



Member Handbook



www.inclusa.org

3349 Church Street, Suite 1 • Stevens Point, WI 54481 • 877-622-6700 | 28526 US Highway 14 • Lone Rock, WI 53556 • 877-376-6113
1407 St. Andrew Street, Suite 100 • La Crosse, WI 54603 • 877-785-6266

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Toll-Free: 1-877-622-6700
TTY: 711 or 1-715-204-1799

Dear Partner:

Our goal is to support you and the community you call home. But we cannot do that without you! We are here to follow your lead, and help you connect to the resources you need to live the life of your choosing.

Thank you for taking the lead in this important partnership. Speaking of partnership, you have a team of people to help you succeed. They are here to support you, so make sure you write down their names and numbers so you can reach them when you need their help.

Community Resource Coordinator

Phone

Health & Wellness Coordinator

Phone

In addition to your team, there is an entire organization working on your behalf. We thought you might like to know more about us.

Who is Inclusa? Inclusa is a values-based organization whose vision is to support full and meaningful lives. We do this by partnering with others to build inclusive communities focused on the collective, and we utilize a set of values to define our business practices and standards of operation. To understand Inclusa, you must first understand our Vision, Mission, and Values.

Our Vision: The innovative leader in building vibrant and inclusive communities, Inclusa empowers full and meaningful lives of those we serve.

Our Mission: We proactively partner with others to build a shared vision of long-term care that offers the people we serve choice, connections, and dignity fostering full participation in communities.

Our Values: Partnership, Respect, Innovation, Integrity, Development, Excellence.

Our History: Inclusa was formed to leverage 48 collective years of experience in delivering a person-centered and community-focused approach to the Family Care program across a large portion of Wisconsin. While the name may be new, Inclusa is not new to long-term care. In fact, its founding organizations—Community Care Connections of Wisconsin, Western Wisconsin Cares, and ContinuUs—have been industry leaders for nearly two decades. In operation since 2000 as county pilot participants, Inclusa's rich history and collective experience is time-tested, refined, and has consistently performed at the high end of MCO metrics regarding quality, cost efficiencies, and member satisfaction. With proven success in multiple expansions into new Family Care counties and service regions, robust network development, and collaborative stakeholder engagement, Inclusa is committed to providing continued excellence in the delivery of Family Care supports and services across Wisconsin.

INCLUSA:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact **INCLUSA** at 1-877-622-6700 or TTY 715-204-1799.

English

ATTENTION: If you speak English, language assistance services are available to you free of charge. Call 1-877-622-6700 (TTY: 1-715-204-1799).

Spanish

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas están disponibles sin cargo, llame al 1-877-622-6700 (TTY: 1-715-204-1799).

Hmong

CEEB TOOM: Yog koj hais lus Hmoob, kev pab rau lwm yam lus muaj rau koj dawb xwb. Hu 1-877-622-6700 (TTY: 1-715-204-1799).

Chinese Mandarin

注意：如果您说中文，您可获得免费的语言协助服务。请致电1-877-622-6700 (TTY 文字电话: 1-715-204-1799)。

Somali

DIGTOONI: Haddii aad ku hadasho afka Soomaaliha, adeegyada caawimada luqadda waxaa lagu heli karaa iyagoo bilaash ah. Wac 1-877-622-6700 (TTY: 1-715-204-1799).

Laotian

ໝາຍເຫດ: ຖ້າທ່ານເວົ້າພາສາລາວ, ທ່ານສາມາດໃຊ້ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໄດ້ໂດຍບໍ່ເສຍຄ່າ. ໂທ 1-877-622-6700 (TTY: 1-715-204-1799).

Russian

ВНИМАНИЕ: Если Вы говорите по-русски, Вам будут бесплатно предоставлены услуги переводчика. Позвоните по номеру: 1-877-622-6700 (TTY: 1-715-204-1799).

Burmese

ကျေးဇူးပြု၍ နားဆင်ပါ - သင်သည် မြန်မာစကားပြောသူဖြစ်ပါက၊
သင့်အတွက် အခမဲ့ဖြင့် ဘာသာစကားကူညီရေး ဝန်ဆောင်မှုများ ရရှိနိုင်သည်။
1-877-622-6700 (TTY: 1-715-204-1799) တွင် ဖုန်းခေါ်ဆိုပါ။

Arabic (right to left)

تنبيه: إذا كنتم تتحدثون العربية، تتوفر لكم مساعدة لغوية مجانية. اتصلوا بالرقم
1-715-204-1799: (هاتف نصي : 1-877-622-6700).

Serbo-Croatian

PAŽNJA: Ako govorite srpsko-hrvatski imate pravo na
besplatnu jezičnu pomoć. Nazovite 1-877-622-6700
(telefon za gluhe: 1-715-204-1799).

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Chapter 1. Important phone numbers and resources

Inclusa Contact Information

The administrative and main office for Inclusa is located in the city of Stevens Point. All of our office locations may be reached by using the toll free number below. ***See Inclusa website for offices open by appointment only.***

Inclusa Main Office (Stevens Point)
8:00 a.m. – 4:30 p.m. Monday – Friday
Toll-Free: 1-877-622-6700
TTY: 711 or 1-715-204-1799
Fax: 1-715-345-5725
Website: www.inclusa.org

If you are experiencing an emergency, call 911

After Hours Contact Information

If you need assistance after hours or on weekends or holidays, call Inclusa's toll-free number (listed below) and your call will be directed to an individual able to authorize urgent help or services to ensure your health, safety, or well-being. Your team will follow up with you on the next business day to determine whether the services

authorized should continue. On-call staff are available 24 hours a day, seven days a week.

Toll-Free: 1-877-622-6700 4:30 p.m. – 8:00 a.m. on
Weekdays
24 hours a day on Weekends & Holidays

Member Rights

Member Relations Managers are specialists in explaining member rights. They are available to help if you have a complaint or grievance. They can give you information or assistance if you want to appeal a decision your team made. Member Relations Managers may be reached at the contact information below.

Toll-Free: 1-877-622-6700
8:00 a.m. – 4:30 p.m. Monday-Friday

Adult Protective Services (APS) Contact Information

Every county has an agency that will look into reported incidents of abuse, neglect, financial exploitation, and self-neglect. Call your county help line if you need to talk to someone about suspected abuse of an adult-at-risk (age 18 to 59). To report abuse of an elder over the age of 60, contact your county elder adult-at-risk agency.

To report abuse, neglect or financial exploitation of an adult, make a confidential report to one of the agencies listed below. The agency to call depends on where the person you are concerned about lives.

- **Adams County** (Health & Human Services Department)
Phone: 608-339-4505

- **Ashland County** (Health & Human Services Department)
Phone: 715-682-7004
- **Barron County** (Department of Health & Human Services)
Phone: 715-537-5691
- **Bayfield County** (Department of Human Services)
Phone: 715-373-6144
- **Brown County** (Human Services)
Phone: 920-448-7885
- **Buffalo County** (Aging and Disability Resource Center)
Phone: 866-578-2372
- **Burnett County** (Health & Human Services Department)
Phone: 715-349-7600
- **Chippewa County** (Department of Human Services)
Phone: 715-726-7788
- **Clark County** (Department of Social Services)
Phone: 866-743-5233

- **Columbia County** (Aging and Disability Resource Center)
Phone: 608-742-9233
- **Crawford County** (Human Services Department)
Phone: 608-326-0248
- **Dodge County** (Aging and Disability Resource Center)
Phone: 920-386-3580
- **Door County** (Human Services)
Phone: 920-746-7155
- **Douglas County** (Department of Health & Human Services)
Phone: 715-395-1304
- **Dunn County** (Aging and Disability Resource Center)
Phone: 715-232-4006
- **Eau Claire County** (Department of Human Services)
Phone: 715-839-7118
- **Forest County** (Human Services Department)
Phone: 888-452-3296
- **Florence County** (Department of Human Services)
Phone: 715-478-7709
- **Grant County** (Department of Social Services)
Phone: 608-723-2136
- **Green County** (Aging and Disability Resource Center)
Phone: 608-328-9499
- **Green Lake County** (Health and Human Services)
Phone: 920-294-4070

- **Iowa County** (Aging and Disability Resource Center)
Phone: 608-930-9835

- **Iron County** (Human Services Department)
Phone: 715-561-3636

- **Jackson County** (Aging and Disability Resource Center)
Phone: 844-493-4245

- **Jefferson County** (Human Services)
Phone: 920-674-3105

- **Juneau County** (Department of Human Services)
Phone: 608-847-2400

- **Kewaunee County** (Human Services)
Phone: 920-338-0626

- **La Crosse County** (Aging and Disability Resource Center)
Phone: 800-500-3910

