Medicare or other health insurance premiums, co-pays and deductibles may be covered under MA-EPD.

Can a person be on MA-EPD and have other health insurance?

Yes, people may have private, group or employer subsidized health insurance or Medicare in addition to MA-EPD. Many services that are not covered by commercial insurance policies or Medicare may be paid for by MA-EPD.
If a person has other health insurance, that insurance must be used first, following the rules of that primary plan (must use network providers, obtain referral or authorization as required, etc.). Then services not covered may be paid through MA-EPD.

How can someone apply for MA-EPD?

Applications are available at most medical clinics and at any local, county human service agency. Applications must be returned to a local, county human service agency for processing.

Need more information on MA-EPD?

For more information on MA-EPD, contact your county human service agency. You may also contact the Department of Human Services by calling (651) 431-2400 or (800) 747-5484 (TTY/TDD: (651) 632-5110 or MN Relay - 711).

Wondering about how working affects other benefits?

For information on how working may affect other benefits (such as Social Security income, Medicare, private disability insurance, subsidized housing, Food Support, etc.), contact the Minnesota Work Incentives Connection at (651) 632-5113 or (800) 976-6728 (TTY/TDD: (651) 632-5110 or MN Relay-711).

AUTHORIZATION

Some covered health services, items, and medications require prior approval or authorization by the patient's private health plan or by the patient's Minnesota Health Care Program (MHCP). This requirement is used to safeguard against inappropriate and unnecessary use of health care services.

Where do I get more information about prior approval or authorization requirements? If the recipient is covered by a private health plan, the health care provider must follow the specific requirements of the health plan. The provider can contact the health plan's Customer Service Department for their requirements and definition of medical necessity. The family may contact the health plan for their appeal process if the approval/authorization request is denied.

For MHCP recipients in a prepaid health plan, the provider must contact the appropriate health plan (UCare, BlueCross/Blue Shield, County Based Purchasing Plan, etc.) for their authorization requirements. Managed care organizations are under contract with DHS to provide, all medically necessary health services that would be covered under MA, GAMC or MinnesotaCare.

For MHCP recipients on Fee-for-Service (FFS) Medical Assistance (MA), the health care provider must follow DHS' authorization procedure. An authorization is the written approval and includes an authorization number by the medical review agent under contract to DHS. Providers must be enrolled as a MHCP provider and get authorization prior to providing a service or, in some circumstances, after a service has been provided.

Obtaining an authorization alone does not guarantee payment to the provider. Providers must, also, follow MHCP billing guidelines and the MHCP recipient must be eligible at the time the service is rendered.

Details and the list of items/services that need to be authorized are found in the MHCP Provider Manual. Or go to the chapter that specifically discusses the particular service, item, medication or equipment. The manual is on the DHS website: **www.dhs.state.mn.us** Click Publications, then Manuals and then Minnesota Health Care Programs Provider Manual.

What are some examples of items or services that need authorization? (This is not a total list.)

- Durable Medical Equipment - certain wheelchairs, accessories & repairs, augmentative communication devices, orthotics & other equipment exceeding a certain amount of money (purchased or projected ongoing rental cost).
- Some dental procedures, orthodontia or more frequent dental care than typical,
- Certain mental health assessments/treatment services or services over specific "threshold" amounts.
- Certain diagnostic tests & surgical procedures (EX: PET and CT scans, MRIs, hysterectomy surgery & some surgeries if they are non-emergency: spinal fusion, cesarean section, insertion of PE tubes for ears).
- Audiology, OT, PT, ST assessment/treatment sessions above specific "threshold" amounts,
- Certain noncontract hearing aids & the provision of more than one hearing aid in 5 years,
- Certain medications, vision therapy and most contact lenses,
- Diapers, incontinence pads, formula/nutritional products and other supplies.
- Personal Care Assistance (PCA) services and more than 9 skilled nurse home visits,
- Surgery or behavior modification for weight reduction or procedures considered cosmetic or investigative.

When does DHS require authorization? DHS requires authorization as a condition of payment if the service:

- Could be considered, under some circumstances, to be of questionable medical necessity
- Requires monitoring to control expenditures;
- A less costly, appropriate alternative service is available;
- Is investigative or experimental;
- Is of a continuing nature and monitoring prevents continuation when it ceases to be beneficial;
- Is newly developed or modified;
- Is comparable to a service provided in a skilled nursing facility/hospital but is provided in a recipient's home; or
- May be considered cosmetic.

Who is responsible for requesting an authorization? The appropriate health care provider (doctor, dentist, pharmacist, mental health professional, home care agency, etc.). must request the authorization. The provider must include assessment information and evidence that the service is medically necessary and effective for the person.

Who processes the authorization? DHS contracts with a medical review agent, Care Delivery Management, Inc. (CDMI). If information is missing, the provider should be contacted to provide more information.

Are authorizations necessary for care obtained in another state? Except for emergency services, out-of-state providers must obtain prior authorization before providing MHCP covered services.

- Providers must be an enrolled Minnesota Health Care Program provider and follows program guidelines;
- Services are medically necessary;

The services meet one of the following criteria:

- Services are provided in response to an emergency while the recipient is out of state; or
- The services are not available in Minnesota or its local trade area, and the attending physician has determined medical necessity and obtained prior authorization from CDMI. The county is responsible for travel expenses associated with obtaining the out-of-state services or
- Services are required because recipient's health would be endangered if required to return to MN for treatment.

How will I know if the service/item has been authorized? DHS notifies the provider and the recipient, in writing, of action taken on the request. Providers may need to send more information to determine medical necessity.

What if the authorization is delayed? If the authorization request is delayed beyond 6 weeks, the family should contact the provider to make sure the authorization request was submitted.

- The provider can contact the **Provider Call Center 651-431-2700 (DHS)** to check the status.
- Recipients/families can call the **MN Health Care Programs Help Desk 651-431-2670 or 1-800-657-3739** to check on the status.

What if the request is denied? If MHCP or CDMI deny or reduce an authorization, the recipient may appeal the decision and receive a fair hearing before a referee from DHS. To request a fair hearing, the recipient must contact the county agency or the Appeals Unit at DHS. Providers do not have the right to appeal a denied authorization request under the MHCP fair hearing process. An authorization frequently is denied because the provider made an error or omission when submitting the request. Providers may submit additional documentation and ask CDMI for a reconsideration of a decision. See **Appeals section of this manual** for more information.

What if no authorization was requested & the person received the service, equipment or supplies? If the provider did not request authorization, the family is not responsible for paying the bill.

What if I have private insurance and MA? The individual's private insurance must be billed first. The provider would then bill MA and include the Explanation of Benefits (EOB) from the insurance company.

HOME CARE SERVICES,
Including PERSONAL CARE ASSISTANCE (PCA) SERVICES

NOTE: The information in this Maze handout is only intended to be a summary of information related to Home Care Services through Minnesota Health Care Programs—Fee for Service Medical Assistance (MA). For the most current, detailed and specific information about policies, procedures, forms & publications go to the DHS website **www.dhs.state.mn.us .** Select Publications, then Manuals & scroll down to the following manuals: **Disability Services Program Manual (DSPM)** & **Minnesota Health Care Programs (MHCP) Provider Manual. Information specifically on personal care assistance (PCA) services is available at: www.dhs.state.mn.us/pca .**

What is home care?
Home care offers a range of medical care & support services provided in a person's home & community. Services range from simple assistance in activities of daily living to a level of care similar to cares provided in a hospital.

NOTE: If you are enrolled in a private health plan, you will need to contact your health plan's Customer Service for specific information on how to get home care services through your private health plan. The phone number for the health plan's Customer Service is on your membership card.

Who is eligible for home care services through Minnesota Health Care Programs (MHCP)?
To be eligible for home care services, recipients must be covered for services under one of the following programs:

- Medical Assistance (MA), including TEFRA.
  NOTE: There are a variety of types of MA such as Refugee Medical (RM), Non-citizen Medical (NM), Emergency Medical Assistance (EMA) etc.; it is recommended that the individual/family check on the individual's eligibility for home care services for these types of MA. (See paragraphs below for whom to contact for questions "**How do I get information about home care services if I am covered by one of the MHCP's above?").**
- MinnesotaCare for pregnant women, children and adults with and without children [**Exclusion: Personal Care Assistance (PCA) and Private Duty Nursing (PDN) services are NOT COVERED for non-pregnant adults on MinnesotaCare**]; and

How do I get information about specific home care services if I am covered by one of the MHCP's above?
If you are enrolled in a **county based prepaid health plan, PMAP or MinnesotaCare**, you, will need to contact your health plan's Customer Service for specific information on how to get home care services through your health plan. The phone number for Customer Service is on your membership card.

If you are on **Fee for Service Medical Assistance (MA)**, call your local county human services agency. Their number is in the phone book under County Numbers. Other resources for information are the **MN Health Care Programs Member Help Desk 651-431-2670 or 1-800-657-3739** & the **Disability Linkage Line 1-866-333-2466**.

Medical Assistance covers the following home care services:

- Private duty nursing (PDN);
- Skilled nursing visits (SNV), either face to face or with tele-home-care technology;
- Home health aides (HHA);
- Rehabilitation therapies, (occupational (OT), physical (PT), respiratory (RT) & speech-language (ST);
- Equipment & supplies (such as wheelchairs & diabetic supplies);
- Personal care assistance (PCA).

Qualifying home care services must be:

- Provided to an eligible recipient on MA, MinnesotaCare or HCBS;
- Prior authorized per home care service authorization guidelines (see next page);
- Medically necessary and cost effective;
- Ordered by a physician if nursing or home health aide;
- Provided to recipients in their own residence (not a hospital, nursing facility or intermediate care facility);
- Documented in a written care plan; and
- Reviewed by the recipient's physician, when required.

Department of Human Services (DHS) requires authorizations for the following:

- All home health aide services;
- All private duty nursing services;
- Skilled nurse visits for more than 9 visits per recipient, per calendar year;
- All tele-home-care skilled nurse visits;
- More than 2 face-to-face PCA assessment visits by the county PHN, per recipient, per calendar year;
- All PCA services & supervision of PCA services.

What is a skilled nurse visit?

A skilled nurse visit is an intermittent home visit to provide professional nursing tasks based on a patient's assessed need for services to maintain or restore health. These visits can only be provided in the person's home.

A skilled nurse visit can include the following services:

- "Hands on" nursing care that requires substantial and specialized nursing skill,
- Health care teaching and training to the recipient and/or their family,
- Observation and assessment of the recipient's physical and/or mental health status.

Who can provide a skilled nurse visit?

Only a registered nurse (RN) or licensed practical nurse (LPN) licensed in Minnesota & employed by a Medicare-certified home health agency may provide this service.

What is private duty nursing (PDN)?

Private duty nursing services are more extensive than a skilled nurse visit and can include:

- Professional nursing care based on an assessment of the recipient's medical needs;
- Ongoing professional nursing observations, monitoring, intervention and evaluation;
- Private duty nursing services can be provided in the person's home or outside the home when normal life activities take the person outside the home, including school and work.

Who can provide private duty nursing (PDN)?

- A registered nurse (RN) or licensed practical nurse (LPN) employed by either a home health agency or PDN;
- Class A licensed agency that are enrolled with Minnesota Health Care Programs;
- An independent RN who is enrolled with Minnesota Health Care Programs;
- An independent LPN with a Class A license, who is enrolled with Minnesota Health Care Programs.

Can a parent or family foster parent of a minor child, spouse, or unpaid legal guardian provide PDN & be paid by MA?

Yes, they could provide PDN **if** the person is a nurse and received approval for a PDN Hardship Waiver from DHS.

What is a PDN Hardship Waiver?

APDN Hardship Waiver allows a parent or family foster parent of a minor child, a spouse or an unpaid legal guardian to be paid by MA for providing private duty nursing services to their family member. There are limits to how many hours can be paid through the PDN Hardship Waiver. A person must meet all of these requirements:

- Be a registered nurse (RN) or licensed practical nurse (LPN) currently licensed in MN;
- Be employed by a Medicare-certified home health agency **or** PDN class A licensed agency;
- Pass a criminal background check;
- Expect to continue non-reimbursed family responsibilities of primary caregiver & emergency backup.

In addition, relatives of the consumer must, also, meet one of the authorization criteria to be eligible for a Hardship Waiver. For more information on the authorization criteria and possible employment, call a private duty nursing agency provider. A **PDN Hardship Waiver Request Form (DHS-4109**) needs to be completed by the private duty nursing agency, signed and submitted to DHS along with the supporting documentation for review and approval. Go to the Minnesota Health Care Program (MHCP) Provider Manual: Home Care Services **at www.dhs.state.mn.us** for more information and to access the form.

What services can home health aides (HHA) provide?
HHAs provide medically oriented tasks required to maintain health or to facilitate treatment of an illness or injury provided in a person's place of residence. HHAs are able to:

- Assist with personal cares such as bathing, dressing, grooming, feeding, toileting, routine catheter and colostomy care, ambulating, transfers or positioning;
- Perform simple dressing changes that do not require the skills of a licensed nurse;
- Assist with medications that are ordinarily self-administered and do not require the skill of a licensed nurse for safe and effective provision;
- Assist with activities that are directly supportive of skilled therapy services but do not require the skill of a therapist to be safely and effectively performed, such as routine maintenance exercises;
- Do routine care of prosthetic and orthotic devices;
- Perform incidental household services necessary to the provision of one of the above health related services;
- Assure recipients get to medical appointments identified in the care plan.

A HHA follows a care plan developed by the registered nurse of the Medicare Certified Class A Licensed Home Health Agency. The home health aide is supervised by the registered nurse or by the appropriate therapist (physical, occupational, speech.

NOTE: HHA visits for the sole purpose of providing household tasks, transportation, companionship or socialization are not covered. Services must be ordered by the primary medical provider and be medically necessary.

What are home care therapies?
Home care therapies are therapies provided in the home to improve/maintain a person's functioning. Home care therapies include physical, occupational, speech-language pathology and respiratory therapies. If a person is able to obtain the needed therapy services at a rehabilitation center or outpatient clinic, they are not eligible for payment through home care services.

PERSONAL CARE ASSISTANCE SERVICES

The Department of Human Services (DHS) has a new home page location for personal care assistance information in greater detail (sometimes referred to as the PCA Portal) **www.dhs.state.mn.us/pca** . DHS updates this site regularly with new information, policy and procedures and resource documents. You can, also, sign up to be notified by email of PCA changes and updates.

What are personal care assistance (PCA) services?
Personal care assistance services provide assistance and support to persons with disabilities living independently in the community including the elderly and others with special health care needs. A PCA may be able to help you if you have a physical, emotional or mental disability, a chronic illness or an injury.

There are four different categories of services a PCA can provide:

1. Assistance with doing **Activities of Daily Living (ADL)**. These are things a person does every day such as dressing, grooming, bathing, eating, positioning, transferring, toileting and mobility;

2. If the person's PCA assessment determines a need for assistance with ADLs, the person may also use some of their time allotted for PCA services, to address assistance with **Instrumental Activities of Daily Living (IADL).** IADL assistance includes meal planning and preparation, assisting with paying bills, shopping for food, clothing, and other items, homemaking tasks, communication by telephone or other means, getting around and participating in community activities including to medical appointments;

(NOTE: IADL's are NOT covered for children under the age of 18, except when immediate attention is needed for health or hygiene reasons integral to the personal care services, for the sole benefit of the child, and the need is listed in the service plan by the assessor.)

3. Assistance in **Health Related procedures and tasks**, are services that can be delegated or assigned by a licensed health care professional such as a nurse or a physician. Health-Related **procedures and tasks** must be provided under the direction of a registered nurse, who is the Qualified Professional (QP). (Read on for more information on QPs later in this document.) Examples of Health Related **procedures and tasks** are range of motion exercises and passive exercise to maintain a recipient's strength and muscle functioning; interventions for seizure disorders, including monitoring and observation, assistance with self-administered medication such as: reminders to take medication, bringing medication to the recipient, assistance with opening medication under the direction of the recipient or responsible party, and respiratory assistance such as tracheotomy NON-sterile surface suctioning.

4. **Observation and Redirection for Behaviors**. For Level I Behaviors, this includes observation and redirection of behaviors that cause or could cause harm.

What is Level 1 Behavior?
Level I behavior means physical aggression towards self, others, or destruction of property that requires the immediate response of another person.

The PCA Care Plan found in the home must describe what the PCA will need to do to observe, monitor and redirect Level I Behaviors. Specific training for the individual PCA needs to occur based on the specific behaviors exhibited by the recipient. PCA staff are NOT trained or paid to do mental health or behavioral therapy.

Where can PCA services be provided?
PCA services may be provided in the person's own home, or workplace, or in the community in places a person may go in a typical day. Places where the services are to be provided must be included on the PCA Care Plan. A PCA may accompany the person in a common carrier or special transportation. The PCA agency's policy will determine whether a PCA may transport the person.

Who is eligible for the personal care assistance (PCA) services through MHCP Home Care?
To be eligible for PCA services, all of the following criteria must be met:

- The person is covered by Medical Assistance (MA), including TEFRA, MinnesotaCare (only pregnant women & children);
  NOTE: There are a variety of types of MA such as Refugee Medical (RM), Non-citizen Medical (NM), Emergency Medical Assistance (EMA) etc.; it is recommended that the individual/family check on the individual's eligibility for PCA services with these types of MA. (See 1st page of this handout, "**How do I get information about home care services if I am covered by one of the MN Health Care Programs' above?" for who to call about PCA services**.)
- The person must have a **stable** medical condition but needs PCA services to live in the community;
- The person lives in their own home or foster care home licensed for 4 or less clients;
- The person is able to make decisions about their care or has a Responsible Party who can make decisions on the person's behalf;
- The PCA services are determined **medically necessary** through the assessment process due to the recipient's illness, injury, physical or mental condition (see next page for more information about assessment for PCA);
- There is a service plan developed at the time of the assessment stating specific PCA needs. A care plan based on the service plan must identify how services will be delivered and supervised by the Qualified Professional (QP);
- The PCA services are prior authorized and approved by DHS with a service agreement in place.

What is a responsible party?
A responsible party is required for a recipient not capable of directing his/her own care or who is under eighteen years of age, whether or not he/she is capable of directing his/her own care. The responsible party is an individual who is over 18 and capable of providing the supportive care necessary to assist the recipient to live in the community.

The responsible party must:

- Attend all PCA assessments and make choices for the person regarding the PCA Program (e.g.; type of PCA provider, hiring and scheduling of the PCA);
- Be accessible to the person and the PCA when services are provided as documented in the PCA care plan and the Responsible Party Agreement;

- Develop the care plan with the qualified professional;
- Monitor the PCA services weekly to ensure the care plan is followed and the care outcomes are met;
- Sign required forms, including the PCAs' time card,
- Determine if the person's health & safety are assured with current PCA services,
- Report suspected abuse/neglect of the person to the local county human service agency,
- Enter into a written agreement with the provider as an assurance of meeting the roles and responsibilities of the responsible party.

All recipients must now have a Qualified Professional (QP) supervise PCA staff and services. A QP means a registered nurse, a mental health professional, a licensed social worker or a qualified developmental disabilities specialist, as defined by Minnesota Law. The QP must work for the PCA provider agency and complete the required DHS provider training. (Read more information about the QP under **"What does the Qualified Professional (QP) do?"** later in this document.)

How can a person find out if they are eligible for personal care assistance services?
A person on a Minnesota Health Care Program, where PCA services are a covered benefit, is entitled to an assessment to determine if they are eligible for PCA services.

What is an assessment for PCA services?
An assessment is a review & evaluation to determine the person's medical need for personal care assistance services. Persons requesting services must first have a face to face assessment to determine the need before PCA services can begin.

How can a person get an assessment?
Ask for an assessment by calling:
- Your county public health nursing agency and ask for a PCA assessment; or
- Your Health Plan if you are on PMAP, MinnesotaCare or a County Based Prepaid Health Plan;
- A home heath agency (HHA) or personal care provider organization (PCPO) and ask about PCA services. They will help you to contact the appropriate person for an assessment.

You/your responsible party will be contacted to schedule an appointment for the assessment in your home.

A new assessment and authorization process for PCA services began, January 1, 2010 as noted below:
- There are new forms called the **Personal Care Assistance (PCA) Assessment and Service Plan (DHS-3244, 5-2010)** and the **PCA Assessment and Service Plan Instructions and Guidelines (DHS-3244A, 5-2010).**
- The assessor will be learning about a person's needs for assistance by evaluating Activities of Daily Living (ADLs), some types of Complex Health-Related Needs, and behavior issues.
- The assessor **will not** be asking for the amount of time it takes for tasks and activities.

NOTE: Access to the PCA Program is only if a person has been assessed as having a dependency in one or more ADLs and/or meets the definition of having a Level I Behavior.

NOTE: A person must be assessed as dependent in an activity of daily living based on the person's daily need **or need on the days during the week the activity is completed,** for **cuing and constant supervision to complete the task; or hands-on assistance to complete the task.**

For children under 18, the assessment identifies the needs of the child with a disability that are over and above what a parent would typically provide for a child the same age **but without a disability**. PCA services are not intended to replace the parent's role and responsibility to meet the basic care, nurturing and supervision needs of minor children. A PCA is not to be performing IADLS that are the responsibility of the parent.

NOTE: After July 1, 2011, the eligibility criteria will be changed to require a dependency in at least 2 Activities of Daily Living (ADLs). Level 1 behaviors will NO LONGER qualify a person for PCA services.

Options in the PCA Program Selected at Time of Assessment

1. **Traditional PCA Provider Option or PCA Choice Option & selection of the agency to provide the service.**

Traditional PCA Provider Option: Under this option, there are two types of service providers: A Personal Care Provider Organization or a Home Health Agency. The PCA Provider provides traditional PCA service delivery and is responsible for hiring, training, and firing of the PCA staff. They assign a Qualified Professional, if the recipient or responsible party selected this. The Traditional PCA Provider, also, bills the state for PCA services, and schedules and pays the PCAs and Qualified Professional.

PCA Choice Option: This option is consumer directed and allows the recipient or his responsible party more choice, flexibility, control & responsibility to provide for the recipient's own service needs. They are responsible for the hiring, training and firing of their PCA staff rather than the PCA agency. Once the person or responsible party has chosen the PCAs, these persons must then be employed by the PCA Choice agency. The PCA Choice agency role is mostly for managing financial matters & it is the fiscal intermediary. The PCA Choice agency provides the qualified professional supervision.

DHS may deny, revoke or suspend the authorization to use PCA Choice Option if the PHN or qualified professional determines that this option jeopardizes the recipient's health & safety, and/or the recipient/responsible party, PCA Choice provider or qualified professional fails to comply with the written agreements and plan of care, and/or there is abusive or fraudulent billing of PCA services. DHS would then require the recipient to receive PCA home care services through a Personal Care Provider Organization (PCPO) or home care agency with less control & flexibility. A recipient/responsible party may appeal the actions. Providers of PCA services may not appeal revoked/denied option.

2. Shared Care Option allows 2-3 recipients to choose to share services in the same setting, at the same time from the same PCA. There must be a back-up plan for times that services cannot be shared as planned. Participation in Shared Care Option does not reduce or increase the total number of service units authorized for each person.

- The PCA must provide shared care services according to each consumer's plan of care & individual needs.
- The PHN/county case manager determines if shared care is appropriate and safe for the recipient and how many service units can be shared.

Pooling PCA Hours, (pooling the sum total of service units among recipients in the same setting) is not a service delivery option for Minnesota Health Care Programs and should not be confused with Shared Care Option.

Flexible Use of Units

All PCA services hours/units are authorized in two 6 month date spans. No more than 75% of the total authorization may be allowed in any six month date span. Unused PCA hours/units do **NOT** transfer from one 6 month span to another 6 month span.

DHS cannot authorize additional hours/units if a recipient has exhausted their hours/units before the end of the authorized date spans.

If the county denies or DHS revokes or denies flexible use, the recipient may be restricted to a more measured use of PCA services. A recipient/responsible party may appeal the action.

What happens after the PHN has completed the Personal Care Assistance Assessment and Service Plan?

The PHN must communicate the results of the assessment to the child's/youth's primary medical provider using the **Communication to Physician of Personal Care Assistance Services Form (DHS-4690).** This is for information only and does not require any action by the primary medical provider.

What if the assessor determines the person is not eligible for PCA services?

Assessors must recommend referrals in writing to other payers, programs or services that may meet the person's assessed needs more appropriately than PCA services, such as a home health aide or county mental health services. The person must follow up to see if he/she is eligible for the programs and services recommended. The person is also given agencies to contact if they need help with the referrals such as the Disability Linkage Line 1-(866)-333-2466.

Reassessments
The assessment needs to be done at least annually to evaluate the person's needs for PCA. The annual assessment may be a service update. This assessment is done by telephone & only when there has not been a significant change in the recipient's condition **and** there is not a need for a change in the authorized amount of PCA services. A service update can be used for two consecutive years, and then must be followed by a face to face assessment. A face to face assessment must be done annually if the person is using the PCA Choice Option.

The PCA provider is responsible for sending a written request for a reassessment to the person's county public health nurse or case manager. The request must be sent out at least 60 days before the end of the current service agreement with DHS. The annual assessment/service update must be completed before the agreement expires.

Who can be a person's PCA?
- There are specific criteria for becoming a PCA such as:
- At least 18 years old (under certain circumstances, a person 16-17 years may be able to be a PCA);
- Must pass a criminal background check;
- Must enroll with Minnesota Health Care Programs as an individual PCA and be given an identification number;
- Must successfully complete the standardized DHS online PCA training before completing enrollment. This training will be available in other languages as well as with accommodations for persons with disabilities;
- Able to provide covered PCA services according to the recipients care plan, respond appropriately to the recipient's needs, and report changes in recipient's condition;
- Be able to communicate with the recipient; and
- Must not work more than 275 hours per month as a PCA.

NOTE
- **Parents of adult recipients, adult children or siblings of a recipient and legal guardians (if they are not being paid for the guardian services), may provide PCA services to a family member if they meet the above criteria to work as a PCA.**
- **Spouses, parents and stepparents of minor children (under 18), paid legal guardians, family foster care providers (with rare exceptions) and/or the responsible party cannot serve as the PCA and get paid by Minnesota Health Care Programs.**

What does the Qualified Professional (QP) do?
The QP (a registered nurse, a mental health professional, a licensed social worker or a qualified developmental disabilities specialist, as defined by Minnesota Law) must work for the PCA provider agency and complete the required DHS provider training.

The QP is responsible for training, supervision, and evaluation of the PCA staff and evaluation of the effectiveness of the PCA services. Some examples are:
- Develops, reviews and revises the PCA care plan that corresponds with the county PHN assessment, service plan & update;
- Orients the PCA to the cares/needs of the recipient;
- Trains and retrains the PCA to provide hands on assistance with special **health-related functions;**
- Provides observation, supervision & monitoring of the work-performance of the PCA to provide effective care;
- Evaluates service outcomes with the recipient/responsible party; and
- Communicates as appropriate when the needs of the person change;
- Maintains written documentation of all QP activities including date, time of supervisory visit and amount of time spent during observation of PCA performing direct cares.

When and how does the QP supervise the PCA?
Under traditional PCA service delivery, the qualified professional must orient, train and evaluate regularly scheduled individual PCAs within seven days of working for a recipient and again within the first 14 days. These visits to a recipient's home are not required under the PCA Choice option. Qualified professionals must visit and evaluate all 16 or 17 year old PCAs every 60 days, on an ongoing basis.

Under traditional PCA service delivery, the qualified professional must also conduct in-person visits to evaluate and oversee the delivery of PCA services:

- At least every 90 days thereafter for the first year of the recipient's services; and
- Every 120 days after the first year of a recipient's service; or
- Whenever needed for response to a recipient's request for increased supervision of the PCA staff;
- Every 180 days at the locations of shared service sites.

Under the PCA Choice option, the QP must conduct in-person visits every 180 days.

NOTE: After the first 180 days of the recipient's service, supervisory visits may alternate between unscheduled phone or Internet technology and in-person visits, unless in-person visits are needed according to care plan. Please note that only in-person visits are a covered service and only in-person visits can be reimbursed by DHS.

Who can provide PCA services for Minnesota Health Care Programs?

There are three types of providers for PCA services and they must be enrolled as a Minnesota Heath Care Program Provider through the Department of Human Services Provider Enrollment Unit. They are:

- Personal care provider organization (PCPO)—provides the traditional services of recruiting and hiring staff, training and orientation, scheduling, collecting time cards, financial management and termination of staff.
- PCA Choice provider—serves in a fiscal intermediary role with the person and their staff.
- Medicare-certified home health agency (HHA)—private or public organization that provides skilled nurse visits, PCA services, home health aide visits, therapies and medical supplies. They are required to meet all federal and state conditions of participation and sign an agreement with Medicare and Medicaid.

How do I find a PCA provider agency in my area?

Visit **www.mnhelp.info** or call one of the linkage lines: Disability Linkage Line (866) 333-2466, Senior LinkAge Line (800) 333-2433, or Veterans Linkage Line (888)546-5838 to find PCA provider agencies in your area.

If you are covered by a health plan instead of MA, call the Customer Service number on the back of your health plan card or look up health plan contacts at **www.dhs.state.mn.us/main/id_052601 .**

Can I get PCA Services when I am living in another state?

- Persons who temporarily live outside of Minnesota may use PCA services if they meet all of the following:
- Maintain enrollment in Minnesota MA and meet MN residency requirements;
- Temporarily live outside of Minnesota for education, training, employment or vacation;
- Receive an annual face to face assessment in the person's permanent home in MN & authorization by the county;
- Are age 18 or older;
- Direct their own care or live with the responsible party while outside the state;
- Have a written service plan that documents how PCA needs will be met during the time the person lives outside
- of Minnesota and describes emergency back up plans; and
- The Personal Care Provider Organization or PCA Choice provider in other states must be enrolled as a Minnesota Health Care Programs Provider and follow all MHCP enrollment requirements, including individual PCA identification numbers and background studies as well as providing Qualified Professional supervision and services according to the specific QP requirements in MN.

TEFRA SUMMARY

What is TEFRA? The **T**ax **E**quity and **F**iscal **R**esponsibility **A**ct (**TEFRA**) of 1982 is a federal law that allows states to make **M**edical **A**ssistance (**MA**) available to certain children with disabilities without counting their parent's income.

- No additional services other than the MA benefit set are provided under the TEFRA option, but TEFRA can extend MA eligibility for children who are disabled and would not otherwise have a basis of eligibility.
- If a child needs additional services, they can apply for **Home and Community-Based Services "Waivers"** [**NOTE**: more information on **"Waivers"** is included later in this DHS topic packet]

Who is eligible? A child must meet **all** of the following:

1. Child is under age 19 years [**NOTE**: Beginning at age 18, the person usually doesn't need TEFRA, since parent income is no longer counted if the youth is disabled.]
2. Child lives with at least one biological or adoptive parent
3. Child is certified disabled [by the **S**tate **M**edical **R**eview **T**eam (SMRT)]
4. Child requires the level of care provided by:
   - A hospital
   - A nursing home, or
   - An **I**ntermediate **C**are **F**acility for persons with **M**ental **R**etardation (ICF/MR) and related conditions
     *The cost for home care must not be more than the cost MA would pay for the child's care in an institution.
5. Child's income is under MA limit of 100% of the Federal Poverty Guideline (FPG) for a household size of one. There are no asset limits. Children with incomes over 100% FPG can "spend down" to 75% FPG.

[**NOTE**: TEFRA is available to noncitizen children as another way to access NMED and EMA services without counting parent's income. For EMA, the child would also need to have a medical emergency.]

How is eligibility determined? The **S**tate **M**edical **R**eview **T**eam (SMRT) determines if the child is disabled, and issues a disability certification for 1-4 years, depending on the severity of the child's conditions(s). At the end of the certification period, the child must reapply with SMRT. To be certified disabled for TEFRA, the child must meet both **(1) disability** and **(2) level of care criteria**:

1. Disability review:

- Medical, psychological and school records are reviewed to determine if the child's condition(s) meet the disability criteria from the **S**ocial **S**ecurity **A**dministration (SSA). [**NOTE**: these disability criteria are contained in the **"Tools"** topic packet in this manual under **SSI Medical Evaluation Guidelines-Part B (for children under age 18 yrs.)**]
- SMRT assigns each case to a SMRT Case Manager, who reviews the case and decides if there is enough evidence to make a disability determination. If SMRT needs more evidence, the SMRT Case Manager can assist the client in obtaining the evidence by:
  - Contacting the client directly,
  - Contacting the client's providers and requesting documents.
  - Arranging an appointment for an evaluation, if necessary.
    *If the client has no coverage, SMRT can authorize payment for an evaluation, including transportation.

2. Level of Care review:

- SMRT determines the level of care using evidence from medical providers, school-based providers, and others.
- Parents' input is also required and is provided by completing a "Children's Disability Worksheet" (DHS #6126). This worksheet allows parents to express their view of their child's condition(s); their child's ability to perform activities of daily living; and their child's behavior at home, at school, and in the community

Can a family appeal a decision that their child does not meet disability criteria? Yes. A fair hearing request must be made orally or in writing within 30 days by telling their county worker or writing to the State Appeals Office at the DHS.

- If the family appeals a recertification denial **within ten days** of receiving the denial notice or before the termination date, TEFRA will continue while the appeal is heard and decided.
- If the family appeals more than 30 days after receiving SMRT's decision, a hearing will be scheduled to decide if there is good reason for requesting the hearing late.
- If the family loses the appeal, they may be asked to repay to MA the child's service costs that were paid during the appeals process.

Is there any cost to the family? Parents may have to pay a **parental fee** based on family size and income. [**NOTE**: Information on **Parental Fees** is included later in this DHS topic packet]

- Children with disabilities whose family income is within "regular" MA income standards do not need TEFRA.
- It may be better for some families to not apply for TEFRA if the child would be eligible for "regular" MA with a spend-down as the spend-down may be less than the parental fee.

What happens when the TEFRA enrollee turns age 18? An application should be made for **S**upplemental **S**ecurity **I**ncome (SSI). The youth's MA is left open (as a disabled child ages 18-21) while the SSI determination is pending.

- If SSI determines that the youth is not disabled and the youth continues to live with the parents, MA eligibility would be determined using the "children under 21" basis and the parent income would be counted.

What if a child with a mental illness or a Severe Emotional Disturbance (SED) is not TEFRA eligible? If the child doesn't meet the TEFRA level of care criteria, the child may still be eligible for certain mental health services from their county human services agency.

- If the child has an SED, the child can receive county case management services and other family community support services under the Children's Mental Health Act. This may include crisis placement, help with independent living and parenting skills, day treatment, respite care, and a number of other services.
- If the child has an emotional disturbance (ED), some services, including crisis assistance, may still be available from their county. [**NOTE**: See **Mental Health** topic packet for more information.]

How do you apply for TEFRA? Contact your county human services (social services) agency and ask to speak with a Developmental Disability Social Worker about TEFRA.

- Complete the MHCP application to determine if there is eligibility for "regular" MA (because it does not require parents to pay a parental fee).
- Provide all required documentation to the county for a SMRT disability determination (unless your child has already been determined disabled by SSA)

[SOURCES: [1] DHS Disability Manual (7-09); [2] MHCP Manual, Sections 03.30.25 and 12.15 (downloaded 7/22/10)].

Minnesota Department of **Human Services**

State Medical Review Team

Medical Assistance – TEFRA Option
Required Documentation for Physical Disability

The following information is required to complete your client's **physical disability** determination. Please **do not** submit the case unless all of these items are included.

- Results of a routine physical examination signed by the physician **(no more than 3 months old)** which includes:
  - Current diagnosis
  - Clinical findings – results of physical or mental status exams
  - Laboratory findings, for example:
    - blood pressure
    - blood test results
    - X-rays
  - Required treatments (include type of treatment, who performs it, and if supervised, credentials of supervisor)
  - Current medications
  - Growth data from the past year (height and weight)
- **Reports from any consulting medical specialists.** The report should be no more than 3 months old and include the primary diagnosis, a detailed summary within the areas of specialty of examination. Also include results of any tests, X-rays, or scans that confirm the diagnosis, and treatment and response.
- A **Children's Disability Worksheet** (DHS-6126) to be completed by the parent/guardian.
- If applicable, an **Individual Education Plan** (IEP) or **Individual Family Service Plan** (IFSP) that is current within 1 year, along with the most recent **Team Assessment Summary** (done every three years). For children under school age, submit an **Early Childhood Assessment Summary**.
- If the client receives **ANY** other special services (e.g. speech, physical, or occupational therapy or rehab), please provide updated evaluations and progress notes regarding these activities.
- Discharge summaries from any recent hospitalizations.

If you have any questions concerning this information, please call SMRT at (651) 431-2493 or (800) 235-7396.

State Medical Review Team
PO Box 64984
St. Paul, MN 55164-0984

Minnesota Department of **Human Services**

State Medical Review Team

Medical Assistance – TEFRA Option
Required Documentation for Developmental Disability

The following information is required to complete your client's **developmental disability** determination. Please **do not** submit the case unless all of these items are included.

- Results of a routine physical examination **(no more than 3 months old)** performed by a medical doctor which includes:
  - Current diagnosis
  - Clinical findings – results of physical exams
  - Laboratory findings, for example:
    - blood pressure
    - blood test results
    - X-rays
  - Current medications
- **Reports from any consulting medical specialists.**
- A **Children's Disability Worksheet** (DHS-6126) to be completed by the parent/guardian.
- An **Individual Education Plan** (IEP) or **Individual Family Service Plan** (IFSP) that is current within 1 year, along with the most recent **Team Assessment Summary**. For children under school age, submit an **Early Childhood Assessment Summary**.
- Most recent achievement and IQ scores
- Adaptive behavior rating by both parent and teacher, for example:
  - The Vineland Adaptive Behavior Rating Scale
  - The Battelle Inventory
  - The Childhood Autism Rating Scale

  These documents are most often found in the Team Assessment Summary that comes from the school, but they may also be performed by psychologists or developmental clinics.
- If the client receives **ANY** other special services (e.g. speech, physical, occupational therapy, rehab), please provide updated evaluations/ progress notes regarding activities.

If you have any questions concerning this information, please call SMRT at (651) 431-2493 or (800) 235-7396.

State Medical Review Team
PO Box 64984
St. Paul, MN 55164-0984

Minnesota Department of **Human Services**

State Medical Review Team

Medical Assistance – TEFRA Option
Required Documentation for Mental Health Disability

The following information is required to complete your client's **mental health disability** determination. Please **do not** submit the case unless all of these items are included.

- Results of a routine physical examination **(no more than 3 months old)** performed by a medical doctor which includes:
  - Current diagnosis
  - Clinical findings – results of physical or mental status exams
  - Laboratory findings, for example:
    - blood pressure
    - blood test results
    - X-rays
  - Current medications
- **Complete psychiatric/psychological evaluation** (no more than 1 year old) performed by a licensed psychologist or psychiatrist. The evaluation must contain **ALL** of the following:
  - Current life situation and sources of stress, including reasons for referral
  - History of client's current mental health problem, including important developmental incidents, strengths, vulnerabilities (include psychiatric and social history)
  - Current functioning and symptoms related to all diagnoses
  - Indicate if the client has a serious and persistent mental illness
  - Diagnosis on ALL 5 axes with GAF scores (no provisional diagnoses)
- **If the evaluation is more than 3 months old or the client's condition has changed, an updated progress report is required, in addition to the complete psychiatric/psychological evaluation. The progress report should include ANY changes in the client's condition (behavior, medication management, change of medication, and/or potential for hospitalization).**
- The most current treatment plan signed by a professional which includes:
  - All medical services being performed (including non-mental health), duration, frequency, and level of professional performing the service
  - Supervision/monitoring – who performs, what times of the day (psychiatric disability requires 24-hour supervision or monitoring)
  - Therapy goals, client progress
- Discharge summaries from any hospitalizations, or day treatment reports
- An **Individual Education Plan** (IEP) that is current within 1 year, along with the most recent **Team Assessment Summary** (performed every 3 years).
- A report from the client's school that that outlines:
  - Grades
  - Behavior in school
  - Most recent achievement scores and intelligence (IQ) test scores
- A **Children's Disability Worksheet** (DHS-6126) to be completed by the parent/guardian.

If you have any questions concerning this information, please call SMRT at (651) 431-2493 or (800) 235-7396.

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PO Box 64984
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Home and Community-Based Services (HCBS) [also called "Waivers"] and Consumer Directed Community Support (CDCS)

Purpose Of The HCBS ("Waivers") HCBS help people meet health needs, get support to stay at home and stay out of medical facilities. Under HCBS, an added list of cost-effective services are covered to help the person live in the community as fully, productively and independently as possible. Persons must have an assessed need for supports and services over and above those available through the regular MA State plan. There are **4 types of HCBS "Waivers",** based on the level of care needed: **CAC** (Community Alternative Care); **CADI** (Community Alternatives for Disabled Individuals); **DD** (Developmental Disabilities); and **TBI** (Traumatic Brain Injury). **NOTE:** HCBS are NOT an entitlement. That means a person could qualify but the HCBS may not be available in the county due to a waiting list. Persons eligible for HCBS are encouraged to get on the waiting list in their county.

Eligibility For HCBS: Must meet **ALL** 6 criteria:

1. **Be on MA or eligible for MA**. Only the individual's income and assets are counted (not the parents or spouses, even if the person lives with their parents or spouse); AND

2. **Be Certified disabled** by either the federal Social Security Administration (SSA) or by the State Medical Review Team (SMRT); AND

3. **Under age 65** (at application time) for CAC, CADI, TBI. (Can be **any age** for the DD Waiver). AND

4. **Have a written support plan assuring health and safety, and outlining services needs**. The county must assure that the health and safety needs of the person will be able to be met by providing the necessary waiver services and supports. AND

5. **Be provided informed choice** – the individual, after becoming familiar with the alternatives, chooses to live in the community rather than the nursing facility; AND

6. **Need a specific level of care, depending on the type of Waiver** (CAC, or CADI, or DD, or TBI):

- **CAC -** for persons chronically ill or medically fragile, requiring a hospital level of care (hospital level of care certified by a primary care physician). A person must meet **all four** of the following:
  - **a.** Need skilled assessment and intervention multiple times during a 24-hour period to maintain health and prevent deterioration; AND
  - **b.** Due to their health condition, has both predictable health needs and the potential for status changes that could lead to rapid deterioration or life-threatening episodes; AND
  - **c.** Require a 24-hour plan of care that includes back-up plan that reasonably assures health and safety in the community; AND
  - **d.** Without the CAC Waiver services, would require frequent or continuous care in a hospital.

- **CADI -** for persons needing the level of care provided in a nursing facility (NF). CADI serves mainly people with physical disabilities or serious mental health needs. A NF level of care requires the person must demonstrate the need for assistance due to **one or more** of the following:
  - **a.** Restorative and rehabilitative or other special treatment; OR
  - **b.** Unstable health; OR
  - **c.** Complex care management; OR
  - **d.** Functional limitation; OR
  - **e.** Existence of complicating conditions; OR
  - **f.** Cognitive or behavioral condition; OR
  - **g.** Frailty or vulnerability

- **DD –** for persons having a condition meeting the definition of developmental disability or a related condition, who need the level of care provided in an intermediate care facility for persons with developmental disability or related conditions (ICF/DD). This requires meeting **all four** criteria:
  - **a.** Diagnosis of developmental disability or a related condition; AND
  - **b.** County screening team determines the person would be placed in an ICF/DD if home and community based services were not provided; or the person lives in an ICF/DD and continues to require an ICF/DD level of care; AND
  - **c.** Requires daily interventions and service needs specified in a 24-hour plan of care. Persons must need "active treatment" (ex: daily intervention, assistance, supervision and on-going habilitation to learn necessary skills and assure health and well-being); AND
  - **d.** Has made an informed choice of waiver services instead of ICF/DD services.

- **TBI** – for persons with a primary or secondary diagnosis of traumatic or acquired brain injury or related neurological conditions (e.g. traumatic brain injury, infections, anoxia, tumors, toxic chemical reactions, stroke, aneurysm), that resulted in significant cognitive and significant behavioral impairment. The brain impairment cannot be congenital. The person must be able to function at a level that allows participation in rehabilitation. The person must need a Nursing Facility level of care or neurobehavioral hospital level of care (meet the criteria in **either a or b)**:
  - **a.** Nursing Facility Level of Care (TBI-NF) – see above under CADI Nursing Facility; OR
  - **b.** Neurobehavioral Hospital Level of Care (TBI-NB) – meet the requirements for the nursing facility level of care, plus meet **all of the following** criteria:
    - Requires specialized brain injury services and/or supports that exceed services available under TBI-NF; and
    - Requires a level of care and behavioral support provided in a neurobehavioral hospital to support persons with significant cognitive and severe behavioral needs (a person does not have to be a resident of a neurobehavioral hospital to require this level of care); and
    - Requires a 24-hour plan of care that includes a formal behavioral support plan and emergency back-up plan to reasonably assure health and safety in the community; and
    - Requires availability of intensive behavioral intervention.

Costs For The Family: Families of children under the age of 18 years are required to pay a "parental fee", if their family income is above a certain amount. [See separate Parental Fee information]

Extra Services Provided under HCBS depend on which waiver the person is on, and the availability of the services. [NOTE: More information on each of the following services can be found on the DHS Website: www.dhs.state.mn.us; click on "publications" across the top; click on "manuals" on the left navigation menu; scroll down to the "Disability Services Program Manual"; Click on "waivers" on the left navigation menu]. **Depending of the type of waiver, the following may be covered**:

- Adult day care
- Adult day care bath
- Assisted living, or Assistive living plus
- Assistive technology
- Behavioral programming
- Caregiver living expenses
- Caregiver training and education
- Case management and Case management aide (paraprofessional)
- Chore services
- Cognitive therapy
- Companion services
- Crisis respite
- Consumer-Directed Community Supports
- Consumer training and education
- Corporate foster care (monthly)
- Day Training and Habilitation
- Environmental Accessibility Modifications
- Family counseling and training
- Family foster care (daily or monthly)
- Help in learnng daily living skills
- Home delivered meals
- Homemaker/chore services
- Housing access coordination

- Independent living skills or Independent Living skills therapies
- In-home family support
- Personal support
- Respite care
- Specialist service
- Additional supplies and equipment
- Supported employment
- Supported living
- Non-medical transportation
- Prevocational services (to prepare persons for paid or unpaid employment)
- 24-Hour emergency assistance
- Extended services in amounts that may exceed normal MA limits for: home health nursing; home health aide; personal care attendant; nutritional therapy; occupational, physical, speech and respiratory therapies; supplies and equipment; and transportation

DD – "Related Conditions" Guideline

"Related Conditions" are those found to be closely related to developmental disability. They include, but are not limited to: Fetal Alcohol Spectrum Disorder; cerebral palsy; epilepsy; autism; and Prader-Willi syndrome. The condition **must meet ALL of the following criteria (A thru G)**:

A. Is severe and chronic [*"Severe"* means a serious or grave condition, giving cause for concern and having a significant affect on most, if not all of the person's life. *"Chronic"* means long drawn out, applied to a disease or condition that is not acute.]; AND

B. Results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with developmental disabilities [Considers intelligence test results and adaptive behavior test results]; AND

C. Requires treatment or services similar to those required for persons with developmental disability. [A combination and/or sequence of special services, interdisciplinary supports and services of varying intensity are needed. The services are needed over a sustained period to provide training and habilitation across environments. There are deficits in cognitive and adaptive skill development in areas such as self-care, understanding and use of language, community living skills, leisure, recreation skills, behavior management, socialization, community orientation, emotional development, cognitive development, motor development, or work.]; AND

D. Is manifested before the person reaches 22 years of age; AND

E. Is likely to continue indefinitely [*"Indefinitely"* means lacking precise time limits, yet expected to go on for an extended period of time.]; AND

F. Is NOT attributable to mental illness (MI) in adults, or an emotional disturbance (ED) in children. [NOTE: "Mental illness" does NOT include autism or other pervasive developmental disorders.]

G. Results in substantial functional limitations [*"Substantial functional limitation"* is characterized by considerable difficulty in carrying out essential major activities of daily living which is not an age appropriate skill.] **in 3 or more of the following areas of major life activity**:
   - **Self-care** = needing physical, gestural, or verbal assistance to meet most or all personal care particularly in eating, grooming, caring for personal hygiene and toileting; or
   - **Understanding and use of language** = effectively communicating either expressively or receptively without great difficulty]; or
   - **Learning** = cognition, retention and reasoning so the person is unable, or is extremely limited in ability, even with specialized intervention, to acquire knowledge or transfer knowledge and skills to new situations]; or

- **Mobility** = ability to move from one place to another or such difficulty that an unusual and protracted amount of time is required in a barrier free environment]; or
- **Self-direction** = inability to exercise judgments basic to the protection of the person's own self interest or rights, without supervision on a regular and continuing basis]; or
- **Capacity for independent living** = performing at age appropriate levels in at least 3 areas of independent living including using a telephone, shopping for food, abilities in social skills, communication, work , leisure, home living, and use of the community.

CONSUMER DIRECTED COMMUNITY SUPPORTS (CDCS)

CDCS gives persons more flexibility and responsibility for directing their services and supports, including hiring and managing direct care staff. [NOTE: A CDCS Brochure and a CDCS Consumer Handbook (DHS-3417) are available on the DHS Website: www.dhs.state.mn.us [click the "Publication" tab at the top of the page; click "E-docs" on the left navigation menu; enter the Handbook DHS number].

CDCS Budget: CDCS annual budget is based on a state-set budget and information from the person's most current screening. Once the annual budget is set, the services and supports needed are described in the Community Support Plan (CSP), approved by the county. The individual budget must include the costs of all waiver services and MA state plan home care services. [Ex: If persons receive PCA through regular MA State plan home care services, then go onto a DD waiver, the PCA funding now comes out of their total waiver funding.]

CDCS Allowable Expenditures must fit into **one of 4 service categories**:

1. **Personal assistance** – Support or assistance provided by someone hired to help with ADLs (activities of daily living) and IADLs (independent activities of daily living) through hands on assistance, cuing, prompting and instruction in tasks. Under CDCS, persons hired can include friends, family members, neighbors and others, including traditional professional staff. Spouses or parents of minors can be paid up to 40 hours/week to perform support tasks they wouldn't perform under other circumstances. [40 hour limit is for both parents combined.] Examples: help during transportation, help with activities of daily living, behavioral aides, companion services, and respite care. [NOTE: Within CDCS, parents of minors can ONLY be paid to provide services under this Personal Assistance service category.]

2. **Environmental modifications and provisions** – Ex: adaptive clothing; assistive technology; home and vehicle modifications; home-delivered meals; special diets; supplies/equipment; transportation; environmental supports (snow removal, lawn care, heavy cleaning, etc); costs associated with an adult fitness/exercise program (when is appropriate to treat, improve, or maintain a physical condition).

3. **Self direction support activities –** Ex: help in finding and maintaining workers; costs for managing the person's budget; development and implementation of the community support plan; fiscal support entity (FSE) administrative fee(s); flexible case management charges; liability insurance and workers compensation; monitoring the provision of services beyond the required monitoring by the county.

4. **Treatment and Training –** Ex: day services/programs; extended therapy treatment; family counseling; habilitative services; independent living services; supported employment; training and education to paid or unpaid caregivers; training and education to persons to increase their ability to manage CDCS.

[SOURCE: DHS Disability Services Manual (HCBS information downloaded 6-21-10)]

PARENTAL FEES

For children approved for Medical Assistance (MA) under TEFRA, CAC, CADI, TBI, a DD Waiver or an out-of-home placement, Minnesota law says that parents may have to pay a parental fee to reimburse the state for part of their child's MA (Medical Assistance) costs.

Who has to pay a parental fee?

- All parents with an **A**djusted **G**ross **I**ncome **(AGI)** over 100% of **F**ederal **P**overty **G**uidelines **(FPG)** will have a fee.
- Parents not living with each other may each have to pay a fee.
- Families with more than one child certified disabled have only one parental fee.

[**NOTE:** The following parents do **not** have a parental fee: (1) Parent Adjusted Gross Income is less than 100% FPG; or (2) Parental rights have been terminated; or (3) Child on MA is emancipated; or (4) Child receives state or Title IV-E adoption assistance.]

What information is used to determine parental fees? Parental fees are set by the State Legislature (Minn. Statute 252.27). Parental fees begin the first month in which MA-TEFRA is effective or HCBS program services are received. Fees are billed through the month the child turns age 18 yrs. Parental fees can change each fiscal year due to annual changes in the FPG or changes in family AGI or family size.
Information used to calculate a parental fee includes:

- AGI (before taxes) from last year's federal tax return. Do not include stepparent income.
- The amount of MONTHLY court-ordered support paid for the child receiving services.
- Household size. Household size includes the natural and adoptive parents and their dependents who live in their home. The child receiving MA services is included in the household size. Stepparents and stepchildren are not counted.
- Whether the child receiving MA lives in the parent's home.
- Whether the child receiving MA has private health insurance. (Fees will increase if parents can obtain health insurance for their child through an employer at a cost of less than 5 percent of their AGI and they choose not to obtain it.)

What happens if parents fail to send DHS the information needed to determine a parental fee or if they do not pay the parental fee? The child does not lose MA and will not be refused MA services.

- If the parent doesn't send DHS the information to determine the parental fee, they will be charged for the full cost of services provided to the child.
- Legal action may be taken against the parent for not paying parental fees, including, but not limited to, turning the account over for collections, taking parent's state tax refund, and garnishing wages.

What if parents pay more in parental fees than MA pays for cost of the child's care?

- Total amount the parent owes for a fiscal year (July through June) will never be higher than the cost of the services paid by MA and the county for that same year
- Shortly after the fiscal year ends, parents receive a statement comparing the cost of the services MA paid on behalf of their child against the fees they were charged for that year
- If the family paid more in parental fees, overpayment is credited to the next year's parental fees. If the child has turned age 18yr. or is no longer of an MA eligibility type that requires a parental fee, overpayment is refunded to the parents

Can the parental fee be changed? Yes. Parents who have questions about or want to ask for a change in their parental fee should call the Parental Fee Unit at (651) 431-3806, or (800) 657-3751 or (800) 366-2919. The Parental Fee Unit should be notified (preferably in writing) as soon as possible of any of the following changes that occur:

These changes **must** be reported within 30 days:

- Your family size changes (increase or decrease of household members).
- Parents separate and no longer live in the same household. Separate accounts will be set up for each parent and each parent will be responsible for their own fee calculation based on their individual income.
- The child on MA has a change in living arrangement (a child living at home goes into out-of-home placement, or a child in out-of-home placement returns home).
- Family income changes by more than 10% from one month to another.

Other circumstances that **may** change the parental fee:

- Parent obtains or cancels insurance coverage for the child receiving MA.
- Family's past medical expenses paid for the child (not covered by other health insurance or MA) is at least 60% less than the family parental fee.
- The AGI reported on the federal tax form includes capital gains used to purchase a home.
- The AGI reported on the federal tax form is different than the amount of income actually distributed to you, creating a unique financial situation. (Withdrawal of IRA and/or pension fund is not a unique financial situation)
- Family qualifies for a change under a "Variance for Undue Hardship". This can be granted for certain out-of-pocket expenses which are allowable as federal income tax deductions. These expenses include: (1) medical expenses not paid by MA, insurance, or a pre-tax medical account for any member of the household (2) expenditures for adaptations to the home or parent's vehicle necessary to accommodate the disabled child; or (3) casualty losses [**NOTE**: College education expenses, most new home purchases and clothing/personal expenses are not allowable as hardship deductions]

Can parents appeal the parental fee? Parents have the right to ask for a review or an appeal of their fee. The request must be made in writing within 30 calendar days of the date of the parental fee Determination Order, or within 90 calendar days if parents have good cause for failing to request a hearing within 30 calendar days. Parental fees can't be changed simply because the parent feels they cannot pay it. Minnesota Law does not give authority to either the Financial Operations Division or the Appeals referee to waive the parental fee.

Can parental fees be counted as a deductible medical expense on IRS taxes? Internal Revenue Service (IRS) Code section 213(a) allows itemized deductions for expenses paid for the medical care of the taxpayer, the taxpayer's spouse, or a dependent (if such expenses exceed 7.5% of adjusted gross income). It doesn't matter that the payments (parental fees) are paid to the state versus directly for the medical services. The expenses paid through TEFRA parental fees are clearly medical expenses considered deductible under IRC 213. Parents should contact their tax preparer for specific questions.

Can parental fees be reimbursed through an employer's flex spending account? Possibly. However, the employer's flex spending account plan manager determines what expenses can be reimbursed and some do not allow parental fees to be included. The Department of Human Services has NO control over the employer's flex spending account rules. The 2009 Minnesota Legislature included a change regarding parental fee refunds. If parents pay their parental fee using their employer medical flex spending account, parents may be responsible for paying taxes on the refunded amount (or the amount credited toward next year's parental fee), since it may be considered taxable income. Parents should contact their tax preparer for specific questions.

ESTIMATING PARENTAL FEES:

A Parental Fees Estimator that will assist in estimating the monthly parental fee while a child is receiving MA TEFRA or Waivered Services is located at the following website: http://pfestimator.dhs.mn.gov/ The calculated monthly fee is only an estimate and not a legally binding amount. The actual fee will be determined by DHS after receiving a completed questionnaire (DHS-2981) and a copy of applicable federal income tax return. The monthly fee will be recalculated each year to account for changes in the family's financial situation. Bills can be paid online after being notified of the actual fee. For questions, or help in estimating fees, please contact the parental fee unit at (651)431-3806 or (800) 657-3751.

Parents will need to enter the following information into the estimator to calculate a fee:

- AGI from the previous years federal tax return
- Number of dependents
- Whether the child on MA lives in the home
- Amount, if any, of child support paid that same year for the child receiving MA.
- Whether the child on MA has other private health insurance
- Number of parents living at child's home

EXAMPLES OF ESTIMATED FEES:

- AIG of $50,000
- 2 dependents
- Child on MA lives in home
- No child support paid
- No private insurance
- 2 parents living in home
- **Estimated Monthly Fee $75.63**

- AIG of $80,000
- 3 dependents
- Child on MA lives in home
- No child support paid
- Yes to other private insurance
- 2 parents living in home
- **Estimated Monthly Fee $227.50**

- AIG of $50,000
- 2 dependents
- Child on MA lives in home
- No child support paid
- No private insurance
- 1 parents living in home
- **Estimated Monthly Fee $112.37**

- AIG of $100,000
- 2 dependents
- Child on MA lives in home
- No child support paid
- Yes to other private insurance
- 2 parents living in home
- **Estimated Monthly Fee $516.39**

[SOURCES: [1]DHS-2977 (4-10); [2] DHS MHCP manual, Section 16.20 (downloaded 8/3/10); [3]Position Statement on Parental Fees (Oct 2008). Arc Minnesota (downloaded 8-3-10)

FAMILY SUPPORT GRANT (FSG)

What is the Family Support Grant? - It provides cash grants to families of children with certified disabilities to offset the higher than average expenses directly related to a child's disability. The goal is to prevent or delay the out-of-home placement of children and promote family health and social well being, by helping families with access to disability services and supports. Families with more than one child with a certified disability may apply for a grant for each eligible child.

Who is eligible?

- Persons under the age of 21 years; and
- Certified disabled: and
- Lives, or will live with their biological or adoptive family home; and
- Family annual adjusted gross income of $91,458 or less, except in cases where extreme hardship is demonstrated. (NOTE: the family annual adjusted gross income limit changes every January.) [Hardship exceptions, determined by the county, are based on factors such as family size, or presence of disability in other family members, or substantial existing family debt due to the child's disability.]

Persons on the Home & Community Based Services ("Waiver") programs of **CAC, or CADI, or TBI are also eligible** to receive FSG. Persons on the **DD Waiver are not eligible** to receive a FSG at the same time. [Ex: family with a child on the DD Waiver waiting list can apply for and receive services under the FSG. However, if the DD Waiver becomes available they must choose which program they want.]

How do families get the FSG and much can a family receive? The amount is based on individual needs, with a maximum of $3,060 per year for each eligible child. Grants may be distributed in either a one-time (lump sum) or in on-going (monthly) payments, depending on the child's needs. FSG funds are issued to families as cash, voucher, or direct payment to vendors.

How can the grant be used? The grant must be spent on services and items directly required by the child's Individual Service Plan (ISP) and unavailable through other funding sources (such as private insurance and Medical Assistance). Examples of allowable expense categories include:

- Computers
- Educational services
- Medical services
- Medications
- Respite care
- Specialized clothing or dietary needs
- Specialized equipment (may include home or vehicle modifications)
- Transportation.
- Daycare (disability related help needed in a daycare setting – not generic daycare expenses)

Where do families apply? Families should contact a county Human Services Disabilities Social Worker to ask about the Family Support Grant. There are often waiting lists. Placement on the waiting list is based on the following criteria: (1) extent and areas of the functional limitations of the child with a disability; (2) degree of need in the home environment for additional support; and (3) potential effectiveness of grant to maintain and support the person in the family environment. **NOTE:** When a person exits the FSG program for any reason, the grant funds stay in the county and may be reused for eligible families on the county's waiting list. **NOTE:** When a family stays on the FSG but moves to another county in Minnesota and the County of Financial responsibility changes, the existing county must transfer the grant funds to the new county of residence.

[Source: DHS Disability Service Program Manual – FSG. www.dhs.state.mn.us (Download 6-18-10) & review 7-9-10 by DHS staff/]
MCYSHN & DHS 7-20-10

CONSUMER SUPPORT GRANT (CSG)

What is the Consumer Support Grant (CSG)? It is a state funded alternative to the MA (Medical Assistance) home care services of personal care assistant (PCA), private duty nursing (PDN) and/or home health aide (HHA). Eligible persons may choose to receive CSG so they may direct, manage and plan their own services in partnership with their county. This gives consumers greater flexibility and freedom of choice in service delivery specifics and service providers. Spouses, parents of a minor child, legal guardians, other relatives, trusted neighbors or friends, as well as licensed providers and employees of a home care agency can be paid for service. [NOTE: CSG recipients are advised to maintain sensible employment practices such as getting background checks and verification of references for prospective employees.]

Who is eligible? Persons must meet **all 5 criteria**:

1. Eligible for MA;
2. Able to direct and purchases their own care and supports or have a family member, legal representative or other authorized representative available to purchase, arrange and direct care on their behalf;
3. Eligible to receive home care services from a MA home care agency (person has currently has been assessed for PCA, PDN and/or HHA services)
4. Have a functional limitation that requires ongoing supports to live in the community;
5. Live in a natural home setting, that is not licensed by MDH (Minn. Dept. of Health) or DHS.
6. Not participating in Home and Community Based Service ("Waiver"), the Alternative Care Program, Minnesota managed care programs, or MA home care program services (PCA, HHA and/or PDN).

How much does a person receive? In general, the amount of the CSG is based on the person's home care assessment rating. (Home care assessment ratings for PCAs are done by the county Public Health Nurse.)

How can the grant be used? Grants are given as cash, vouchers for services, or direct payments to vendors. The CSG can be used for a variety of supports and services, which must be related to the person's functional limitation and provide supports needed to live in their own home. The services and goods must be over and above the costs of supporting a person without a disability. Eligible persons develop a CSG service plan with their county DHS (Department of Human Services) case manager. CSG recipients arrange, manage and pay for the goods, services, and supports described in their county approved plan. All other available sources of payment should be exhausted before using CSG. Examples of allowable expense categories include, but are not limited to:

- Companion services
- Human assistance (Ex: PCA)
- Home adaptations
- Nutrition services
- Chore services
- Family counseling
- Home delivered meals
- Respite care
- Specialized equipment
- Transportation

How do persons get the CSG? Contact your county DHS and ask for a disability social worker. .
NOTE: CSG is not available in all counties. Persons can ask their county DHS to consider adding the CSG program.

MCYSHN & DHS 7-16-10

Cultural Resources

PUBLIC BENEFITS FOR NON-CITIZENS

Public benefits for non-citizens are complicated. They involve both immigration and public benefits law. These laws have changed a lot in the last 13 years. To learn about your situation, talk to a lawyer who knows both immigration and public benefits law. Public benefits come from the government to help you or your family with living expenses like food, clothes, housing or medical care. Different programs pay for different items. Each program has rules about who can get the benefits. There are rules about whether people who are not citizens can get benefits. To know whether you can get a benefit, you have to know your immigration status. Check your immigration papers. Remember that the INS has changed its name to USCIS (U.S. Citizenship and Immigration Services).

First we will talk about what programs you can apply for. Getting public benefits can make it harder to get a residency card for **some**, but not all immigrants. Be sure to check for 3 things as you read this fact sheet:

- What public benefits you can get
- Whether getting the benefit will make it harder for you to become a permanent resident
- Whether getting the benefit will make it harder for you to be a sponsor to bring family members to the U.S.

• PEOPLE FLEEING PERSECUTION

People fleeing persecution came to the U.S. to escape danger or extreme hardship in their home country. Not everyone can get this status from the USCIS. Getting the status depends on what country you came from. Check your immigration papers. If you are in one of the following categories, you may get some benefits from the U.S. government:

- **Refugee.**
- **Asylee.**
- **USCIS put a hold on deporting you because of danger in your home country.**
- **Cuban or Haitian entrants.** This does not mean every person from Cuba and Haiti. You are a Cuban or Haitian entrant if you were "paroled" into the U.S. as a "Cuban or Haitian entrant"; you have applied for asylum; or the USCIS has started exclusion or removal actions for you.
- **Amerasians.** You are "Amerasian" if you were fathered by a U.S. citizen in certain Southeast Asian countries during the Vietnam War years.

People in the above categories are called "qualified immigrants." They may be able to get SSI, MFIP, GA, food benefits, and MA (Medical Assistance). If you are not a "person fleeing persecution" go to page 3. See below to find out what each program offers people fleeing persecution. There are special rules for each program.

▲ SSI (Supplemental Security Income)

This program pays $674 every month if you are elderly or you are disabled and cannot work. The amount can be less if the people you live with help you pay for housing or food or if you are married and your spouse works or gets SSI. Some disabled children can get SSI. You apply for SSI at a Social Security office. To find one near you, call 1-800-772-1213. SSI has special rules for people who are not U.S. citizens:

- If you were getting SSI before August 22, 1996, you can keep getting SSI without time limits.
- If you were in the U.S. legally on a permanent basis before August 22, 1996, but you were not getting SSI before that date, you can get SSI without time limits only if you are now disabled. You can no longer get SSI based on your age.
- If you came to the U.S. **after August 22, 1996,** you can get SSI only for 7 years after the date you got your status from the USCIS. When 7 years is up, SSI will not pay anymore, until you become a citizen. But you may qualify for a 2 or 3 year extension. Check with your local legal aid office to see if you can get an SSI extension.

▲ MFIP (Minnesota Family Investment Program)

This program helps families with children. The amount of money you can get each month depends on the size of your family. **Most** legal immigrants can get MFIP for 60 months (5 years). Parents who get MFIP usually have to look for work. You have to meet with MFIP job counselors to find out what kind of work you can do to get off MFIP. Sometimes you can get training instead of looking for work. Taking English classes can count as work training in this program, but Minnesota limits how much ESL (English as a Second Language) you can take while on MFIP. MFIP families also get MA (Medical Assistance) to pay for doctors and hospitals for their children. Many parents can get MA also. Ask your worker. You can also get food benefits to help you buy food.

▲ GA (General Assistance)

GA is mostly for single or married people who do not have an income. Usually you have to be a lawful permanent resident of the U.S. to get GA. However, you may be able to get GA if you are applying for permanent status. GA only pays $203 a month. If you get GA, you may be able to get food benefits. You can also get GAMC (General Assistance Medical Care or MinnesotaCare) to pay for doctors and hospitals. If you are disabled, you may be able to get MA. Ask your worker. GA has special rules for people who are not citizens. If you are under 70 years old and have been in the U.S. for at least 4 years, you have to take "steps" toward citizenship. You don't have to take "steps" if you live in a nursing home or group home. Steps include:

- Being in a class to learn citizenship, literacy, or ESL **or** being on a waiting list for such a class.
- Applying for citizenship and waiting to take the test or for the citizenship ceremony, OR
- Having been denied citizenship because you failed the test 2 times or because you could not understand the rights and duties of being a citizen.

▲ Food

People fleeing persecution may be able to get food benefits. But, some immigrants cannot get food stamps (now called SNAP) for the first 5 years they are in the US. If you are not eligible for food stamps and you are 50 or older, you may get state food benefits worth the same amount as food stamps. You will have to take "steps" toward citizenship.

• IF YOU ARE NOT A "PERSON FLEEING PERSECUTION"

If you are not a "person fleeing persecution," you may still be a "qualified immigrant." You may be able to get the benefits listed above if you are:

- A legal permanent resident (have a residency card)
- "Paroled" by USCIS for at least 1 year
- A person who is being hurt or threatened by a spouse or parent, if the spouse or parent is a U.S. citizen or lawful permanent resident.

The rules for Food Benefits and SSI are more limited than other programs. To get Food Stamps, you may have to wait 5 years. But your children will not have to wait. You may not get SSI. It will depend on when you came to the U.S. and what your immigration status is. In most cases, to get **SSI**, you must be blind or disabled and have come to the U.S. before August 22, 1996.

If you have questions about getting help from these programs, call your legal aid office.

• IF YOU HAD A SPONSOR WHEN YOU CAME TO THE U.S.

Many people come to the U.S. by having a relative sponsor in the U.S. A relative sponsor is a family member who is a citizen or has a residency card (legal permanent resident). The sponsor agrees to be responsible for you in the U.S. Sponsors must promise the USCIS that if you become poor, they will support you. If you came to the U.S. after mid-December 1997 through a relative sponsor, the government can count your sponsor's income and assets as if they were yours. Since all public benefits programs have income and asset limits, this could keep you from getting public benefits. Your sponsor's income and assets may count even if you lose contact with your sponsor. Counting your sponsor's income and assets may put you over the limit for benefits. You may still be able to get emergency medical help. Your children may still be able to get Food Stamps.

The government may not apply your sponsor's income and assets to you if you are in danger of going hungry or becoming homeless. The government also won't apply your sponsor's income and assets if you or your child are being hurt or treated with extreme cruelty by your sponsor.

If you came through the visa lottery ("diversity" visa) or some other way after December 18, 1997, the government cannot count your sponsor's income and assets for any program except MFIP. Then the income and assets will count only for a short time. Check with your legal aid office if you have questions about whether your sponsor's income and assets should count as income and assets to you.

• IF YOU ARE A U.S. VETERAN OR ACTIVE DUTY MEMBER OF THE U.S. ARMED FORCES

You can get SSI without any time limit if you are disabled or 65 or older. You may also be able to get MFIP, health care and food benefits. You may be able to get GA, but you may need to take "steps" towards citizenship (see above). Your spouse and your unmarried, dependent children are eligible for the same programs. Unfortunately, Hmong and Lao army veterans are not considered U.S. veterans.

• NON-IMMIGRANTS AND PEOPLE WITHOUT IMMIGRATION PAPERS (UNDOCUMENTED)

Non-immigrants are people who are here legally but temporarily – for example, as visitors, students, or temporary workers. People without immigration papers (undocumented) are people who never had or no longer have USCIS permission to be in the U.S. If you are in one of these categories you cannot get any public benefits, except for:

- You may get free medical help for emergencies, if you are elderly, disabled, (you must be certified disabled by the state or social security), under 18, or pregnant, and you intend to stay in the U.S. permanently. If you are a pregnant woman, you can get free medical help for your whole pregnancy, and for 60 days after your child is born. When you apply, you should tell the county agency you cannot get regular MA because of your immigration status. Do not answer any questions about your immigration status.

- You may also be able to get medical help through the Center for Victims of Torture, 612-436-4800.

- If you are in the process of adjusting your immigration status, you may be able to get state-funded cash or medical benefits.

- You can also get:
  - free school breakfast and lunch benefits,
  - Women, Infants and Children (WIC) benefits,
  - immunizations from public health, and
  - benefits through Head Start.

• HOUSEHOLDS WITH AN UNDOCUMENTED MEMBER

A household is a group of people who live together in the same house or apartment. They do not all have to be family members. People are "undocumented" if they never had permission from the USCIS to be in the U.S. or if their permission has run out. Many households have some members who are citizens or here with documents, and some members who are undocumented. Here are some examples:

- An undocumented parent may have citizen children who were born in the U.S. Those children can get MFIP, food stamps, and medical benefits, but the parent has to apply for them. If you are undocumented you can apply for benefits for your children. Do not answer any questions about your immigration status. Just say "I am only applying for my children. I am not eligible because of my immigration status."

- If you have a residency card (legal permanent residency), you may apply for benefits while living with a friend, relative, or spouse who is undocumented.

If some members of your household are undocumented and others are here with documents, you live in a "mixed" household. If you are in a "mixed" household, talk to a lawyer **before** you apply for benefits.

HOW GETTING BENEFITS CAN AFFECT IMMIGRATION STATUS

• GETTING A RESIDENCY CARD

If you or someone in your household might apply for a residency card (legal permanent residence) sometime in the next 3 years, talk to a lawyer before you apply for benefits. The USCIS can deny a residency card to you if it thinks you are likely to be a "public charge." A public charge is someone who relies on long-term cash public benefits such as SSI, MFIP or GA. USCIS may also consider you a public charge if you get long-term nursing home care. If your household has used public benefits in the last 3 years, USCIS may decide you are likely to be a public charge. Talk to a lawyer.

The public charge rule **does not apply to refugees or asylees.** It also **does not apply** to benefits you get that are not cash, such as:

- MA (Medical Assistance)
- WIC (Women, Infants and Children)
- Housing assistance
- Food Stamps
- Energy assistance
- medical care for pregnant women
- child care

• BEING A SPONSOR TO BRING FAMILY TO THE U.S.

If you want to become a sponsor for someone else in the next few years, you may not want to apply for public benefits. The USCIS could decide that you cannot take financial responsibility for a new immigrant if you were on public benefits yourself.

When you apply for benefits you have the right to an interpreter if you need one. Government agencies that give out benefits must provide a free interpreter to people with limited English. They cannot make you bring your own interpreter. You can bring someone to help you if you want to. See our fact sheet, *Your Right to an Interpreter.*

Southern Minnesota Regional Legal Services (SMRLS) helped with this Fact Sheet.