- **Lafayette County** (Human Services)
Phone: 608-776-4800

- **Langlade, Lincoln, and Marathon Counties** (North Central Community Services)
Phone: 855-487-3338 or 715-841-5160

- **Marinette County** (Aging and Disability Resource Center)
Phone: 715-732-3850

- **Marquette County** (Human Services)
Phone: 608-297-3124

- **Menomonee County** (Health & Human Services)
Phone: 715-799-3861

- **Monroe County** (Aging and Disability Resource Center)
Phone: 800-500-3910
- **Oconto County** (Health & Human Services)
Phone: 920-834-7000
- **Oneida County** (Department of Social Services)
Phone: 715-369-7499
- **Ozaukee County** (Human Services)
Phone: 262-284-8200
- Pepin County** (Aging and Disability Resource Center)
Phone: 866-578-2372
- **Pierce County** (Aging and Disability Resource Center)
Phone: 715-273-6780
- **Polk County** (Human Services Department)
Phone: 715-485-8400
- **Portage County** (Health & Human Services Department)
Phone: 715-345-5350
- **Price County** (Health & Human Services)
Phone: 715-339-2158
- **Richland County** (Aging and Disability Resource Center)
Phone: 608-647-4616
- **Rock County** (Human Services Department – ADRC)
Phone: 608-741-3600 or 855-741-3600
- **Rusk County** (Department of Health & Human Services)

Phone: 715-532-2299

- **St. Croix County** (Department of Health and Human Services)

Phone: 715-246-8255

- **Sauk County** (Department of Human Services)

Phone: 608-355-4200

- **Sawyer County** (Health & Human Services Department)

Phone: 800-569-4162

- **Shawano County** (Department of Social Services)

Phone: 715-526-4700

- **Sheboygan County** (Aging and Disability Resource Center)

Phone: 920-467-4700

- **Taylor County** (Human Services Department)

Phone: 715-748-3332

- **Trempealeau County** (Aging and Disability Resource Center)

Phone: 800-273-2001

- **Vernon County** (Aging and Disability Resource Center)

Phone: 800-500-3910

- **Vilas County** (Department of Social Services)

Phone: 715-479-3668

- **Walworth County** (Department of Health & Human Services)

Phone: 262-741-3200

- **Washburn County** (Health & Human Services Department)
Phone: 715-468-4747
- **Washington County** (Aging and Disability Resource Center)
Phone: 262-335-4497
- **Waukesha County** (Aging and Disability Resource Center)
Phone: 262-548-7848
- **Waushara County** (Department of Human Services)
Phone: 920-787-6618
- **Wood County** (Department of Social Services)
Marshfield Area Phone: 715-387-6374
Wisconsin Rapids Area Phone: 715-421-8600

If an immediate response is needed to prevent harm or injury, call 911

Aging and Disability Resource Centers

Aging and disability resource centers (ADRCs) are the first place to go to get accurate, unbiased information on all aspects of life related to aging or living with a disability. ADRCs are friendly, welcoming places where anyone—individuals, concerned families or friends, or professionals working with issues related to aging or disabilities—can go for information tailored to their situation. The ADRC provides information on programs and services, helps people understand the long-term care options available

and helps people apply for programs and benefits. ADRCs in Inklusiv's service regions are:

- **Aging & Disability Resource Center Serving Adams, Green Lake, Marquette, and Waushara Counties**
Toll-Free: 1-877-883-5378
- **ADRC of Barron, Rusk & Washburn Counties**
Toll-Free: 1-888-538-3031
- **ADRC of Brown County**
Toll-Free: 920-448-4300
- **ADRC of Buffalo and Pepin Counties**
Toll-Free: 866-578-2372
- **ADRC of Central Wisconsin**
Serves residents of Langlade, Lincoln, Marathon, and Wood Counties
Toll-Free: 1-888-486-9545
- **ADRC of Chippewa County**
Toll-Free: 1-888-400-6920
- **ADRC of Clark County**
Toll-Free: 866-743-5144
- **ADRC of Columbia County**
Toll-Free: 1-888-742-9233
- **ADRC of Dodge County**
Toll-Free: 1-800-924-6407
- **ADRC of Door County**
Toll-Free: 855-828-2372
- **ADRC of Douglas County**

Toll-Free: 1-866-946-2372

- **ADRC of Dunn County**

Phone: 1-715-232-4006

- **ADRC of Eagle Country**

Serves residents of Crawford, Juneau, Richland and Sauk Counties

Toll-Free: 1-877-794-2372

- **ADRC of Eau Claire County**

Toll-Free: 1-888-338-4636

- **ADRC of Florence County**

Toll-Free: 1-855-528-2372

- **ADRC of Jackson County**

Toll-Free: 1-844-493-4245

- **ADRC of Jefferson County**

Toll-Free: 1-866-740-2372

- **ADRC of La Crosse County**
Toll-Free: 1-800-500-3910
- **ADRC of the Lakeshore County**
Serving residents of Kewaunee and Manitowoc Counties
Toll-Free: 877-416-7083
- **ADRC of Marinette County**
Toll-Free: 888-442-3267
- **ADRC of Monroe County**
Toll-Free: 1-888-339-7854
- **ADRC of the North**
Serves residents of Ashland, Bayfield, Iron, Price, and Sawyer Counties
Toll-Free: 1-866-663-3607
- **ADRC of Northwest Wisconsin**
Serves residents of Burnett and Polk Counties and the St. Croix Chippewa Tribe
Toll-Free: 1-877-485-2372
- **ADRC of the Northwoods**
Serves residents of Forest, Oneida, Taylor, and Vilas Counties
Toll-Free: 1-800-699-6704
- **ADRC of Ozaukee County**
Toll-Free: 1-866-537-4261
- **ADRC of Pierce County**
Toll-Free: 1-877-273-0804
- **ADRC of Portage County**
Serves residents of Portage County

Toll-Free: 1-866-920-2525

- **ADRC of Rock County**

Phone: 1-608-741-3600 or

Toll-Free: 1-855-741-3600

- **ADRC of St. Croix County**

Toll-Free: 1-800-372-2333

- **ADRC of Sheboygan County**

Toll-Free: 800-596-1919

- **ADRC of Southwest Wisconsin**

Serves residents of Grant, Green, Iowa, and
Lafayette Counties

Toll-Free: 1-877-794-2372

- **ADRC of Trempealeau County**

Phone: 1-715-538-2001 or

Toll-Free: 1-800-273-2001

- **ADRC of Vernon County**
Toll-Free: 1-888-637-1323
- **ADRC of Walworth County**
Toll-Free: 800-365-1587
- **ADRC of Washington County**
Toll-Free: 1-877-306-3030
- **ADRC of Waukesha County**
Toll-Free: 1-866-677-2372
- **ADRC – Wolf River Region (Shawano, Oconto & Menomonee Counties)**
Toll-Free: 855-492-2372

Visit www.dhs.wisconsin.gov/adrc/index.htm for more information about ADRCs.

Ombudsman Programs

An ombudsman (om-budz-man) is an independent advocate or helper who does not work for Inclusa. Anyone who is receiving Family Care services can receive free help from an ombudsman. The number to call depends on the member's age.

If you are **age 60 or older**, contact:
 The Wisconsin Board on Aging and Long-Term
 Care
 1402 Pankratz Street, Suite 111
 Madison, WI 53704-4001
 Toll-Free: 1-800-815-0015

Fax: 608-246-7001

If you are **18 to 59 years old**, contact:

Disability Rights Wisconsin

131 W. Wilson Street, Suite 700

Madison, WI 53703

General: 608-267-0214

TTY: 888-758-6049

Fax: 608-267-0368

Madison toll-free: 1-800-928-8778

Milwaukee toll-free: 1-800-708-3034

Rice Lake toll-free: 1-877-338-3724

Income Maintenance Consortia

You must report changes in your living situation or finances within 10 days. If you move, you must report your new address. These changes can affect whether you are eligible for Medicaid and Family Care. Report these changes to your county's income maintenance consortium and Includa. Consortia in our service regions are:

- **Bay Lake Consortium**

Serves residents of Brown, Door, Marinette, Oconto and Shawano Counties

Phone: 1-888-794-5747

Fax: 1-855-293-1822

- **Capital Consortium**

Serves residents of Adams, Columbia, Dane, Dodge, Juneau, Richland, Sauk, and Sheboygan Counties

Phone: 1-888-794-5556

Fax: 1-855-293-1822

- **Central Consortium**

Serves residents of Langlade, Marathon, Oneida, and Portage Counties

Phone: 1-888-445-1621

Fax: 1-855-293-1822

- **East Central Consortium**

Serves residents of Calumet, Green Lake, Kewaunee, Manitowoc, Marquette, Outagamie, Waupaca, Waushara, and Winnebago