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Snapshot

FEBRUARY 2009

Immigrant and refugee mental health

Best practices in meeting the needs of immigrants and refugees

Compared to their native counterparts, immigrants and refugees are at higher risk for developing mental health problems due to previous trauma and/or the stress of migration and resettlement; such as war, violence, poverty, and acculturation.

Mental health issues including major depression disorder, post-traumatic stress disorder, and general anxiety disorder are common among newly arrived immigrants and refugees. While many immigrants and refugees are resilient, traumatic experiences and migration stressors have a great impact on their mental well-being.

Barriers and service gaps

In addition to common barriers to receiving mental health services – such as lack of transportation, child care, information, and health insurance – immigrants and refugees face additional barriers that limit their use. These include:

Language
Few services are available for immigrants and refugees in their native languages. Translated written materials are sometimes available; however, immigrants and refugees may not be literate in their native language. Mental health conceptions also vary from culture to culture, making translation of mental health concepts and terms complex and challenging. As a result, it is difficult to provide meaningful written materials or assessments in different languages.

Stigma
Stigma of mental illness is especially pervasive among immigrant and refugee communities where being mentally ill translates to being "crazy." Individuals with mental health issues are often isolated and ostracized by the community especially when symptoms are severe.

Also, information about someone's mental health issues can spread quickly in close-knit ethnic communities, potentially damaging a family's reputation. For example, in some communities, mental illness is perceived as hereditary and can damage an individual's likelihood of getting married.

Cultural considerations

Be familiar with cultural conceptions of health and mental health
Many cultures have a holistic view of health and well-being and believe in spiritual causes for illness, such as the loss of one's soul in the Hmong culture or the "evil eye" curse in the Somali culture.

Hire and support bilingual/bicultural service providers
Immigrants and refugees are more likely to seek services from bilingual/bicultural service providers who share the same background as they do. Bilingual/bicultural

What are somatic symptoms?

Somatic symptoms are physical symptoms of psychological distress, such as physical pain, headaches, lack of sleep, loss of appetite, nausea, dizziness, and fatigue.

Why are somatic symptoms prevalent among immigrant and refugee populations?

- Mental health is not recognized in many non-western cultures and emotional symptoms are not perceived as indicators of a potential health issue.
- In some cultures, the expression of emotions is discouraged and interpreted as a sign of weakness.
- Emotional symptoms are more stigmatizing and easier to suppress than somatic symptoms.

service providers bridge the language gap and understand clients' needs and issues in a cultural context. They are often more successful at incorporating both western and traditional treatments, as well as educating clients about western mental health. Unfortunately, there is an extreme shortage of service providers who can meet the demand.

To encourage the growth of bilingual/bicultural service providers, efforts should be made to attract and recruit bilingual/bicultural individuals to the mental health field. Providing support during education, licensing, and practice is important. Mentorships are effective for training future bilingual/bicultural service providers, as well as exchanging knowledge of cultural mental health concepts.

Use interpreters who are trained in the mental health field

When bilingual/bicultural service providers are not available, interpreters are commonly employed to close the language gap and assist in providing culturally competent services. Interpreters may also include paraprofessionals and translators.

It is critical to use professional interpreters who are knowledgeable in mental health. The following are recommendations for service agencies:

- Ensure interpreters understand and abide by confidentiality agreements. Within a closely-knit ethnic community, it is possible for interpreters and clients to know each other. Keeping mental health information confidential is essential in building trusting relationships and providing effective services to clients.
- Match clients with an interpreter who has similar characteristics (e.g., ethnicity and gender).
- Consistently use the same interpreter for each client to build a trusting relationship.
- When using interpreters, extend appointment times to ensure clients have enough time to build a relationship with service providers. The translation process during appointments limits the amount of time clients have to interact and get to know service providers.
- Outline clear roles and responsibilities for interpreters.
- Ensure interpreters have the necessary supports to manage their own mental well-being because listening to a client's story may evoke memories of their own traumatic experiences.
- Ensure interpreters have a manageable caseload to avoid burn out.
- Provide on-going mental health training and professional development opportunities to educate and retain interpreters.
- Allow time before and after appointments for service providers and interpreters to discuss and explain mental health beliefs and to reflect on what occurred during the appointment.

When interpreters are unavailable, family members and/or spiritual/religious leaders are often used to translate. While it may be convenient, this is generally discouraged because family members and spiritual/religious leaders tend to lack mental health knowledge and interpreter training, which is crucial in helping clients understand their symptoms, diagnosis, and treatment. Also, when a family member or spiritual leader is present, clients may be less willing to disclose certain information that they consider shameful or stigmatizing.

Collaborate with other health care providers
Immigrants and refugees are more likely to seek care from general health practitioners than from mental health providers, primarily because it is less stigmatizing. In addition, immigrants and refugees frequently seek care from general health practitioners to relieve somatic symptoms, such as physical pain, headaches, and lack of sleep. Somatic symptoms are common among immigrants and refugees. They are more widely accepted as indicators of a health problem than mental or emotional symptoms and typically are the first signs of a mental health issue.

General health practitioners can serve as a gateway to mental health services; however, the referral process can be confusing and complicated. To reduce access barriers it is important for providers to work with one another to provide coordinated services when serving immigrant and refugee populations.

In an effort to reduce issues that may arise due to contradicting or different health beliefs, health care service providers should also partner with traditional and spiritual healers from the community, such as a shaman or imam. They can work together to understand traditional and western health practices and provide appropriate and comprehensive services.

Integrate traditional health and healing practices
It is common for immigrants and refugees to use traditional and religious healing methods before turning to western health care, or in combination with western health services. Service providers should be aware of traditional and religious health and healing practices and be supportive when clients use these techniques.

Service providers should be familiar with traditional healing methods of their service population to understand the different kinds of treatment clients are receiving. For example, in the Hmong community, many continue to use traditional therapies to relieve physical pain, such as dermal abrasion, massage therapy, acupuncture, and herbal therapy. Some of these techniques have been mistaken for physical abuse because they can bruise, scar, or redden the skin. Providers can also support clients by encouraging traditional healing methods or integrating them into service plans.

Effective therapy/service models

Psychoeducation
Education about mental illness, called psychoeducation, can help immigrants and refugees increase their knowledge and awareness of western mental health concepts and practices. It also has the potential to reduce stigma within immigrant and refugee communities.

However, providing culturally competent psychoeducation is challenging due to the limited culturally relevant resources and tools and the difficulty in translating mental health concepts. Service providers and facilitators need to be resourceful and thoughtful when presenting mental health information to immigrant and refugee communities.

Group therapy
Group therapy interventions have proven effective for immigrants and refugees from collectivistic cultures, where the family or a collective group is valued over the individual. One-on-one talk therapy can seem threatening and intimidating.

In collectivistic cultures, it is common for families to be the first source of support for personal problems or health concerns. Family group therapy is especially effective for elders because they tend to hold more traditional beliefs and are more reluctant to seek help and disclose information to those outside of the family.

All clients in a therapy group should be the same gender and ethnicity and share the same mental health issue. Facilitators should be bilingual and have similar characteristics to their clients.

To learn more about this issue go to www.wilderresearch.org

Home visits

Home visits are a useful strategy for collecting and sharing information with immigrant and refugee clients. Home visits can serve multiple purposes, including sharing information about available services, providing psychoeducation, and conducting outreach. Home visits help eliminate transportation and child care barriers and allow clients to be in a non-threatening environment.

Home visits are most effective when done by bilingual providers or with the assistance of an interpreter. Providers, interpreters, and clients should all be matched by gender.

Medication

Medication is a familiar form of treatment across many cultures and is most effective for relieving somatic symptoms. However, psychotropic medication is regarded negatively among immigrants and refugees. It is usually only accepted when symptoms are severe and all other resources have been exhausted.

Non-compliance rates of psychotropic medication are high among immigrants and refugees due to language and literacy barriers, discomfort with side effects, and perceptions of the effectiveness of the medication when results are not immediate. In addition, medication is seen as ineffective when the illness is attributed to spiritual causes.

Overall, when prescribing medication for mental health issues, service providers should thoroughly inform immigrant and refugee clients about their options related to medication, the risks and benefits associated with the medication and the proper procedures for taking the medication, and be sensitive to clients' concerns about the side effects.

Additional resources

Jaranson, J., Forbes Martin, S., & Ekblad, S. (2000). Refugee mental health services: Issues for the new millennium. In R.W. Manderscheid, & M.J. Henderson (Eds.), *Mental health, United States, 2000* (Chapter 13). Rockville, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. Retrieved from: http://mentalhealth.samhsa.gov/publications/allpubs/SMA01-3537/default.asp

Pumariega, A.J., Rothe, E., & Pumariega, J.B. (2005). Mental health needs of immigrants and refugees. *Community Mental Health, 41(5),* 581-597.

Yu, M. (1997). Mental health services to immigrants and refugees. In T.R. Wakins & J.W. Callicut (Eds.), *Mental health policy and practice today* (164-181). Thousand Oaks, CA: SAGE Publications, Inc.

Author: MaoThao, Wilder Research
FEBRUARY 2009

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Children and Family Services Division

451 Lexington Parkway North
Saint Paul, Minnesota 55104
651-280-2700; FAX 651-280-3700

Multicultural Resources:
Resources for serving diverse populations in Minnesota

2008 Health Resources Serving Diverse Cultural Communities
This document compiled by the Refugee Health Program of the Minnesota Department of Health, was created to be a quick reference for individuals working to identify appropriate health services for refugees and immigrants. The directory has been expanded and now includes the following counties: Anoka, Carver, Dakota, Hennepin, Kandiyohi, Olmsted, Otter Tail, Ramsey, Rice, Scott, Stearns and Washington. Listings have been selected either because they have special expertise in serving diverse populations or offer low-cost care options such as reduced fees or sliding fees. Although listings are divided by county of location, many agencies serve residents from multiple counties. This guide an be accessed at: **http://www.health.state.mn.us/divs/idepc/refugee/directory.html**

Directory of Minnesota Organizations Serving Diverse Populations
This is a reference guide, published in 2006 by the Minnesota Department of Human Services, Children & Family Services Division. It includes nonprofit social service organizations, tribal governments, state agencies, and mental health practitioners who identify themselves as serving culturally specific or diverse populations in Minnesota. Providers are categorized by their service to one of five cultural groups: African American—African, American Indian—Native American, Asian—Southeast Asian, Latino—Chicano, or Multicultural—European American. A copy of this directory may be downloaded from the following web address:
http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4411-ENG

Directory of Resources for Children and Families in Minnesota
This directory provides information on resources that may help families, providers and others working with families and children. Users are able to search for resources by specific counties or school districts (Help Me Grow - Early Intervention only). There is also information included within each search that provides statewide resources and programs available to Minnesota families. The directory is available at the following web address: **http://www.health.state.mn.us/mcyshn** For those who do not have Internet access, please contact the Minnesota Children and Youth with Special Health Needs Information and Assistance Line at: 651-201-3650 or 1-800-728-5420 for assistance in locating services or resources.

Directory of Nonprofit Organizations of Color In Minnesota
The *Directory of Nonprofit Organizations of Color in Minnesota* is a listing of not-for-profit associations, organizations, and mutual assistance and fraternal groups in the state of Minnesota that primarily serve communities of color. **www.cura.umn.edu/publications/npoc**

Office of Minority and Multicultural Health (OMMH) – Minnesota Department of Health
Examples of key activities carried out by OMMH include: Providing leadership and collaboration for MDH regarding community minority health activities; building state and community capacity to meet the needs of populations of color and American Indians in disease prevention, health promotion, and health care systems, and to close the gap on health disparities; identify minority health resources available to community based organizations; and working in partnership with communities throughout the state to ensure the issues of minority health are addressed.
Address: Freeman Building, 5C , 625 Robert St. N, St. Paul, MN 55164-0975
General office information: (651) 201-5813 **http://www.health.state.mn.us/ommh/index.html**

East Side Neighborhood Services, Inc. - a nonprofit human services agency that provides basic needs resources and social services to immigrant, refugee and low income individuals, families and neighborhoods primarily, but not exclusively, in Northeast and Southeast Minneapolis. Counseling services are available with a Spanish interpreter. The agency headquarters is located at 1700 2nd Street, NE Minneapolis, MN 55413 **Telephone numbers**: (612) 781-6011) or (612) 787-4000. Web address: **www.esns.org**

Hennepin County Office of Multicultural Services
The goal of the Office of Multi-Cultural Services is to facilitate the delivery of County services to its diverse, Limited English Proficiency populations in an efficient, effective, and culturally sensitive manner. OMS staff serve at co-locations throughout Hennepin County. Contact their office via email at: oms@co.hennepin.mn.us

U.S. Department of Health and Human Services - Indian Health Service
The above website contains information related to the Indian Health Service – The Federal Health Program for American Indians and Alaskan Natives. On the IHS Home Page, you will note several options to click on including: Medical Programs and Area Offices and Facilities. Detailed information related to Minnesota can be found by clicking on **Area Offices and Facilities** and then clicking on the **Bemidji Area** which covers Indiana, Michigan, Minnesota and Wisconsin. If you click on the **About Us** tab, there is a **Primary Care Provider newsletter** under Publications and Reports. http://www.ihs.gov/

Center for Cross Cultural Health (CCCH)
The focus for CCCH is to build cultural competency in human services and health care organizations and to engage communities in co-creating solutions to address cultural and ethnic health disparities. Since 1997, the CCCH has been actively involved in the education, consultation, assessment, and training of providers, educators, and organizations in the State of Minnesota and beyond. The CCCH also serves as an information resource by offering publications, referrals, newsletters and networking opportunities. In October of 2008, the International Health Education Alliance (IHEA) merged with the Center for Cross Cultural Health, an organization recognized for its vision to improve health and well-being and increase health equity. IHEA has focused on educating individuals from diverse backgrounds about the prevention of chronic conditions. Address: The Center for Cross Cultural Health, 34 Thirteenth Ave. NE, Suite B002B, Minneapolis, MN 55413, Tel: 612-331-3311, Fax: 612-331-3337 **www.crosshealth.com**

Cultural Competence Case Studies
The goal of this course is to expose the learner to the potential differences between cultures, so that when a provider enters an encounter with a patient and family he or she is sensitive to differences that may exist, has the skills to explore these with the patient in order to learn more about the patients' beliefs and customs, and is able to join with the patient to find a mutually acceptable, and beneficial treatment plan. The course includes case studies, interactive learning activities and quizzes, plus resources for further study. This project is funded by the US Health Resources and Service Administration's Maternal and Child Health Bureau. http://support.mchtraining.net/national_ccce

Guidelines for Culturally Competent Organizations, Second Edition – May 2004
This is an excellent resource developed by the Minnesota Department of Human Services. You can access this document via the web address below. http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-3963-ENG

eXchange - Multilingual Health Resources
Based in Minnesota, the Exchange is a partnership formed to exchange information and resources about health communication and to share multilingual health materials. The Exchange resources and information are open to everyone, but the online library of translated health materials and the forum are for members only. Partners include: private health care organizations, public health agencies, community groups and individuals interested in multilingual health education. You can participate in the Exchange as a partner, sponsored partner, a corporate affiliate, or as a guest. For more information contact: Coordinator Patricia Ohmans at 651-222-9460 or go to: http://www.health-exchange.net/

Immigrant Law Center of Minnesota
Provides comprehensive immigration services to low income immigrants; training, consultation and outreach on immigration affairs/issues, including Special Immigrant Juvenile Status (SIJS); policy, educational articles and other resources. The Immigrant Law Center of Minnesota, is dedicated to providing high quality legal services to low-income immigrants in Minnesota. 651-641-1011 (office line) or 1-800-223-1368 (client line) or www.immigrantlawcentermn.org

United States Citizenship and Immigration Services (USCIS)
The USCIS is responsible for the administration of immigration and naturalization adjudication functions and establishing immigration services policies and priorities. In the "About Us" section of http://www.uscis.gov/portal/site/uscis you can find information to introduce you to U.S. Citizenship and Immigration Services within the Department of Homeland Security. You can also access information related to Naturalization and Citizenship at this site using the Search Function at the top right corner of the screen.

Health Care Eligibility for Noncitizens (Updated June 30, 2008)
This *Guide*, developed by the Minnesota Department of Human Services, is designed to supplement the information in the Health Care Programs Manual to further help with the process of determining noncitizens' eligibility for Minnesota Health Care Programs (MHCP). It provides an overview on immigration; MHCP eligibility for Noncitizens; immigration classification; documentation of immigration status; sponsor deeming; an overview of the uses for the Systematic Alien Verification for Entitlements (SAVE) system, including when and when not to use the system and how to access, request and read information; and system coding. You can access this document via: http://hcopub.dhs.state.mn.us/hcpmstd/Noncitizen_Guide.pdf

Language Services

DHS Multilingual Referral Lines:
Language Phone Number

Arabic (800) 358-0377
Hmong (888) 486-8377
Khmer (Cambodian) (888) 468-3787
Laotian (888) 487-8251
Oromo (888) 234-3798
Russian (888) 562-5877
Serbo-Croatian (Bosnian) (888) 234-3785
Somali (888) 547-8829
Spanish (888) 428-3438
Vietnamese (888) 554-8759

Deaf and Hard of Hearing Telecommunications Assistance (Minnesota Relay/TTY/TDD)
1-800-627-3529
http://www.state.mn.us/portal/mn/jsp/content.do?id=-536881376&agency=Commerce

Health Care Interpreter Roster
Health care providers are now able to locate health care interpreters through a searchable database on the Minnesota Department of Health web site. The health care interpreter roster is available at http://www.health.state.mn.us/interpreters. Providers can simply click on "Interpreter Search" and begin searching by language and geographic area.

Language Line
Language Line is provided by the Office of Enterprise Technology's (OET) Telecommunication Services. If your agency is interested in enrolling in this service, contact your telecommunications coordinator or you could call the service desk at OET directly. An account with OET needs to be set up prior to using this service. There are some eligibility restrictions, for example, OET works primarily with government entities. However, city and county agencies as well as schools are all eligible. For more information, contact the Service Center at OET (651) 297-1111 or click on the link below. The most recently published rate for this service is $1.25 per minute.
http://www.mnet.state.mn.us/voice/language-line/index.php

Language Line Services http://www.languageline.com/page/welcome/
Language Line Services include over the phone interpretation services, video interpreter services, document translation, etc. There is a wealth of information on the website listed above including how to set up an account. If you or your agency only need to use an interpreter occasionally, there is an option to "pay as you go." Language Line Over-the-phone Interpretation Service (click on the link below for Questions and Answers related to this specific service). http://languageline.com/main/files/OPI_QandA_071708.pdf

Quick Links for Immigration/Refugee and Child Welfare Information

A collection of available resources for immigration practitioners, community organizations, law enforcement, social workers, judges, family advocates and attorneys working in immigrant child welfare matters:

Immigration Legal Resource Center: http://ilrc.org/
Provides information on remedies for immigrant youth, etc: Living in the United States: A Guide for Youth (English, Spanish and Korean); Special Immigrant Juvenile Status (SIJS): Highlighting Changes Implemented by the Trafficking Victims Protection and Reauthorization Act (March 2009), Immigration Bench Book for Juvenile and Family Courts (PDF, 1.7 MB, 2005), Fact Sheets: Immigration Options for Undocumented Children

Asista: http://www.asistahelp.org/
Provides information on violence against women immigrant survivors of domestic violence and sexual assault, torture and human trafficking, etc;

Helping Low Income Minnesotans Solve Civil Legal Problems: http://LawHelpMn.org
Has resources and documents in 22 languages; glossary of legal terms such as right to an interpreter, green card, becoming a U.S. citizen; immigration bonds; website search feature for legal resources/agencies; and Immigration and Customs Enforcement (ICE) offices in Minnesota.

Legal Aid Society of Minneapolis: midmnlegal.org
Immigration Law Project: provides direct legal client services for low income immigrants or seniors residing in Hennepin County.

Southern Minnesota Regional Law Services: http://www.smrls.org/
Provides legal services for low income people; addresses some immigration issues. Services listed in various languages on the website.

MinnesotaHelp Information: http://MinnesotaHelp.info/public
Website provides contact information for a host of services, legal, child and family client services, housing for battered immigrant women, etc. Enter "immigration" in the key word search engine.

United States Citizenship and Immigration Services (USCIS):
http://www.uscis.gov/portal/site/uscis All immigration forms, documents, requirements, visas, refugee and asylum; humanitarian; on the website enter "child welfare" in search engine to find child welfare related memorandums; in particular, enter "TVPRA" for a field guide memorandum on Trafficking Victims Protection Reauthorization Act of 2008: Special Immigrant Juvenile Status Provisions, March 24, 2009.

Bridging Refugee Youth and Children's Services: http://www.brycs.org/
Provides guidance to states serving refugee and immigrant children; see child welfare page. Website has many publications, including a list of suggestions (publications) for interviewing recently arrived refugee and or immigrant children for child abuse, education, health, etc.

International Social Service-United States of America – ISS USA: http://WWW.ISS-USA.ORG
The following services are available to children in the child welfare system:

- Home studies – In collaboration with the ISS federation, home studies are performed by qualified social workers living in, and with specific knowledge of, the country being considered for placement of a child.
- Family tracings are performed to locate adoptive or extended family members living in other countries for the purpose of permanency planning, or to request communication between separated family members.
- Searches – Examples of the documents ISS-USA can often obtain in other countries include criminal background and child abuse registry checks, as well as birth, death and marriage certificates.

American Red Cross: http://www.redcross.org/ (click “Getting Assistance/Contact Family Members”) American Red Cross can provide family tracing and communication in war zones.

Embassies, Consulates: http://www.state.gov/s/cpr/rls/dpl/32122.htm
Embassies and consulates can sometimes provide birth and death certificates, or other documentation; website has an international listing of consulates and embassies.

Mexican Consulate: http://www.sre.gob.mx/saintpaul The consulate assists counties with locating and contacting parents and relatives in Mexico. E-mail: conspaul@sre.gob.mx.

Insurance & Appeals

FAMILY VOICES STATEMENT
ON THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

Family Voices is an organization of families whose children have special health care needs. Its mission is to achieve family-centered care for all children and youth with special health care needs and/or disabilities.

Family Voices is very pleased that the *Patient Protection and Affordable Care Act* and the *Health Care and Education Affordability Reconciliation Act* will be the law of the land.

The new law makes a number of improvements in our nation's health care system for children and youth with special health care needs (CYSHCN) and disabilities. These include several benefits that would take effect within the next six months, including:

- **Elimination of lifetime benefit caps and a prohibition against rescinding coverage when someone get sick.**

Example 1: A premature baby is in hospital for many months and has been diagnosed with multiple health issues. Due to the length of stay in the hospital, the family is near reaching its lifetime maximum for the child. With the elimination of lifetime caps, the family will not have to worry whether child will be able to continue to receive medical treatment.
Example 2: A family has had coverage for several years. Their teenage child is injured and needs expensive rehabilitation. The insurance company suddenly rescinds the policy, claiming that the family had failed to disclose that the child had the pre-existing condition of acne, and therefore, the policy is invalid. The new law prohibits such cancellation of policies, absent intentional fraud on the part of the insured.

- **A prohibition against denying children coverage for treatment of pre-existing conditions. (By 2014, no one can be denied access to insurance or coverage for treatment related to a pre-existing condition; HHS intends to clarify by regulation that, six months from the bill's passage, children will have access to insurance regardless of pre-existing conditions.)**

Example 1: Sally, age 7, has cerebral palsy and is in need of a baclofen pump to assist with spasticity. Prior to the law's passage, the insurance company could have denied this due to her pre-existing condition of cerebral palsy. With passage of the law, this should no longer happen.
Example 2: A 6-month old is discovered to have a congenital heart defect. The insurance company refuses to cover necessary surgery because the defect is considered a pre-existing condition. This would be prohibited under the new law.
Example 3: Laurie has Down Syndrome. Once the regulations are issued to clarify that children cannot be denied insurance policies due to pre-existing conditions, Laurie's family will be able to add her to their plan.

- **The establishment of a national high-risk pool for those who have been uninsured due to pre-existing conditions (until 2014, when insurance can be purchased on "Exchanges").**

Example: Christina, a self-employed young adult, age 28, has been unable to get insurance due to her Type 1 diabetes. If she has been uninsured for at least six months, she can get coverage through a high-risk pool that will be established within the 90 days from the signing of the bill.

- **A requirement that young adults be permitted to stay on their parents' insurance policies until age 26, unless they have an offer of employer coverage.**

Example: Sam is a 23 year-year old with spina bifida, unable to find a job since he graduated from college, and unable to get insurance on his own because of his preexisting condition. Under the new law, Sam can stay on his parents' insurance until he is 26 years old.

- **No-cost preventive care for children in new insurance plans (excluding ERISA plans), based on the "Bright Futures" recommendations of the Maternal and Child Health Bureau and the American Academy of Pediatrics.**

Example: Children will be able to receive comprehensive preventive care, including developmental screenings, at no cost.

Other important provisions, to take effect in 2014, include:

- Expansion of the Medicaid program to *all* individuals with incomes up to 133% of the federal poverty level. (Currently, states cannot receive federal Medicaid funds for covering childless adults.)
- Elimination of all pre-existing condition exclusions (i.e., guaranteed issue of insurance), and a prohibition on charging higher premiums for people with pre-existing conditions.
- Elimination of annual benefit caps.

Example: Jack has required extensive hospitalization for multiple heart surgeries in his first year of life, exceeding the annual limit his insurance company will pay on his behalf. Under the new law, there will be no arbitrary annual limits, so Jack's family will not have to pay out-of-pocket for the balance of his expenses that year.

- A loan repayment program aimed at reducing shortages of pediatric subspecialists, including non-physician providers of mental and behavioral health care and substance abuse prevention and treatment services.
- Incentives for more community-based, long-term care in Medicaid and establishment of a voluntary, public long-term care insurance program (the CLASS Act).
- Support for establishment of medical home models.
- Significant increases in funding for prevention and wellness efforts and the development of the public health infrastructure.
- Authorization of a new program to support school-based health centers and provision of $200 million for immediate construction of such centers.
- Provisions to improve the oral health of children. (Inclusion of oral health care among the benefits required of insurance plans offered through state "Exchanges" with no charge for preventive pediatric oral health services.)

NOTE: This is a preliminary summary. The new law is over 2,400 pages long, and there will be many regulations issued to implement it. We will provide further analysis and information as it becomes available.

MINNESOTA COMPREHENSIVE HEALTH ASSOCIATION (MCHA)

Since becoming operational in 1977, MCHA has served as an insurance safety net for Minnesotans who have been turned down for individual health insurance due to pre-existing conditions. There are many different circumstances that cause Minnesotans to turn to MCHA such as:

- Self –employed individuals who want insurance but are rejected due to pre-existing conditions
- Individuals who exhaust COBRA benefits
- HIPAA eligible persons (generally, persons leaving employer group coverage)
- Spouses & dependents of employees whose employer doesn't offer dependent health coverage
- Individuals eligible under the Trade Adjustment Assistance (TAA), alternative TAA, or Pension Benefit Guaranty Corporation (PBGC)
- Changes in self-insured employer or union plans (changes in/cancellation of benefits)
- Persons reaching lifetime maximums in their insurance policies
- Persons reaching lifetime maximums in their employer's self-insured plans
- Individuals working for employers who do not offer health insurance benefits
- Individuals laid off/terminated by self-insured employers who don't offer conversion policy
- People waiting for employer coverage while fulfilling probationary employment period
- People who had individual health coverage or group coverage that was cancelled by their insurance company
- Former employees of bankrupt companies
- Former insured's of HMOs or insurance companies that become insolvent
- Some recipients of Ryan White funding

Eligibility - MCHA's eligibility criteria are set in Minnesota Statute 62E.14. The following eligibility requirements are meant to serve as general information only. You are eligible for MCHA if you:

Are a Minnesota resident on the date of application for MCHA coverage and

- have lost group coverage. You must be an "eligible individual" under Health Insurance Portability and Accountability Act (HIPPA); or
- are also eligible for the Health Coverage Tax Credit (HCTC) program. You must be eligible for Trade Adjustment Assistance (TAA), Alternative Trade Act Adjustment Assistance (ATAA), or between ages 55-64 and receive pension payments from the Pension Benefit Guaranty Corporation (PBGC); or

Have been a Minnesota resident for the six months immediately prior to the date of application for MCHA coverage and

- have reached age 65 or over and are not eligible for the health insurance benefits of the Federal Medicare Program; or
- within the past six months have been rejected for individual health coverage from a Minnesota based insurance carrier or have received a rejection of coverage from a health insurance agent due to health related reason(s); or
- have been treated within the last three years for one of the special "Presumptive Conditions" listed in the "MCHA Instructions and Application for Individual Coverage" document..

Important Information on Pre-existing Conditions:
For all MCHA policies, no benefits are payable during the first six months of coverage for expenses for any preexisting condition, injury, illness or other physical or mental condition that was diagnosed, treated or evaluated during the 90 days preceding the effective date of coverage. However, Minnesota State law does provide some exceptions to the preexisting condition limitation. To determine if you may be eligible for a waiver, you must request a waiver of the preexisting condition limitation by completing the applicable section of the MCHA application.

Minnesota Comprehensive Health Association, Customer Service, Mail Route CP555,
401 Carlson Parkway Minnetonka, MN 55305 1-866-894-8053 www.mchamn.com

Sample Appeals Letter

Use these guidelines to organize your letter:

- State your purpose for writing
- Explain your child's diagnosis and how it affects the child
- Give specific reasons why your child needs the service or equipment
- Mention the supporting documentation you are including
- Close by focusing on action

Here is a sample letter that follows these guidelines

	January 1, 2XXX ABC Insurance Company 1234 Insurance Lane Anytown, MN 12345
Child's name & policy number	RE: John Smith Policy Number: 123456
	Dear Insurance Company Representative:
Purpose for Writing	I am writing to appeal your recent decision denying a wheelchair for my son John Smith. I understand from your letter dated January 1, 2XXX, that you will only pay for a wheelchair if John is unable to walk without it.
Diagnosis explained	My son John is a six year old, in kindergarten who was diagnosed with XYZ syndrome at the age of six months. XYZ syndrome causes John to have weak muscles in his legs and so he has difficulty walking long distances. John has great difficulty walking through the grocery store, and cannot walk during trips to the zoo or other similar family outings.
Reasons child needs service or equipment	In order for John to be able to participate in family and school activities with his siblings and friends, John needs a wheelchair. John is too old for a stroller and resents the implications of being a baby, especially at school. A wheelchair would allow John to maneuver independently from adults, which is important for his psycho-social development.
Supporting documentation	I have attached letters from John's pediatrician and neurologist who both feel John needs a wheelchair, and have outlined their medical opinions. I have also attached a letter from John's physical therapist explaining the type of wheelchair he needs and why. Also attached you will find a bid for the cost of the wheelchair John needs from two equipment companies that have contracts with your company.
Action	We understand from your appeal process that you have 60 days to respond to our appeal, and we will await your written reply.
	Sincerely, George and Kathy Smith 9876 Consumer Avenue Anytown, MN 12345 (123) 456-7890
People who will receive a copy of your appeal	cc: Dr. Mary Jones Pediatrician Address

Minnesota Department of **Human Services**
Your Appeal Rights

Your Appeal Rights

Reasons for appeal

If you have applied for or are getting financial help, Medical Assistance, Food Support, or social services through the county or state agency, and:

- The county agency does not act quickly enough and you think it has gone beyond the legal time limit to act, you can appeal.
- The county agency decides you can not get help, you can appeal.
- The county agency providing you with assistance or services reduces or stops them, you can appeal.
- The state agency denies you a specific medical service, you can appeal.
- The county or state agency thinks you maltreated a child or a vulnerable adult, you can appeal.

When you disagree with any county or state agency action, you have the right to appeal. You must ask for a fair hearing by the state.

Time limits

Your request for a hearing must be received within 30 days after you get a written notice about the county's or state's decision. If you show “good cause” for not appealing within this time limit, you may appeal up to 90 days after you get the notice. “Good cause” is when you have a good reason for not appealing on time. The human services office will decide if your reason is a good cause reason. With Food Support you may appeal up to 90 days after you get a notice of the county's decision and **do not** have to show good cause.

After the state gets your request, it will set a date for a hearing. The state will tell you the exact date, time, and place.

Preparation for a hearing

Get all the information about your case.

- Bring a letter from a doctor if a medical question is involved.
- Bring any other papers you want the hearing officer or appeals referee to see.
- Ask others who know about your case to come to the hearing.

It is a good idea to make a list ahead of time of the points you want to make and bring it with you to the hearing.

Hearings

A Human Services judge, who has not been involved in the decision you are appealing, will look at the facts in your case. He or she will look at the evidence and hear arguments by you and the county or state agency. Every effort is made to get all information needed to arrive at a fair decision based on the law. Your hearing may be conducted by telephone unless you object.

Lawyer or friend can speak for you

You may have a lawyer or another person speak for you at the hearing. However, the state or county agency can not get a lawyer for you or pay for one. Contact the legal services office in your area if you want a lawyer.

The county may pay for some of the costs of your appeal. These costs may be for transportation and child care expenses.

Decision

You usually will be told of the judge's final decision within 60 days of your Food Support appeal or 90 days of all other appeals.

How to Appeal

Request a hearing. This is easy to do. Your request for a hearing must be in writing. You or someone who represents you must sign the request. With Food Support appeals you may make a verbal request for a hearing. Send or make the request to the county agency or to:

Minnesota Department of Human Services
Appeals Office
PO Box 64941
St. Paul, MN 55164-0941
Metro: (651) 431-3600 (Voice)
Outstate: (800) 657-3510
TTY: (800) 627-3529
Fax: (651) 431-7523

Attention. If you want free help translating this information, ask your worker or call the number below for your language.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاسأل مساعدك في مكتب الخدمة الاجتماعية أو اتصل على الرقم 1-800-358-0377.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែពត៌មាននេះដោយមិនគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿងរបស់អ្នក ឬ ទូរស័ព្ទទៅលេខ 1-888-468-3787 ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, pitajte vašeg radnika ili nazovite 1-888-234-3785.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, nug koj tus neeg lis dej num (worker) lossis hu 1-888-486-8377.

ໂປດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການ ການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງຖາມນຳພນັກງານຊ່ວຍວຽກຂອງທ່ານຫຼື ໂທຣ໌ຫາຕາມເລກໂທຣ໌ 1-888-487-8251.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, hojjataa kee gaafaddhu ykn lakkoofsa kana bilbili 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в переводе этой информации, обратитесь к своему социальному работнику или позвоните по следующему телефону: 1-888-562-5877.

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjamadda macluumaadkani oo lacag la'aan ah, weydii hawl-wadeenkaaga ama wac lambarkan 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para traducir esta información, consulte a su trabajador o llame al 1-888-428-3438.

Chú Ý. Nếu quý vị cần dịch thông tin nầy miễn phí, xin gọi nhân-viên xã-hội của quý vị hoặc gọi số 1-888-554-8759.

LB2-0004 (10-09)

ADA3 (5-09)

This information is available in alternative formats to individuals with disabilities by calling (651) 431-3600 or (800) 657-3510. TTY users can call through Minnesota Relay at (800) 627-3529. For Speech-to-Speech, call (877) 627-3848. For additional assistance with legal rights and protections for equal access to human services programs, contact your agency's ADA coordinator.

FREQUENTLY ASKED QUESTIONS ON PERSONAL CARE ASSISTANCE (PCA) CHANGES & APPEALS 2009 & 2010 LEGISLATIVE SESSIONS

Updated August 4, 2010

MN Disability Law Center

www.mylegalaid.org/mdlc

NOTE: At the web address directly below, you will find many resources & documents discussing PCA changes from the 2009 Legislative Session and a document summarizing the 2010 Legislative Session changes to the PCA Program. You can, also, access THIS very document online, which when it is online, is able to link you directly to specific websites and the actual current DHS documents used for the PCA Program.

http://www.mylegalaid.org/mdlc/current-projects/pca-changes

1. What are the changes which will affect current Personal Care Assistance (PCA) recipients?

1) Eligibility for PCA services has been tightened. (DHS calls this "Access to PCA Services")

*****Until July 1, 2011, a person must have either: A dependency in an Activity of Daily Living (ADL), OR Qualify as having Level I Behavior.**

*** **After July 1, 2011**, **the eligibility criteria will be further tightened to require a dependency in at least 2 ADLs. Persons with Level I behavior will no longer qualify for PCA services**. (See #1.6) on next page for more information on the July 2011 changes).

2) Dependency definition has been changed.
The 2009 stricter definition of "Dependency" requires that the person has a need on a daily basis for hands-on physical assistance or constant cuing and supervision. During the 2010 Legislative session, the definition was changed so that those who are dependent, but do not need or choose to accomplish the task daily, still qualify as dependent.

The **2010 definition of dependency**: requires that the person has a need on a daily basis or on the days during the week the task is completed for hands-on physical assistance to complete the task **or** cuing & constant supervision to complete the task.

NOTE: The old criteria for dependency included: "Help of another - Person able to participate." Prompting to begin or accomplish tasks no longer qualifies as a dependency.

Activities of Daily Living (ADLs) Include: (1) Grooming; (2) Dressing; (3) Bathing; (4) Transferring; (5) Mobility; (6) Positioning; (7) Eating; (8) Toileting.