Phone: 1-888-256-4563

Fax: 1-855-293-1822

- **Great Rivers Consortium**

Serves residents of Barron, Burnett, Chippewa, Douglas, Dunn, Eau Claire, Pierce, Polk, St. Croix, and Washburn Counties

Phone: 1-888-283-0012

Fax: 1-855-293-1822

- **Moraine Lakes Consortium**

Serves residents of Fond du Lac, Ozaukee, Walworth, Washington, and Waukesha Counties

Phone: 1-888-446-1239

Fax: 1-855-293-1822

- **Northern Consortium**

Serves residents of Ashland, Bayfield, Florence, Forest, Iron, Lincoln, Price, Rusk, Sawyer, Taylor, Vilas, and Wood Counties

Phone: 1-888-794-5722

Fax: 1-855-293-1822

- **Southern Consortium**

Serves residents of Crawford, Grant, Green, Iowa, Jefferson, Lafayette, and Rock Counties

Phone: 1-888-794-5780

Fax: 1-855-293-1822

- **Western Consortium**

Serves residents of Buffalo, Clark, Jackson, La Crosse, Monroe, Pepin, Trempealeau, and Vernon Counties

Phone: 1-888-627-0430

Fax: 1-855-293-1822

Medicaid (Wisconsin ForwardHealth)

If you are having problems using your ForwardHealth card for services or items that are not in the Family Care benefit package (such as eyeglasses, visits to your doctor, or prescriptions), call ForwardHealth Member Services toll-free at:

1-800-362-3002

Reporting Public Assistance Fraud

Fraud means getting coverage or payments you know you should not get or helping someone else get coverage or payments you know they should not get. Anyone who commits fraud can be prosecuted. If a court determines that a person received health care benefits by committing

fraud, the court will require that person to pay back the state for those benefits, in addition to other penalties.

If you suspect anyone of misuse of public assistance funds, including Family Care, you can call the fraud hotline or file a report online at:

Toll-Free: 1-877-865-3432
www.reportfraud.wisconsin.gov

or

Toll-Free: 1-877-622-6700
fraud@inclusa.org

Wisconsin FoodShare (QUEST Card)

If you have questions or concerns about FoodShare, if you want to know the balance on your FoodShare/QUEST card, or to report a lost or stolen QUEST card, call the FoodShare customer service line toll-free at:

1-877-415-5164

Wisconsin Division of Quality Assurance

If you think a caregiver, agency, or facility has violated state or federal laws, you have the right to file a complaint with the Wisconsin Division of Quality Assurance. When

filing a complaint, you may be asked for the county in which the provider is located. To file a complaint, call toll-free:

1-800-642-6552

Inclusa Billing Questions

If you have questions about cost share, room and board charges, or billing processes, call our main office toll free at 1-877-622-6700 during normal business hours (8:30 to 4:30, Monday – Friday) and ask to speak to a Member Liabilities Specialist. They can also help you if you are not able to pay a bill or want to set up automatic billing and payment.

1-877-622-6700

Chapter 2. Welcome and Introduction

Welcome to Inclusa

Welcome to Inclusa, a managed care organization that operates the Family Care program. Family Care is a Medicaid long-term care program for eligible adults with physical or developmental/intellectual disabilities and frail elders. Family Care is funded by state and federal tax dollars.

This handbook will give you the information you need to:

- Understand the basics of Family Care.
- Become familiar with the services in the benefit package.
- Understand your rights and responsibilities.
- File a grievance or appeal if you have a problem or concern.

If you would like help in reviewing this handbook, please contact the Inclusa staff you are working with (your team). Your team will provide business cards with contact information during your first meeting. You may also call your local office at the number listed starting on page 9 to request contact information for your team.

In general, the words “you” and “your” in this document refer to you, the Member. “You” and “your” may also mean

your authorized representative, such as a legal guardian or activated power of attorney.

The end of this document (page 112) contains definitions of important words. These definitions can help you understand the words and phrases frequently used in this handbook.

If you are not yet a member and have questions, or want more information about how to enroll in Family Care or other programs, please contact the Aging and Disability Resource Center (ADRC) in your area. ADRCs provide information and assistance and help people apply for programs and benefits. The ADRC is a separate agency and is not part of Inclusa. The ADRC is available to help you, whether or not you decide to become a Family Care member. The address and phone number of your local ADRC can be found on page 9.

How can the Family Care program help me?

A main goal of Family Care is to ensure that people are safe and supported at home. When people live in their own home or in their family's home, they have more power over their lives. They can decide when to do certain things, such as when to wake up and eat meals, and how to plan their day.

Family Care:

- Can improve or maintain your quality of life.
- Helps you live in your own home or apartment, among family and friends.
- Involves you in decisions about your care and services.
- Maximizes your independence.

When you join Family Care, we will talk with you about services that can help you live at home. This **might** include building a wheelchair ramp or using a medical alert system.

Family Care provides care management and a range of services that are designed to meet your needs. Help with bathing, transportation, housekeeping, and home-delivered meals are just some of the services we offer. (See chapter 4, page 48, for a list of covered services.)

Inclusa will help you live as independently as possible in your home or other cost-effective setting. We will make sure you get the care you need to be healthy and safe. We will also help you maintain your ties with your family, friends, and community.

If you are a young adult preparing to move out on your own, Includa can help you become more independent. For example, we can help you develop the skills you need to find a job or learn how to prepare your own meals.

Who will help me?

When you become a Family Care member, you will work with a team of professionals from Includa. This is your care team and it includes YOU and:

- Anyone you want to be involved, including family members or friends;
- A Health & Wellness Coordinator;
- A Community Resource Coordinator; and
- Other professionals may be involved depending on your needs. For example, this could be an occupational or physical therapist, or a mental health specialist.

You are a central part of your care team and you should be involved in **every part** of planning your care. Let your team know if you need any assistance to take part in the process.

The job of your care team is to work with you to:

- Identify your strengths, resources, needs, and preferences.
- Develop a care plan that includes the help you need.
- Make sure the services in your plan are actually provided to you.
- Ensure that the services Family Care provides meet your needs and that they are cost-effective.
- Make sure your care plan continues to work for you.

Inclusa encourages family members, friends, and other people who are important to you to be involved in your care. Family Care does not replace the help you get from your family, friends, or others in the community. We will work with you to build on these important relationships. We can also help find resources in your community that can assist you, such as libraries, senior centers, and churches.

When needed, we can also help find ways to strengthen your support network. For example, if the people who help you need a break, we can provide respite services. Respite provides a temporary break for your caregivers to give them time to relax and maintain their own health.

What does it mean to be a member?

As a member of Inclusa's Family Care program, you and your care team will work together to make decisions about

your health and lifestyle. Together you will make the best possible choices to support you.

You will receive your long-term care services through Includa providers. When you join Family Care, we will give you information on how to get a list of service providers who have agreed to work with us. You and your care team will work together to choose providers that best support your needs.

Includa believes our members should have personal choice when receiving services. Choice means having a say in how and when care is provided. Being a member and having personal choice also means you are responsible for helping your care team find the most cost-effective ways to support you.

Includa is responsible for meeting the long-term care needs of ALL of our members. We can only do that if all of our members help us develop care plans that work but are also reasonable and cost-effective. By working together, we can make sure Family Care remains available to other people who need our services.

You can keep your current physicians, hospitals, clinics, and pharmacies where you get your prescription medicines. **Inclusa's Family Care program is not responsible for these services.** They are paid for by Medicare, Medicaid, or other insurance—not the Family Care program. However, your care team will help coordinate both Family Care services and the services from your doctors and other medical providers. Examples of these are your general physician, prescription medications, podiatrist, dentist, and chiropractor.

Who can be a member of Inclusa?

It is your choice whether to enroll with Inclusa. Membership is voluntary. To be served by Inclusa, you must:

- Be an adult with a physical or developmental/intellectual disability or be age 65 or older;
- Be a resident of one of our service areas (see below for the list of our service areas);
- Be financially eligible for Medicaid;
- Be functionally eligible as determined by the Wisconsin Adult Long Term Care Functional Screen; and
- Sign an enrollment form.