3) Requirements for Level I Behavior: (1) Physical aggression towards self; **or** (2) Physical aggression towards others; **or** (3) Destruction of property **and** (4) requires the immediate response of another person.

(For discussion of changes in the behavior documentation requirements, see pages 8-10 of the **PCA Assessment and Service Plan Instructions and Guidelines (DHS-3244A, 5-10).** You can link to these DHS forms on the MNDLC website. **www.mylegalaid.org/mdlc/current-projects/pca-changes**
More information on the New Assessment Formula next page #2)

NOTE: To qualify for Level I behavior, one of the behaviors must have occurred within the past 12 months. (DHS trainer stated the 12-month standard during the Assessor trainings given across the state in the Fall 2009.)

NOTE: Nearly 1,000 persons under 65 and perhaps 150 seniors have been terminated from PCA services entirely as of July 2010, because they are not dependent under the new definition in an ADL or do not qualify as having Level I behavior.

4) PCA time (authorized hours) reduced.
Hours of PCA service will be reduced for thousands by instituting a new assessment with a specific formula to determine hours of care. See the three-step authorization chart and new decision tree with the 10 new home care ratings (HCR) and time allotted for each HCR. The document is on the MNDLC website entitled: **DHS Colored Assessment Chart [10-09] and Decision Tree with Base Amount of Hours [1-1-10].**
www.mylegalaid.org/mdlc/current-projects/pca-changes

NOTE: It is estimated that between 6,000 and 7,000 current PCA recipients out of over 16,000 recipients under age 65 and nearly 2,000 seniors will have their hours of service cut by some amount. It is expected that some may receive an increase in hours.

5) Hours a PCA can be paid limited to 275 hours per month.
The Legislature limited the hours a PCA could work to 310 hours per month in 2009. The Governor reduced the PCA monthly work hours further to 275 hours through unallotment in June, 2009. The 2010 Legislature ratified the Governor's unallotment, so that 275 hour monthly PCA work limit is now in statute.

6) Stricter PCA eligibility criteria becomes effective July 1, 2011.
As of July 1, 2011, persons will need to qualify as dependent (see #1.2 on first page) in at least 2 activities of daily living (ADLs). Level One behavior will no longer qualify a person for PCA services. DHS is required to develop recommendations for alternatives for those with mental health conditions or behavioral problems who are terminated from PCA services. The recommendations are due in a report to the Legislature by January 15, 2011. About $4 million dollars per year for two years was set aside to match federal Medicaid funds for the alternative PCA services.

DHS data on the PCA assessments show that in addition to the over 1,000 persons whose PCA services were terminated by July 1, 2010, another 2,000 will lose PCA services by July 2011.

QUESTIONS ON NEW ASSESSMENT FORMULA

2. Where can I get information about the new assessment?
The new assessment document is called the **Personal Care Assistance (PCA) Assessment and Service Plan (DHS-3244, 5-10).** There is a companion instruction document called the **PCA Assessment and Service Plan Instructions and Guidelines (DHS-3244A, 5-10)**. You can link to these forms on the MN DLC website or these forms can, also, be found on the DHS website **www.dhs.state.mn.us**. You can access the forms by going to the blue horizontal bar and click on Forms-eDocs and then type in the form number.

There are **three steps** to the new assessment:
(Step 1) Determine eligibility for PCA service (dependency in an ADL and/or Level I behavior); and

(Step 2) Determine the home care rating based on the number of activities of daily living (ADL), behavioral issues and complex health needs; and

(Step 3) Add:

(a) Time for critical ADLS's (eating, transferring, mobility, toileting);

(b) Behaviors-if these occur four times a week:

(1) Increased vulnerability due to cognitive deficits or socially-inappropriate behavior;
(2) Resistive to care, verbally aggressive; or
(3) Physical aggression toward self, others or property destruction; and

NOTE: The maximum time for all behavior criteria allowed is 90 minutes per day in addition to the basic home care rating number of hours in step 2

(c) Complex health conditions, such as catheters, bowel program, wound care or other interventions, which are listed, can add 30 minutes per complex health procedure.

3. Are those using the CONSUMER SUPPORT GRANT (CSG) affected by the PCA changes to eligibility, PCA hours limits and the assessment?

YES. See the new CSG Monthly Budget Chart for the new limits. The chart is available on the MN DLC Website. Because CSG is based on the PCA program, CSG participants are also being terminated and reduced due to the tightened PCA criteria and hours formula.

4. What should I do to prepare for the assessment?

a. If you have medical documentation of your disability and need for assistance, it is important to have copies of that for the assessment.
b. If you have Level I behavior, it is important to have documentation of those problems from your physician, mental health provider or psychologist, school, day care provider, or anyone else in the community aware of the issues.
c. If you have complex health procedure needs which have been ordered by your doctor such as tube feeding, wound care, bowel program, seizures, and so on, it is important to have the doctors' orders for the assessment. If you have been getting PCA service help with those needs, use the documentation of those needs from your current PCA provider. The new law says that to get PCA time for complex health procedures, they must be ordered by a doctor. You are not required to show the assessor the doctor's orders, but if you can do that, you will avoid problems and reduce the need to appeal.
d. Read the **PCA Assessment and Service Plan Instructions and Guidelines (DHS-3244A-ENG 5-10)** to find out what the process is like.
e. The guidelines have been updated since some assessors were trained, so be sure they follow the online instructions. (For instance, the draft Guidelines defined "constant supervision" as 100% visibility, eyes on the person, but the updated Guidelines on p. 10 define constant supervision as "continued interaction and/or visibility to ensure person's safety and task completion.")

TERMINATION OF PCA SERVICES

5. What if I am terminated from PCA services?

If you are cut off of PCA services and think that the assessor did not fairly consider your need for physical help or cuing and constant supervision or your behavioral issues which meet the Level I criteria, you have the right to appeal.

You will get two mailings about changes in your PCA services: 1) your completed "Assessment and Service Plan" from the county or health plan nurse and 2) a computer generated notice from the Minnesota Department of Human Services that your PCA services have been terminated and information about your appeal rights.

In thinking about the fairness of your assessment, it will be helpful to review your completed assessment and the **PCA Assessment and Service Plan Instructions and Guidelines. (Form DHS 3244A)-ENG 5-10).** It is

important to review your assessment so that you can be specific at your appeal about where mistakes were made or you disagree with the assessment.

If you decide to appeal, it is very important that you ask for the **appeal in writing within 30 days of the date on the notice. Also, if you need your PCA services to continue during the appeal, you must ask for continued services when you request an appeal.** DHS is required to authorize PCA hours to continue during the appeal period at the level you were getting before the new assessment. PCA hours used during the appeal period should not be subtracted from the PCA hours authorized after the appeal.

If you need the PCA services to continue at the current level and you lose your appeal, it is important to understand that the commissioner of DHS may bring a claim against you for the PCA payments made pending appeal. However, the Disability Law Center is not aware of any case involving medical assistance where this has been done by DHS since the law was passed in 1991.

It is most important to consider the circumstances of the person who has lost services and wants to appeal, including whether the assessor may have made mistakes or didn't consider necessary information about the person's condition. Continuing services during an appeal is often necessary to be able to stabilize people, keep them in their homes and keep their trained care givers. During an appeal, if vulnerable children or adults are unsafe in their homes, get injured or lose trained caregivers, they will suffer serious harm even though they might win their appeals. That is why the law provides for services pending appeal.

If you need an interpreter to be at the hearing, you should call or write the human services judge as soon as possible. Tell the human services judge what help you need. The human services judge will make sure that an interpreter is at the hearing. These services are available to you at no charge. Your request for an appeal and for your PCA services to continue during the appeal process must be sent or faxed, within 30 days of the notice, to:

MN Dept. of Human Services--Appeals Office **Phone: 651-431-3600 or Toll Free 1-800-657-3510**
P.O. Box 64941, St. Paul, MN 55164-0941 **TTY: (800) 627-3529, FAX: 651-431-7523**

DHS has a lot of information about appeals on their website **www.dhs.state.mn.us** . Go to left column and click on **A-Z Topics**, scroll down **A Listings** and click on **Appeals**.

Use the **Fair Hearings Decision Database** to search human services appeals decisions. The database contains a comprehensive collection of decisions, with private data and county identifying data removed, dating back to July 2001. The archive includes a keyword search function, and is available to members of the public interested in seeing how the appeals function has addressed particular issues.

The **Frequently Asked Questions About State Appeal Hearings** page has information about how to request a hearing. The form **Information about State Appeal Hearings (DHS-2811)** is, also, available in DHS **eDocs (eForms) library,** along with the form **Instructions for Requesting an Appeal (DHS-0033).**

However, if you think the assessment was accurate and you no longer qualify for PCA services because of the changes, then it is most important to try to find other services as soon as possible. The Assessor nurse is required to provide you with a list of other possible services. **See questions farther below on Referrals to Other Services.**

REDUCTION IN HOURS OF PCA SERVICE

6. What if my hours of service are reduced and I want to appeal?

If you have your PCA hours reduced and think that the assessor did not fairly consider your need for physical help or cuing and constant supervision, your behavioral issues or your complex health procedures, you have the right to appeal.

You will get two mailings about changes in your PCA services: 1) your completed Assessment and Service Plan from the county or health plan nurse required to be sent to you within 10 working days of your assessment; and 2) A notice that your PCA units (15 minute per unit) have been reduced and information on how to appeal.

In thinking about the fairness of your assessment, it will be helpful to review your completed assessment and the DHS "Instructions and Guidelines" for Assessors. It is important to review your assessment so that you can be specific at your appeal hearing about where mistakes were made or where you disagree with the assessment.

Did the assessor note down all the areas (ADLs, qualifying behaviors and complex health procedures) with which you said you needed help? If there are activities of daily living, behaviors or complex health needs that you need help with that are not written on the assessment, those are the areas to gather information on for your appeal.

Remember, the amount of time you need for each activity is no longer important because the PCA time now is figured according to a formula for everyone.

The only way to get more PCA time is to qualify as dependent in more activities of daily living or having the listed behaviors or complex health procedures for which PCA time is allowed.

PLEASE NOTE: The following recommendations for "persons whose PCA services were reduced" are the same recommendations as those for "persons whose PCA services were terminated").

If you want to appeal, it is very important that you ask for your **appeal in writing within 30 days of the date on** the notice. Also, **if you need your PCA services to continue while you appeal, you must ask for continued PCA services during the appeal process.** DHS is required to authorize PCA hours during the appeal period at the level you were getting before the new assessment. PCA hours used during the appeal period should not be subtracted from the PCA hours authorized after the appeal.

If you need the PCA services to continue at the current level and you lose your appeal, it is important to understand that the commissioner of DHS may bring a claim against you for the PCA payments made pending appeal. However, the Disability Law Center is not aware of any case involving medical assistance where this has been done by DHS since the law was passed in 1991.

It is most important to consider the circumstances of the person who has lost services and wants to appeal, including whether the assessor may have made mistakes or didn't consider necessary information about the person's condition. Continuing services during an appeal is often necessary to assure safety, keep people in their homes and keep their trained care givers. During an appeal, if vulnerable children or adults are unsafe in their homes, get injured or lose trained caregivers, they will suffer serious harm even though they might win their appeals. That is why the law provides for services pending appeal.

If you need an interpreter to be at the hearing, you should call or write the human services judge as soon as possible. Tell the human services judge what help you need. The human services judge will make sure that an interpreter is at the hearing. These services are available to you at no charge. Your request for an appeal and for your PCA services to continue during the appeal process must be sent, within 30 days of the notice, to:

MN Dept. of Human Services--Appeals Office
P.O. Box 64941, St. Paul, MN 55164-0941

PHONE: 651-431-3600, Outstate (800) 657 3510
TTY: (800) 627-3529, FAX: 651-431-7523

There are a number of organizations to call for help with your appeal. Arc Minnesota, NAMI Minnesota, Brain Injury Association of Minnesota, MS Society, Minnesota Disability Law Center (MDLC), Legal Aid office in your area. See a partial list of **Disability Advocacy Organizations & Legal Aid Offices** on the last page.

REFERRALS TO OTHER SERVICES REQUIRED

7. What if my hours of service are reduced or I am terminated because of the changes made to PCA services, but I think the assessment was accurate?

What if I cannot get along with fewer hours of PCA service, how can I get the help I need?
If you think the assessment was accurate and you no longer qualify for PCA services or your reduction in hours was consistent with the changes to PCA services, then it is most important to try to find other services if you need help at home, as soon as possible.

You should receive the PCA Assessment and Service Plan document within 10 working days of your assessment. This 10-page assessment should have been filled out by the public health nurse and signed when you were assessed. The public health nurse is supposed to provide you with a list of other services on the last page of the assessment, called **Recipient Referrals.**

You can call your county human services agency, listed on the MDLC & DHS websites, or health plan and request:
• A home and community waiver slot through your county;
• Adult or child mental health services, or
• Other MA home care services such as a home health aide;
• MA Health Care services such as physical therapy, psychology, etc.

You have the right to apply for these other services. If you are turned down, the county must provide you a written notice of denial and information on how to appeal the denial. Disability advocacy organizations may be able to help you appeal. See the resource list at the end of the questions. An appeal must be sent in writing within 30 days of the notice of denial to the DHS Appeals Office address listed in Questions 5 & 6.

8. Is there any way I can get more PCA hours than I qualify for under the new PCA assessment criteria?
Yes. Home and Community-Based Waiver services can include "extended" PCA services which can be more hours than you qualify for under the new PCA criteria. People who need more PCA hours may be able to get them through the CAC, CADI, DD or TBI waivers. Extended PCA service under the home and community waivers is defined in the PCA statute as including additional PCA hours beyond the amount allowed by the PCA assessment or PCA hours needed less frequently than daily. **2010 PCA Legislative Report #V.A.2.b.[256B.0659 subdiv.1(g)]**

Home and Community-Based Waivers are for those who qualify for institutional services such as a nursing home or intermediate care facility for persons with developmental disabilities, but need alternative services to remain in their homes, apartments or a community group home. Information about waivers can be found on the **DHS website.**

If you already get waiver services, your allowed waiver budget may have to be increased by your county if your health, safety and welfare are threatened without more PCA services. You can call the Disability Linkage Line to help you get a hold of your county to apply for waiver services or check www.MinnesotaHelp.info.

NOTE: Waiver slots are limited and you may be told there is a waiting list. You have the right to apply anyway and the right to appeal the denial of waiver services.

9. What if I had been referred for other services, but cannot find any providers?
If you need other services, such as child or adult mental health services, services for fetal alcohol or a brain injury, and cannot find anyone to provide them, call the Disability Linkage Line (1-866-333-2466) for help in locating a provider. If you cannot find a local provider, call a disability advocacy group, CCD, the Minnesota Disability Law Center, an ombudsman's office or other Legal Aid office near you for help.

Since DHS told the Legislature that some PCA recipients would be better served with other services, if you cannot find the other services, it is important for the Commissioner of DHS, the Governor and your legislators to know this. If services are really not available, it is important for you to provide information about your experience so that

those advocacy groups working for change have your information. You can document your problems and efforts through the PCA survey link on the CCD website, **www.mnccd.org**

10. I have a chronic illness or disability and have used PCA services but now have been terminated. What other service can come to my home and help me with medications, meals, doctor's appointments and maintaining my apartment?
There are a variety of services that may be helpful to you. You can find the services below on the DHS website: **www.dhs.state.mn.us** or call your county human service agency and ask to talk to a disability social worker. You can, also, find information about these services in this Manual in the **DHS & Children's Mental Health Packets.**

One service that may help you if you are an adult, is called Home Health Aide (HHA). A Home Health Aide is provided through a Medicare certified home health agency.

You may also qualify for Adult or Children's Mental Health Services through your county. These services can include mental health aides who can come to your home. For adults, these aides are called AMHRS (Adult Mental Health Rehabilitative Services. For children, a behavioral aide can come to your home as part of a mental health service called CTSS (Children's Therapeutic Services and Supports).

You can start by calling the Disability Linkage Line, 1-866-333-2466, for providers of home health aides or adult or children's mental health services near you.

If you cannot get the services you need to maintain your home or apartment in the community, call a disability advocacy organization, CCD, Minnesota Disability Law Center, Ombudsman's Office or other Legal Aid office for help Also, consider documenting your problems and efforts through the survey link on the CCD website, **www.mnccd.org .** You can also file a complaint with the **Office of Civil Rights in Chicago. www.hhs.gov/ocr/civilrights/complaints/index.html**

11. I had been getting PCA services under the MT or CS rating which was eliminated. What should I do?
The MT and CS ratings have been eliminated. People with those ratings are being offered a home and community waiver service slot. If you are cut and do not have replacement services, it is important to appeal as soon as you receive the notice of your cut.

Also, if you have not yet had a PCA reassessment but know that you have a CS or MT home care rating currently, go to your county and apply for a home and community waiver slot as soon as possible. The legislation provided funding for waiver slots for people in the MT and CS home care rating to move to waivers, about 70 people across the state.

QUESTION ON CIVIL RIGHTS UNDER OLMSTEAD DECISION, AMERICANS WITH DISABILITIES ACT (ADA)

12. What if I have to leave my apartment or home because of cuts to my PCA services?
You may have a civil rights claim under the Americans with Disabilities Act (ADA) Olmsted Decision. People should not have to live in more restrictive settings when they have been able to live in homes and apartments with PCA services. If you are at risk of losing your home or apartment because of cuts in your PCA services, call the Minnesota Disability Law Center or other Legal Aid office for help (See question #16 for contact information) and fill out the survey linked on the CCD website**: www.mnccd.org** . You can also file a complaint with the **Office of Civil Rights in Chicago. www.hhs.gov/ocr/civilrights/complaints/index.html**

QUESTIONS ON 275 HOUR LIMIT PCAs CAN BE PAID PER MONTH

3. What should I do if my PCA had usually worked more than 275 hours per month?
You are still eligible for your authorized hours of care, so it is important for you to find and train an appropriate

person to provide all of the hours you need. If your PCA provides care to you for your authorized hours over 275 hours per month without pay, you may not be assessed to need the hours of service you need. Also, it is important for everyone to have more than one person trained to provide the care they need in case of illness, emergency or other change in staff.

14. What if I am not able to find someone to fill my hours or have hired people who are not competent or leave after a short time?
It is very important that you document the difficulties you have in filling your PCA hours of care. Go to the website www.mnccd.org which allows you to provide information about your difficulties. You do not have to use your name to submit your experience. This information can be used to keep track of the impacts of PCA changes and to try to get changes to these PCA cuts.

If your well-being is threatened or you cannot continue to live at home, you should call the Minnesota Disability Law Center intake line for help: 612-334-5970; 1-800-292-4150; TDD: 612-332-4668.

15. What if I live in a home owned or controlled by my PCA agency?
You will be required to either choose a new agency which does not own or control your home, group home or apartment or move to a different home and continue with the same PCA agency. By August 1, 2010, PCA agencies are prohibited from providing PCA services to persons living in PCA agency owned, leased or rented homes or apartments.

16. What should I do with this information I am keeping track of?
It is extremely important to keep track of this information so that if bad things happen, you can use it in any appeal you may have and you can fill out the CCD survey so this information can go to your legislators and ask for changes and use it in other ways to try to help people continue to live at home with the services they need.

Disability Advocacy Groups and Legal Aid Resources

17. How do I contact disability advocacy organizations or local Legal Aid offices? (Partial List Below)

- **Arc Minnesota www.arcmn.org**
- **Brain Injury Association of Minnesota www.braininjurymn.org**
- **Courage Center www.couragecenter.org**
- **National Multiple Sclerosis Society, MN Chapter www.nationalmssociety.org/chapters/MNM/index.aspx**
- **Minnesota Organization for Fetal Alcohol Syndrome (MOFAS) www.mofas.org**
- **National Alliance for Mental Illness-Minnesota (NAMI) www.namihelps.org**
- **Consortium for Citizens with Disabilities, CCD www.mnccd.org**
- **Link for Consortium members www.mnccd.org (Go to left column & click on MN-CCD Members)**
- **Link for PCA stories www.mnccd.org (Go to left column & click on Spotlight Issue: Tracking…PCA Prog.)**
- **Find a Legal Aid Office or other resource near you in Minnesota www.lawhelpmn.org/MN**

18. What changes were made to the PCA program by the Legislature in 2010?
There were many policy changes affecting PCA provider requirements, definitions, staff training and other related areas. **Some problems which came to light after the 2009 law were fixed, including allowing IADLs (Instrumental Activity of Daily Living) for children who need immediate attention for health or hygiene reasons related to PCA services. This means a PCA can clean up or do a load of laundry, if needed and included in the service plan developed during the assessment.**

Also, changes were made to prohibit PCA agencies from limiting the future employment of PCAs and excluding family member PCAs from Unemployment Insurance coverage. A full list of the 2010 Legislative changes to PCA services can be found on the PCA Changes portion of the MNDLC website:
www.mylegalaid.org/mdlc/current-projects/pca-changes

[NOTE: If you have Fee- For- Service Medical Assistance (MA), TEFRA, EMA or MA-EPD refer to the Welfare Appeals handout in this section. Or, call Minnesota Health Care Programs Member Help Desk 651-431-2670 or 1-800-657-3739. For Self Insured/Self Funded health plans refer to the Self Insured/Self Funded Health Plan Complaints in this section.]

Appeal Options for Persons Covered by Health Plans

There are several reasons, situations and appeal options when an enrollee is dissatisfied with their health plan. It may be something as simple as being charged an improper copayment or as complex as seeking coverage for an innovative procedure to treat a rare condition. Either way, if you have been denied any type of coverage, feel your rights have been infringed upon or are dissatisfied with how you have been treated or served, you have options.

Start With Your Health Plan for Help

Starting with your health plan may be the quickest and easiest option to resolve the dispute. It is important to read your health insurance policy AND health benefits handbook to find out how to appeal a decision with your health plan. This is an internal appeal. All Minnesota health plans are mandated by MN law to have an internal appeals process, though the steps you must take to appeal may vary somewhat depending on the type of health plan you have. **It is very important for you to know and follow your health plans specific timeline requirements for making an appeal.**

If you need help understanding your health plan's appeal process, call your health plan's member or customer services representative. The phone number should be on the back of your health plan card and in your benefit handbook. Or you can write a letter to your health plan. Make sure to keep a copy.

It is important to inform your health care provider that you want to make an appeal to your health plan. Your health care provider may be able to provide you with helpful information to support your appeal. If your health plan is purchased through work, you may also want to notify your employer of your appeal.

Your health plan is required to respond promptly to your appeal. MN state law, rules and regulations specify procedural rights and deadlines, including an expedited process for urgent medical matters. The health plan must notify you of its decision in writing. You may have the right to a second appeal if you still are not satisfied with your health plan's decision. You have the right to a hearing, if you request one.

Many complaints and appeals are resolved internally by the health plans to the member's satisfaction. Unfortunately some are not. If you are not satisfied, there are other places outside of the health plan to go for help. If a delay in the process will seriously jeopardize your life, health or ability to regain maximum function, an expedited appeal is available. Call your health plan's member services and tell them you want an expedited appeal.

Help From Outside the Health Plan

If you are enrolled in a Prepaid Minnesota Public Health Care Program such as **MinnesotaCare, Prepaid Medical Assistance (PMAP) or Prepaid General Assistance Medical Care**, and your health plan has not resolved your concern or granted your appeal request, you can:

- Contact your **local Managed Care County Advocate**. The advocate can be contacted by calling your local county Human Services/Family Services agency found in the county government section of the phone book; **and/or**

- Contact the **Ombudsman Office for State Managed Health Care Programs** 651-431-2660 or 1-800-657-3729. They are located in the MN Department of Human Services http://www.dhs.state.mn.us and/or request a state fair hearing**.**
- Review the Grievances and Appeals section on the Department of Human Services website at: http://www.dhs.state.mn.us and use the search engine to look for Grievances and Appeals

If a delay in the process will seriously jeopardize your life, health or ability to regain maximum function, an expedited appeal is available. Call your health plan's member services or call the Ombudsman office at (651) 431-2660 or (800) 657-3729 and tell them you want an expedited appeal.

Help From a State Regulatory Agency

If you have a Minnesota-licensed health plan, the telephone number to call for state agency or regulatory help is frequently listed on the back of your membership card & in your member handbook. The state has the power to investigate and overturn a health plan's decision. The state regulatory agency has the power to impose fines or revoke a health plan's license.

• **If your health plan is a Minnesota-licensed HMO**, you can appeal to the Minnesota Department of Health, the state agency that regulates HMOs. 651-201-5100 or 1-800-657-3916. **www.health.state.mn.us/divs/hpsc/mcs/options.htm**

• **If your health plan is a Minnesota-licensed health insurance company**, you can appeal to the Minnesota Department of Commerce, the agency that regulates health insurance companies. (651) 296-2488 or 1-800-657-3602. **www.commerce.state.mn.us**

Help From an External Review

• If you have a health insurance claim that continues to be denied by a health plan company, you have the right to appeal that denial by an external appeal. The State of Minnesota contracts with an independent company to review appeals for persons who are dissatisfied with the health plans internal complaint and appeal process. Minnesota law establishes procedures and deadlines for the **external review**. External Review may be available to persons enrolled in a fully insured plan, issued by a state licensed health plan company, and after the internal appeal process has been exhausted. There is a $25 fee for each External Review unless it is waived for hardship. Maximus, the independent company, its employees and physicians are impartial, separate from and has no affiliation with any health plan. The result of an External Appeal is nonbinding on you, the insured, but is binding on the health plan company. If you lose, you have the right to appeal the decision in court. If the health plan company loses, it cannot appeal the decision. To learn more about the External Review Process and to print a Request for an External Review go to **www.health.state.mn.us/divs/hpsc/mcs/options.htm**

Help From the Court System

• You may choose to file a lawsuit with the courts. Patients may file a lawsuit to enforce their rights under their health plan contract and require the health plan to pay for treatment.

Information from **www.mnhealthplans.org**, **http://www.health.state.mn.us/divs/hpsc/mcs/options.htm** and **www.commerce.state.mn.us**

Self Insured/Self Funded Health Plan Complaints

Minnesotans who receive coverage through their employers in a self-funded plan should work directly with their employer.

What is a self-insured health plan?
A self-insured group health plan (or a 'self-funded' plan as it is also called) is one in which the employer assumes the financial risk for providing health care benefits to its employees. In practical terms, self-insured employers pay for each - out of pocket - as they are incurred instead of paying a fixed premium to an insurance carrier, which is known as a fully-insured plan.

Self-insured plans are set up by employers to pay the health claims of its employees. The employer sets aside funds for the health claims. The *employer* assumes the risk of providing the benefits and is obligated to pay all the claims. Sometimes self-insured plans are confused with fully insured plans because employers often hire an insurance company to pay the claims. If you do not know what kind of plan you have; ask your employer or plan administrator. Federal laws enforced by the US Department of Labor govern legitimate self-insured plans. States are not allowed to regulate these plans. This means that state laws requiring specific benefits in health care plans do not apply to self-insured plans.

What kind of health plan do you have?
If you have health insurance through your employer, you can find what you need to know about the plan by reading your benefits handbook. Then, if you are still not sure, ask the people who work in your human resources or union benefits office. If you work for a large company or government, there's a chance your health plan is self-insured.

These self-funded plans are not insurance. The employer pays employee health care costs from the employer's own pocket. That's why these self-funded plans tend to work best for companies that are large enough to offer good coverage and pay large claims for expensive medical services. A self-insured plan may seem just like traditional insurance to you, but it does not always work the same way. And the differences can be important. As long as claims are being paid you may not notice whether your employer is fully insured or self-funded.

Find out how your health plan works
All self-insured employer plans do not work exactly the same way. Your plan's details are explained in your benefits handbook. It's your right and responsibility to know how your plan works... so read your handbook.

Self-insured employers & TPAs
It is common for self-insured plans to turn over the administration of their health plans to a Third Party Administrator (TPA). The TPA handles all administrative tasks including claims processing and payments.
• Often the employer can contract with an insurance company to act as a TPA for all health care claims. This can disguise the facts if your plan is self-funded.
• The names of both the TPA and employer appear on the benefits handbook and claim forms… just as if the TPA were actually your insurance company.
• A self-funded employer takes on the roles the insurance company usually plays. These roles can include paying claims, deciding on benefits, and determining which claims to pay.
• TPAs simply follow the employer's orders.

Why do employers self fund their health plans?
There are several reasons why employers choose the self-insurance option. The following are the most common reasons:

1. The employer can customize the plan to meet the specific health care needs of its workforce, as opposed to purchasing a 'one-size-fits-all' insurance policy.
2. The employer maintains control over the health plan reserves, enabling maximization of interest income - income that would be otherwise generated by an insurance carrier through the investment of premium dollars.
3. The employer does not have to pre-pay for coverage, thereby providing for improved cash flow.
4. The employer is not subject to conflicting state health insurance regulations/benefit mandates, as self-insured health plans are regulated under federal law (ERISA).
5. The employer is not subject to state health insurance premium taxes, which are generally 2-3 percent of the premium's dollar value.
6. The employer is free to contract with the providers or provider network best suited to meet the health care needs of its employees.

If your claim is denied
Self-funded plans usually have an internal process to review claim denials. You must complete that process before seeking outside help. The process is explained in your health benefits handbook.

What you can do
• Read and make sure you understand your benefits handbook.
• Your company's benefits manager can help if you need to file a claim for payment. Then, if the claim is denied, you should request that the denial be reviewed.
• Are you in a labor union? The union can file a grievance for you, investigate the employer's financial status, and help you negotiate payments on your past medical bills.
• If you are still not satisfied, file a complaint with the U.S. Department of Labor. That federal agency investigates complaints about self-funded employers.
• Consider legal assistance as another resort. The company may have violated an implied contract by refusing to pay medical bills which came about while self-insured health benefits were being offered.

The U.S. Department of Labor investigates consumer complaints about self-insured employer plans
Most self-insured health plans fall under the Employee Retirement Income Security Act (ERISA). ERISA is federal law that is enforced by the U.S. Department of Labor, Employee Benefits Security Administration (DOL-EBSA). If you are a member of a self-insured health plan through your employer security or union, then you can contact the DOL-EBSA for assistance.

However, the DOL-EBSA does **not** regulate self-insured health plans that are sponsored through school districts, other municipalities, and churches. If you are a member of this type of plan, you can file a complaint with the plan directly or you may seek a legal remedy through a court of law. The DOL-EBSA is available to answer questions about self-insured employer plans that come under ERISA regulation. You can gain information on the type of plan that you participate in by contacting your employer or union. If there is still some question, then you can contact the DOL-EBSA for clarification.

How to contact the U.S. Department of Labor:

Employee Benefits Society Administration
1100 Main Street, Suite 1200
Kansas City, MO 64105
(816) 426-5131 Tel. (816) 426-5511 Fax
(866) 444-3272 (toll free)
website: www.dol.gov/ebsa/

With what laws must self-insured group health plans comply?
Self-insured group health plans come under all applicable federal laws, including the Employee Retirement Income Security Act (ERISA), Health Insurance Portability and Accountability Act (HIPAA), Consolidated Omnibus Budget Reconciliation Act (COBRA), the Americans with Disabilities Act (ADA), the Pregnancy Discrimination Act, the Age Discrimination in Employment Act, the Civil Rights Act, and various budget reconciliation acts such as Tax Equity and Fiscal Responsibility Act (TEFRA), Deficit Reduction Act (DEFRA), and Economic Recovery Tax Act (ERTA).

8/13/08 Adapted from MN Department of Commerce Website **www.commerce.state.mn.us** Click on Consumer Information & Services, Click Insurance & then Medical Insurance.

Resources for Letters of Medical Necessity and Appeals

1. **Utah Collaborative Medical Home Project**
http://www.medicalhomeportal.org/issue/writing-letters-of-medical-necessity
This website describes how important it is for the clinician to understand the legal issues involved in writing a letter of medical necessity, pertinent components of a medical necessity letter, and how to write the letter in a manner that lays the groundwork for an appeals letter if needed. What to confirm before even beginning to write the letter, key components of a letter of medical necessity and links to sample letters are also available.

2. **Dr John Bach's sample letters http://www.doctorbach.com/letters**
This site developed by Dr. John Bach, Professor of Physical Medicine Rehabilitation and Co-Director of the Jerry Lewis Muscular Dystrophy Association Clinics, offers a variety of sample letters of medical necessity and allows the user to create his/her won letter by filling in the blanks.

3. **Rifton Equipment http://www.rifton.com/resources/lettersofmedicalneed/index.html 1-800-571-8198**
This website has pictures of equipment to include when writing a letter of medical necessity as well as sample letters for Rifton pieces of equipment (IE: bathing system, dynamic standers, supine standers, seating system, trikes & their toileting system). Also included on this website is an excellent article "Letters of Medical Necessity" written from a legal perspective by Sarah Rollman.

4. **Family Voices of Colorado http://www.familyvoicesco.org/hp/index.htm#private**
Family Voices of Colorado has a template on their website to assist providers and families in crafting expert letters of medical necessity and/or appeals packets to be able to use to get funding sources to cover necessary, medical services and supports.

5. **Appeal Solutions: Claims Resolutions for Healthcare Providers http://www.appeallettersonline.com**
This website has a database of over 1400 medical appeal letters that can be emailed to the provider and a monthly email newsletter called "The Appeal Letter". The sample appeal letters are designed to assist medical providers with appealing wrongfully denied insurance claims. The site also offers audio conferences on Appeals to train health care staff on reducing denied and underpaid claims. Power of Appeals Software is available.

6. **Patient Advocate Foundation (PAF) www.patientadvocate.org 1-800-532-5274**
PAF is a national non profit organization, which seeks to safeguard patients through effective mediation assuring access to care, maintenance of employment and preservation of their financial stability relative to their diagnosis of life threatening or debilitating disease. Examples of direct services provided to patients, by phone or internet, at no cost include mediating and expediting insurance appeals, negotiating pre-authorization approvals, resolutions to coding and billing errors and negotiating access to pharmaceutical agents, chemotherapy, medical devices and surgical procedures. The Patient Advocate Foundation (PAF) Co-Pay Relief Program (CPR) currently provides direct financial support to insured patients. The program offers personal service to all patients through the use of call counselors; personally guiding patients through the enrollment process. Their website includes numerous publications including: Fundraising Ideas for Patients, Your Guide to the Appeals Process and A Greater Understanding, Financial Assistance & Debt Crisis Intervention.

7. **Office of the Attorney General Lori Swanson**. **www.ag.state.mn.us** 651-296-3353 or 1-800-657-3787
How to get the Health Care you Need: This section is for consumers who have encountered a problem with their health plan, such as, not being able to get a referral to a specialist. Or health plan administrators are saying that treatment is not "medically necessary" or is "experimental." Or the health plan says that the treatment your health care provider recommends is not covered. There are general tips to help consumers navigate the health care maze.
http://www.ag.state.mn.us/consumer/health/mmhc/mmhc_fighting.asp ***Mental Health Care***
http://www.ag.state.mn.us/Brochures/pubMentalHealthCare.pdf This 4 page fact sheet offers tips for a person to get the mental health care they need when they are having a problem with their health plan. It, also, lists regulatory agencies in Minnesota, briefly discusses group health plans, including self insured health plans (ERISA), mental health consumer protection laws and health maintenance organizations, ("HMOs").

8. **A Consumer Guide to Handling Disputes with Your Employer or Private Health Plan**
http://www.kff.org/consumerguide/7350.cfm
This booklet is written by The Henry J. Kaiser Family Foundation and can be found at their website. Anyone enrolled in a health plan should be familiar with their plan's internal review process and any external review program in their state in case problems arise. (This guide is not applicable for resolving disputes if you have Medical Assistance (MA) or Medicare coverage). The report includes understanding your type of coverage and what laws apply, appealing to your health plan (informal and formal appeals, health plan review and arbitration), getting an independent opinion—external review in your state, and state by state external review programs.

9. **HealthCareCoach.com** **www.healthcarecoach.com**
This website is packed with facts and do-it-yourself tips o everything from health insurance to patient care to help you help yourself and take control of your health care. For over three decades, their independent, nonprofit group of health law specialists has given the consumers the information they need to get the best out of the health care system.

SSI APPEALS

Social Security has to send you a written notice to deny your application, cut you off or lower your SSI. To get SSI, you must show that you have a long-lasting disability that keeps you from working. It can be mental or physical. You have the right to appeal an SSI decision if you think it's wrong. The first step of an appeal is called "reconsideration." We will call this "recon".

1ST STEP: RECON

- Get the form "Request for Reconsideration" from the Social Security Office. Fill it out and send it to Social Security.
- Social Security must get your request within **60 days** from when you got the denial notice from them. If your papers are late, you have to give a good reason, or they make you start all over with a new application.
- If Social Security wants to cut off your benefits, you can keep getting SSI while you appeal. But you have to send the request within **10 days** of getting the notice.
- If you don't appeal, you lose your right to appeal. But, if you apply again within a certain time, you can ask that the first decision be opened, and ask for back benefits to that date.

You can do this yourself or get an attorney. Call your legal aid office.

There are 3 kinds of recon: case review, informal conference, and formal hearing. Choose the one that works best for your situation.