Only individuals who are residents of one of the counties in our service area can enroll with Inclusa. To be served

by Inclusa, you must remain a resident in a county in this service area. Our service area includes these counties in Wisconsin:

Adams	Forest	Marquette	Sawyer
Ashland	Grant	Menomon	Shawano
Barron	Green	ee	Sheboyga
Bayfield	Green	Monroe	n
Brown	Lake	Oconto	Taylor
Buffalo	Iowa	Oneida	Trempeal
Burnett	Iron	Ozaukee	eau
Chippewa	Jackson	Pepin	Vernon
Clark	Jefferson	Pierce	Vilas
Columbia	Juneau	Polk	Walworth
Crawford	Kewaunee	Portage	Washburn
Dodge	La Crosse	Price	Washingto
Door	Lafayette	Richland	n
Douglas	Langlade	Rock	Waukesha
Dunn	Lincoln	Rusk	Waushara
Eau Claire	Marathon	St. Croix	Wood
Florence	Marinette	Sauk	

If you plan to move out of the service area, you must notify your team. If you move outside of our service area, you

may not be able to remain a Family Care member. (For more information, see page 46.)

Once you become a member, you must continue to meet financial and functional eligibility requirements to stay enrolled.

- **Financial eligibility** means eligibility for Medicaid (also known as Medical Assistance, MA, or Title 19). The income maintenance agency looks at an individual's income and assets to determine if the person is eligible for Medicaid. Sometimes to be financially eligible, members will have to pay a share of the cost of the services they receive. This is called "cost share" and it must be paid to remain eligible for Medicaid. If you will have a cost share, staff from the ADRC will discuss this with you before you make a final decision about enrolling. For more information about cost share, see page 58. The income maintenance agency will review your financial eligibility and cost share at least once a year to make sure you are still financially eligible for Family Care.
- **Functional eligibility** is related to a person's health and need for help with such things as bathing, getting dressed, and using the bathroom. The ADRC can tell you if you are functionally eligible for Family Care. Your care team will review your functional eligibility at least once a year to make sure you are still eligible.

How do I become a member?

If you are not already a member, but are interested in becoming a member of Inclusa, please call or visit the aging and disability resource center (ADRC) in your area. The address and phone number of your local ADRC can be found on page 9.

The ADRC will help assess your level of need for services and make sure you are functionally eligible for Family Care. They will give you information about other programs available. They will help you choose the most appropriate resource or program for you.

During the enrollment process, the ADRC will ask you to:

- Provide information about your health and needs.
- Provide information about your income and assets.
- Sign a “Release of Information” form for your medical records.
- Complete and sign an enrollment form.

You will also meet with an income maintenance worker. This person will determine if you meet financial eligibility for Family Care.

Chapter 3. Things to Know About Getting Services

How does Family Care work?

Personal Experience Outcomes

When you enroll in Family Care, you and your care team will do an **assessment** of your needs, strengths, and preferences. Part of this process is for you to tell your team about the kind of life you want to live and the support you need to live the kind of life you want. This gives your team a clear understanding of what is important to you.

During the assessment, your care team will help you identify your **personal experience outcomes**. These outcomes are the goals you have for your own life and they include:

- Input on:
 - Where and with whom to live
 - Needed support and services and who provides them
 - Your daily routines
- Personal Experience—having:
 - Interaction with family and friends
 - A job or other meaningful activities
 - Community involvement
 - Stability

- Respect and fairness
 - Privacy
- Health and Safety—being:
 - Healthy
 - Safe
 - Free from abuse and neglect

Only you can tell your care team what is important to you. YOU define what these outcome statements mean to you and your life. For example, a person might want to:

- Be healthy enough to enjoy visits with his or her grandchildren;
- Have a paid job; or
- Be independent enough to live in his or her own apartment.

You have a right to expect that your care team will work with you to identify your personal experience outcomes. This does not mean Includa will always provide services to help you achieve your outcomes. **The things you do for yourself and the help you get from your family, friends, and others will still be a very important part of the plan to support your outcomes.**

Before Includa buys services for you, your care team has to consider which ones support your needs best and are the most cost-effective.

Long-Term Care Outcomes

During the assessment process, you and your care team will also identify your **long-term care outcomes**. This helps you and your team know which services will meet your long-term care needs. Long-term care outcomes are those things Family Care can help you achieve to have the kind of life you want. For example,

- Being able to get your daily needs met.
- Getting what you need to stay safe, healthy, and as independent as possible.

Having these things in place will let you focus on the people and activities that are most important to you. For example, getting help to dress or take a bath may also help a person feel well enough to go to work or visit family and friends.

Your care team will develop a care plan that will help you move toward the outcomes that you and your team identify during the assessment process.

What should be in your care plan?

Your care plan will be clear about:

- Your physical health needs and your ability to perform certain tasks and activities (such as eating and dressing).
- Your strengths and preferences.
- Your personal experience and long-term care outcomes.
- The services you will receive.
- Who will provide you with each service.
- The things you are going to do yourself or with help from family, friends, or other resources in your community.

Your care team will ask you to sign your care plan, which shows that you participated in its development. You will get a copy of your signed plan. If you are not happy with your plan, there are grievance and appeal procedures available to you. (See chapter 8, page 78 for more information.)

Your care team will be in contact with you on a regular basis to talk about how you are doing and check if your services are helping you. Your team is required to meet with you in person at least every three months. Your team

may meet with you more often if there is a need for more frequent visits.

How are services selected and authorized?

Your care team must approve all services **BEFORE** you receive them. Inlusa is not required to pay for services you receive without our prior approval. **If you arrange for services yourself without your care team's approval, you may have to pay for them.** Please talk with your team if you need a service that is not already approved and in your care plan.

Note: If you are considering moving to an assisted living facility or nursing home, please see page 62. Inlusa will only authorize residential services in certain situations.

Inlusa is responsible for supporting your long-term care outcomes, but we also have to consider cost when planning your care and choosing providers to meet your needs.

To do this, your care team will use the **Resource Allocation Decision (RAD)** process as a guide in making decisions about services. The RAD is a step-by-step tool you and your team will use to find the most effective and

Basic rules for getting services

We will generally cover your services as long as:

- The services are included in the Family Care benefit package (see page 50).
- The services

efficient ways to meet your needs and support your long-term care outcomes.

Cost-effectiveness is an important part of the RAD. Cost-effectiveness means effectively supporting an identified long-term care outcome at a reasonable cost and effort. For example, if two different providers offer the assistance you need, Inclusa will purchase the more economical service.

You have the right to know and understand all your options, including how much things cost. Your responsibility is to talk with your care team about these options so you can make decisions together. This includes asking questions and sharing your opinions.

During the RAD, you and your care team will talk about the services you need. Together you will explore the options available to meet your long-term care outcomes. This includes talking about how friends, family, or others can help. Many times, you can achieve one or more of your outcomes without a lot of help from Inclusa because family, friends, or other people are able and choose to help you. Inclusa purchases services that your own supports cannot provide.

Our goal is to support the people in your life who already choose to help you. These “natural supports” keep people who are important to you in your day-to-day life. Building on, instead of replacing, the assistance you get from your family and friends strengthens these invaluable

relationships and helps Inclusa pay for services where and when they are needed.

At the end of the RAD, you and your care team will talk about how you can have more control in your life and if you are interested in directing your services. For more information about directing your services, see page 42.

Your care team will find service providers to help you. These providers must have a contract with Inclusa. See page 40 for information about using our providers.

If you are unhappy with any provider, you have the right to request a new provider, but you must talk with your care team first. Your team must authorize all services you receive.

What if my needs change?

Your services may change over time as your health and life situation change. For example, your services may decrease if your physical health improves. If your needs increase, we will make sure you get the assistance you need to remain safe, healthy, and as independent as possible. One of our goals is to provide the right service, in the right amount, and in the right place.

If your needs change, please let your care team know. Please know we will always be there to support you.

How do I use the provider network?

You and your care team will select your providers from a “provider network.” The list of the providers we routinely use is on our website at www.inclusa.org. We call this the Provider Network Directory. If you want a paper copy of the Provider Network Directory, instead of using the Internet, you can request a copy from your care team.

Let your team know if you want information about the abilities of our providers. For example, providers that have staff who speak a certain language or understand a particular ethnic culture or religious belief.

We contract with providers that help support our members’ long-term care outcomes. Our providers work with us in a cost-effective way and must meet our quality standards. Our provider network is intended to give you a choice of providers, whenever possible. However, Inclusa also has to make sure the provider is a cost-effective choice.

After your care team approves your services, you and your team will choose from the providers in Inclusa’s Provider Network Directory. You usually have to receive your care from a network provider. However, we might use a provider outside of our network if we do not have one that can meet your needs, or if all of our regular providers are located too far from where you live. To choose a provider not in our network, you must talk with your care team.