- To appeal denial of an application for disability benefits, a **case review** is your only choice. In a case review, you can add more evidence and facts to your file. You don't meet with the person who reviews your file.

- To appeal overpayments, you can get an **informal conference.** You get to meet with the person who decides your appeal. The meeting is usually at the Social Security office.

- To appeal a decision to cut off your benefits, you can choose a **formal conference.** You get to meet with a hearing officer who reviews your file. This meeting usually takes place at the state Disability Determination Services (DDS) office.

Be ready for your meeting. Write out a statement of the facts, including any new evidence. Tell Social Security about any new doctors, hospital stays, or medical treatments.

2ND STEP: THE HEARING

If you lose the recon, you can ask for a hearing with an administrative law judge (ALJ). This is the most important step. Try to get a lawyer or advocate. To ask for a hearing, file a "Request

for Hearing" form with Social Security within **60 days** of the date on your recon decision. You must file it within **10 days** to keep getting SSI while you appeal a termination.

- Prepare for your hearing! Look at your social security file. It has your medical records, statements and forms filled out by you or Social Security. The file is at the Office of Hearings and Appeals. You can call the Hearings office at (612) 348-1230 to set up a time to go see your file.

- If any of the papers in your file are wrong, or need to be explained, be ready to do this at your hearing.
- If you have new doctors' reports or letters from employers or social workers about your ability to work, give them to the Hearing Office before the hearing.
- You can take someone with you to the hearing to testify, or just to support you.

The hearing is recorded. The judge will look at all the evidence and testimony and will mail the decision to you after the hearing. Make sure the Office of Hearings and Appeals has your mailing address.

3RD STEP: APPEALS COUNCIL

If you lose the hearing, you can ask for a review by the Appeals Council in Virginia.

- You must file a "Request for Review of Hearing Decision" within **60 days** of getting notice of the ALJ's decision. Get the form from Social Security.
- Put in any new reports or evidence you have, but don't put off filing the request because you can't get the evidence together. File first if you have to, then send the new evidence as soon as you can.
- The Appeals Council reviews the recording of the hearing and the papers in your file plus any new written evidence that you send. They can send the case back for another hearing, deny your appeal, or overrule the ALJ and find you eligible.

4TH STEP: COURT

If the Appeals Council rules against you, you can appeal to federal court. You can get the paperwork for this appeal at the federal courthouse. There are federal courthouses in Minneapolis and St. Paul. You should have an attorney help you at this step.

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SSI OVERPAYMENT

An overpayment means that you got more SSI money than you were supposed to. This can happen because you forgot to report a change in your income, that you were in the hospital, the death of a spouse, or other things. Or Social Security can make a mistake. Even if it was their fault, Social Security can ask you to pay back the money.

HOW CAN I AVOID AN OVERPAYMENT?

Report changes right away to Social Security. Even if you report right away, the next check may be sent before the amount can be changed. Then you have an overpayment.

Some examples of things that could cause an overpayment are: getting married; working; or getting a large payment, like an insurance award or car accident settlement. If you think such a change may happen, get legal advice about choices you can make to avoid an overpayment.

WHAT HAPPENS IF I GET AN OVERPAYMENT?

Social Security will try to get the money back from you. They can also report the overpayment to credit bureaus so it's on your credit report.

- SSI can ask you to repay the whole amount now, or to repay it over time. You do not have to agree to this.
- They can take the money out of your SSI checks. They can only take up to 10% of your check. This is called "recoupment."
- They can take your federal tax refund or other federal money due you or your spouse if your spouse is on SSI.
- They can sue in court for the overpayment plus court costs. They do not do this if you are still on SSI.

WHAT IF THE OVERPAYMENT IS SMALL?

If it is $500 or less, Social Security will not try to get the money, if you ask them not to. This is called an "administrative waiver."

WHAT IF SOCIAL SECURITY IS GOING TO RECOUP FROM MY CHECK?

You can do these things:

- **Agree** to pay it back and work out a payment plan. This way you get some control of how much is taken out of your check. See if they will take less than 10% per check.

- **Appeal**. If you do not think you were overpaid, you can appeal. File a written appeal right away.
  - Appeal within **10 days** of getting the notice if you want your checks to stay at the same amount during the appeal
  - Appeal within **60 days** of getting the notice, or you lose the right to appeal.

- **Ask for a "waiver".** This means that even if you were overpaid, you should not have to pay it back. If you cannot afford to pay the money back, file for a waiver right away. If you file within 30 days of getting the overpayment notice, Social Security cannot take money from your check until you have a meeting with them. They have to give you the waiver if **the overpayment wasn't your fault, and:**

    - It would be unfair to make you repay it (for example, you cannot afford to pay it back, and it would be a great hardship), or

    - The overpayment is small and not worth the time and energy to collect it.

You can file for both an appeal and a waiver at the same time.

WHAT IF I LOSE MY APPEAL?

If your first overpayment appeal and waiver request is denied, you can appeal further. See our fact sheet, *SSI Appeals*.

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Mental Health

Mental Health Services for Children and Youth

Behavioral and Mental Health Concerns in Children and Youth

What should a family do if there is a concern about their child's behavior or mental health?
Concerns about a child's or youth's development, mental health or behavior may be first noticed by the parent/s. Sometimes concerns are observed by the day care provider, teacher, grandparent or medical provider. Or a concern may be noted when the parent fills out a developmental and/or social emotional screening tool about their child. The Ages and Stages Questionnaire (ASQ) and Ages and States Questionnaire: Social Emotional (ASQ-SE) are examples of screening tools for young children. These tools may be used by public health nurses, by Headstart Programs, at Early Childhood Screening or at a well child checkup at a medical clinic. The Pediatric Symptom Checklist (PSC) is a psychosocial screening tool used in some medical clinics to identify cognitive, emotional and behavioral concerns in older children, including adolescents.

When there are developmental, emotional or behavioral concerns, parents may find it helpful to schedule an appointment with their primary medical care provider to discuss these concerns.

What will the medical provider do?
The medical provider will want to be sure there is not physical problem or medical illness causing the emotional or behavioral concern. He/she will ask the family and/or child a variety of questions and may ask the parents to obtain written information from the teacher or daycare provider about the concern. Depending on the concern and results of the history and physical exam, medical tests may be ordered.

What happens after the medical evaluation?
Depending on the results of the medical evaluation, the health provider **may:**

- Refer the child/youth to a mental health professional for a mental health evaluation. This evaluation is called a **diagnostic assessment (DA).** (See further along for more on DA); and/or

- For very young children birth to 5 years, call or recommend the parents call the toll free **HELP ME GROW** line, **1-866-693-4769 (GROW)** for a referral for an Early Childhood Assessment to determine if the child may be eligible for early childhood intervention services. Or for older children, recommend the parents ask the school for a Child Study Team Assessment. Some children may qualify for special education services related to their emotional, mental health or behavioral concerns. Or sometimes these assessments determine the child has an unidentified speech/communication delay, learning disability or other condition that would qualify the child for special education services; and/or

- Refer the family to community and county resources and services; such as the Children's Mental Health Program at their county human services agency, the county public health nurse, Early Childhood Family Education (EC/FE), the Headstart Program or a private preschool etc.

In addition to the above, parents may find it helpful to:

- Join a parent support group
- Attend parenting classes
- Read parenting books & magazines
- Sign up for social/recreational activities for their child
- Sign up for a Big Brother/Big Sister Program for their child

Note: Families may get a mental health evaluation even if they have not seen a medical provider, the medical provider does not feel a diagnostic assessment is necessary and/or does not refer them to a mental health clinic.

Who can help families get a mental health evaluation or diagnostic assessment?

- The primary care provider, nurse or care coordinator at the child's medical clinic (heath care home) can help the family to get an appointment with a mental health professional.

- The Customer Service Department of a private or public health plan can help provide information about the plan's mental health benefits, if a physician's referral is necessary and help find a mental health provider in the health plan's provider network. Their phone number is on the back of the health plan card.

- County children's mental health case managers can help the family locate a mental health provider and schedule an appointment. They can also help identify potential financial resources to pay for the diagnostic assessment including assisting the family to check their health plan benefits if they have private insurance. Children with no insurance or even some children with private insurance **may be** income eligible for a MN Public Health Care Program such as Medical Assistance (MA) or MinnesotaCare. The county social worker/financial worker can assist the family to apply for one of the programs. Families can contact their local county human services/family services agency and ask to speak to intake for the children's mental health program. (The number can be found in the phone book under County Offices.)

- Tribal mental health programs can help the family locate an appropriate mental health provider.

Mental Health Diagnostic Assessment

What should a family do if their child has to wait a long time to get a mental health appointment?
If this happens, the family should call their health plan's Customer Service phone number and explain this problem. Health plans may be able to assist families to get an earlier appointment. Or the health plan may give the family permission to "go out of the health plan's provider network", to obtain an appointment sooner.

Families may wish to discuss the long wait with the child's medical provider or someone in their county Children's Mental Health Program. If there is a significant concern about the child's mental health and/or behavior and the possibility of the child physically harming or endangering himself/herself or others, the medical provider or county worker may help the family develop a plan for their child. (See the next hand-out **MN Mental Health Resources** for agencies and organizations that the family can talk to about the long wait.)

In any event, if the child is an immediate danger to himself/herself or to others, call 911 and ask for help!

Do we need to do anything before my child's appointment with the mental health professional?
Before the appointment, the youth/family may be asked to complete some forms from the mental health clinic or professional. If the child/youth was referred by the physician, school or county children's mental health case manager, they may send referral information to the clinic. Other information might be requested such as school assessments, medical records or past mental health evaluations and treatment. For young children information may be gathered from the daycare provider, grandparents/relatives or the preschool teacher.

What is a diagnostic assessment?
A diagnostic assessment is a written evaluation by a mental health professional to determine whether a child or youth has a mental health disorder. The mental health professional completes a face to face interview with the child and/or family to gather information about the child's life situation, such as:
- Onset, frequency, duration and severity of current symptoms;
- History of current mental health problems (developmental incidents, strengths, stressors, etc.);
- Relevant family and social history; and
- Effects of symptoms on functioning in home, school and community.

Can a diagnostic assessment interview be done if my child is developmentally disabled or is very young?
Yes, a diagnostic assessment can be done but may be done differently for some children because the child may be too young to talk, is unable to verbally communicate or understand the mental health professional if he/she were to use ordinary adult language. The provider may use toys, other physical aids and/or non verbal activities to obtain information.

For very young children birth through 4 years, specially trained mental health professionals are able to use the **Diagnostic Classification of Mental Health and Developmental Disorders of Infancy & Early Childhood**,

(DC: 0-3R) to complete a diagnostic assessment. The DC: 0-3R, is both an age-appropriate tool and a unique approach for assessing infants, toddlers and preschool children. It classifies and describes developmental & mental health disorders in very young children in relationship to their families, their culture and their communities.

- To find a mental health professional serving young children in their area, parents or providers working with families can call the toll free Help Me Grow line. 1-866-693-4769 (GROW).
- Parents should also check if this mental health professional or clinic is a provider for their health plan whether it be a private health plan, or a public health plan such as (PMAP/MinnesotaCare) by calling the health plan's Customer Service number on the back of their health plan card. If the child is covered by Fee For Service, MA, the family should ask the provider if they are an MA provider. If there are any problems or concerns about coverage, the family should talk with the health plan's Customer Service or a children's mental health case manager at the county about what to do . Otherwise, the parents may end up having to pay the bill.

- The **DC: 0-3R** determines **if** the child needs treatment and, if so**, what type** of treatment. It can, also, help establish whether a child qualifies for early childhood intervention services through Help Me Grow-Infant and Toddler.

  Families and providers can find a list of diagnosed social or emotional conditions that have a high probability of resulting in a delay at school age on the Minnesota Children &Youth with Special Health Needs' website: **http://www.health.state.mn.us/divs/fh/mcshn/ecipelig/conditions.htm#6** Click on the fact sheets to learn more about the conditions. These fact sheets were developed by the Children's Mental Health Division at DHS.

What does child's/youth's functioning in home, school and community mean?

This includes information about the child's/youth's:

* Interpersonal functioning, including relationships with family & peers
* Educational and/or vocational functioning
* Social functioning, including the use of leisure time
* Use of drugs and alcohol
* Financial assistance needs
* Self-care and independent living capacity
* Medical and dental health
* Housing and transportation needs
* Other needs and problems.

During the diagnostic assessment interview, the mental health clinician will, also, examine the child's general behavior, motor activity, speech, alertness, mood, intellectual functioning and attitude about his/her symptoms.

After the diagnostic assessment interview, the mental health professional writes a summary with documentation to substantiate:

- If the child's/youth's symptoms are significant enough to meet the criteria to be diagnosed with a specific mental health diagnosis;
- A determination of the level of severity of the child's/youth's mental health disorder and the need for more intense services;
- The need for specific developmentally, culturally appropriate mental health services that are **medically necessary** to address an identified mental health disorder, disability and/or functional impairment;
- If there is a need for referral for further evaluation such as: psychological or psychometric testing, psychiatric consultation, evaluation for prescribed medications, physical exam, neurological evaluation and/or chemical dependency assessment. A referral for special education testing by the school may also be considered.

What happens after the diagnostic assessment determines a mental health disorder?

An Individual Treatment Plan (ITP) is written by the mental health professional & developed with the family and/or child. An ITP is a plan of interventions/services based on the information & outcome of the diagnostic assessment. The ITP is under the clinical supervision of a mental health professional and includes: goals & measureable objectives of treatment as well as a schedule for accomplishing them; treatment strategies; and individuals responsible for providing the services.

Diagnostic assessments are used to determine eligibility for a variety of programs and services such as:

- County mental health services, including mental health targeted case management;
- Children's Therapeutic Services & Supports (CTSS) & outpatient mental health services in the MA benefit set;
- TEFRA, MA-EPD or CADI Home and Community Based Waiver;

- Supplemental Security Income (SSI);
- Mental health benefits through a health plan;
- Mental health services in a special education plan at school: Individualized Family Service Plan (IFSP), Individual Education Plan (IEP), or Individual Interagency Intervention Plan IIIP. (See School Topic Packet);
- 504 Plan at school for accommodations for children not qualifying for special education services. This refers to Section 504 of the Rehabilitation Act & the American with Disabilities Act. (See School Topic Packet).

Families find it helpful to keep copies of their child's most current diagnostic assessment to share with their health plan, other agencies and professionals in order to access appropriate and necessary services in a timely manner.

What do "medically necessary" mental health services mean?
Mental health services must be **medically necessary** to be covered by MA & MinnesotaCare. This means the recommended mental health service is consistent with the child's/youth's mental health diagnosis/condition; **AND**

- Is recognized as the prevailing standard of care or current practice; **AND**
- Is rendered in response to a life threatening condition or pain; to treat an injury, illness, or infection; **OR**
- To treat a condition that could result in physical or mental disability**; OR**
- To achieve a level of physical or mental function.

Private health plans also require mental health services be **medically necessary** in order for the health plan to pay for them. Families can contact the Customer Service Department or check the Member Benefit Book for their health plan's definition of medically necessary.

How often does a diagnostic assessment have to be done?
Diagnostic assessments have to be redone at certain times based on the child's needs & eligibility criteria for services.

The Department of Human Services is promoting several tools for case managers and mental health professionals to use to determine "Level of Care" or "intensity of services" needed by a child/youth with a diagnosed mental health disorder. The tools can, also, be used to determine outcomes in functioning in the child/youth in response to the specific mental heath treatment plan. These tools include: the Child & Adolescent Service Intensity Instrument (CASII), The Strengths & Difficulties Questionnaire (SDQ), and the Early Childhood Service Intensity Instrument (ECSII). It is anticipated that these tools will determine "Level of Care" and measure outcomes in a more standardized manner.

If no specific mental health disorder is determined by the mental health professional doing the diagnostic assessment, parents may find it helpful to:

- Ask the MH professional for ideas
- Consider 2nd opinion from another MH professional
- Find a parent mentor
- Have the child talk with school counselor, nurse, social worker
- Talk to the child's medical provider
- Call a MN mental health advocacy organization
- Attend a workshop about the child's behaviors

Who Can Help a Family Obtain the Mental Health and Other Services Their Child or Youth Needs After the Diagnostic Assessment?

Some children/youth may have a mental health disorder that minimally impacts their functioning. Their individual treatment plan, may have a short list of recommended services that are easy to find, easy to access, and easy to coordinate and to pay for. And the child's family is comfortable and knowledgeable to pursue getting this done independently. Or if the family needs minimal assistance they can always seek assistance from agencies and advocates listed on the next handout **MN Mental Health Resources.**

However, some children/youth with a mental health disorder may have more severe symptoms that impair their functioning at home, school or in the community. These individuals may require many different kinds of more intense mental health services as well as many other services from multiple providers in a variety of different settings. These services may be difficult to find access and pay for. The family may need help to do this.

These families could benefit from working with a **mental health case manager**, who could help them locate, access, and coordinate the variety of medically necessary mental health services the child/youth needs as well the other services, resources and supports they require.

The **mental health case manager** writes and develops a plan (called an **Individual Family Community Support Plan (IFCSP)** with the family and child based on the results of the diagnostic (including functional) assessment. It identifies specific services needed by a child and the family to:

- Treat the symptoms & relieve conditions leading to the emotional disturbance & improve the child's well-being;
- Improve interpersonal and family relationships including family functioning;
- Enhance daily living skills and vocational development;
- Improve functioning in education and recreation settings;
- Assist in obtaining mental health services as well as physical and dental health, educational, vocational, advocacy and legal services, transportation, housing, and employment.

A critical part of the case manager's job is to assess and reassess the delivery, appropriateness and effectiveness of services for the child/youth over time. An important method of assessment is to look for improved outcomes or improved functioning of the child.

How Does a Child/Youth Get a Mental Health Case Manager?

Children/youth covered by a private health plan—Most likely are not able to get mental health case management services through their health plan because private plans typically do not provide them. However, these children/youth may be able to access case management services through their local county human services agency. A youth 18-21 would need to call to request these services or give consent for the parents to call and request these services. Health plans do not typically pay for county case management services. The parent may have to pay a fee to the county for county case management services.

Children/youth with/without private health coverage or those covered by Fee-For- Service Medical Assistance (MA) – Families seeking help and/or case management services may be able to get help through the children's mental health program in their county. A youth 18-21 years of age, who is diagnosed for the first time with a mental illness, may be able to get help and/or case management through the adult mental health program in their local county human services agency. The youth would have to call to get help or give consent to the parents to call and get help. The child's or youth's diagnostic assessment is used by the county to determine eligibility for children's or adult services. The parents may have to pay a fee to the county for county case management services.

Children/youth covered by PMAP (Prepaid Medical Assistance Plan) or MinnesotaCare thru a Managed Care Organization (MCO) –Managed care organizations (MCOs) contracting to provide prepaid Minnesota Health Care Program (MHCP) services are responsible to provide/manage mental health targeted case management services to eligible enrollees. Many MCOs are contracting with counties to provide case management services. A family would need to call the number for Customer Service or Behavioral Health on the back of their health plan card and ask for a children's mental health case manager for their child. A youth 18-21 years of age, who is diagnosed for the first time with a mental illness, may be able to get help and/or case management through the adult mental health program. A youth 18-21 could need to request these services or give consent to the parents to request these services. The parents would not be asked to pay a parental fee for case management.

Children's Mental Health Services in Minnesota

There are many mental health services and funding resources available to residents of Minnesota. Minnesota's publicly provided mental health system is state-supervised and county-administered, reflected in the Minnesota Comprehensive Children's Mental Health Act (Minnesota Statutes 245.487 to 245.4887) which designates the county as the local mental health authority.

I. County Children's Mental Health Services

As stated in the Minnesota Comprehensive Children's Mental Health Act, each county is responsible for using available resources to develop and coordinate a system of locally affordable children's mental health services. Because of potential differences in availability of county funding, these services frequently vary from county to county. This does not mean that the county is necessarily required to provide or pay for these services, only to ensure availability of these services listed below. For example: A county may be so small that they cannot support a day treatment program. Instead they may contract day treatment from another county, or intensive services from a community provider.

The children's mental health service system developed by each county board must include the following services: (Services are listed in order of intensity, starting with least intense and ending with the most intense services)

- **Education and prevention services** - about predictors and symptoms of mental health disorders and their prevention, mental health services available in the county, and how to access these services.
- **Mental health identification and intervention services** – services designed to identify children who are at risk of needing or who need mental health services.
- **Outpatient services** – diagnostic assessment, psychological testing, individual, group and family therapy, physician visits and medication management.
- **Family community support services –** services provided under the clinical supervision of a mental health professional and designed to help each child with severe emotional disturbance (SED) to function and remain with the child's family in the community.
- **Professional home-based mental health services** - intensive services provided to a child at risk for out-of-home placement or to a child who is returning from out-of-home placement. Services, provided in the home, are designed to promote family preservation and unification and reduce out-of-home placement. Services include individual and family therapy, activities to promote skill development for the child and family in daily living, family relationships and recreation/leisure and other community activities.
- **Therapeutic support of foster care** - intensive treatment services available to a foster family (providing foster care to a child needing services) to provide a therapeutic family environment or support for the child's improved functioning. These services are intended to enable a child to improve or maintain emotional or behavioral functioning in order to reduce or prevent the reliance upon more intensive, restrictive, and costly services and/or to reunify the child with the child's family after out of home placement.
- **Mental health crisis services** - mental health crisis services within the county to meet the needs of children with emotional disturbance residing in the county who are determined, through an assessment by a mental health professional, to be experiencing a mental health crisis. The mental health crisis services provided must be medically necessary for the safety of the child or others regardless of the setting.
- **Emergency services** – immediate mobile response services available 24-hours every day for children having a mental health emergency. Intervention & stabilization services, & a crisis plan is written. (See **crisis services**.)
- **Case management services** – activities that are coordinated with the family community support plan and are designed to help the child and the child's family to obtain needed services.
- **Day treatment services** – structured program of group psychotherapy and other intensive therapeutic services provided by a multidisciplinary team, under the clinical supervision of a mental health professional to stabilize the child's mental health status while developing and improving the child's independent living and socialization skills.
- **"Screening" residential treatment** – prior to admission and except in the case of emergency admission, evaluate all children referred for treatment of severe emotional disturbance in a treatment foster care setting, residential treatment facility or informally admitted to a regional treatment center, if public funds are used to pay for services.
- **Residential treatment services** – 24-hour-a-day program under the clinical supervision of a mental health professional, in a community residential setting other than an acute care hospital or regional treatment center inpatient unit.
- **Acute care hospital treatment services** – inpatient hospital multidisciplinary team services supervised by a mental health professional for an acute episode of mental illness. Children who are hospitalized must meet "inpatient psychiatric admission guidelines" criteria to be admitted.

II. Mental Health Services Provided by Private Health Plan

Private health plans may not cover the same mental health services that Minnesota Public Health Care Programs (MA or MinnesotaCare) cover or that Minnesota counties may have available. Health plans are not required to provide a standard mental health benefit set. As a result, mental health benefits can and do vary across different health plan companies as well as vary by different plan options within one insurance company**. It is important to know that young single adults can continue to be covered under their parent/s' or guardian's health plan until age 25, even if they are not a full time student.**

III. Mental Health Services Covered by Minnesota Health Care Programs (MHCP)

Payment Mechanisms for Children's Mental Health Services in Minnesota Health Care Programs

Mental health services under Minnesota Health Care Programs (MHCP) are delivered and reimbursed one of two ways, fee-for-service (FFS) or prepaid health plans (PPHP).

- **FFS**-DHS establishes service standards for recipient eligibility, provider qualifications, specific parameters for scope, frequency and duration of services, documentation and level of care. Eligible providers must enroll as an MHCP provider; meet any additional provider eligibility requirements (eg: Certification for Children's Therapeutic Services and Supports (CTSS) and bill MHCPs (DHS) for reimbursement.

- **PPHP**-DHS contracts with health plans and county based purchasing (CBP) entities to reimburse providers for services provided to eligible recipients. Each health plan has an established provider network. Providers must be members of the network or have a relationship with the health plan to receive reimbursement from the health plan and must comply with the health plan policies. (**www.dhs.state.mn.us** -- Prepaid MHCP Provider Manual).

- Prepaid MHCP Provider Manual @ **NOTE: PMAP enrollment exclusions**----Recipients who have a serious and persistent illness (SPMI) or severe emotional disturbance (SED) **can be excluded** from participation in PMAP. Recipients with SED or SPMI are not required to enroll in a prepaid health plan and if they are enrolled, have the option to **disenroll.** They can, however, voluntarily enroll or continue in PMAP. Recipients must work with their county workers to choose the most beneficial option.

Mental health services paid for by MA/MinnesotaCare are listed below. For more information go to www.dhs.state.mn.us Click on Publications, then Manuals, then Minnesota Health Care Programs Provider Manual: "Mental Health Services". You can also contact your county human/family service agency and ask to talk to someone in the children's mental health program.

- Children's MH Crisis Response Services
- Outpatient Services
- Children's Therapeutic Services & Supports (CTSS)
  - ◇Children's Day Treatment
- Children's MH Residential Treatment Services
- MH Case Management Services

Children's Therapeutic Services and Supports (CTSS) are covered services in the MA Benefit Set.

CTSS is a flexible package of mental health services that are time-limited, and have varying levels of intervention and can be put together in varying combinations. The continuum of services range from limited community based services resembling traditional office-based practice, to services that are more structured and intensive (such as day treatment). The services are put together to reach the specific outcomes in the child's individual treatment plan.

CTSS services are designed to resolve an acute episode of emotional disturbance, in order to reduce the risk of out-of-home placement, improve the basic functioning of the child and the child's family in the activities of daily living, and improve the social functioning of the child and the child's family in areas important to the child's maintaining or re-establishing residency in the community.

CTSS providers must be recertified at least every 3 years. (See **School Topic Packet** and **Individualized Education Program (IEP) Services - DHS Handout** for information about schools becoming CTSS certified).

What services and supports are in the CTSS mental health services MA benefit package?

- **Crisis Assistance--**Crisis assistance requires the development of a plan that addresses prevention & intervention strategies in a potential crisis, including arranging for admission to acute care hospital inpatient treatment; crisis placement; community resources for follow-up; & emotional support to the family.
- **Psychotherapy**--Psychotherapy is a planned and structured treatment of a child's mental health disorder through the psychological, psychiatric or interpersonal method most appropriate to the child's needs, as identified in the diagnostic assessment, directed toward change in an underlying mental health condition or disorder, designed to reduce the symptoms of a disorder/ameliorate the effect of symptoms on the person's functioning.
- **Skills Training--**Skills training is mental heath treatment. It means individual, family, or group training, delivered by or under the direction of a mental health professional, designed to facilitate the acquisition of psychosocial skills that are medically necessary to rehabilitate the child to an age-appropriate developmental trajectory heretofore disrupted by a psychiatric illness or to self-monitor, compensate for, cope with, counteract, or replace skills deficits or maladaptive skills acquired over the course of a psychiatric illness.
- **Mental Health Behavioral Aide (MHBA) Services--**MHBA services are medically necessary mental health treatment services. They are one-on-one activities performed by a trained paraprofessional to assist a child retain or generalize psychosocial skills as taught by a mental health professional or mental health practitioner as described in the child's individual treatment plan and individual behavior plan. Activities involve working directly with the child, child-peer groupings, or child-family groupings to practice, repeat, reintroduce, and master the skills as previously taught by a mental health professional or mental health practitioner.

CTSS Programs

Sometimes individual mental health service components are put together to create structured programs. The 2 programs described below require a variety of professionals & practitioners from the same agency to work together under the supervision of a mental health professional to provide services.

- **Therapeutic Preschool Program**--Provides early intervention in a licensed, structured day program that by multidisciplinary staff under the direction of a mental health professional at least 2 hours per day, 5 days per week, 12 months each calendar year. The provider is able to identify the needs & strengths of the child & family and to focus the education of the family/caregivers on developing skills to reduce & resolve symptoms of the child's emotional disturbance. Children must be at least 33 months old & have not yet attended the first day of kindergarten.

- **Children's Day Treatment**:--Is a structured program consisting of group psychotherapy and other intensive therapeutic services provided by a multidisciplinary team and available at least 2 hours a day (with at least one hour of psychotherapy and the remainder time as either psychotherapy or skills training), 15 hours a week and 12 months of the year. The multidisciplinary team consists of mental health professionals and practitioners from different disciplines. The program must stabilize the child's mental health status while developing and improving the child's independent and socialization skills. The goal is to reduce or relieve the effects of mental illness and provide training to enable the child to live in the community.

Accessing Children's Residential Mental Health Treatment

What is Children's Residential Mental Health Treatment?

Children's Mental Health Residential Treatment Services is a 24-hour-a-day program under the clinical supervision of a mental health professional, and provided in a community setting, other than an acute-care hospital or regional treatment center. Services are designed to stabilize the crisis and to prevent placement in more intensive, costly or restrictive settings. These services are designed to help the child improve family living and social interaction skills as well as to gain the necessary skills to return to the community. Program staff, work with families throughout the placement to improve the ability of the families to care for their children at home. Children must be under age 18 years, and have been screened by the county (fee for service MA) or screened by the county **and** health plan (PMAP/MinnesotaCare) as needing residential treatment services before placement in the facility. This is called the level of care screening using the Child and Adolescent Service Intensity Instrument (CASII).

Families may contact National Alliance on Mental Illness-Minnesota (NAMI-MN) for important information regarding a Voluntary Placement Agreement when they are considering residential treatment for their child/youth. NAMI Minnesota, 800 Transfer Road, #31, Saint Paul, MN 55114. Phone: 651-645-2948 toll free: 1-888-NAMI-HELPS. Website: www.namihelps.org Email: nami-mn@nami.org

Because Residential Treatment is a relatively expensive form of care, it is particularly important to pay attention to the kind of coverage the family has and to get the proper authorizations prior to entering treatment!

- **Private health coverage.** If the family has private health insurance, the family should first determine if it covers residential treatment and pursue getting an authorization for treatment through their private coverage. State law (MS § 62A.151) requires that insurers cover children's residential mental health treatment on the same basis as they cover hospitalization. However, this state requirement does not extend to "self-insured" health plans offered by many larger employers. These "self-insured" plans are governed by federal law instead. Private policies may have limits on the length of coverage. If there are limits to the family's private coverage, they should simultaneously look to the publicly funded options below in order to continue funding for care if needed beyond the limits of their private coverage.

- **Coverage through PMAP (Prepaid Medical Assistance Plan) or MinnesotaCare through a Managed Care Organization.** In cases where the child is enrolled in a Managed Care Organization (MCO) for their MA or MinnesotaCare, families should first contact their MCO or the MCO's contracted behavioral health care provider for authorization for children's residential mental health services. The MCO will then coordinate with the child's county of financial responsibility for full authorization of the placement (see county funded treatment below).

- **County funded treatment and Medical Assistance-Fee-For-Service (FFS).** The family's county of financial responsibility is always involved in the funding and authorization of publically funded children's residential mental health treatment. In this state, these facilities are considered foster care settings, so the county is always responsible for at least the placement costs not related to treatment. When the treatment costs are covered by Medical Assistance or Minnesota Care, the county pays for the balance of the per diem costs. When Medical Assistance and Minnesota Care coverage are not available, the county pays for the entire cost of care. Counties are solely responsible for the level of care determination and authorizations for children's residential mental health treatment when the child is on fee-for-service Medical Assistance or has no private coverage for the service. When the child is enrolled in a PMAP plan, the MCO and county coordinate the authorization for treatment. The county authorization process is governed by MS § 245.4885.

- **Parental Fees.** Parents are often subject to parental fees when their child is in residential treatment. These fees are collected by the Department of Human Services and are governed by MS § 252.27.

Transition Services for Youth Turning 18

Certain youth ages 18 thru 20 may receive adult treatment, children's treatment or a combination of both, depending on medical necessity.

- **Intensive Residential Treatment Services (IRTS) --** Intensive Residential Treatment Services (IRTS) are for recipients 18 years and older who are in need of more restrictive settings versus community settings and are at risk of significant functional deterioration if they do not receive these services. They must meet specific IRTS admission criteria. IRTS are designed to develop and enhance psychiatric stability, personal and emotional adjustment, self-sufficiency and skills to live in a more independent setting.

- **Adult mental health case management services --** Minnesota Statute says that if a child is receiving children's mental health case management services or family community support services at 17 years of age, upon turning 18 that young adult (with a mental health professional's recommendation) may continue receiving mental health case management services. In this situation, mental health case management service for the

young adult over age 17 but under 21 years of age may continue to be provided by the children's service system (if the person is receiving special education services through the local school district, or it is in the best interest of the person to continue services) or by the adult service system. This young adult would not be subject to the SPMI eligibility definition for adult case management services at this time as long as the service continues uninterrupted.

- **Adult Day Treatment --** Adult day treatment is a structured program of group psychotherapy and other intensive therapeutic services provided by a multidisciplinary team to stabilize a recipient's mental health status while developing and improving his/her independent living and socialization skills. The goal is to reduce or relieve the effects of mental illness and provide training to enable the recipient to live in the community.

Glossary of Definitions

What are emotional disturbance (ED), severe emotional disturbance (SED), mental illnesses (MI) and serious and persistent mental illness (SPMI)? Why are they important?
These definitions are used to determine eligibility for a variety of services & programs including county services & Minnesota Health Care Program benefits and services. Private health plans do not use these definitions.

Emotional Disturbance (ED) - means the child has an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory or behavior that:
Is listed in the clinical manual of the International Classification of Diseases (ICD-9 CM), current edition, code ranges same as MI, or in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-MD), current edition, Axes I, II, or III; and

- Seriously limits a child's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, school and recreation.

Note: "Emotional Disturbance" is a general term and is intended to reflect all categories of disorder described in the DSM-MD, current edition a "usually first evident in childhood or adolescence".

Severe Emotional Disturbance (SED) - means the child has an emotional disturbance (ED) (see above) and meets **one** of the following criteria:

- Has been admitted to inpatient treatment/residential treatment or is at risk of being admitted, within the last three years; or
- Is a MN resident and is receiving the inpatient treatment or residential treatment for an emotional disturbance through the interstate compact; or
- A mental health professional has determined the child has one of the following:
    a. Psychosis or clinical depression;
    b. Risk of harming self or others as a result of emotional disturbance; or
    c. Psychopathological symptoms as a result of being a victim of physical, sexual abuse or psychic trauma within the past year; or
- A mental health professional has determined the child has a significantly impaired home, school or community functioning lasting at least one year, or in the written opinion of a mental health professional presents a risk of it lasting at least one year, as a result of emotional disturbance.

Mental Illness (MI) – Means the youth or adult has an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is listed in the current edition of the ICD-9CM, code range 290.0 to 302.99 or 306.0 to 316.0.

Serious and Persistent Mental Illness (SPMI) – The condition of an adult or child (at least 18, but under age 21), with a mental illness diagnosis, and meets at least **one** of the following criteria:

- Has been treated by a crisis team two or more times in the preceding 24 months; or
- Has undergone two or more episodes of inpatient care for mental illness within preceding 24 months; or
- Has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months duration within the preceding 12 months; or
- Has a diagnosis of schizophrenia, bipolar disorder, major depression, or borderline personality disorder; evidences a significant impairment in functioning; and has a written opinion from a mental health profession stating he/she is likely to have future episodes requiring inpatient or residential treatment, unless community support program services are provided; or
- Has, in the last three years, been committed by a court as a mentally ill person under Minnesota statutes, or the adult's commitment as a mentally ill person has been stayed or continued; or
- Was eligible under one of the above criteria, but the specified time period has expired; or
- The recipient was eligible as a child with severe emotional disturbance, and the recipient has a written opinion from a mental health professional, in the last three years, stating the he/she is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in the above criteria, unless ongoing case management or community support services are provided.

Who Pays for Mental Health Services for Children/Youth?

What are financial resources that may pay for children's mental health services?
There are a variety of potential different payment sources and frequently **"Who Pays"** for services depends on the:

- Severity of the mental health condition, * Amount and type of funding available, and
- Eligibility of the child to receive the funding. * Specific mental health service recommended.

Possible Funding Sources for Children's Mental Health Services May Include One or More Below:

1. Local County Funding

The amount of funding available for children's mental health services varies in different counties. Larger counties with larger populations may have more funding available compared to smaller counties with smaller populations. Families need to contact their local county social services agency and talk to a social worker in the Children's Mental Health Program to find out what funding and services are available through their county. Some families may have to pay a monthly parental fee to the county for certain county mental health services.

2. Private Insurance Benefits

There are a variety of health plans available. There are private individual or family policies persons may purchase themselves and pay a monthly premium out of their pocket. There may be employee health plans available through an individual's employer. The employer may pay all or a portion of the employee coverage. Family coverage may, also, be available through the employer. Frequently the employee must pay the entire premium for family coverage. This can be very expensive. It is common for employees **not** to purchase family coverage.

Health plans can vary significantly in their benefits, limitations and exclusions. They also vary in amount of deductibles and co-pays. Some plans have cheaper premiums if the person chooses a plan without maternity benefits and/or mental health benefits and/or chemical treatment benefits.

It is very important to know the following about your insurance's mental health benefits:

- Specific benefits, co-pays, limitations exclusions for mental health services including medications; and
- The definition your plan uses for **medically necessary;** and
- If it is necessary to get a physician's referral to a mental health provider for the mental health services to by covered by the health plan; and
- Does the health plan have a specific network of mental health providers that must be used for the plan to pay.

NOTE: A child/young adult can have private insurance AND may be eligible for Medical Assistance (MA).

An example of private insurance is TRICARE military health care coverage for a parent serving in the U.S. Armed Forces, an activated National Guard or Reserve member, and their families. Go to: **http:tricare.osd.mil** for details about TRICARE plans, providers and benefits. Or call the number on the back of the TRICARE health card.

3. Minnesota Health Care Programs (MHCP)

Minnesota Health Care Programs (MHCP) provided by Minnesota Department of Human Services (DHS) are a major source of public funding for mental health services.

***MA (Medical Assistance)** – Helps pay for past (last 3 months), current & future medical costs for low-income families with children (less than age 21), seniors (age 65 or older) & people with disabilities. There are income & asset limits. [Assets are not considered for pregnant women & children under age 21]. Persons over income may still be eligible for MA after meeting a "spenddown". Must be a US Citizen or Non-citizen lawfully in the U.S.

(Supplemental Security Income (SSI) for Children thru the Social Security Administration (SSA)–may be an avenue for children to access MA coverage & benefits. Children certified disabled by SSA with a mental health condition and who financially qualify for SSI, may receive SSI monthly cash payments. **If the child is eligible for and receives SSI, the child is also eligible to receive MA**. To access MA, the parent/guardian must show the child's SSI documentation of disability to the county financial worker at their family/social services agency.)

- **EMA (Emergency Medical Assistance)** – For **undocumented or nonimmigrant persons only,** who are ineligible for MA due to their immigration status or deeming of sponsor income & assets. Must have a medical emergency. (**For definition of medical emergency, see Tools Packet: MEDICAL FUNDING SUMMARY-- EMA)** The medical emergency may be an acute or chronic, physical or mental health condition or birth. Must have an MA "basis of eligibility": pregnant, families with children under 21, (under 65), blind or disabled & meet all other MA eligibility requirements including financial and state of residence. If over income, may be eligible with a "spenddown".

- **TEFRA-MA** – Allows some children (under age 19) who are certified disabled, living with their families, to be eligible for MA, without counting parent's income. Only the child's income & assets are used to determine eligibility. There may be a state parental fee for TEFRA based on parent income and family size. Eligibility can go back 3 months from date of application. Persons must be US Citizens or Non-citizens lawfully in U.S.

- **MA-EPD (MA for Employed Persons with Disabilities)** – Allows working persons (ages 16 to 65) who are certified disabled to qualify for MA. Persons pay a sliding fee premium (based on individual's income & household size), with no maximum income limit or maximum premium amount. The asset limit is $20,000. Must be a US Citizen or Non-citizen lawfully in U.S.

- **HCBS (Home & Community-Based Services)** – Persons must first be eligible for MA & certified disabled. HCBS provide funding to cover a wide variety of items/services not paid for by MA, in order to prevent out-of-home placement. There are different waivers based on the disability and level of care needs. Children with SED or SPMI may qualify for a CADI Waiver. There may be a state parental fee based on parent income and family size. There are often waiting lists at counties for the HCBS. Persons must be US Citizens or Non-citizens lawfully in the U.S.

***MinnesotaCare** – State-subsidized health insurance for persons without children and/or families (with children less than age 21) who do not have access to affordable health care coverage (including Medicare). You must have lived in Minnesota for 6 months. Eligibility is based on age, income, assets and insurance. There are exceptions to the asset requirements (for pregnant women and children) and exceptions to the insurance restrictions (for certain low income children). There is a monthly premium to pay based on income and family size. Eligibility begins the month **after** the premium is paid. Persons must be US Citizens or Non-citizens lawfully in the U.S.

4**. American Indians** can access mental health services through federal, state, county, or tribal governments, or through American Indian Health Boards. Per state statute, twenty-five percent of the federal block grant funding is designated for mental health services for American Indian Communities.

5. Parent/Families Pay for Mental Health Services

Families may pay all or part of the costs of mental health services. Some mental health centers have contracts with their county to provide mental health services & frequently have a sliding fee schedule based on family income or ability to pay. If their income is lower, the parent/guardian may be able to pay a reduced fee. It is important for the parent or guardian to ask the clinic's business office or the individual in private practice, before any services are provided, how much the charges will be for each kind of service and if a sliding fee option is available. Charges for various mental health services and reduced payment fees frequently can vary among mental health centers.

6. Local Public or Private Partnerships

Sometimes there is special funding available when different service agencies (counties, school districts, mental health clinics, juvenile corrections) make an agreement to provide integrated, coordinated & unduplicated services, pool resources and design community based mental health services that are easier for the child & family to access.

- **Children's Mental Health Collaboratives or Family Service Collaboratives** that may pay for or provide some mental health services but because of decreased funding, the services offered have decreased.
- **Special time-limited grant money**. Ask a county children's mental health social worker, the county public health nurse, or the school social worker or nurse if there is any special project/grant funding available.

7. See **Additional Resources** at the end of the **Tools Packet** for more potential funding resources.

NYU Child Study Center
NYU LANGONE MEDICAL CENTER

Choosing a Mental Health Professional for Your Child: Who, What, When, Where, How

Why should you get help?

Every child experiences emotional difficulties from time to time but at some point, a child's problems may warrant professional attention. Yet parents are usually less familiar with, or feel confused about, obtaining mental health care. When a child is sick with the flu or breaks a leg, parents usually head straight for the doctor. And as a parent, you are well versed in the standard routine doctor visits for everything from vaccinations to ear aches. Physical symptoms seem more obvious and unfortunately, may get more professional attention than mental health symptoms.

But just like physical problems, the prognosis is better when the mental health problem is treated early. Surprisingly, many problems seen by medical doctors have a psychological component.

It is estimated that over 15 million children and teens have a mental health or substance abuse problem. Sadly, only one in five of the children with a mental health problem gets treated-a figure far smaller than the number of children being treated for a medical ailment. What accounts for the disparity? Parents may not readily recognize their child's symptoms as a mental health problem. They may feel embarrassed or ashamed, think they should handle the problem on their own, feel the situation is hopeless, disagree when others suggest the need for outside help, or dismiss or misunderstand a child's problem. Unfortunately, misconceptions and shame may delay or prevent adults and children from getting the help they need. When parents are concerned about a possible mental health issue they can benefit from seeking guidance from a professional. In fact, once addressed, parents may be reassured that their child's experiences are developmentally appropriate, and that alone can ease discomfort. Or, they may decide to engage in a course of treatment that will result in better functioning for both the child and family.

When should you seek help?

Many physical and emotional signs suggest a possible mental health problem. Problems can range from those of serious concern, for example, when a child or adolescent has lost touch with reality or is in danger of harming himself, to those of less concern, for example, when a child or teen experiences a change in eating or sleeping, feels frustrated, or is particularly fearful of something. But any problem that is personally bothersome warrants evaluation. Further

investigation may be warranted when a child seems out of step with peers or exhibits changes or problems in any of the following areas:

- Eating/appetite
- Sleeping
- School work
- Activity level
- Mood
- Relationships with family or friends
- Aggressive behavior
- Return to behavior typical of a younger child
- Developmental milestones such as speech and language

In general, any of the above symptoms would first be evaluated with respect to the:

- intensity
- duration
- age appropriateness
- interference with the child's and family's life

Where do I start?

Looking for information can be a crucial first step. Parents may not be sure their child has a mental health problem, not know exactly what it is, or wonder whether it is serious enough to seek help. All of these questions can be discussed with a professional.

A variety of obstacles may get in the way of seeking mental health treatment-all of them can and should be overcome. Some of the roadblocks are real; some are due to common myths and misinformation about what it means to need help and what will happen. The following are some typical concerns and solutions.

"I'm embarrassed and uncomfortable about the problem"

Solution Feeling uncomfortable talking about personal problems is not uncommon. This can stem from feeling guilty and blaming oneself or believing certain issues should remain private. As a way to avoid addressing a problem, parents may ignore it, hoping the child will "outgrow" it. Like many things in life, individuals often imagine far worse than is the reality. Mental health professionals have experience with the issues, are familiar with your concerns, and are trained to put parents and children at ease.

"My child won't go"

Solution Children and teens rely on and require the confident, clear thinking of their parents to get them involved in treatment. Talking directly and honestly with children can also allay their concerns. Forcing someone into treatment is usually unsuccessful. But an attitude of concern that transmits understanding of how difficult it is to accept help will be appreciated. It may be useful

to point out how the problem interferes with enjoyment of life. If parents have a positive attitude about getting help they will enable their child to follow suit. Approaching the issue as everyone's problem and involving everyone in the solution will foster cooperation.

"I don't know any mental health professionals"

Solution As in seeking help from any professional, it is useful to employ some tried and true strategies.

1. Talk things over with the child's pediatrician, school teacher or guidance counselor. Not only do they know you and your child well but they should also be involved in any assessment of the problem.
2. Get a recommendation from a trusted friend or family member.
3. Check with a clinic affiliated with a local hospital or medical school.
4. Contact national or local professional organizations.

"I don't know how I would fit it in"

Solution it is important to make time available for treatment and to adjust your family's schedule. Be realistic about the logistics of getting to treatment. If the best professional is an hour away you must decide whether you are willing to make the necessary arrangements or prefer to ask the professional for a comparable referral nearby, thus increasing the likelihood of your engaging in treatment.

"I can't afford treatment"

Solution There are a variety of lower cost clinics, often through graduate training programs or hospitals. Recent laws have improved insurance company reimbursement for mental health treatment and are moving to a point of being on par with reimbursement for physical illness. Insurance companies also usually have a list of approved clinicians in your network. If you find someone who is not covered by your insurance plan, or whose fees are beyond your means, it is worthwhile to ask the professional if s/he has a sliding scale, and/or ask your insurance provider if it can make a one time exception and add the professional to the provider list for your individual case.

"If I need help it must mean I'm a bad parent"

Solution Unfortunately mental illness is stigmatized in our society. Media images and news stories may portray distorted images of those with a mental illness as being violent and out of control and parents as being uncaring and uninvolved. But mental illness is real, it can be treated and should be considered similar to any illness. Like medical illness we often do not know what the cause is. Certainly no one would avoid treatment for diabetes or cancer, but the same person might feel ashamed of having a mental illness. The greatest harm comes from leaving mental illness untreated.

"I heard that treatment lasts forever"

Solution Certain myths generated by popular culture are outdated. Treatment only lasts as long as is necessary. The goal of any mental health treatment is for the individual to function independently and to feel successful and fulfilled in life. Different problems require different types of treatments for differing amounts of time. Certainly the sooner treatment is begun the better-the sooner the improvement and the better the prognosis.

"All they do is give drugs"

Solution Medication is only one option among many for certain disorders. A wide variety of treatments is available. The use of medication is dependent upon the individual, the problem, and his/her preferences. Once options are explained, any treatment decision is best made between the professional and the parent. Some treatments are carried out alone, some in combination with medications and all involve parents to some extent. With children, the treatment can involve talking and/or playing as a way of understanding the child's concerns and working out solutions. Some of the more common non-medication treatments include:

1. cognitive behavior therapy (CBT): provides skills that help individuals learn new ways of thinking and behaving and is often used when there are symptoms of anxiety and/or depression
2. dialectical behavior therapy (DBT): this is a form of CBT with several enhancements and is used with adolescents who have mood symptoms and self-destructive/self-injurious behaviors
3. behavior therapy: provides tools for dealing with problem behaviors
4. verbal psychotherapy: one's current problems are discussed, perhaps in light of past difficulties, and options for coping with different feelings and behavior and for engaging in different relationships in more effective ways are developed
5. marital or family therapy: the professional helps members of the couple or family understand how their behaviors affect one another and the children, and provides instructions and strategies for making changes
6. roup therapy: issues are explored within a group setting with individuals who share similar problems
7. interpersonal psychotherapy: feelings and responses are explored within the context of different interpersonal or social relationships and situations

"Other people will find out and think there's something wrong with me or my child"

Solution A therapist and a client/patient engage in a confidential relationship. Licensed professionals are bound by both a code of ethics and state laws which allows information told to a therapist to be kept confidential between the patient and therapist. A mental health professional's main goal is to protect both the physical and emotional well being of the patient. In certain situations, however, action must be taken or information revealed. In the interest of patient and public safety, mental health professionals are obligated to report any instances or information they have about abuse of children, the elderly, mentally or physically handicapped. In addition, action must be taken when there is a risk of danger to the self or others, e.g. by suicide or by threats on someone's life. Other instances in which certain information can be revealed include giving specific information to an insurance company as stated by their policy, to

collection agencies, when involved in legal matters concerning the person's mental health, and when involved in legal complaints against the professional.

Who does the treatment?

Individuals might consider the following checklist of questions to ask and issues to consider when deciding on a professional and a type of treatment.

- Professional's credentials and training: consider the training of the professional and inquire as to his/her experience or expertise with the problem. If the professional is licensed in your state make sure the professional has the appropriate credential. The most common licensed professionals are:

- Psychiatrists, have an M.D. degree and can provide therapy in addition to prescribing medication
- Psychologists have a Ph.D. or Psy.D. degree and can provide therapy in addition to conducting psychological tests
- Social Workers have a masters degree and are identified by the LCSW license
- Marriage and Family Counselors usually have a masters degree and are identified by the MFCC license
- Other possible licensed professionals include Mental Health Counselors and Pastoral Counselors.
- Some professionals, without state licensure, may be certified by their own professional organization.

- Experience: the professional should have training and experience with children and expertise with the particular problem of concern.
- Involvement: it is important to understand how parents are involved in the child's treatment.
- Type and format of treatment: parents and children should understand the scope of the treatment, the procedures used and the frequency and duration of the sessions.
- Cost, insurance policy: it is the parents' responsibility to know their own financial resources and any insurance requirements and limitations
- Location, ease of accessibility: treatment must balance convenience with availability of the professional

How do I decide if this is the right professional?

Once a parent has decided on a therapist, it is important for the child or teen and parents to feel comfortable with the treating professional or agency. Having confidence in the person is essential for establishing a positive working relationship and important when facing difficult moments or decisions. Parents often benefit from having an initial consultation or one or two sessions before making a decision about ongoing treatment. The "fit" must be right in order to establish a good working relationship. What may work for one person may not feel right for another. However, if the parents or child feel uncomfortable after a few sessions, this should be discussed in order to assess the source of the problem. For example, is the difficulty due to

embarrassment about discussing the problem, a child who is resistant due to being angry at the parents for suggesting treatment, or is it incompatible styles between the professional and the patient?

What is the role of the parent?

The initial session or two, with the parents and/or the child, is usually used to evaluate the problem. This is typically done by interview and may also involve questionnaires. In the case of a child, the professional will need information from the parents about the family history, home environment, child's physical and emotional development, friendships, and may consult other relevant medical and educational professionals for information. Soon after the evaluation phase, the professional should discuss the assessment and outline a plan of treatment. Parents should be informed about their role in treatment, preferred method of communication with the professional, schedule for feedback and updates, coordination with outside resources or professionals, strategies for helping their child participate in treatment, alternative treatments, risks and goals.

Successful therapy usually requires an investment of time and energy on the part of the professional, parents and child. The therapist may act as a guide, instructor, cheerleader, sounding board, and confidante. However, the parents and child must also participate and take responsibility for putting the learning into practice. It is important for everyone involved to monitor change and progress.

About the Author

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What Is the Role of Teachers in Children's Mental Health?

What can I do when I'm concerned about the mental health of a child in my care?

Educators and caregivers may be among the first people to notice changes in a child's mental health. Here are important steps to take when a child's behavior raises concerns:

- Observe and take notes on the child throughout the day. Do this over several days or weeks to help you see patterns. Does the behavior that concerns you occur at certain times of day? In certain parts of the building? Be sure to note the child's strengths as well as areas of concern.
- Share your concerns with your program's director, principal, or social worker. Be as specific as possible in explaining why you are concerned. Give details: "Emily pried the arms off of all the dolls twice this week. Every day after lunch, she slammed into children who were playing alone, knocked them down, and ran away laughing. She seemed to single out children who are smaller than she is."
- Learn and follow your program's procedures for working with children with challenging behaviors. Whose responsibility is it to talk to the family? If a child's actions are dangerous, can an extra adult stay in the room to help out? Does the school have a referral process in place?
- Be ready to talk with the child's family about your concerns.

When a child you know seems to be having mental health difficulties, you can take action to help the child. It is important to be sensitive to a child's individual needs. For example, a child who is overly watchful as a result of trauma may not want to take part in any activity that involves closing his eyes. A child who is grieving may need some time to cry in private or on a teacher's lap. Relationships with adults who are warm, nurturing, and respectful of the child can be extremely helpful.

Validate the child's feelings, but set some limits. For example, let the child know you can accept his being angry, but he is not allowed to hurt people or pets. It may be necessary to have an extra person in the classroom to help out if a child's aggressive or reckless behavior poses a safety threat to herself or others.

Maintain a consistent routine to reassure children who have been through chaotic times such as disasters or family trauma. If there will be a change in routine, try to let children know ahead of time what to expect.

Keep in mind that a child who believes he is bad and unlovable may act in ways that make others dislike him. This is sometimes called a "recursive cycle." He may believe that the teacher cares less about him than about the other children. Reassuring the child may be very difficult, especially if he seems to reject what you say. It may take awhile for children to understand that there is a difference between themselves and the things they do. Specifically separating the behavior from the child can be helpful. For example, you might say, "I really don't like for you to hit people, but I still like you."

Some children will respond positively to suggestions for ways to express feelings effectively, or ways to act on their own behalf: "When you feel so angry you want to hit, you could punch this pillow or stomp your feet." "When you feel lonesome and sad, would you like to ask a friend or a teacher for a hug?" "If you don't like what Jake says, you can tell him to stop."

A traumatized child may need opportunities to draw or play about what has happened. Provide toys and materials that children may use to help express feelings or relieve stress. A child may start to cope with fear, anxiety, anger, or grief by playing with play dough, clay, water, puppets, dollhouses, art supplies, and other "open-ended" items. A child involved in such therapeutic play may need to be able to play alone. Asking him or

her to share or take turns at such times may not be helpful. Keep extra materials around in order to avoid conflict.

Be aware of how other children in the class may be feeling about the child who is having difficulties. Are they afraid of her? Worried about her? Angry? Rejecting? Your modeling can be very important. You can model acceptance of the child's needs, while at the same time assuring the class that each of them deserves the care and concern of everyone in the group. Help children find ways to express care and support for a child who is recovering from a difficult experience. Show them how to stand up to someone who is aggressive and hostile, and show them how to defuse aggression.

How should I approach the family when I am concerned about a child's mental health?

When a teacher or caregiver notices that a child's mental health may be in jeopardy, it is important to talk with the child's family. Such conversations call for tact and thoughtful preparation.

Being well prepared for the conversation is extremely important. If your program has social workers, nurses, or counselors, talk with them about the child's behaviors. Ask them for suggestions about the best ways to approach the family. Before talking with the family, ask your local school district and mental health agencies about available support services. Who can evaluate a preschooler's mental health? Is affordable counseling or play therapy available? Collect materials about these resources to give to the family.

With others in your program, decide what you or other staff members can do to help the child. For example, what will you do if the child puts herself in danger? Can an aide be provided for a child with serious problems? Be ready to present these options to the family.

Consider which staff members know the child or the family best. Be sure to include them in meetings with the family.

Also, be aware that if the family's cultural background is different from your own, you may want to find out first what some of their perspectives might be on mental health and social-emotional development. A librarian may be able to help you find information about cultural variations in ideas about mental health. But it will be very important as you talk with the family to listen closely to what they seem to believe about the child's behavior and about children's mental health in general. You may need to spend extra time establishing some common ground in order to work most effectively with the family. If possible, you might want to find someone who works regularly with immigrant and refugee families who can give you firsthand information about what to expect and how to approach mental health issues in this situation.

Similarly, if you have concerns about the mental health of a child whose home language is not English, it would be helpful to use an interpreter who can translate ideas and terminology so that everyone can understand each other during potentially sensitive discussions about a child's behavior and well-being.

No parent wants to hear bad news about his or her child, and some parents may be defensive. They may accuse others, even program staff, of causing the child's difficulties or of exaggerating the problems. Other parents may not be ready to accept that a problem exists; this is sometimes known as denial. Still others may be deeply relieved that someone else shares their concerns about the child. In any case, when you express your concerns to the family, it is important to be tactful but candid. Here are some points to remember:

- Explain that you need to hear the family's point of view. You might say something like, "We need your help. We've seen a change in Olivia. She cries very hard for more than an hour every day. Will you meet with us to talk about ways to help her feel better at school?"

- Avoid labels. If you say, “Olivia seems depressed,” the parents will not be able to picture her behavior. Instead, describe clearly what the child does. For example, “Olivia hides under her coat and cries herself to sleep. Nothing we do seems to comfort her.”
- Ask the parents if they see similar behaviors at home. What have they tried that helps the child feel better?
- Invite parents to watch the child in the classroom, so they can see what you have described.
- If necessary, explain how the child’s behavior gets in the way of friendships and learning activities. Again, it is important to describe exactly what you have seen the child do. Instead of saying, “She doesn’t like her friends any more,” you might say, “She stopped playing with friends about two weeks ago. When someone invites her to play, she just turns away. She doesn’t watch the others play. She just curls up inside her coat.”
- Do not use diagnostic terms--even if parents press you to do so. A mental health specialist should be the one who diagnoses and explains such conditions as depression, autism, etc.
- Word your comments with care so that parents do not feel blamed for the child’s troubles. Ask them what they think might be going on.
- Be sure to spend time talking about the child’s strengths as well as her difficulties. Her strengths are what you and the family can build on to help her.

It also helps to show the family that you do not expect them to “fix” the child by themselves. Give the parents or guardians materials you have collected. They might appreciate free pamphlets about children’s social and emotional well-being or materials about mental health services in the area. If it seems appropriate, you might also make referrals to community resources such as mental health clinics or play therapists who have been recommended by other parents.

Engage the family in planning some ways to help the child. For example, the parents might agree first to take the child to a pediatrician, and you might agree to write a letter to the doctor carefully describing what you have noticed about the child’s behavior. Or the parents might decide to find counseling, while the center director agrees to have an aide stay near the child during the day. The plan should include setting a time to touch base in three or four weeks to discuss how things are going for the child.

Keep in mind that it may take time for parents to think about what to do when a child seems to be having problems that affect his or her mental health.

Information from: Illinois Early Learning Project, funded by the Illinois State Board of Education
http://illinoisearlylearning.org/faqs/mentalhealth.htm#do

Minnesota Mental Health Resources

Alliance for the Mentally Ill of Minnesota
Please see new listing under National Alliance on Mental Illness, NAMI-MN

Arc Greater Twin Cities
2446 University Avenue W, Suite 110
St. Paul, MN 55114
952-920-0855
info@arcgreatertwincities.org
www.arcgreatertwincities.org
Advocacy and support for people with intellectual and developmental disabilities and their families

The Arc of Minnesota
770 Transfer Road, Suite 26
St. Paul, MN 55114
651-523-0823 • 800-582-5256
mail@arcmn.org
www.thearcofminnesota.org
Advocacy and support for people with intellectually and developmental disabilities and their families

Attention Deficits Support Services
Please see new listing under Learning Disabilities Association, LDA-Minnesota

Autism Society of Minnesota
AuSM
2380 Wycliff Street, Suite 102
St. Paul, MN 55114
651-647-1083
info@ausm.org
www.ausm.org
Advocacy and education for individuals with autism and their families

Behavioral Institute for Children and Adolescents
1711 West County Rd B Suite 110S
Roseville, MN 55113
651-484-5510
info@behavioralinstitute.org
www.behavioralinstitute.org
Trainings and resource information for working with children and adolescents with emotional and behavioral challenges

Children and Adults with Attention Deficit Disorders of MN
CHADD
800-233-4050
Twin Cities: 952-922-5761
Duluth: 218-340-9319 (Joanne)
Rochester: 507-280-6937
www.chadd.org (Click find support, then find local chapter, choose state at bottom of page)
Support groups and resources for children and adults with AD/HD

Children's Home Society and Family Services
CHSFS
1605 Eustis Street
St. Paul, MN 55108
651-646-7771 • 800-952-9302
www.chsfs.org
Provides education advocacy for people with learning disabilities and attention deficit disorders, adoption, and post-adoption support

Depression and Bipolar Support Alliance
Please see new listing under MHAM, Mental Health Association of Minnesota

Disability Minnesota
www.mndisability.gov
This website provides easy links to all state services relating to disability

Institute for Minority Development
IMD
1710 Douglas Drive Suite 145
Golden ValleMN 55422
763-544-2748
In-home and community-based family support services for children and adults with developmental disabilities

Learning Disabilities Association
LDA-Minnesota
6100 Golden Valley Road
Golden Valley, MN 55422
952-922-8374
info@ldaminnesota.org
www.ldaminnesota.org
Offers child and adult education, AD/HD support groups and workshops, assessments, tutoring, and referrals

Attention Deficits Support Services
A program/service of LDA Minnesota

Mental Health Association of Minnesota
MHAM
2021 E Hennepin Avenue, Suite 412
Minneapolis, MN 55413
612-331-6840 or 800-862-1799
info@mentalhealthmn.org
www.mentalhealthmn.org
Support and information regarding adults and transition services for youth with mental health needs

Depression and Bipolar Support Alliance
Minnesota support groups administered by Mental Health Association of Minnesota

Minnesota Legal Assistance
www.mylegalaid.org
Legal advice, referrals and representation to low-income families or people with disabilities

Legal Aid Society of Minneapolis
Downtown Office
430 1st Avenue N, Suite 300
Minneapolis, MN 55401-1780
612-332-1441

St. Cloud Area Legal Services
830 W. St. Germain, Suite 300
P.O. Box 886
St. Cloud, MN 56302
320-253-0121 • 888-360-2889

Western Minnesota Legal Services
415 7th St. SW, Suite 101
P.O. Box 1866
Willmar, MN 56201
320-235-7662 • 800-622-4011

Minnesota Adoption Resource Network
MARN
430 Oak Grove Street, Suite 404
Minneapolis, MN 55403
612-861-7115 • 866-303-MARN
info@mnadopt.org
www.mnadopt.org
Adoption information, education, and resources

Minnesota Association for Children's Mental Health
MACMH
165 Western Avenue N, Suite 2
St. Paul, MN 55102
651-644-7333 • 800-528-4511
info@macmh.org
www.macmh.org
Support and information for families and professionals

Minnesota Disability Law Center
MDLC
Mental Health Advocacy Project
430 1st Avenue N, Suite 300
Minneapolis, MN 55401
612-332-1441 • 800-292-4150
TDD 612-332-4668

Duluth	218-722-5625
Grand Rapids	218-326-7044
Mankato	507-389-9826
Moorhead	218-230-9870

www.mylegalaid.org
Free civil legal assistance to individuals with disabilities

Minnesota Mental Health Resources

Minnesota Kinship Caregivers Association
MKCA
161 St. Anthony Avenue, Suite 940
St. Paul, MN 55103
651-917-4640
www.mkca.org
Advice, advocacy and support for grandparents and other kinship caregivers

Minnesota Organization on Fetal Alcohol Syndrome
MOFAS
1885 University Avenue, Suite 395
St. Paul, Minnesota 55104
651-917-2370 • 866-90-MOFAS
info@mofas.org
www.mofas.org
works collaboratively within communities to provide resources and support for families living with Fetal Alcohol Spectrum Disorders (FASD)

National Alliance on Mental Illness
NAMI-MN
800 Transfer Road, Suite 7A
St. Paul, MN 55114
651-645-2948 • 888-NAMIHELPS
nami-mn@nami.org
www.namihelps.org
Support, information, and advocacy for persons with mental illness

Parent Advocacy Coalition for Educational Rights
PACER Center
8161 Normandale Boulevard
Minneapolis, MN 55437
952-838-9000 • 800-53-PACER
TTY 952-838-0190
pacer@pacer.org
www.pacer.org
Advocacy, information, and referral resources for children and young adults with disabilities and their families

Suicide Awareness Voices of Education
SAVE
8120 Penn Avenue S, Suite 470
Bloomington, MN 55431
952-946-7998
National Lifeline: 800-273-TALK
www.save.org
Suicide prevention and educational resources

Chrysalis Cente
4432 Chicago Ave S
Minneapolis, MN 55407
612-871-0118 • TTY: 612-824-2780
24 Hour hotline: 612-825-0000
www.tubman.org
Services for children and families struggling with the challenge of Fetal Alcohol Spectrum Disorder (FASD)

Tourette Syndrome Association Minnesota Chapter
TSA-MN
2233 University Avenue, Suite 338
St. Paul, MN 55114
651-646-0099
www.tsa-mn.org
Education, support, and public awareness programs for individuals and their families affected by Tourette Syndrome

United Way 211
Greater Twin Cities United Way
2-1-1 or 651-291-0211 (cell users)
www.unitedwaytwincities.org/communityinfo/211.cfm
www.thebeehive.org/local/resource-locator
Information and referral service to community resources

State of Minnesota

Minnesota Children with Special Health Needs
MCSHN
Minnesota Department of Health
85 E 7th Place
PO Box 64882
St. Paul, MN 55164
651-201-3650 or 800-728-5420
mcshnweb@health.state.mn.us
www.health.state.mn.us/mcshn
Information and referral resources for children with special needs and their families

Minnesota Department of Commerce
MDC
Consumer Concerns Market Assurance
651-296-2488 • 800-657-3602 (MN only)
market.assurance@state.mn.us
www.commerce.state.mn.us
Regulates licensed fee-for-service or indemnity plans

Minnesota Department of Education
MDE
Division of Special Education
1500 W Highway 36
Roseville, MN 55113-4266
651-582-8200
www.education.state.mn.us
Regulates special education services and programming in Minnesota

Minnesota Department of Health
MDH
P.O. Box 64975
St. Paul, MN 55164
651-201-5000 • 888-345-0823
www.health.state.mn.us
**Regulates licensed HMOs and CISNs*

Minnesota Department of Human Services
DHS
Children's Mental Health Division
PO Box 64985
St. Paul, MN 55164
651-431-2321
www.dhs.state.mn.us
Regulates children's mental health services and programming

Ombudspersons

Ombudspersons for Families
Ensures that children and their families are guaranteed fair treatment by all agencies that provide child welfare services.

African-American Families
651-642-0897

Asian-Pacific Families
651-643-2514

Hispanic Families
651-643-2537 or 888-234-4939

Indian Families
651-643-2523

Ombudsman for Mental Health and Developmental Disabilities
121 7th Place E, Suite 420
Metro Square Building
St. Paul, MN 55101-2117
651-296-3848 • 800-657-3506
TTY 800-627-3529
ombudsman.mhdd@state.mn.us
www.ombudmhdd.state.mn.us
Designated to assist you to overcome the delay, injustice or impersonal delivery of services

Ombudsman for State Managed Health Care Programs
PO Box 64249
St. Paul, MN 55164
651-431-2660 • 800-657-3729
www.dhs.state.mn.us
Assists persons enrolled in MN Health Care Programs, Medical Assistance, & MinnesotaCare

CHEMICAL HEALTH

How to recognize a problem:

According to a national survey, more than 4.6 million Americans who meet the criteria for needing treatment do not recognize they have a problem. Frequently it is family and friends of the person needing alcohol or drug treatment that identify the chemical abuse. Chemical dependency is an illness that usually requires treatment. AlcoholScreening.org is a free service of Join Together, a project of the Boston University School of Public Health. AlcoholScreening.org helps individuals assess their own alcohol consumption patterns to determine if their drinking is likely to be harming their health or increasing their risk for future harm. Through education and referral, the site urges those whose drinking is harmful or hazardous to take positive action, and informs all adults who consume alcohol about guidelines and caveats for lower-risk drinking.
http://www.alcoholscreening.org

A number of primary care providers use adolescent screening tools that assess both mental health and chemical health. Also, some schools provide universal screening using a variety of standardized tools.

How to get an assessment:

Whether or not a screening is done, the best way to determine if someone's use/abuse of chemicals requires treatment is to get a chemical dependency assessment through a professional. This will entail a complete assessment of an individual's chemical use. Also, it's important to note that the assessment process can be complicated by undiagnosed and/or untreated mental health or academic/employment issues (i.e. anxiety, depression, attention deficit disorder, learning disabilities, etc.). When indicated, further psychological testing or assessment of specific concerns may be recommended. These could include: child and family problems, marital concerns, work and financial considerations, anger and violence concerns, self-esteem difficulties, depression, or anxiety. It is very important to determine the underlying cause(s) of an individual's chemical use so that the most effective treatment can be prescribed. (Refer to the attached Fact Sheet on Dual Diagnosis).

There are a number of places you can start:

Primary care physician – Primary Care Providers may be able to provide resources regarding referrals to chemical health as well as mental health providers.

Employee assistance programs (EAP's) - EAP's offer trained professionals who can provide you with information and referral to your health plan and community services. Check your employer's personnel handbook to identify whether you have an EAP available to you and how to connect with it.

Health plans/Health Insurance - If you have health insurance coverage, ask them about providers and services that are covered under your policy. Look on the back of your health insurance card for the number to the customer service department. They will provide you with a list of numbers for providers covered under your health plan.

County human services - In Minnesota, the county is responsible for providing public chemical dependency treatment services. County staff can help you identify where to begin and have staff knowledgeable about providers in your county and the services they provide. Counties also offer publicly funded chemical dependency services (See description of Rule 25, below). Counties contract with chemical dependency treatment providers to provide treatment on a sliding-fee scale. If you use one of the county providers, the charges for assessment and treatment will be reduced based on your ability to pay. For more information call your county or visit their website.

Information and referral services – MinnesotaHelp.info is an information and referral provider that can help you find and connect with a variety of services.

If you are a member of a federally recognized American Indian tribe, you can go to your County to receive services or you may contact your tribal office for information about chemical dependency assessment and treatment.

People receiving Medical Assistance, Prepaid Medical Assistance Program or MinnesotaCare, can get information about provider referrals, prior authorization guidelines and contacts for chemical dependency services from their county or the specific health plan they are enrolled in.

What is Rule 25?
When a person is seeking chemical dependency treatment and needs public funding to pay for the treatment, they get a chemical use assessment, sometime referred to as a Rule 25 Assessment. The assessor gathers information from the client and concerned others and applies criteria to determine whether the person needs treatment and what sort of treatment would be best. This assessment process and the decision criteria are governed by Rule 25 (Minnesota Rules, parts 9530.6600 through 9530.6655).

Treatment Options:

The Substance Abuse and Mental Health Services Administration (SAMHSA) sponsors a **Substance Abuse Treatment Facility Locator**. This is a searchable directory of more than 11,000 addiction treatment programs around the country that treat alcoholism, alcohol abuse and drug abuse problems. It includes programs that serve all ages, including adolescents. It is easy to use and the information in the directory is updated on an annual basis.

The Locator includes outpatient treatment programs, residential treatment programs, hospital treatment programs, and partial hospitalization/day treatment programs for drug addiction and alcoholism. All information is updated on an annual basis. New facilities are added monthly. The Substance Abuse Treatment Facilitator Locator can by found on the Internet at: http://www.findtreatment.samhsa.gov

Payment Options:

In general, the following forms of payment are acceptable, however, this will vary, depending on the treatment facility: self payment, state financed insurance (other than Medicaid), private health insurance, military insurance (e.g., VA,TRICARE)

Resources:

Chemical Health Division located in your County, or call the Minnesota Department of Human Services (DHS) at 651-582-1832 or visit the state DHS website at:
http://www.dhs.state.mn.us/Contcare/Chemicalhealth

H.E.A.R.T. (Help Enable Alcoholics / Addicts Receive Treatment) reaches out and helps support people with financial hardships, who are struggling to enter or remain in treatment. H.E.A.R.T. provides the necessary funding to enable recovering individuals to receive treatment or counseling at any H.E.A.R.T. affiliated facility. The mission of H.E.A.R.T. is to help people and their families achieve and maintain a chemically free life. For more information, contact H.E.A.R.T. Inc. **H**elp **E**nable **A**lcoholics / **A**ddicts **R**ecieve **T**reatment, at 10800 Old County Road 15, Suite 100, Plymouth, MN 55441
763/746-8488 – Phone, 763/746-8489 – Fax, 866/933-8488 - Toll Free or visit their website at:
https://www.heartinc.org

Narcotics Anonymous

Narcotics Anonymous (NA) provides a recovery process and peer support network that are linked together. One of the keys to NA's success is the therapeutic value of addicts working with other addicts. Members share their successes and challenges in overcoming active addiction and living drug-free, productive lives through the application of principles contained within the Twelve Steps and Twelve Traditions of NA. The primary service provided by Narcotics Anonymous is the NA group meeting. Each group runs itself based on principles common to the entire organization, which are expressed in NA literature. For more information, including finding a meeting go to:
http://www.na.org/

Nar-Anon

Nar-Anon is a twelve-step program designed to help relatives and friends of addicts recover from the effects of living with an addicted relative or friend. Nar-Anon's program of recovery uses Nar-Anon's Twelve Steps and Twelve Traditions. The only requirement to be a member and attend Nar-Anon meetings is that there is a problem of drugs or addiction in a relative or friend. Nar-Anon is not affiliated with any other organization or outside entity. For general information about Nar-Anon, or to locate a Nar-Anon group, go to the following link: www.nar-anon.org

Alcoholics Anonymous

Alcoholics Anonymous® (AA) is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism. The only requirement for membership is a desire to stop drinking. There are no dues or fees for AA membership; AA is self-supporting through member contributions.
For more information on AA and to locate a meeting, go to: www.aa.org

Al-Anon/Alateen

Al-Anon and Alateen members are people who have been affected by someone else's drinking. They are parents, children, spouses, partners, brothers, sisters, other family members, friends, employers, employees, and coworkers of alcoholics. In Al-Anon and Alateen, members share their own experience, strength, and hope with each other. For more information, including how to find a meeting in your area, go to: http://www.al-anon.alateen.org/

Association of Recovery Schools - The Association of Recovery Schools advocates for the promotion, strengthening, and expansion of secondary and post-secondary programs designed for students and families committed to achieving success in both education and recovery. Member organizations of the Association of Recovery Schools meet certain criteria. Some examples include:

- Recovery Schools are of two types. Recovery schools at the secondary level meet state requirements for awarding a secondary school diploma. Such schools are designed specifically for students recovering from substance abuse or dependency. Eligible colleges, similarly, offer academic or residential programs / departments designed specifically for students recovering from substance abuse or dependency.
- Recovery Schools provide academic services and assistance with recovery (including post-treatment support) and continuing care. However, they do not generally operate as treatment centers or mental health agencies.
- Recovery Schools require that all students enrolled in the program be in recovery and working a program of recovery determined by the student and the School. Consequences of relapse are addressed by the individual School.