There might be times when you want to switch providers. Contact your care team if you want to change from one provider to another in the network. **If you change providers without talking to your team and getting approval first, you may be responsible for the cost of the service.**

For providers that come to your home or provide intimate personal care, we might be able to purchase services from people who are familiar to you, such as a family member. The person you choose to use must be qualified and agree to work at a cost similar to our other providers.

Another option for arranging your services is self-directed supports (SDS). See page 42 for more information.

How does Family Care help you manage your own services?

Inclusa strives to respect the choices of our members. For example:

- Living arrangement, daily routine, and support services of your choice are examples of the outcome categories Family Care supports. You will say what is important to you in these outcome areas. You will work with your care team to find reasonable ways to support your outcomes. If you do not think your care plan offers reasonable support for your outcomes, you can file a grievance or appeal. (See page 86 for more information).

- If you ask, we will consider using a provider we do not usually use.
- For providers that come to your home or provide intimate personal care, we will—at your request—purchase services from any qualified provider you choose, including a family member. **The provider must meet our requirements and accept our rates.**
- You have a right to change to a different care team, up to two times per calendar year. You do not have to say why you want a different team. Inclusiona may not always be able to meet your request or give you the specific team you want.
- You may choose to self-direct one or more of your services. (See the following section for more information.)

What are self-directed supports?

You can choose the self-directed supports (SDS) option if you want to manage some of your long-term care services. Choosing SDS means you will have more say in how, and from whom, you receive your services. It is an option you can use if you want to have more responsibility and be more involved in the direction of your own services.

With some types of SDS, you have control over and responsibility for your own budget for services. You may also have control over your providers, including responsibility for hiring, training, supervising, and firing

your own direct care workers. With other types of SDS, you can select your own provider, but an agency takes care of the actual hiring, training, and supervision of staff.

Though frequently used for in-home care, SDS can also be used outside of the home for services, such as transportation and personal care at your work place. Your care team can tell you which services can be self-directed in Family Care.

You can choose how much you want to participate in SDS. It is not an “all or none” approach. You can choose to direct one or more of your services. For example, you could choose to self-direct services that help you stay in your home or help you find and keep a job. Then you could work with your care team to manage services aimed at other outcomes in your care plan.

If you choose SDS, you will work with your team to determine a budget for services based on your care plan. You will manage the purchase of services within that budget, either directly or with the help of another person or agency you choose.

If you are interested in SDS, please ask your care team for more information about the benefits and limitations of SDS.

What should I do in case of an emergency?

If you have an emergency, call 911

*You do NOT need to contact your care team or
get prior authorization
in an emergency.*

An emergency means you believe that your health is in serious danger. An emergency could be a sudden illness, suspected heart attack or stroke, a broken bone, or a severe asthma attack.

If you have a medical emergency:

- Get help as quickly as possible. Call 911 or go to the nearest emergency room, hospital, or urgent care center.
- If you go to the emergency room or are admitted to the hospital, tell hospital staff that you are a member of Inclusa
- As soon as possible, you or someone else should contact your care team to tell them about your emergency care.

Although Family Care does not cover medical services, it is important to let your care team know if you go to the emergency room or you are admitted to the hospital. That way we can let your current providers know you are in the hospital and we can coordinate follow-up services. For example, before you leave the hospital, your doctor might refer you to a home health agency for follow-up services. Your care team would need to authorize the home health service before your discharge.

How do I receive care after normal business hours?

If you have an urgent need that cannot wait until the next business day, please dial 1-877-622-6700. On-call staff are available 24 hours a day, seven days a week. The on-call staff can temporarily authorize needed services to continue until the next business day. Your care team will

follow-up with you to determine whether the services should continue.

What if I need care while I am out of the area?

If you are going to be out of Inclusa's service area and you want to keep getting your services while you are gone, you must **notify your care team as soon as possible**.

Inclusa will consult with the income maintenance agency to find out if your absence will affect your status as a county resident.

- If you will **no longer be a resident** of a county served by Inclusa, you should contact the aging and disability resource center (ADRC) in the county you are moving to. The ADRC can tell you about the programs available in that county. Family Care must be available in the county you are moving to in order for you to remain in the Family Care program.
- If you will **still be considered a resident**, Inclusa will work with you to plan a cost-effective way to support your needs and keep you healthy and safe while you are gone.

If Includa believes it cannot develop a cost-effective plan that meets your needs and ensures your health and safety while you are out of our service area, we can ask the state to disenroll you from the program. If we ask the State to disenroll you, you will be given the opportunity to challenge our request through the appeal process. (See chapter 8, page 86 for more information.)

Includa does not pay for care if you permanently move out of our service area. If you are planning a permanent move, contact your care team as far ahead of time as possible. Your team will talk with you about the consequences of a permanent move. You can work with your team to coordinate the transition of services to providers in your new location.

Chapter 4. The Family Care Benefit Package

What services are provided?

Inclusa's Family Care program provides long-term care services. The list of services we provide is called the "Family Care Benefit Package."

You and your care team will use the Resource Allocation Decision (RAD) process to create the most cost-effective care plan for you. Although the services in the benefit package are available to all members, it does not mean that you can get a service that is listed just because you are a Family Care member. You will only get services that are necessary to support your long-term care outcomes and ensure your health and safety.

Please note that:

- Some members may have to pay a cost share for Medicaid eligibility. See page 58 for more information.
- There are rules for authorization of residential services and nursing home stays in Family Care. Inclusa will only authorize residential services in certain situations. See page 62 for more information.
- Only certain services in the benefit package are eligible for self-direction in Family Care. Please ask your care team, if you would like more information.

Your care team must approve all services before you start receiving them.

Inclusa might provide a service that is not listed. Alternative support or services must meet certain conditions. You and your care team will decide when you need alternative services to meet your long-term care outcomes.

The services that are available to you generally depend on your level of care. Family Care has two “levels of care:”

- 1.) “Nursing home level of care”—if you meet this level of care, it means that your needs are significant enough that you are eligible to receive services in a nursing home. (This does not mean you have to be in a nursing home to receive services.) A very broad set of services is available at this level of care.
- 2.) “Non-nursing home level of care”—if you meet this level of care, it means that you have some need for long-term care services, but you would not be eligible to receive services in a nursing home. A limited set of services is available at this level of care.

If you don’t know your level of care, ask your care team.

Family Care benefit package chart

The following services are available if they are:

- Required to support your long-term care outcomes;
- Pre-authorized by your care team; and
- Stated in your care plan.

	Nursing Home Level of Care	Non-Nursing Home Level of Care
COMMUNITY-BASED MEDICAID STATE PLAN SERVICES		
Alcohol and Other Drug Abuse (AODA) Day Treatment Services (in all settings except hospital-based or physician provided)	✓	✓
Alcohol and Other Drug Abuse (AODA) Services (except inpatient or physician provided)	✓	✓
Care/Case Management Services	✓	✓
Community Support Program (except physician provided)	✓	✓
Durable Medical Equipment and Medical Supplies (except hearing aids,	✓	✓

	Nursing Home Level of Care	Non-Nursing Home Level of Care
prosthetics, and family planning supplies)		
Home Health	✓	✓
Mental Health Day Treatment Services (in all settings)	✓	✓
Mental Health Services (except inpatient or physician provided)	✓	✓
Nursing (including respiratory care, intermittent and private duty nursing)	✓	✓
Occupational Therapy (in all settings except inpatient hospital)	✓	✓
Personal Care	✓	✓
Physical Therapy (in all settings except inpatient hospital)	✓	✓
Speech and Language Pathology Services (in all settings except inpatient hospital)	✓	✓
Transportation to medical appointments (except ambulance)	✓	✓

	Nursing Home Level of Care	Non-Nursing Home Level of Care
INSTITUTIONAL MEDICAID STATE PLAN SERVICES		
Nursing Home, including intermediate care facility for individuals with intellectual disabilities (ICF-IID) and institution for mental disease (IMD) (IMD not covered for residents between ages 22-64)	✓	¹
HOME AND COMMUNITY-BASED WAIVER SERVICES²		
Adaptive Aids	✓	
Adult Day Care	✓	
Assistive Technology/Communication Aids	✓	
Consultative Clinical and Therapeutic Services for Caregivers	✓	
Consumer Education and Training	✓	
Counseling and Therapeutic Services	✓	

¹ If your health requires a nursing home admission, this service may be available through your Medicaid ForwardHealth card. When you are admitted to a nursing facility, your care team will meet with you to determine if your level of care has changed.

² See Appendix 2 for a definition of each service.