For more information regarding schools, including schools located in Minnesota, go to the following web address: http://www.recoveryschools.org

NAMI MINNESOTA
National Alliance on Mental Illness

Fact Sheet

800 Transfer Road, Suite 31, St. Paul, MN 55114 Tel: 651-645-2948 or 888-NAMI-HELPS Fax: 651-645-7379 www.namihelps.org

Dual Diagnosis: Adolescents with Co-occurring Brain Disorders & Substance Abuse Disorders

Adolescents are often referred to treatment for substance abuse, but are not referred to a qualified mental health professional for appropriate diagnosis and treatment of any underlying cause for their drug and alcohol abuse. However, many teens have symptoms of a mood disorder that may in fact have led to self-medicating with street drugs and alcohol.

Families and caregivers know how difficult it is to find treatment for an adolescent who abuses drugs or alcohol, but who also is diagnosed with a brain disorder (mental illness); i.e., ADHD, depression, or bipolar disorder. Traditionally, programs that treat individuals with brain disorders do not treat individuals with active substance abuse problems, and programs for substance abusers are not geared for people with mental illness. Adolescents are often caught in this treatment or services gap.

Is dual diagnosis common?

The combination of mental illness and substance abuse is so common that many clinicians now expect to find it. Studies show that more than half of young persons with a substance abuse diagnosis also have a diagnosable mental illness.

What causes these disorders?

Mental health and addiction counselors increasingly believe that brain disorders and substance abuse disorders are biologically and physiologically based.

What kind of treatment works?

Families and caregivers may feel angry and blame the adolescent for being foolish and weak-willed. They may feel hurt when their child breaks trust by lying and stealing. But it's important to realize that mental illness and often substance abuse are disorders that the adolescent cannot take control of without professional help.

Teens with difficult problems such as concurrent mental illness and substance abuse disorders do not respond to simplistic advice like "just say no" or "snap out of it."

Psychotherapy and medication combined with appropriate self-help and other support groups help most, but patients are still highly prone to relapse.

Treatment programs designed primarily for substance abusers are not recommended for individuals who have a diagnosed mental illness. Their reliance on confrontation techniques and discouragement of use of appropriate prescription medications tend to compound the problems of individuals with mental illness. These strategies may produce stress levels that make symptoms worse or cause relapse.

What is a better approach?

Increasingly, the psychiatric and drug counseling communities agree that **both disorders must be treated at the same time**. Early studies show that when mental illness and substance abuse are treated together, suicide attempts and psychotic episodes decrease rapidly.

Since dually diagnosed clients to not fit well into most traditional 12-step programs, special peer groups based on the principle of treating both disorders together should be developed at the community level. Individuals who develop positive social networking have a much better chance of controlling their illnesses. Healthy recreational activities are extremely important.

What's the first step in treatment?

The presence of both disorders must first be established by careful assessment. This may be difficult because the symptoms of one disorder can mimic the symptoms of the other. Seek referral to a psychologist or psychiatrist. Local NAMI affiliates are happy to refer families to mental health professionals their members recommend. (**Call the NAMI HelpLine at 1-800/950-6264 for a local contact**).

Once a professional assessment has confirmed a dual diagnosis of mental illness and substance abuse, mental health professionals and family members should work together on a strategy for integrating care and motivating the adolescent.

What do model programs for treating mental illness and substance abuse look like?

There is a growing number of model programs. Support groups are an important component of these programs. Adolescents support each other as they learn about the negative role that alcohol and drugs has had on their lives. They learn social skills and how to replace substance use with new thoughts and behaviors. They get help with concrete situations that arise because of their brain disorder (mental illness). Look into programs that have support groups for family members and friends.

If your teen has a substance abuse disorder ...

1. **Don't regard it as a family disgrace. Recovery is possible just as it is**

with other illnesses.

2. **Encourage and facilitate participation in support groups during and after treatment.**
3. **Don't nag, preach, or lecture.**
4. **Don't use the "if you loved me" approach. It is like saying, "If you loved me, you would not have tuberculosis."**
5. **Establish consequences for behaviors. Don't be afraid to call upon law enforcement if teens engage in underage drinking on your premises. You can be held legally responsible for endangering minors if you do not take timely action.**
6. **Avoid threats unless you think them through carefully and definitely intend to carry them out. Idle threats only make the person with a substance abuse disorder feel you don't mean what you say.**
7. **During recovery, encourage teens to engage in after-school activities with adult supervision. If they cannot participate in sports or other extracurricular school activities, part-time employment or volunteer work can build self-esteem.**
8. **Don't expect an immediate, 100-percent recovery. Like any illness, there is a period of convalescence with a brain disorder. There may be relapses and times of tension and resentment among family members.**
9. **Do offer love, support, and understanding during the recovery.**

Reviewed by Patrick C. Friman, Ph.D., A.B.P.P., Director of Clinical Services & Research at Father Flanigan's Boys' Home and associate professor, Creighton University School of Medicine.

School

Individualized Education Program (IEP) Services
Department of Human Services (DHS)

NOTE: **The IEP Services Technical Assistance Guide** provides policy, billing, rates and payment information for Minnesota Health Care Programs (MHCP) covered IEP Services. The current IEP Services Technical Assistance Guide can be downloaded from the DHS Web site at: **www.dhs.state.mn.us/provider/iep**

What are Individualized Education Program (IEP) Services? Covered Minnesota Health Care Programs (MHCP) IEP services are those on a school Individualized Education Plan (IEP), an Individualized Interagency Intervention Plan (IIIP) or on an Individual Family Service Plan (IFSP).

Which schools can be IEP service providers for Minnesota Health Care Programs (MHCP)?
The following public schools and school districts can enroll with DHS as IEP services providers:

- Charter schools, education districts, intermediate districts and state academies
- Public school districts
- Service cooperatives & spec. ed. co-ops
- Tribal schools - schools receiving Bureau of Indian Affairs (BIA) funding

DHS does not directly pay private schools for covered IEP services. The public school responsible for providing the IEP services to the children attending a private school bills DHS & receives the payments.

Which students are eligible for their school services to be billed to MHCP?

- Enrolled in MA or MinnesotaCare; and
- Under the age of 21; and
- Have covered IEP services on a current IEP/IFSP/IIIP and;
- Receive covered IEP services.

Which school services are covered by MHCP?
Schools are responsible for assuring that the covered IEP services billed to MHCP are provided by qualified staff within the provider's scope of practice and/or licensure/certification. Services eligible for payment must meet **all** the following criteria plus any other requirements for the specific service:

- Medically necessary;
- Provided to an eligible MA/MinnesotaCare recipient under age 21;
- Included in the recipient's IEP/IFSP/IIIP, and authorized by the IEP/IFSP/IIIP team;
- Documented in the recipient's record;
- Provided by the school during school day;
- Health related services necessary for the recipient to benefit from his/her education.

MHCP will cover the following services provided in school if the above criteria are met:

1. **Physical therapy (PT):** IEP evaluations provided by a physical therapist. Individual, group and specialized maintenance therapy provided by a physical therapist or PT assistant, under the direction of a physical therapist.

2. **Occupational therapy (OT):** IEP evaluations provided by an occupational therapist. Individual, group and specialized maintenance therapy provided by an occupational therapist or certified OT assistant, under the direction of an occupational therapist.

3. **Speech-language pathology and audiology services:** IEP evaluations provided by a speech-language pathologist (SLP), educational speech-language therapist or audiologist. Individual and group therapy provided by an SLP or educational speech-language pathologist. Specialized maintenance therapy provided by an SLP. Audiology services provided by an audiologist.

4. **Nursing services**: Face-to-face nursing care provided by an LPN/RN/PHN/LSN.
   - Nursing care includes: catheterization, tube feeding, suctioning, ventilator care, nursing assessment and diagnostic testing such as glucose testing, vital signs, health counseling and simple and complex medication administration. Complex medication administration is a service requiring the skill of a nurse and is administered rectally or through an IV, injection, nebulizer, or gastrostomy tube. Simple medication administration is the administration of prescription medications by a licensed nurse who is employed by or

under contract with a school district. To be a covered service, simple medication administration must be related to a child's disability & identified in the child's IEP/IFSP/IIP for treatment of the identified disability.

- ❑ Medication management provided by an RN, LSN, PHN, or LSN that includes: a review of a recipient's current medications and adherence to the prescribed medication; nursing evaluation for adverse reactions to medications; educating the recipient about his/her medication and proper medication administration; and any contacts with the physician about prescriptions, tolerance or adherence to the medication regimen.

- ❑ IEP evaluations provided by an RN, PHN, or LSN.

5. **Personal care assistant (PCA) services:** PCA services are medically necessary services that are provided to a child who is unable, because of his/her medical diagnosis or condition, to manage the activities him/herself. However, if most children the age of the child need assistance with the activity, the activity is not covered if provided by a PCA.

- ❑ The PCA must be employed by the school or district as a PCA or paraprofessional or be contracted to provide PCA services through an agency agreement with the school or district. Training and orientation is the responsibility of the school or district and is provided by a qualified professional (QP). QPs include: RN, PHN, LSN, mental health professional, physical therapist, occupational therapist, speech therapist, audiologist, physician, social worker or developmental disabilities specialist.

- ❑ PCAs must be supervised by a qualified professional as designated in the IEP. One or more qualified professionals may provide supervision as appropriate. Supervision must be through direct (face to face) training, demonstrations, observation and consultations. The QP must provide ongoing monitoring and supervision of a child's PCA services. **Supervision of PCA services cannot be provided by phone or by consulting with the teacher.** There are specific requirements for frequency of PCA supervision**. See www.dhs.state.mn.us/provider/iep**

- □ Communication with a child's primary care provider is required using the **Communication to Physician of Personal Care Assistance Services Form (DHS-4690).** It is for information only and does not require any action by the primary medical provider.

⌘ **Effective July 1, 2009:**

- Instrumental Activities of Daily Living (IADL) are not covered for children.

⌘ **Effective January 1, 2010:**

- To qualify for PCA services, the child must be dependent in at least one activity of daily living or meet the definition of having a Level I Behavior. (See next page for definition of Level 1 Behavior.)
- A PCA who provides tracheostomy suctioning or services to children on a ventilator must be trained by a nurse, respiratory therapist or a physician. Supervision for these services must be provided by a nurse.

- ❑ IEP PCA services are provided only at school on scheduled school days during regular school hours (not weekends, school breaks, holidays or beyond the regular school day). This includes providing these services during off-campus activities such as field trips during the regular school day**.**

- ❑ Covered personal care services must be included in the IEP/IFSP/IIIP and documented on an approved checklist. Covered services are:

  - ***Activities of daily living (ADL):*** Services & supports provided as needed, to assist the child to accomplish the activities of daily living - eating, toileting, grooming, dressing, bathing, transferring, mobility, and positioning. Assisting & supporting a child/student with schoolwork is not covered. **See www.dhs.state.mn.is/provider/iep for definitions of each activity of daily living (ADL).**

  - ***Health related procedures and tasks*** including those listed below, that do not require the skill of a nurse and can be assigned, under state law, by a health care professional to be performed by a PCA. PCAs cannot complete sterile procedures or give injections. They can:

1. Provide range of motion & passive exercise to maintain a level of strength & muscle functioning,
2. Assist with self-administered medication (Medication taken orally, by injection or insertion or applied topically **without the need for assistance).** Setting up and administering medications is not covered.
3. Observe, monitor and intervene for seizure disorders when a child has had a seizure within the last three months.

- ***Intervention and redirection for behavior*** that is medically necessary and related to the child's diagnosis. Intervention and redirection for Level I behaviors which means physical aggression towards self, others or destruction of property that requires an immediate response from another person.
  - Self injurious behavior - causes injury to one's own body; examples: hitting, biting, head-banging, burning, poking, cutting, eating foreign objects/substances, pulling out hair & suicide threats.
  - Physical injury to others – causes or has the potential to injure others by hitting, biting, pinching, scratching, kicking, stabbing and pulling out hair.
  - Destruction of property – causes or has the potential to break windows, lamps, furniture, tearing clothes, setting fires and using tools or objects to damage property.

6. Assistive technology devices MHCP covers rental, purchase and repairs. Covered devices are:

- ❑ Augmentative communication devices
- ❑ Hearing amplification devices
- ❑ Mobility devices
- ❑ Positioning devices
- ❑ Hardware and software essential to use a covered device

Assistive technology devices:

- ❑ Must be identified and documented in the IEP/IFSP/IIIP, including its function and medical necessity;
- ❑ Can be used at school only by the recipient for whom purchased or rented;
- ❑ Cannot be primarily for education, such as Math Blaster software or a device to assist with homework;
- ❑ Equipment purchased with MHCP funds belongs to the child & is only used by them; and
- ❑ Can be used for home and school as needed.
- ❑ Augmentative communication devices are dedicated to transmitting or producing messages or symbols in a manner that compensates for the child's impairment and disability with severe expressive communication disorders (e.g., communication picture books, communication charts and boards, and mechanical/electronic devices). Devices requested for use only at school and for education are not covered.

7. Transportation –Station to station transportation provided by a school or school district for a child in a school owned or contracted vehicle: to and from school on a day when another covered IEP services is provided, to and from a contracted community provider to receive another covered IEP service, or, to and from a medical appointment that occurs during a regular school day.

Covered only when the following apply:

- ❑ The child has a physical or mental health condition or mental impairment that prevents him/her from safely accessing & using a non-school common carrier (such as a van, taxi, car, bus or school vehicle) that is not equipped with a special adaptation or an aide for the child;
- ❑ The child requires a special adaptation to the bus such as a wheelchair lift, special harness, safety vest or special car seat (not a regular car seat/seat belt) or a one-on-one aide;
- ❑ The reason the child needs transportation is documented on the IEP/IFSP/IIIP.

8. Language Interpreter Services

- □ **Oral language interpreter services** are covered when:
  - provided to a child with limited English proficiency in conjunction with another covered IEP service when the child, service provider and interpreter are present; or
  - provided to a parent with limited English proficiency in order to obtain & relay information regarding the child during a covered IEP service/evaluation of a child when both the child and parent are present. A competent interpreter is one who: demonstrates proficiency in both English and another language; uses appropriate modes of interpreting given the situation; understands their role as an interpreter; has a fundamental knowledge in both languages of specialized health terms & concepts; is

sensitive to the family's culture; and follows confidentiality and impartiality rules. Interpreter services provided by a family member, friend or minor child are not covered.

□ **Sign language interpreter services (SLIS)** are covered when provided by a competent sign language interpreter during the provision of a direct, person-to-person, covered health care service when:

- provided to a deaf child, who communicates by signing, in conjunction with another covered IEP service (except transportation) when the child/student, service provider and interpreter are present, or
- provided to a parent who communicates by signing, in order to obtain and relay information regarding the child/student during a covered IEP service or evaluation when the child/student, parent, service provider and interpreter are present at the evaluation or service.

SLIS must be an accurate and quality service provided by a qualified interpreter. DHS encourages the use of certified sign language interpreters. SLIS provided by a family member, family friend or minor child is not covered. Lists of sign language interpreters are available @: **www.interpreterreferral.org;** and the Registry of Interpreters for the Deaf which lists agencies & interpreters by zip code & city: **www.rid.org**

9. Mental Health Services

A. Mental Health Services--NOT Covered as IEP Services or Under Children's Therapeutic Services & Supports (CTSS)

❑ **Psychological testing and diagnostic assessments (DA)**

- Psychological tests and psychometric tests are provided by a licensed psychologist and are used to determine the status of the child's mental, intellectual, and emotional function.
- A diagnostic assessment is a written evaluation, provided by a mental health professional that is used to determine a child's eligibility for mental health services. A diagnostic assessment must include all 5 Axes to be covered by Medical Assistance/MinnesotaCare.
  - ✶ **(See MHCP Provider Manual: Mental Health Services Overview—Diagnostic Assessment for: "Who Can Do Mental Health Diagnostic Assessments & Psychotherapy?" Updated 5-3-2010. Now includes Licensed Professional Clinical Counselors.**
  - ✶**See Children's Mental Health Topic Packet: "Behavioral & Mental Health Concerns in Children and Youth"** for more information on diagnostic assessment.
- The licensed psychologist or mental health professional performing the testing or diagnostic assessment must enroll separately as an individual MHCP provider in order to bill for these services. Services must be billed by the individual following directions in the MHCP Provider Manual.

B. Mental Health Services—Covered IEP Services, NOT Covered Under Children's Therapeutic Services & Supports (CTSS)

❑ IEP evaluations provided by a mental health professional or school psychologist that are health related and result in an IEP/IFSP/IIIP or determine the need for continued services. Activities included are: administering tests, interpreting test results & writing reports. IEP evaluations are billed under the school's IEP provider number. IEP evaluations are billed only if the child receives services or continues to receive services. Concerns about mental illness or emotional disturbance should be referred to a mental health professional for a diagnostic assessment and treatment. (See above).

C. Mental Health Services—Covered IEP Services, Covered Under Children's Therapeutic Services & Supports (CTSS).

❑ Schools & districts must be certified as Children's Therapeutic Services and Supports (CTSS) providers in order to bill Medical Assistance or MinnesotaCare for covered CTSS services. (IEP evaluations are not covered under CTSS). **(See Children's Mental Health Topic Packet: "Children's Mental Health Services"** for more information on CTSS Services.)

❑ Schools and districts may choose from Option 1, 2, or 3 after reviewing the Options Chart regarding becoming a CTSS provider. If the school or district chooses Option 2 or 3 & becomes certified, all

policies must be followed & billing must follow specific instructions. **See the Individualized Education Program (IEP) Services: Technical Assistance Guide (DHS-4439)** for:

- Options 1, 2, 3 Chart,
- CTSS Certification Application,
- Required services for school to provide,
- Coordination of services requirements,
- CTSS eligible providers & supervision,
- Eligible children for CTSS,
- Authorization & requirements,
- Billing procedures.

- CTSS services are provided to a child with an emotional disturbance(ED)/youth with a mental illness (MI) and those who meet the criteria for severe emotional disturbance (SED) and serious and persistent mental illness (SPMI). (See IEP Services Technical Assistance Guide for more information.)

- A diagnostic assessment is required within 180 days **before beginning** any currently covered IEP mental health services or CTSS services for children under 18 years and youth 18-20 years. Thereafter, a child under 18 who continues to receive CTSS services must have an annual diagnostic assessment. For youth 18-20 years old, an annual update of the diagnostic assessment is required. A diagnostic assessment is not a covered CTSS service.

- **Children's Therapeutic Services and Supports (CTSS)** include:
  Psychotherapy – Individual, group & family psychotherapy is provided by a mental health professional. Psychotherapy is a planned and structured face-to-face treatment of a child's diagnosed mental illness through the psychological, psychiatric, or interpersonal method most appropriate to the needs of the child according to current community standards of mental health practice; and is directed to accomplish measurable goals and objectives specified in the child's Individual Treatment Plan (ITP).

NOTE: **Clinical supervision by a mental health professional is required for mental health practitioners who provide skills training, crisis assistance and direction for mental health behavioral aides.**

- **Skills Training** – is social, communication, & organizational skills training or self-regulatory skills training to assist the child to develop skills that are compromised or have failed to develop due to the child's mental health condition. Skills training is **NOT** teaching independent living skills (ILS) training. When children are trained in groups, all children must have similar needs and capacity to develop the skills so they can benefit equally from small group (3-8) intervention. A classroom is not a group. Parents may benefit by receiving training for alternative parenting skills fitted to the ways children with mental health diagnosis process information and respond different to their environments.

- **Crisis Assistance** is developing a crisis plan. The plan is developed by a mental health professional or mental health practitioner when reviewed and approved by a mental health professional and is intense, time-limited, and designed to resolve or stabilize a crisis through arrangements for direct intervention and support services to the child/student and family. The crisis plan must utilize resources designed to address abrupt or substantial changes in the child/student and family's functioning as evidenced by a sudden change in behavior with negative consequences for well being, loss of usual coping mechanisms, or presentation of danger to self or others. The plan is implemented in a crisis situation.

- **Mental Health Behavioral Aide (MHBA) Services**—provided by a mental health behavioral aide who meets all the qualifications, training and orientation requirements for an MHBA. The MHBA is under the direction of a mental health professional or mental health practitioner who is under the clinical supervision of a mental health professional. .

✶MHBA activities may include providing cues or prompts and practicing skills with the child; reinforcing and generalizing skill building activities and intervening as necessary to redirect and de-escalate target behaviors.

✶An Individual Behavior Plan (IBP) is required for the MHBA. It provides specific service delivery instructions to the MHBA & outlines the MHBA's responsibilities in assisting the child to achieve treatment outcomes. The IBP is not a behavior management plan. The IBP reinforces the goals & objectives of the Individual Treatment Plan (ITP), & is based on the Diagnostic Assessment.

Service Limitations and Authorization Requirements

- Orders are required for nursing services that require such orders. Orders must be obtained annually by the school, can cover a period of time of up to one year & must be in place at the time the service is billed. Signatures must be dated. Orders can be provided by a physician, physician assistant, or nurse practitioner.
- Communication with the primary care provider is required for PCA services.
- The child's IEP/IFSP/IIIP team authorizes the services in the plan.
- IEP services do not count against limits/thresholds for persons on Home & Community-Based Services (HCBS) such CAC, CADI, MR/RC and TBI.
- IEP services are not calculated in parental fees.
- IEP services do not count against authorization caps for home-care services.

More detailed and specific information about **non-covered services**, **documentation requirement**s necessary to be a MHCP Provider and **billing requirements** to bill IEP and CTSS services, are all available in the **IEP Services Technical Assistance Guide. www.dhs.state.mn.us/provider/iep .**

Third Party Billing

There are federal regulations and state laws that give rights to students, who are eligible for special education, and to their parents. The regulations and laws also tell school districts certain actions they must take. One of those actions is to assess the needs of the student. Another is to write the student's Individualized Education Program* (IEP). Sometimes, the assessments and services on the IEP are health related services that may be eligible for payment from Medical Assistance (MA), MinnesotaCare (MNC), or a private insurance plan. Getting payments for health related services can be complex for school districts. It may raise questions from parents. But, third party billing brings extra money to the district. This money can really help the school district to pay for the services we provide for children with special needs. We want to make sure that parents have answers to their questions about third party billing. Following, you will find common questions. If you have questions that are not answered here, you may want to contact:

- Minnesota Department of Human Services about MA or MNC questions: 651-431-2622;
- Minnesota Department of Education about third party billing for related services: 651-582-8263;
- PACER Center for answers from an advocate: 952-838-1347; 1-800-537-2237; 952-838-0190 (TTY)
- Arc Minnesota for answers from an advocate: 651-523-0823; 1-800-582-5256
- Your school district about district policies related to third party billing:_____; or
- Your own health plan.

**When we use the term IEP, we also mean an Individualized Family Service Plan (IFSP) and an Individual Interagency Intervention Plan (IIIP).*

Q. What are health related services?

A. Health related services are defined by Congress in the Individuals with Disabilities Education Act (IDEA). They include the support services a child with a disability needs to benefit from special education. They are part of the IEP, but they are not instructional in nature. Health related services support a child's instructional program. Health related services include supports such as:

- Diagnosis, evaluation and assessment;
- Speech, physical and occupational therapy;
- Mental health and behavioral services;
- Audiology;
- Special transportation; and
- Health services such as nursing and personal care assistant services.

Q. Why does my child's district want to bill Minnesota Health Care Programs (MHCP) and private health plans for health related services?**

A. Federal and state laws are very clear that districts must make sure students get all services identified on the IEP. The law is also clear that students get the services with no cost to parents. But, the law states the district is not responsible to pay for all of the services. In Minnesota, districts are required to try to get non-educational funds to pay for health related services. Some health related services are paid for by public and/or private health plans.

***Minnesota Health Care Programs includes Medical Assistance (MA) and MinnesotaCare (MNC). The term MA includes children who are eligible under fee for service, a Prepaid Medical Assistance Plan (PMAP), waivers, or the TEFRA Option.*

Q. If my district gets money from MHCP or my private health plan, does the district get less money from the Department of Education for the cost of special education?

A. No, the money a district gets from the Department of Education does not go down because they get paid by MHCP or your health plan. This is why it is important for the district to try to get payment from MHCP or your health plan. It is additional money for the district. Often, districts must ask for extra money from local resources to cover the costs of special education. When districts get paid from third parties, such as MHCP or private health plans, it helps to cover the cost of special education.

Q. Can my school district bill MHCP if I don't want them to bill?

A. Your district does need your permission to share the information necessary to bill MHCP. To do this, the district must give you an initial and annual notice. This notice is in the Notice of Procedural Safeguards. Your district may also give you the notice in an easier to read form. If the parent or legal representative agrees to share the private information needed for billing, they sign a consent form. The consent to release information can be valid as long as the student is eligible for special education, for up to one year, or until the parent ends the release in writing. There are some things you need to know:

- The district will bill MA or MNC for covered services on your child's IEP. This includes some assessments done to determine if your child is eligible for special education.
- If you ask, the district will send you copies of all the records they share with a third party to get paid.
- You can take back your permission to share your child's records at any time. You can't take back permission for records already shared.
- If you do not give permission, or you take back your permission, your child's IEP services will not change or stop.

Q. What things about billing MHCP should I know?

A. One of the most important things to know is that Minnesota's laws currently have protections:

- Services provided by the district and paid by MA or MNC do not count toward any monthly, annual or lifetime limits for the same or similar services. For example, if your child's IEP includes occupational therapy services, it does not affect therapy service limits your child might need or receive from a rehab agency.
- Services provided by the district and paid by MA or MNC do not count toward any home care or waiver caps. For example, if your child's IEP includes staff to assist with eating and toileting, it does not affect the amount of personal care services your child can receive at home.
- Services provided by the district and paid by MA or MNC do not affect services your child gets from other providers or those covered by a PMAP.
- Services provided by the district and paid by MA do not count toward the amount of a parental fee. If only IEP services are paid by MA, there is no parental fee. If parents of children eligible for MA under the TEFRA Option choose to not use MA for other services, they can request a disparity agreement. This means they do not pay a parental fee, unless services other than IEP services are billed. To find out about getting a disparity agreement, parents can call DHS at 651-431-3801.
- Services provided by the district and paid by MA do not count toward a spenddown.

Q. Can my school district bill my private health plan if I don't want them to bill?

A. No, the district must give you information about what might happen if your district bills for health related services once a year. Then, every year the parent or legal representative must make an informed decision about whether the district should or should not bill a private health plan. Your decision must be in writing. It can be valid for up to one year. You can change your decision at any time in writing. If you give your district permission to bill your health plan, it does not mean the plan will pay the district for related services.

Q. What things about billing my private health plan should I know?

A. There are many important things to consider before making a decision about whether your school district should bill your private health plan:

- If your plan pays the district for covered services, some service limits and prior authorization limits may be affected.
- If your plan pays the district for covered services, some annual and/or lifetime limits may be affected.
- If your plan pays the district for covered services, the cost of your private health insurance could go up.
- If your private plan pays the district for covered services and there is a copay or deductible, there is no cost to you. The district will cover the copay and/or deductible for those services.
- You can agree to let the district bill your private plan for some, but not all, types of related services on your child's IEP.
- You can decide your district should not send a bill to your health plan, but allow your district to ask your health plan if the plan would pay the district for services. This is only something to think about if your child is also covered by a public plan like MA. (See next question)

Q. What if my child is covered by a public plan like MA and a private plan?

A. You probably know that when using your child's MA coverage, the doctor or other provider must first bill your private plan to see if they pay for the service. If your private plan denies the payment, then MA can consider whether or not they can pay the claim. School districts must follow the same rules. This could be the type of situation when a parent decides they do not want the district to bill their private health plan for IEP related services. However, the parent might agree the district could find out if the private plan does or does not cover IEP related services. When parents give permission to the district to ask the health plan about coverage, if the plan states they do not cover IEP related service, the district may submit the claim to MA. This assumes the parent or legal representative has given the district an annual informed signed consent.

Q. How does third party billing affect due process?

A. There is nothing about third party billing that has any affect on due process:

- If you do not let the district share information with DHS or use your private health plan benefits, the district must still make sure your child gets all of the services identified on the IEP.
- The amount or types of services on your child's IEP does not depend on the ability to get money from a third party. The IEP is written before asking questions about third party options.
- Once you agree to your child's IEP, the district must start giving services even if the district is waiting to find out if a third party will pay.
- The district can't change or stop services if they find out a third party won't pay.
- Districts must follow all privacy regulations. This means that only staff who have a need to know about your health care coverage should have that information.
- Services will still be provided in the least restrictive environment, even if a third party will pay for services if they are provided in a different setting.
- Families will not incur any direct costs linked to third party billing

Q. How will I know what my district is being paid for related services?

A. If your district is paid by MHCP for services, the payment will be listed on the Explanation of Medical Benefits (EOMB) you get from the Department of Human Services. The services are described as:

- School-based IEP services, bundled, physical therapy
- School-based IEP services, bundled, occupational therapy
- School-based IEP services, bundled, speech therapy
- School-based IEP services, bundled, mental health services
- School-based IEP services, bundled, nursing services

- School-based IEP services, bundled, PCA/paraprofessional services
- School-based IEP services, bundled, assistive technology devices
- School-based IEP services, bundled, special transportation
- Interpreter Services

Note that all but interpreter services include the word "bundled." This means that many forms of a service fall into each group. For example, speech therapy includes assessments and evaluations of speech, language and hearing. It also includes treatment services provided by a speech therapist or an audiologist.

The EOMB tells the amount the school was paid. However, the amount on the EOMB is not the money the school gets in a check from MHCP. This is because the check is only for the federal dollars that are paid by MA or MNC. The district gets a little less than 50% of the amount shown on the EOMB. The EOMB is not a bill. You can never owe MHCP or the district for any costs related to your child's IEP services.

If your district is paid by your private health plan, you should get the same kind of payment report that you do for payments made to other providers.

Q. What happens with the money my district gets from third party billing?

A. Minnesota laws are very specific about the use of money districts get from third party billing. There are several things you should know:

- If your district gets money from third party billing, it does not reduce any other state aide the district gets for education or special education.
- Payments from third parties for services given to your child do not go directly to offset costs for your child.
- Money your district gets for third party billing can only be used for three things:
  1. For the benefit of students with special needs in your district;
  2. To pay for the cost of doing third party billing; and
  3. To get training and help to increase the amount of third party billing.

Minnesota Department of Education

MC Griffin 06-18-08

This information is available in other forms to people with disabilities by contacting your local school district or the Minnesota Department of Education at the numbers on the first page.

TDD users can call the Minnesota Relay at 711 or 1-800-627-3529. For Speech-to-Speech Relay, call 1-877-627-3848.

504 Plans

What is a 504 Plan?

- The "504" in "504 Plan" refers to Section 504 of the Rehabilitation Act and the Americans with Disabilities Act and falls under civil-rights law
- This plan is an attempt to remove barriers and allow students with disabilities to participate freely
- It seeks to level the playing field so that students with disabilities can safely pursue the same opportunities as everyone else
- Schools **DO NOT** receive additional money to provide accommodations or services in 504 plans

Who is covered under a 504 Plan?

- Qualified students with disabilities who attend schools receiving Federal financial assistance (Parochial schools receiving NO federal aid do not have to do 504 plans)
- Qualified students must have a **physical or mental impairment** that substantially limits one or more **major life activities**
- Examples of a **physical or mental impairment include**:
  - any **physical disorder or condition** such as:

    arthritis
    chronic asthma or severe allergies
    cancer
    cerebral palsy
    diabetes
    muscular dystrophy
    orthopedic conditions
    seizure disorders
    spinal cord or traumatic brain injury
    visual or hearing impairments
  - any **mental or psychological disorder**, such as:

    ADHD
    anxiety
    depression
    recovering drug or alcohol addicted students
    specific learning disabilities
- Examples of **major life activities** include:

caring for self	hearing	working
walking	communicating	performing manual tasks
seeing	breathing	learning

How are evaluation and placement decisions made under a 504 plan?

- A parent, school personnel, or other service provider may request a 504 evaluation
- School districts must have standards and procedures for initial evaluations and periodic re-evaluations (timing of re-evaluations is not specified but **MUST** be done prior to a significant change of placement, which would include a suspension of more than 10 days)
- School districts are required to draw from a variety of sources in the evaluation process
- Amount of information required, eligibility and placement is determined by a multi-disciplinary committee including persons knowledgeable about the student, the meaning of evaluation data, and placement options
- School districts must **NOT** consider the ameliorating effects of any mitigating measures that the student is using (with the exception of ordinary eyeglasses or contacts) when determining eligibility
- The placement decision must be made in conformity with the least restrictive environment
- Each school district must designate an employee to coordinate compliance with Section 504

What about Postsecondary Educational Institutions?

- Section 504 also covers students at postsecondary institutions receiving federal financial assistance.
- A qualified student is a student with a disability who also meets the academic and technical standards required for admission or participation
- Postsecondary institutions must provide students with appropriate academic adjustments and auxiliary aids and services that are necessary to afford equal opportunity to participate

What is required for parental consent and notification?

- Parental permission is required for initial evaluations (while not specified, this would most likely be a written consent)
- Parents may refuse evaluation and/or services
- School districts may use due process hearing procedures to seek to override the parents' denial of request to initiate evaluation
- School districts are required to provide notice to parents explaining any evaluation and placement decisions

Additional information on 504 plans can be found at the following organizations website:

Minnesota Department of Education

http://education.state.mn.us/MDE/Accountability_Programs/Compliance_and_Assistance/Section_504_of_the_Rehabilitation_Act/index.html

Wrightslaw

http://www.wrightslaw.com/info/sec504.adaaa.htm

US Dept. of Ed – Office for Civil Rights:

Frequently asked Questions About Section 504
http://www2.ed.gov/about/offices/list/ocr/504faq.html

Fact Sheet: Your Rights Under Section 504
http://www.hhs.gov/ocr/civilrights/resources/factsheets/504.pdf

About.com: Special Need Children:

What is a 504 plan? http://specialchildren.about.com/od/504s/f/504faq1.htm
How does a 504 plan differ from an IEP? http://specialchildren.about.com/od/504s/f/504faq2.htm
How do I get a 504 plan for my child? http://specialchildren.about.com/od/504s/f/504faq3.htm

LawHelpMN.org (click on the Disability button)
http://www.lawhelpmn.org/MN

Examples of Possible Accommodations (PACER)
http://www.pacer.org/parent/php/php-c49.pdf

Example of a 504 Plan
http://www.childrenwithdiabetes.com/504/

SCHOOL RESOURCES

Directory of Resources for Children and Families in Minnesota – This directory provides information on resources that may help children, families, providers and others working with families and children. Access this directory through the MN Department of Health, Children & Youth with Special Health Needs Program Web page at: **http://www.health.state.mn.us/mcyshn**

Minnesota Parents Know - www.MNParentsKnow.info This website provides parenting information, resources, and activities related to infants, children and youth through Grade 12. You can also access "Help Me Grow" from this website. From the "Newborn", "Age 1-2" or "Age 3-5" page, just click below the "Help Me Grow" logo and from here you can search for programs or refer a child to "Help Me Grow"

PACER Center - http://www.pacer.org PACER (**P**arent **A**dvocacy **C**oalition for **E**ducational **R**ights) Center is a *parent training and information center* for families of children and youth with disabilities from birth through 21 years old. Parents can find publications, workshops, and other resources to help make decisions about education, vocational training, employment, and other services for their children with disabilities

The University of Minnesota's "Center for Early Education and Development" (CEED): **http://cehd.umn.edu/ceed/publications** has "Questions About Kids" flyers and a series of "Tip Sheets" on the topics of Social and Emotional Growth, Challenging Behaviors, and Mental Health. The "Tip Sheet" section links to various resources on topics including:

- Respond Calmly
- Definition of Infant Mental Health
- The Functional Behavioral Assessment
- Behavior Analysis
- Communicative Alternatives
- Positive Behavioral Support Plans
- Catch Your Child Being Good
- Change the Setting

Minnesota Disability Law Center – Fact Sheets and Resources This link **www.mylegalaid.org/mdlc/mdlc-publications** will take you to the web site of the Minnesota Disability Law Center. Scroll down to the **Special Education** section to access a series of Fact Sheets that include:

- Advocacy Steps and Dispute Resolution
- Child Find in MN
- Conditional and Prohibited Procedures
- Developing IEPs in MN
- Extended School Year Services
- Termination of Services
- Independent Education Evaluations in MN
- Transition
- Placement of Students with Disabilities in the Least Restrictive Environment

Additional legal resources addressing educational issues can be accessed at **www.lawhelpmn.org** Scroll down and click on the "Education" button. From there, click on the "Special Education Rights" bullet. Topics here include:

- The Rights of Children with Disabilities to Receive Services from Daycare Providers
- What Makes a Good Individual Education Plan for Your Child?
- Discipline of Students with Disabilities – Frequently Asked Questions
- Resolving Disputes with the School About Your Child's Special Education

Transition

READY TO MANAGE YOUR OWN HEALTH CARE

Name_____ Date_____

This health care check list can be used to set goals for building independence.