	Nursing Home Level of Care	Non-Nursing Home Level of Care
Daily Living Skills Training	✓	
Day Services	✓	
Financial Management Services	✓	
Home-Delivered Meals	✓	
Home Modifications	✓	
Housing Counseling	✓	
Personal Emergency Response System	✓	
Prevocational Services	✓	
Relocation Services	✓	
Residential Care: 1-2 Bed Adult Family Home (AFH)	✓	
Residential Care: 3-4 Bed Adult Family Home (AFH)	✓	
Residential Care: Community-Based Residential Facility (CBRF)	✓	
Residential Care: Residential Care Apartment Complex (RCAC)	✓	
Respite Care	✓	
Self-Directed Personal Care Services	✓	

	Nursing Home Level of Care	Non- Nursing Home Level of Care
Skilled Nursing	✓	
Specialized Medical Equipment and Supplies	✓	
Support Broker	✓	
Supported Employment—Individual and Small Group Employment Support Services	✓	
Supportive Home Care	✓	
Training Services for Unpaid Caregivers	✓	
Transportation (specialized transportation)—Community and Other Transportation	✓	
Vocational Futures Planning and Support	✓	

What services are not provided?

The following services are not in the Family Care long-term care benefit package, but are available to you through your ForwardHealth card:

- Alcohol and other drug abuse services (provided by a physician or in an inpatient setting)
- Audiology: including evaluation of hearing function and rehabilitation of hearing impairments
- Chiropractic
- Crisis intervention
- Dentistry
- Emergency care (including air and ground ambulance)
- Eyeglasses
- Family planning services
- Hearing aids and hearing aid batteries
- Hospice (supportive care of the terminally ill)
- Hospital: inpatient and outpatient, including emergency room care (except for outpatient physical therapy, occupational therapy, and speech and language pathology, mental health services from a non-physician, and alcohol and other drug abuse services from a non-physician)
- Services in an institution for mental disease (IMD) are not covered in most situations (it is only covered in a

nursing home IMD for people under age 22 or age 65 and older)

- Independent nurse practitioner services
- Lab and X-ray
- Medications/prescription drugs
- Mental health services (provided by a physician or in an inpatient setting)
- Optometry
- Physician and clinic services (except for outpatient physical therapy, occupational therapy, and speech and language pathology, mental health services from a non-physician, and alcohol and other drug abuse services from a non-physician)
- Podiatry (foot care)
- Prenatal care coordination
- Prosthetics
- Psychiatry
- School-based services
- Transportation by ambulance

Family Care does not cover the services listed above, but you are eligible to receive them through the regular Medicaid program. Your care team will work closely with you to help you get these services when you need them. If you have Medicare, Veterans (VA) benefits, or other insurance besides Medicaid, these insurances may cover the services listed above. There might be a co-payment for these services.

In addition to the above list, the following items and services are not provided:

- Services that your care team did not authorize or that are not included in your care plan.
- Services that are not necessary to support your long-term care outcomes.
- Normal living expenses, such as rent or mortgage payments, food, utilities, entertainment, clothing, furniture, household supplies, and insurance.
- Personal items in your room at an assisted living facility or a nursing home, such as a telephone or a television.
- Room and board in residential housing. (See chapter 5, page 61 for more information).
- Guardianship fees.

Chapter 5. Understanding Who Pays for Services and Coordination of Your Benefits

Will I pay for any services?

You are not required to pay for any services in the Family Care benefit package that are identified in your care plan as necessary to support your long-term care outcomes. If you arrange for services that are not in your care plan, you will be responsible to pay for them.

You ARE responsible for co-payments for services you get from the regular Medicaid program. This includes co-payments for medications, doctor visits, and hospital visits.

There are two other types of expenses you may have to pay for each month:

- Cost share
- Room and board

Cost share and room and board are two different things. It is possible that you may have to pay for both.

COST SHARE

Some members may have to pay a monthly amount to remain eligible for Medicaid and Family Care. This monthly payment is known as a **cost share**. Your cost

share is based on your income and eligibility for Medicaid and Family Care.

If you have a cost share, you will receive a bill from Includa every month. Although you mail your payment to Includa, the income maintenance agency determines the amount you must pay each month.

The amount of your cost share will be looked at once a year, or anytime your income changes. **You are required to report all income and asset changes to your care team and the income maintenance agency within 10 days of the change.** Assets include, but are not limited to, motor vehicles, cash, checking and savings accounts, and cash value of life insurance.

Failure to pay your monthly cost share may result in loss of eligibility and you might be disenrolled from Family Care. If you think your cost share is incorrect, you can file an appeal with the Wisconsin Division of Hearings and Appeals (DHA). See page 100 for more information.

If you have questions about cost share, contact your team or your Member Liabilities Specialist at 1-877-622-6700 toll free.

Cost Share Reduction

If you are unable to pay your monthly cost share because of your necessary living expenses, you may qualify for a reduction of your cost share amount. Necessary living expenses include mortgage payments, rent, home/renter's insurance, property taxes, utilities, food, clothing, hygiene items, and the cost of operating and maintaining a vehicle.

A cost share reduction may make your monthly living expenses more affordable, and allow you to stay enrolled in Family Care.

To request a reduction of your cost share, you must complete an "Application for Reduction of Cost Share." See [Appendix 3](#) for a copy of the application, or download a copy at <https://www.dhs.wisconsin.gov/library/f-01827.htm>.

Along with the application, you will need to submit proof of your monthly income, your monthly expenses, and the cost share amount you pay to Includa each month. The application tells you what kind of proof is needed and gives examples of the types of documents that provide that proof.

If you need help completing the application, you can obtain assistance, free of charge, from an ombudsman. Contact information for the Family Care ombudsmen program is on page 105.

ROOM AND BOARD

You will be responsible to pay for room and board (rent and food) costs if you are living in, or moving to, a residential care setting. Residential care settings include adult family homes (AFHs), community-based residential facilities (CBRFs), residential care apartment complexes (RCACs), and nursing homes.

Includa will pay for the care and supervision portion of your services. You will be required to pay the room and board (rent and food) portion of the cost. We will tell you how much your room and board will cost, and we will send you a bill each month.

If you have questions about room and board, or cannot make a payment, contact your team or your Member Liabilities Specialist at 1-877-622-6700 toll free. If you feel you cannot afford your room and board, please

contact your care team to explore other options. Your care team may be able to help you find a facility that meets your needs at a more affordable rate.

How do I make a payment?

Payments can be made by check or money order, and can be sent to the address referenced on your monthly statement.

Automatic withdrawal from your bank account may also be available. Ask your care team for details.

What if I get a bill for services?

You do not have to pay for services that your care team authorizes as part of your care plan. If you receive a bill from a provider by mistake, do not pay it. Instead, contact your team so they can resolve the issue.

Does Family Care pay for residential services or nursing homes?

An important goal of Family Care is to help members live as independently as possible. All people—including people with disabilities and seniors—should be able to live at home with the support they need, participating in communities that value their contributions.

Studies and surveys show that most people want to live in their own home or apartment, among family and friends.

Most Family Care services can be provided at home for most people and living at home is usually the most cost-effective option.

The Family Care benefit package includes residential care services and nursing home stays. However, moving from home to a care facility or nursing home should be a “last resort.”

Your care team will authorize residential care or nursing home stays only when:

- Your health and safety cannot be ensured in your home; or
- Your long-term care outcomes cannot be cost-effectively supported in your home; or
- Moving into a facility is the most cost-effective option for supporting your long-term care outcomes.

Even if residential care is the only option, you may not be able to stay at, or move to, the facility you want. That facility may not have a contract with Inlusa or may not be willing to accept the rate we pay. Family Care cannot force providers to accept our rates.

If you are living in your own home and you and your care team agree that you should no longer live there, you will decide together about residential services. You and your team are responsible for finding the most cost-effective residential options within Inlusa’s provider network. Your

team will continue to work with you while you are in a residential facility or nursing home.

Your care team must authorize all residential services.

It is very important that you do not select a residential provider on your own. You must work with your team on these decisions to make sure Inlusa will pay for these services.

You will be required to pay the rent and food portion of the facility's cost. These costs are also called “room and board” expenses.

How are Medicare and my other insurance benefits coordinated?

When you enroll with Inlusa, we will ask you if you have insurance other than Medicaid. (Medicaid is also known as Medical Assistance, MA, or Title 19.) Other insurance includes Medicare, retiree health coverage, long-term care insurance, and other private health insurance.

It is important that you give us information about other insurance you have. **If you choose not to use your other insurance, we may refuse to pay for any services they would have covered.**

Before Medicaid, including Family Care, pays for services, other insurance must be billed first. Inlusa expects members to:

- Let us know if you have other insurance, including Medicare parts A and/or B.
- Update us if there are changes to your Medicare parts A and/or B coverage or other insurance.
- Let us know if you receive a payment from an insurance company, since you may have to reimburse Inlusa. How you handle these payments may affect your eligibility for Family Care.

If you do not currently have Medicare because you feel you can't afford it, your care team may be able to find a program that will help you pay for Medicare premiums.

If you do have Medicare, it will cover most of your health care costs, including physicians and hospitals. The part of the cost that Medicare does not cover is called "Medicare cost share." Medicaid will pay the Medicare cost share for you.

For some services, we will pay the Medicare cost share for you **if your care team pre-approves the service**, and the service is also in the Family Care benefit package. This means your care team must approve the service BEFORE you receive the service. If you do not get pre-approval from your care team, you may have to pay the Medicare cost share yourself. Be sure to get pre-approval from your care team for:

- Durable medical equipment, prosthetics, orthotics and supplies

- Diabetes supplies
- Home health care
- Outpatient cardiac rehabilitation
- Outpatient mental health services
- Outpatient pulmonary rehabilitation (for chronic obstructive pulmonary disease)
- Occupational therapy
- Physical therapy
- Skilled nursing facility care (for rehabilitation)
- Speech therapy

It is important for you to know that Medicare decides if it will pay for a service. Just because your care team pre-approves a service does not mean Medicare will pay for the service.

The pre-approval from your care team only means Inlusa will pay the **Medicare cost share** if Medicare decides it will pay for the service. If Medicare decides it will not pay for the service your care team pre-approved, Inlusa will cover the Medicaid cost of the service.

What is estate recovery? How does it apply to me?

If you are already on Medicaid, or a member of Inlusa, the estate recovery rules apply to you. Medicaid estate recovery applies to most long-term care services whether they are provided by Inlusa or through other programs.

Through estate recovery, the state seeks to be paid back for the cost of all Medicaid long-term care services.

Recovery is made from your estate, or your spouse's estate, after both of you have died. The money recovered goes back to the state to be used to care for others in need.

Recovery is made by filing claims on estates. The state will not try to be paid back from your estate when your spouse or child with a disability is still alive. Recovery will happen after their death.

For more information about estate recovery, ask your care team. Information about the Medicaid Estate Recovery Program is also available through the resources listed below:

Toll-free: 1-800-362-3002

TTY: 711 or 1-800-947-3529

Visit:

www.dhs.wisconsin.gov/medicaid/erp.htm

Or write to: DHS - Estate Recovery Program

P.O. Box 309

Madison, WI 53701-0309

Chapter 6. Your Rights

We must honor your rights as a member of Inclusa.

- 1.) **We must provide information in a way that works for you.** To get information from us in a way that works for you, please contact your care team.
- 2.) **We must treat you with dignity, respect, and fairness at all times.** You have the right:
 - To get compassionate, considerate care from Inclusa staff and providers.
 - To get your care in a safe, clean environment.
 - To not have to do work or perform services for Inclusa.
 - To be encouraged and helped in talking to Inclusa staff about changes in policy that you think should be made or services that you think should be provided.
 - To be encouraged to exercise your rights as a member of Inclusa.
 - To be free from discrimination. Inclusa must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on a person's race, mental or physical disability, religion, gender, sexual orientation, health, ethnicity, creed (beliefs), age, national origin, or source of payment.

- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. This means you have the right to be free from being restrained or forced to be alone in order to make you behave in a certain way or to punish you or because someone finds it useful.
- To be free from abuse, neglect, and financial exploitation.
 - **Abuse** can be physical, emotional, financial, or sexual. Abuse can also be if someone gives you a treatment, such as medication, or experimental research without your informed consent.
 - **Neglect** is when a caregiver fails to provide care, services, or supervision, which creates significant risk of danger to the individual. Self-neglect is when an individual who is responsible for his or her own care fails to obtain adequate care, including food, shelter, clothing, or medical or dental care.
 - **Financial exploitation** can be fraud, enticement or coercion, theft, misconduct by a fiscal agent, identity theft, forgery, or unauthorized use of financial transaction cards, including credit, debit, ATM, and similar cards.

What can you do if you are experiencing abuse, neglect, or financial exploitation? Your care team is available to talk with you about issues that you feel may be abuse, neglect, or financial

exploitation. They can help you with reporting or securing services for safety. You should always call 911 in an emergency.

If you feel that you or someone you know is a victim of abuse, neglect, or financial exploitation, you can contact Adult Protective Services. Adult Protective Services help protect the safety of seniors and adults-at-risk who have experienced abuse, neglect, or exploitation. They also help when a person is unable to look after his or her own safety due to a health condition or disability.

Page 2 lists the phone numbers to call to report incidents of witnessed or suspected abuse.

- 3.) **We must ensure that you get timely access to your covered services.** As a member of Inlusa, you have a right to receive services listed in your care plan when you need them. Your care team will arrange for your covered services. Your team will also coordinate with your health care providers. Examples of these are doctors, dentists, and podiatrists. Contact your team for assistance in choosing your providers.
- 4.) **We must protect the privacy of your personal health information.** If you have questions or concerns about the privacy of your personal health information, please call your care team. See Appendix 7, page 155, for Inlusa's Notice of Privacy Practices.

- 5.) **We must give you access to your medical records.** Ask your care team if you want a copy of your records. You have the right to ask Inclusa to change or correct your records.
- 6.) **We must give you information about Inclusa, our network of providers, and available services.** Please contact your care team if you want this information.
- 7.) **We must support your right to make decisions about your services.**
- You have a right to know about all of your choices. This means you have the right to be told about all the options available, what they cost, and whether they are covered by Family Care. You can also suggest other services that you think would meet your needs.
 - You have the right to be told about any risks involved in your care.
 - You have the right to say “no” to any recommended care or services.

- You have the right to get second medical opinions. Ask your care team if you need help getting a second opinion.
- You have the right to give instructions about what you want done if you are not able to make decisions for yourself. Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means if you want, you can develop an “**advance directive**.” There are different types of advance directives and different names for them. Documents called “**living will**” and “**power of attorney for health care**” are examples of advance directives. Contact your care team if you want to know more about advance directives.

8.) **You have the right to file a grievance or appeal if you are dissatisfied with your care or services.** Chapter 8 (page 78) includes information about what you can do if you want to file a grievance or appeal.

Chapter 7. Your Responsibilities

Things you need to do as a member of Includa are listed below. If you have any questions, please contact your care team. We're here to help.

- 1.) Become familiar with the services in the Family Care benefit package. This includes understanding what you need to do to get your services. See chapters 3 and 4 for more information.
- 2.) Participate in the initial and ongoing development of your care plan.
- 3.) Participate in the Resource Allocation Decision (RAD) process to find the most cost-effective ways to meet your needs and support your long-term care outcomes. Members, families, and friends share responsibility for the most cost-effective use of public tax dollars.
- 4.) Talk with your care team about ways your friends, family, or other community and volunteer organizations may help support you or ways in which you can do more for yourself.
- 5.) Follow the care plan that you and your care team agreed to.

- 6.) Be responsible for your actions if you refuse treatment, or do not follow the instructions from your care team or providers.
- 7.) Use the providers or agencies that are part of Inclusa, unless you and your care team decide otherwise.
- 8.) Follow Inclusa's procedures for getting care after hours.
- 9.) Notify us if you move to a new address or change your phone number.
- 10.) Notify us of any planned temporary stay or move out of the service area.
- 11.) Provide Inclusa with correct information about your health care needs, finances, and preferences and tell us as soon as possible about any changes in your status. This includes signing a "release of information" form when we need other information you do not have easily available.
- 12.) Treat your team, home care staff, and service providers with dignity and respect.
- 13.) Accept services without regard to the provider's race, color, religion, age, gender, sexual orientation, health, ethnicity, creed (beliefs), or national origin.

- 14.) Pay any monthly costs on time, including any cost share or room and board charges you may have. Let your care team or Member Liabilities Specialist know as soon as possible if you have problems with your payment.
- 15.) Use your Medicare and private insurance benefits, when appropriate. If you have any other health insurance coverage, tell Inlusa and the income maintenance agency.
- 16.) Take care of any durable medical equipment (DME), such as wheelchairs, and hospital beds provided to you by Inlusa.
- 17.) Report fraud or abuse on the part of providers or Inlusa employees. If you suspect anyone of misuse of public assistance funds, including Family Care, you can call the fraud hotline or file a report online at:

Report Public Assistance Fraud

1-877-865-3432 (toll-free) or visit

www.reportfraud.wisconsin.gov

- 18.) Do not engage in any fraudulent activity or abuse benefits. This may include:
 - Misrepresenting your level of disability
 - Misrepresenting income and asset level
 - Misrepresenting residency

- Selling medical equipment supplied by Inclusa

Any fraudulent activity may result in disenrollment from Family Care or possible criminal prosecution.