	Able to do independently	Can do partially	Needs practice	Needs Assistance
I understand and can describe chronic illness or disability				
I understand how my chronic illness or disability affects my daily life				
I prepare for and ask questions of doctors, nurses and therapists				
I know what medications I take, what they're for and possible side-effects				
I take my own medication				
I can do my own treatments				
I am able to get a prescription filled or refilled				
I know who my primary doctor is and who my specialty doctors are				
I have a health care summary, and participate in updating and reviewing it on a regular basis with my primary doctor and my parent				
I carry my health care summary and list of medications with me				
I know my height/weight, birthdate or carry the information with me				
I know how to keep a calendar of important dates and when I have been to the doctor				
I know how to use and read a thermometer				
I know how to use, maintain and troubleshoot my own equipment				
I know when I am sick, and when and how to see my doctor				
I know when and how to take non prescription medication when I am sick				
I know about medical insurance coverage and how to use it				
I know where my medical records are kept				
I know about my physical changes in becoming an adult (such as puberty, sexuality, pregnancy and sexually transmitted disease)				
I know the importance of general health maintenance-exercise, healthy diet				
I know about how smoking, drinking and drugs affect my health				
I know what community advocacy organizations there are and how to contact them				
I know how to look for an adult health care provider				
I know how to interview an adult care provider				
I know if I need a personal care attendant, how to hire and manage one				
I know how to get transportation when needed				

THINGS YOU NEED TO KNOW ABOUT TRANSITION

Individualized Education Plans (IEP): When students reach the age of 14, the IEP must tell what the student needs to make the transition from school to work or community life. When the student is 14 or older, his/her input is especially important. This is the age when the team needs to know what the student is interested in. If the student isn't there, the team has to find another way to get information about what the student needs and wants. If the student is 18 years old not on guardianship, s/he should come to the IEP meeting. Starting at least one year before the student turns 18, the IEP must tell the student what rights s/he has once s/he reaches 18. For more information, see the fact sheet developed by the Minnesota Disability Law Center titled, **Special Education Transition Planning**. http://www.mnddc.org/resources/factsheets/Transition_Planning.pdf

Medical Care: If a youth hasn't already switched to a primary care physician who sees adults, now is the time to do it. Having a doctor who sees a person for all of their health needs is important. If the youth is still seeing a pediatrician, get his or her recommendations for an adult primary physician and, if appropriate, specialists who sees adults.

Records: It's a good idea for youth to start keeping a file of medical reports, where they need to make appointments, and other medical information. He/she may be asked to supply this information for medical appointments, employment or other programs. Some of the information they need to know includes:

- Their diagnosis;
- What prescriptions they take
- Treatments they've had, including surgeries
- Transition Care Plans: The Boston Tool was expanded and adapted by the Lexington Hospital to reflect the potential needs of younger and older adolescents. These two care plans facilitate transition planning for early/mid teen years and later teen years. Topics include plans for health condition management, health insurance, functional independence, school to work, independent living and community inclusion. Examples of care plans can be found on the Health and Ready to Work website http://www.hrtw.org/tools/check_care.html

Health insurance coverage of dependents – disabled adult child

Effective October 2010, because of National Health Care Reform legislation, children up to the age of 26 must be allowed to stay on a family insurance policy unless they are eligible for their own employer based health coverage. For many families, this change will not become effective until their insurance carriers next open enrollment period (typically January 1, 2011). While MN had a similar provision that became effective in 2008, it excluded self-insured groups. National Health Care Reform applies to all insurance groups. Children up to the age of 26 regardless of whether they are married, students, or dependent on parents must be allowed to remain covered or become covered if they had previously lost eligibility for the family policy. The only exception would be for children who have access to their own employer based health coverage. Dependent children over the age of 26 who are disabled may be able to remain on a family policy and parents should call their insurance provider to see what their specific policy allows.

If a young person can't be on his/her parents' insurance he/she may be eligible for one of the Minnesota's public programs in order to pay medical bills. More information on each of the programs is included in this packet and can also be found on the Department of Human Services (DHS) website at: www.dhs.state.mn.us Contact your county human services department to apply for these programs.

The Minnesota Health Care Programs include:

- **Medical Assistance (MA);** Under some circumstances, MA eligibility can go back for up to three months prior to application. You can have MA in addition to other private or employer offered health insurance. MA may even pay your other health insurance premiums if you meet certain criteria. There are several "doors" into MA, including:
  - MA for pregnant women and families with children ("children" defined as up to age 21).
  - Another basis for eligibility for MA includes persons who are blind or disabled.
  - PASS (Plan for Achieving Self Support) allows persons (ages 15 and older) with a disability, to exclude some income and/or resources which would otherwise be counted when determining income eligibility for MA (blind or disabled basis). The PASS money you exclude must be used for a work goal and some occupational objective, i.e. self support. A PASS can be used for anything that can be specifically tied to achieving an occupational objective, (such as assistive technology, laptop computer, tuition and books, child care, tutoring or testing fees. A PASS proposal written for MA is submitted to and approved by the county Department of Human Services.
  - If you get SSI, you may qualify for Medical Assistance (MA)
  - If you are an Emancipated Minor (by marriage or by court decision), you may qualify for MA, or continue MA due to income or disability status.
  - **Medical Assistance for Employed Persons with Disabilities (MA-EPD)** allows working people (ages 16 to 65) with disabilities to qualify for MA – see fact sheet included in this packet.
  - **Emergency Medical Assistance (EMA)** for non-citizens with a qualifying medical emergency, who are not eligible for regular MA because of their immigration status. EMA does not cover all of the items covered by regular MA.

- **Minnesota Care** is a state-subsidized program for persons who do not have health insurance. There are eligibility restrictions related to access to employer offered insurance (there are exceptions). MinnesotaCare has six different benefit sets, depending on who you are (i.e. child, pregnant woman, parent, or adult without children) and your income. Some persons may be eligible for either Minnesota Care or MA, but cannot have coverage from both programs at the same time (there are some exceptions).

Other Options To Buy Private Health Care Insurance:

- **College** – student plan;
- **Employed** – group plan;
- **Self-pay** – single plan;
- **Ticket to work** – Worker can opt to buy-in and receive MA;
- **COBRA** (Consolidated Omnibus Budget Reconciliation Act) – option for employees who can't continue buying their employer offered insurance (they've left their job or decreased work hours);
- **State High Risk Pools** – In Minnesota this is called Minnesota Comprehensive Health Association (MCHA) insurance.

A 35 page booklet titled "Youth With Disabilities in Transition: Health Insurance Options and Obstacles" is available at the **Healthy and Ready to Work** website located at: www.hrtw.org/tools/documents/HealthInsuranceOpportunities_Obstacles.doc

Supplemental Security Income (SSI): SSI is a Federal program giving people extra monthly income, if they qualify by income and with a disability. If you get SSI, you may qualify for Medical Assistance (MA) for payment of your medical bills.

Some children under age 18 did not qualify for SSI due to family income. However, at age 18 a person may now qualify for SSI because they would be considered a single adult head of household. SSI will only count the youth's income, not the parent's income, even if the youth is living in his/her parent's home.

For persons on SSI before age 18, a redetermination is made at 18, looking only at the youth's income (not parent or spouse income). SSI will also look again to see if the youth still meets the SSI disability criteria. If the youth is found ineligible during redetermination, they may continue to receive SSI benefits IF they began receiving state vocational rehabilitation agency services before their 18th birthday. Section 301 allows young adults to retain benefits (SSI and MA) while he/she participates in approved vocational rehabilitation program. [For more information on Section 301 go to Healthy and Ready to Work www.hrtw.org/healthcare/sect_301.html]

Applying For A Job: Be sure you let an employer know about your disability or health problem. When applying, consider things like: Does the job fit your disability or health problem? (Examples: If you are on medications that make you sleepy, you don't want to be working with dangerous equipment; or, is there a specialist in "ergonomics" at the work site who can make sure your work area is meeting your physical needs?) See the **Accommodations Categories Chart** from PACER CENTER, located in this packet.

If you are getting a job, asking about health insurance coverage is important. Some questions to ask:
- Is health insurance offered?
- When does it go into effect (How long do I have to work to get insurance?)
- Will it cover my pre-existing condition?
- Can I keep my health care providers or do I have to switch?
- Does the insurance cover the equipment or supplies I need?

Driver's License/Handicapped Parking Permit: Do you have a disability that interferes with driving or do you need special adaptations to a car to allow you to drive? First, you need to check with your doctor to make sure you will be able to drive. If driving is possible, Courage Center has a program for assessing people's ability to drive, provides lessons, and helps plan adaptations to cars. The phone number to call is 763-520-0325. If you need a handicapped parking permit contact your local Department of Motor Vehicles. Your doctor needs to sign the application to show you need a handicapped parking permit.

Reduced Metro Bus Fares: If you have a mobility disability and can't drive because of your disability, contact the Metro Transit Company (612-373-3333) and press **3** to be connected with ***Customer Relations***. You can request a limited mobility form. Take this to your doctor to complete and return to Metro Transit. You can then apply for a MN non-driver ID to be eligible for .50 bus fares.

HELPING YOUTH TRANSITION FROM OUT-OF-HOME CARE TO ADULTHOOD: BEST PRACTICES GUIDE

This Best Practices Guide was developed by the Minnesota Department of Human Services, Child Safety and Permanency Division, October, 2006. It was specifically developed for social workers, however, other providers and parents will find it extremely valuable. This resource provides practice recommendations, sample goals and objectives and outlines skills/behaviors. The content of this Best Practices Guide includes:

- Guidance on assessing youth's independent living skills using an on-line assessment tool

- Guidance on developing a complete and meaningful Independent Livng plan
- Resources for each section of the Independent Living Plan
- Information on teaching youth life skills and where to find curriculum
- An explanation of the Support for Emancipations and Living Functionally (SELF) program, which provides counties with funding to help prepare youth for adulthood
- Information on how caregivers and other significant adults can help prepare youth for adulthood.

The easiest way to access this document is by simply going to Google and typing in the following: Best Practices Guide: Helping Youth Transition From Out-of-Home Care to Adulthood.

Legal Requirements for Transition Planning for Older Youth in Foster Care

DHS Bulletin 09-68-01 dated April 22, 2009
Minnesota law was strengthened in 2008 to provide greater judicial oversight of county social service agency efforts to prepare youth for discharge from foster care. The annual court review hearing for youth age 16 and older will include a review of actual plans for each item of a youth's required independent living plan. If the youth is within six months of his/her 18th birthday, the court will also determine whether the county social service agency has advised them, their parents or legal guardian, and foster parents of the availability of foster care benefits up to age 21. If the youth indicates a desire to remain in foster care and receive services beyond age 18, the county agency has an affirmative obligation to develop a plan with that youth to remain in foster care. Persons between the ages of 18 and 21 who had been under state guardianship may request these services and benefits at any time regardless of whether they left care or continued in care at age 18.

Education and Training Voucher (ETV)

To get DHS information on ETV Google "Education and training voucher dhs mn"
This program is federally funded through the Chafee Foster Care Independence Act, which was enacted to help provide opportunities for youth who age out of the foster care system to attend post-secondary education and training programs. ETV awards can be up to $5,000 per school year to pay for tuition, fees, books housing, transportation and other school–related costs.

All ETV applicants must be both:

- Under 21 at the time of the application deadline
- Accepted into an accredited post-secondary or training program (college, vocational, technical or trade school)

In addition, applicants **must meet at least one** of the following:

- In foster care on or after 16th birthday, and continue to be in foster care up to or beyond 18th birthday
- Adopted from foster care after 16th birthday
- In foster care on or after 16th birthday when a relative/kin accepted a transfer of permanent legal and physical custody through a juvenile court order
- Are or were under state guardianship (also know as "state wards")

MINNESTOA REHABILITATION SERVICES-VOCATIONAL REHABILITATION PROGRAM (VR) PROGRAM

VR Transition Services - VR can help students make a plan for employment while they're in high school and help them complete that plan when they leave school. A VR counselor is assigned to

each secondary school system in the State of Minnesota. VR counselors can work closely with school districts as well as families, to help in transition planning for youth with disabilities. Transition experts advise parents and youth to invite VR counselors to Individualized Education Program (IEP) meetings at least two years before the student exits school. VR counselors know about community employment. They can also discuss the student's occupational goals and what skills he or she must have to reach them.

One goal of VR is to maintain an online list of transition counselors and the schools to which they are assigned. To access this list, go to: www.deed.state.mn.us/rehab/transition/ or call Minnesota VR at (651) 296-5619 or (800) 328-9095. Also, VR is located in all of Minnesota's Workforce Centers.

There are two levels of VR Services: Core Services and Intensive Services

VR Core Services include meeting with any interested student with a disability, regardless of having applied for VR intensive services, to help with basic/short-term career planning questions. This also includes education students on both Workforce Center and VR services as well as referring them to other services that could meet their needs.

VR Intensive Services are for those students who face substantial barriers to employment beyond what could be addressed through WorkForce Center and VR Core Services. A student needs to qualify for these services (based on a documented disability and information which supports known or possible barriers to employment.

PROJECT C3 – CONNECTING YOUTH TO COMMUNITIES AND CAREERS

Project C3 is a partnership between PACER Center, Pathways to Employment, the Minnesota Department of Employment and Economic Development (DEED), the Minnesota Department of Education, and other state and local organizations. The goal of the project is to improve employment and postsecondary outcomes for youth with disabilities. www.c3online.org

Project Pride - (PACER's Rehabilitation Act Information and Disability Education) provides information and training about the Rehabilitation Act for youth with disabilities, their families and professionals. PACER's transition staff helps families explore options for postsecondary education and careers that will fit their youth's interests and skills. PACER's transition staff can be reached at (952) 838-9000 or (800) 537-2237 or www.pacer.org

MinnesotaHelp.info – Youth Corner

The MinnesotaHelp.info has a new interactive website that is designed to help Minnesota's youth, their families, youth workers, and others locate needed services in their own neighborhood. You can use the Youth Resources Navigator to help create a transition plan for yourself or someone else.
http://youth.minnesotahelp.info

College Planning for Students with Disabilities

As a student with disabilities, you face unique considerations as you plan for college. To help you address these issues, the University of Nebraska-Lincoln Project NETS and EducationQuest Foundation have developed a handbook titled, ***College Planning for Student with Disabilities – a supplement to the College Prep Handbook***. You can order a free copy of this handbook by going to the following website. http://www.educationquest.org/

The importance of self-advocacy - Becoming a self-advocate in high school will help you succeed in college. At the college level, ***you*** will be responsible for identifying and requesting support services. Parents aren't automatically involved with your college education, and most colleges prefer working directly with the student.

What is a self-advocate? Self-advocates are those who:

- make choices based on their preferences, beliefs, and abilities
- take control and make decisions that impact the quality of their lives
- take risks and assume responsibility for their actions
- advocate on behalf of themselves and others

As a "self-advocate" you communicate your needs with logical and positive language. To be an effective self-advocate, you must understand your disability, know how it impacts your learning, and become comfortable with describing your disability and academic-related needs to others.

These practices will help you become a self-advocate: Review your case file with your parents and Individual Education Plan (IEP) team to better understand your disability and its effect on your learning. Ask for copies of your IEP and other assessment reports. Ask these questions:

- What is my disability?
- How does it affect how I learn?
- What are my academic strengths?
- How do I learn best?
- What strategies can I use to help me learn?

Consider meeting with the doctor or school psychologist who performed your assessment (testing) for the terms needed to explain your disability.

Take an active part in the discussions at your IEP meetings. Understanding your learning strengths and weaknesses gives you valuable knowledge that can influence your IEP planning and the services you may request in college.

Before each IEP meeting:

- Understand the purpose of the meeting.
- Know who will be there and their role at the meeting.
- Review the report from your last IEP meeting. Understand the goals listed on the report.
- Practice saying how you accomplished the goals.
- Establish new goals and be prepared to state them.

At the IEP meeting:

- Summarize your past goals and accomplishments.
- State your new goals.
- Ask for ideas and feedback from other members.
- Know what support and help you will need to accomplish your goals — and ask for it.
- Ask questions if you don't understand.

Exploring career options - Follow these steps in high school to help determine a course of study when you get to college.

Step 1: Ask your guidance counselor or school transition specialist about career interest inventories and a vocational assessment to help you explore and identify your career interests. Ask how your learning needs may influence these career areas.

Step 2: Discuss career options with your parents, friends, and people working in jobs that interest you. Look into job shadowing, attend local career fairs and explore volunteer opportunities in your areas of interest.

Step 3: Become involved in extracurricular activities. Volunteer and paid work can teach responsibility, reliability and teamwork. A part-time job is also a good way to earn money for college.

Preparing for college entrance and placement exams

ACT/SAT entrance exams - You typically take the ACT and/or SAT entrance exams in the spring of your junior year and again in the fall of your senior year. When you schedule your exams, you may need to request accommodations. When requesting accommodations, you must provide documentation of your disability. For details, visit www.act.org/aap/disab/index.html and

ASSET and COMPASS - Test-taking accommodations also apply to the ASSET (Assessment of Skills for Successful Entry and Transfer) or COMPASS (Computer Adaptive Placement Assessment and Support System) tests - a series of short placement exams often required by community colleges. These exams are designed to help identify your strengths and needs. For more information, visit www.act.org/compass or www.act.org/asset/index.html.

Accommodations for the SAT, ACT, ASSET and COMPASS may include:

- Individual administration of the test
- Audiocassette tape or large print test editions
- Special answer sheets
- Extended testing time and breaks
- Interpreter
- Braille editions

Selecting a college - Finding a college that meets your needs will require research, campus visits and asking the right questions. See our Guided Tour for High School Students and Parents for steps to follow.

Another resource is *Educational Opportunities Beyond High School in Nebraska* at http://edweblab.unl.edu/edopportunities/intro.html which provides options for postsecondary education in Nebraska. It contains information for students with disabilities including accommodations and support services.

The disability services coordinator - Most colleges have an office that provides services to students with disabilities. If not, the school will have a person who coordinates these services. The office or disability services coordinator is usually located in the college's counseling center or in student services.

Once you narrow your college choices, it's important that you meet with the disability services coordinator at each college to determine services and accommodations that may be available. This may help determine the college that will best meet your needs. To review a list of questions to ask the disabilities services coordinator, go to the following website.
http://www.educationquest.org/swdquestions.asp

Applying for admission and financial aid - As you visit or correspond with colleges that interest you, ask about deadlines and the process for applying for admission, financial aid and college-based scholarships. Ask about scholarships that may be available for students with disabilities.

How disability-related expenses may affect financial aid - As a student with a disability, you may face expenses that other students do not encounter. When you apply for financial aid, inform the financial aid administrator of your disability-related expenses keeping in mind that financial aid will not cover expenses already covered by assisting agencies.

Possible disability-related expenses include:

- services for personal care attendants
- special education equipment related to your disability and its maintenance
- special transportation
- medical expenses relating directly to your disability not covered by insurance

Seek help - The financial aid process can be overwhelming and frustrating at times so ask for help. EducationQuest Foundation and the college financial aid staff will answer your questions and help you complete this process.

Steps to follow once you're accepted to college - Once you select a college, it's important to take certain steps to ensure a successful start to your college career. Keep in mind that ***you will receive services related to a disability only if you:***

- contact the coordinator of disability services
- provide the required documentation
- request services each term or semester

Step 1: Gather required documentation
All colleges require documentation of a student's disability to determine eligibility for services and specific services that are needed. To ensure you have the most recent documentation:

- **Request a copy of your high school IEP before you graduate**. If you had an IEP in high school, that means you were tested by the school psychologist or a medical doctor. A copy of that assessment may be sufficient documentation of your disability.
- **Update your tests**. Some colleges have a three-year time limit on accepting certain documentation, particularly if you have a learning disability or Attention Deficit Disorder (ADD). If you received testing in high school, work with your school to have your tests updated the last year you receive special education services. Disability testing after high school graduation can be expensive.

Step 2: Meet with the disability services coordinator
Meet with the disability services coordinator at your college to review the documentation and discuss accommodations. After meeting with you and evaluating your documentation, the disability services

coordinator will understand how your disability impacts your learning and can determine possible accommodations. The law does NOT state that all students with a disability must receive ALL accommodations.

Step 3: Request accommodations
Partner with the disability services coordinator and the course instructor to find **accommodations that work best for you**. Although the college may not always agree to your request for a specific accommodation, they are required by law to provide an effective accommodation. Determining effective accommodations may involve experimenting and making adjustments.

You must request services from the disability services office each term or semester. You will not receive services unless you make the request.

Step 4: Become familiar with the campus environment

Register for campus orientation. The disability services coordinator may also provide a special campus orientation.

Determine where to go and who to contact in case of an emergency. If you have special needs (especially medical needs) inform appropriate college personnel of any advance preparation that should be in place.

Ask the admissions office if a summer transition program is offered.

Obtain a copy of your class schedule and visit all buildings where your classes will be held to become familiar with locations and layout.

If you are commuting and will drive yourself, become familiar with parking facilities and procedures.

Consider signing a release of information so the school has permission to share information with your parents.

Your legal rights and responsibilities
By understanding your rights and responsibilities, you will know what you need to do, and what the college is required to do, for you to have an equal opportunity for success.

Federal laws – The following is a description of laws and how they pertain to you as a college student with a disability.

Section 504 of the Rehabilitation Act - This civil rights statute is designed to prevent discrimination against persons with disabilities, as amended in 1990. It provides that:

No **otherwise qualified** individual with disabilities in the United States shall, solely by reason of his/her disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. This law requires that postsecondary schools be prepared to make **appropriate accommodations** and **reasonable modifications** to their college's procedures and practices, so that you can fully participate in the same programs and activities that are available to students without disabilities.

The Americans with Disabilities Act - The Americans with Disabilities Act (ADA) is also a civil rights law. It helps to implement and enforce Section 504, and also outlines additional protections. While Section 504 of the Rehabilitation Act states that public institutions cannot discriminate on the basis of disability if they receive federal funds, the Americans with Disabilities Act (ADA) of 1990 states that with or without federal funds, public institutions cannot discriminate on the basis of disability. Private colleges and universities are covered under the ADA, unless they are completely owned and operated by religious organizations.

Discrimination complaints - Some individual instructors are not familiar with ADA or Section 504 requirements, or with the purpose of accommodating students with disabilities. The disability services coordinator can serve as a liaison between you and the instructor, and can advocate for reasonable accommodations.

Some colleges have an appeals committee that conducts informal hearings related to alleged violations of student rights.

If you cannot resolve your situation informally, follow the school's internal grievance procedure. All colleges are required to have complaint or grievance procedures related to discrimination. The procedures are formal steps outlined to resolve the issue.

- The formal process usually begins with the faculty or staff member most directly involved, the student and a mediator. If satisfactory resolution is not reached, the process may continue with the person's supervisor, then the department head, a Dean, and possibly members of the college's Board of Education.
- All colleges are required by law to designate at least one staff person to coordinate compliance with Section 504 and the ADA. That person may be located in the Disability Services Office. If not, inquire there to find out who to contact. If you believe you were discriminated against on the basis of disability, you can receive help from the Section 504/ADA compliance coordinator. You also have the right to file a complaint with the U.S. Department of Education's Office of Civil Rights for investigation. You must submit the complaint within 180 days of the alleged discrimination.

SUGGESTED SKILLS FOR TRANSITION

EMPLOYMENT

(Developing employment skills and good work habits, opportunities for community work experiences, and vocational training)

Approximate target age: 9-11 years

- Demonstrates on task behavior in the classroom
- Can write own signature
- Independently follows one step directions
- Categorizes everyday objects
- Can verbalize likes and dislikes

Approximate target age: 12-14 years

- Has volunteered in the community
- Employment at home (i.e., baby-sitting, lawn mowing, shoveling)
- Can follow school schedule independently
- Attends class prepared
- Follows two or more step directions independently

Approximate target age: 15-18 years

- Advocates for self to peers/adults
- Accepts feedback (both positive and constructive)
- Self-directed
- Dresses appropriately for activity/weather
- Has completed a job application
- Has prepared a resume and cover letter
- Employment in the community
- Can name 2-3 career interest areas (identify jobs in those areas)
- Connect with appropriate county agencies (i.e., Social Services, Rehabilitation Services)

Approximate target age: 18-21 years

- Advocates for self to peers/adults
- Accepts feedback (both positive and constructive)
- Self-directed
- Dresses appropriately for activity-weather
- Has completed a job application
- Has prepared a resume and cover letter
- Employment in the community
- Can name 2-3 career interest areas (identify jobs in those areas)

RECREATION AND LEISURE

(Everyone needs recreational activities on a regular basis to maintain and health existence. Learners identify what activities they like to do and can plan to be involved in social and free time activities: movies, plays sports, listening to music, spending time with other people, hobbies.)

Approximate target age: 9-11 years

- Communicates what he/she likes to do for fun

- Has activities he/she likes to do independently
- Has participated in at least one school activity
- School activities/clubs
- Can list 2-3 hobbies/clubs that he/she may participate in

Approximate target age: 12-14 years
- Participate in after school activities
- Plans activities with others
- Communicates what he/she likes to do for fun
- Has activities he/she likes to do independently
- Has participated in at least one school activity

Approximate target age: 15-18 years
- Participate in after school activities
- Plans activities with others
- Communicates she he/she likes to do independently
- Has activities he/she likes to do independently
- Has activities he/she likes to do with a group
- Has participated in at least one school activity
- Can list 2-3 hobbies/clubs that he/she may participate in

Approximate target age: 18-21 years
- Participate in after school activities
- Plans activities with others
- Communicates what he/she likes to do for fun
- Has activities he/she likes to d independently
- Has activities he/she likes to do with a group
- Has participated in at least one school activity
- Can list 2-3 hobbies/clubs that he/she may participate in

HOME/DAILY LIVING

(Learner has or is in the process of developing the skills necessary to live as independently as possible. Learner will need personal management skills which include clothing care, housing, security, and household management. They will need to become more responsible for their personal budgets. Some learners will need supported living arrangements while others need the skills required to obtain apartments, live in a college dormitory, or own their home.)

Approximate target age: 9-11 years
- Money skills (add/subtract sums up to $20)
- Independently completes chores with less than 2 cues
- Uses calendar “to do” list for organization
- Can read time (analog hour, ½ hour, ¼ hour)
- Reading skill – labels, signs, warnings, etc.
- Can independently get beverages at home
- Can independently prepare snacks

Approximate target age: 12-14 years
- Measurement (solid, liquid, distance)
- Plans and cooks simple meals/snacks
- Can budget weekly/monthly

- Comparison-shops for best buys at food stores
- Cleans their own room
- Can make simple home repairs (change a light bulb)

Approximate target age: 15-18 years
- Measurement (solid, liquid, distance)
- Plans and cooks simple meals
- Can budget weekly/monthly
- Comparison-shops for best buys at food stores
- Cleans their own room
- Can make simple home repairs (change a light bulb)

Approximate target age: 18-21 years
- Measurement (solid, liquid, distance)
- Plans and cooks simple meals
- Can budget weekly/monthly
- Comparison-shops for best buys at food stores
- Cleans their own room
- Can make simple home repairs (change a light bulb)
- Consider living options

COMMUNITY PARTICIPATION

(Developing skills to interact and access the community, develops knowledge base for problem solving and decision making for adult life)

Approximate target age: 9-11 years
- Independent telephone use (answer and take short message)
- Able to read a menu and place food order
- Walks/bikes around neighborhood independently

Approximate target age: 12-18 years
- Can make his/her own doctor/dental appointments
- Learn about insurance (auto, medical, etc.)
- Driver's permit
- Driver's license
- Demonstrates consumer/comparison skills
- Independently gets around the community
- Know how to access advocacy and assistance agencies
- Independently demonstrates how to use a savings/checking account
- Independently demonstrates where to go in the community to meet his/her needs (groceries, gas, bank, library, and pharmacy).
- Has belonged to community support groups
- Participates in community activities (i.e., Scouts, 4H)
- Address Guardianship/Conservatorship

Approximate target age: 18-21 years
- Make own appointments (i.e., medical, hair, etc.)
- Familiar with independent access to transportation available in the community
- Participates in community activities
- Accesses community (i.e., groceries, bank, library, etc.)

- Gain knowledge about insurance (i.e., auto, medical, etc.)

POST-SECONDARY EDUCATION/TRAINING

(Develop skills to access life-long learning opportunities: e.g., preparation for and application to technical, vocational, community colleges, or universities, adult education and community education)

Approximate target age: 9-11 years

- What are their favorite classes
- Written language skills (sentence and paragraph formation, essay writing, etc.)
- Works well in groups (large versus small)
- Uses a computer keyboard

Approximate target age: 12-14 years

- What interesting careers do they talk about what they'd like to try
- Can edit and create written assignments on computer independently
- Attends classes prepared (appropriate assignments and materials)
- Works well in small groups
- Works well in large groups

Approximate target age: 15-18 years

- What educational requirements do their career interest areas have
- What classes have they taken that have helped them explore their career interest areas
- Have the requirements for their school diploma been set and met
- What classes should they take in high school to prepare for their post-secondary level
- Attends classes prepared (appropriate assignments and materials)
- Works well in small groups
- Works well in large groups
- Assist with college application process

Approximate target age: 18-21 years

- What educational requirements do their career interest areas have
- What classes have they taken that have helped them explore their career interest areas
- Have the requirements for their school diploma
- Attends classes prepared (appropriate assignments and materials)
- Works well in small groups
- Works well in large groups
- Assist with college application process

SILS Program (Semi-independent Living Services)

What is SILS? It is a DHS (Department of Human Services) program for adults with Developmental Disabilities. SILS helps people successfully live in their community, by supporting them in ways that help them achieve personally desired outcomes and lead self-directed lives. [NOTE: Persons using Home & Community Based Services (the "Waivers") are **not** eligible for SILS.]

Who is eligible? Persons must meet **all four criteria**:

1. Be age 18 years or older;
2. Have a Developmental Disability (dd) or a Related Condition (rc), with the eligibility determination made by a county-based screening team. [NOTE: "Certified" disabled level is not required].
3. Can function and live independently if they have SILS. [SILS is only for highly functional adults with developmental disabilities.]
4. **NOT** at risk of placement in an ICF/MR (Intermediate Care Facility for Persons With Mental Retardation).

What services are covered under SILS? SILS includes training and assistance for:

- Activities making it possible for an adult with dd/rc to live in the community;
- Social, recreation and transportation skills, including appropriate social behavior;
- Learning and exercising the rights and responsibilities of community living;
- Self-administering medication;
- Maintaining personal appearance and hygiene;
- Managing money, prepare meals and shop;
- Obtaining and maintaining a home;
- Performing first aid and obtaining help in an emergency;
- Using the phone and other utilities.

A one time housing allowance of up to $1,500 can be provided to cover some of the costs related to damage or security deposits for housing rentals, utility deposits and connection costs, household furnishings and other items necessary to enable participant to secure a home in which to receive SILS.

The methods, materials and settings used to provide SILS must be designed to:

1. Increase independence by teaching skills so tasks and activities may be performed without dependence on caregivers;
2. Increase opportunities to interact with people without disabilities who are not paid caregivers;
3. Provide daily schedules, routines, environments and interactions similar to those of people of the chronological same age without disabilities;
4. Provide skill training in an environment where the skill will be used; and
5. Support development of decision making skills and informed choices in all aspects of daily living including selection of service providers, goals and methods, location and decor of residence, roommates, daily routines, leisure activities and personal possessions.

How are SILS services paid? Counties may pay agencies or SILS workers directly, or issue vouchers or cash grants to enable a person to pay providers for their services. If a person on SILS identifies a friend or neighbor from whom they wish to receive SILS, and the county is satisfied with the prospective provider's capability, the friend or neighbor could be paid to deliver the services without being licensed.

For more information: Contact your county Dept. of Human Services. [There may be waiting lists.]

[SOURCE: DHS Disability Services Program Manual – SILS (downloaded 6-18-10)]

Transition Resources

The MCYSHN transition website at http://www.health.state.mn.us/divs/fh/mcshn/transition.htm contains a variety of resources. Some additional transition web resources are listed below.

National Resources:

www.disabilityinfo.gov
Website of the federal government that is a starting point for all government services and information sites.

www.nichcy.org
National Dissemination Center for Children with Disabilities (new name – focus especially on educational issues). State pages of resources at http://www.nichcy.org/states.htm

http://www.hrtw.org/
Healthy and Ready to Work (HRTW). Information and connections to health and transition expertise nationwide – from those in the know, doing the work and living it.

http://das.kucrl.org/iam/resources.html
Web resources for assisting college students with disabilities.

Education:

http://www.rrfcnetwork.org/content/view/117/172/
North Central Regional Resource Center
These individuals are assigned primary responsibility for assisting state and local education agencies with secondary education and transition services.

http://ici.umn.edu/
Institute for Community Integration, University of Minnesota. Part of a national network of similar programs in major universities and teaching hospitals across the country.

http://www.hhs.gov/ocr/
Your Rights Under Section 504. Office for Civil Rights (OCR) Responsible for enforcing the nondiscrimination requirements involving health care and human service providers and institutions.

http://www.ndpc-sd.org
National Dropout Prevention Center for Students with Disabilities

Health and Health Care:

http://www.survivorshipguidelines.org/
Resource for clinicians who provide ongoing healthcare to survivors of pediatric malignancies. A basic knowledge of ongoing issues related to the long-term, follow-up needs of this patient population is assumed.

http://www.shrinershq.org/hospitals/TwinCities/
Comprehensive care for children with orthopaedic conditions, including care coordination and transition services

http://www.gillettechildrens.org/default.cfm?pid=1.3.8.3#Transition%20Services
A variety of transition handouts and resources for transition planning are available on this website.

http://depts.washington.edu/healthtr/
Adolescent Health Transition Project. Designed to help smooth the transition from pediatric to adult health care for adolescents with special health care needs. This site is a resource for information, materials, and links. Checklists that can be downloaded.

www.strengthofus.org
NAMI launched this web site designed to empower young adults through resource sharing and peer support and to build connections for navigating the unique challenges and opportunities in the transition-age years.

Financial:
www.dhs.state.mn.us Type keyword "MA-EPD" in the advanced search.
MA-EPD allows working people with disabilities to qualify for MA under higher income and asset limits than regular MA. For more information contact your county human services department or call the Department of Human Services at 651-431-2400 or 800-747-5484.

http://www.ssa.gov/
Social Security Administration's main web page.

Employment:
http://www.mnwfc.org
Minnesota Workforce Center (Vocational Rehabilitation)
Minnesota WorkForce Centers (WFCs) provide the tools, resources and services needed for job search, career planning and training needs

Independent Living:
http://www.macil.org
Minnesota Association of Centers for Independent Living
Eight Centers for Independent Living in Minnesota provide information about independent living services and advocate for people with disabilities so they can live independently in communities of their choice.

http://www.fosteringconnections.org/
FosterClub's Transition Toolkit includes an overview of the skills, knowledge and resources needed for young people leaving foster care and preparing for life on their own as young adults.

www.c3online.org
On this web site there are various programs and services available to teens and young adults in their community.

Advocacy and Legal Rights:
http://www.minnesotaguardianship.org
Minnesota Association for Guardianship and Conservatorship
Information on guardianship

http://www.mndlc.org
Disability Law Center
Serves the unique legal needs of persons with disabilities

http://www.pacer.org/publications/index.asp
Pacer Center
Variety of publications, books and videos on transition issues for parents, youth and professionals.

http://www.thearcofminnesota.org/
Arc offers a workshops GetSet! for Transition that helps parents understand the special education transition process and outlines the process for developing their child's transition Individualized Education Plan (IEP). The Guardianship Overview explores substitute decision-making for individuals who need assistance in meeting their needs.

http://www.mylegalaid.org/wp-content/uploads/2009/01/399061705%20-%20Transition.pdf
Minnesota Disability Law Center Fact Sheet on Transition

Printed on recycled paper.

If you require this document in another format call 651-201-3650 (metro area) or toll-free 1-800-728-5420.

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St. Paul MN 55164-0882