19.) Call your care team for help if you have questions or concerns.

20.) Tell us how we are doing. From time to time, we may ask if you are willing to participate in member interviews, satisfaction surveys, or other quality review activities. Your responses and comments will help us identify our strengths as well as the areas we need to improve. Please let us know if you would like to know the results of any surveys. We would be happy to share that information with you. Please contact the Quality Management Department at 1-877-622-6700 for more information or to request the results of any surveys. Results of the most recent member satisfaction survey are available on our website at www.inclusa.org. You may obtain a paper copy by contacting Quality Management.

Chapter 8. Grievances and Appeals

Introduction

We are committed to providing quality service to our members. There may be a time when you have a concern. As a member, you have the right to file a grievance or appeal a decision made by Includa and to receive a prompt and fair review.

If you are unhappy with your care or services, you should talk with your care team first. Talking with your team is usually the easiest and fastest way to address your concerns. If you do not want to talk with your team, you can call one of our member rights specialists. The member rights specialist can tell you about your rights, try to informally resolve your concerns, and help you file a grievance or appeal. The member rights specialist can work with you throughout the entire grievance and appeal process to try to find a workable solution.

For assistance with the grievance and appeal process, contact one of Includa's member rights specialists, at:

Includa
Member Relations
3349 Church Street, Suite 1

Stevens Point, WI 54481
Toll-free: 1-877-622-6700
TTY: 1-715-204-1799
E-mail:
MemberRelations@inclusa.org

If you are unable to resolve your concerns by working directly with your care team or a member rights specialist, Family Care gives you several ways to address your concerns. You can:

- File a grievance or appeal with Includa.
- Ask for a review by the Wisconsin Department of Health Services (DHS).
- Ask for a state fair hearing with the Wisconsin Division of Hearings and Appeals (DHA).

Each way has different rules, procedures, and deadlines.

This handbook tells you about all the ways you can file a grievance or appeal, which can be confusing. You don't have to know or understand all the information in this chapter, because people are available to help you.

If you have a particular type of concern that you do not know how to resolve, you can ask your care team or one of Inclusa's member rights specialists. There are ombudsman programs available to help all Family Care members with grievances and appeals. See page 104 for contact information. You can also have a family member, friend, attorney, or advocate help you. A member rights specialist may be able to give you information about other places that can help you, too.

Copies of your records

You can get a free copy of your records if you think you need them to help you with your grievance or appeal. To request copies, contact Member Relations at 1-877-622-6700.

You will not get into trouble if you complain or disagree with your care team or providers. If you file a grievance or appeal with Inclusa or the State of Wisconsin, you will not be treated differently. We want you to be satisfied with your care.

Grievances

What is a grievance?

A grievance is when you are not satisfied with Includa, one of our providers, or have concerns about the quality of your care or services. For example, you might want to file a grievance if:

- Your personal care worker often arrives late.
- You feel your care team doesn't listen to you.
- You have trouble getting appointments with a provider.
- You aren't satisfied with your provider's incontinence products.

Who can file a grievance on my behalf?

Your authorized representative, such as a legal guardian or activated power of attorney for health care, can file a grievance for you. Your family, a friend, or a provider can file a grievance for you if they have your written permission.

What is the deadline to file a grievance?

You can file a grievance at any time.

What are my options?

If you want to file a grievance, you have two options. You can:

- 1.) Start by filing a grievance with Includa.
→ See Option 1, on page 47.
- 2.) Start by asking for a review by DHS.
→ See Option 2, on page 48.

You can use Option 1 and/or Option 2 together or at different times.

GRIEVANCE OPTION 1: File your grievance with Includa.

Includa wants you to be happy with your care and services. One of our member rights specialists can work with you and your care team to try to resolve your concerns informally. Often, we can take care of your concerns without going further. However, if we are unable to solve your concerns, you can file a grievance with Includa by calling or writing to us at:

Includa
Attn: Member Relations Department
3349 Church Street, Suite 1
Stevens Point, WI 54481

Toll-Free: 1-877-622-6700

TTY: 711 or 1-715-204-1799

E-mail: MemberRelations@inclusa.org

What happens next?

If you file a grievance with Inclusa, we will send you a letter within five business days to let you know we received your grievance. Then, Inclusa staff who are not on your care team will try to help informally address your concerns or come up with a solution that satisfies both Inclusa and you. If we are unable to come up with a solution, or if you do not want to work with Inclusa staff to informally address your concerns, our Grievance and Appeal Committee will review your grievance and issue a decision.

- The committee is made up of Inclusa representatives and at least one “consumer.” The consumer is a person who also receives services from us or represents someone who does. Sometimes other people who specialize in the topic of your grievance might be part of the committee.
- We will let you know when the committee plans to meet to review your grievance.

- The meeting is confidential. You can ask that the consumer not be on the committee, if you are concerned about privacy or have other concerns.
- You have the right to appear in person. You can bring an advocate, friend, family member, or witnesses with you.
- The committee will give you a chance to explain your concerns. You may provide information to the committee.
- Your care team or other Includa staff will likely be at the meeting.
- The committee will make a decision within 20 business days from the date we first got your grievance. You will get a written notice of the decision.

What if I disagree with the Grievance and Appeal Committee's decision?

If you disagree, you can ask for a review by DHS, unless you have already done so. You could also talk to one of our member rights specialists or an advocate for advice on other options.

GRIEVANCE OPTION 2: Ask for a DHS review

You can also ask DHS to review your grievance before, after, or instead of filing a grievance with Includa. DHS is the agency in charge of the Family Care program. The purpose of a DHS review is to see if you and Includa can work out an informal solution.

Your concerns can often be resolved directly with Inclusa before asking DHS to review the situation. Using Inclusa's grievance process first is not a requirement, but it is encouraged.

To ask for a DHS review, call or e-mail:

DHS Family Care Grievances

Toll-free: 1-888-203-8338

Email: dhsfamcare@wisconsin.gov

What happens next?

DHS works with an outside organization called "MetaStar" to review grievances. If you ask for a DHS review, MetaStar will contact you.

- MetaStar will reply in writing to let you know they received your grievance.
- They will ask you for information about your concerns. They will also contact your care team. MetaStar will try to resolve your concerns informally.
- **MetaStar will not issue a decision.** Instead, they will review your concerns and try to come up with an informal solution that is acceptable to you and Inclusa.

- If MetaStar tells DHS that Inclusa failed to comply with certain requirements, DHS may order us to take steps to fix the problem.
- MetaStar will complete the review and send you a letter with their findings within 20 business days of your request.

What if I disagree with the DHS review?

If you are not happy with the result of the DHS review, you can file a grievance with Inclusa, if you have not already done so. You could also talk to one of our member rights specialists or an advocate for advice on other options.

Appeals

What is an appeal?

An appeal is a request for a review of a decision made by Inclusa. For example, you can file an appeal if your care team denies a service or support you requested. Other examples are decisions to reduce or end a service, or to deny payment for a service.

Who can file an appeal on my behalf?

Your authorized representative, such as a legal guardian or activated power of attorney for health care, can file an appeal for you. Your family, a friend, or a provider can file an appeal for you if they have your written permission.

What types of issues can I appeal?

You have the right to file an appeal in the following types of situations:

1.) You can file an appeal if Inclusa:

- Plans to stop, suspend, or reduce an authorized service you are currently getting.
- Decides to deny a service you asked for and that service is in the Family Care benefit package.*
- Decides not to pay for a service that is in the benefit package.*

If we take one of the actions listed above, we must send you a “**Notice of Action.**” The Notice of Action includes the date we plan to stop, suspend, or reduce your services. To see what a Notice of Action looks like, go to Appendix 7.

*Note: Family Care provides the services listed in the benefit package chart (see page 50). If you ask for a service that is not listed, Inclusa does not have to provide or pay for the service. We will consider your request, but if we deny it, you cannot appeal our decision. We will send you a letter to notify you that the service you requested is not in the benefit package.

2.) You can file an appeal if:

- You do not like your care plan because it:
 - Doesn't support you to live in the place where you want to live.
 - Doesn't provide enough care, treatment, or support to meet your needs and identified

outcomes. (Refer to chapter 3 for information about outcomes.)

- Requires you to accept care, treatment, or support items you don't want or you believe are unnecessarily restrictive.
- Inclusa fails to:
 - Arrange or provide services in a timely manner.
 - Meet the required timeframes to resolve your appeal.

In these situations, Inclusa will send you a notification of your appeal rights.

3.) You can file an appeal related to decisions about your eligibility for Family Care.

- At least once a year, a worker from the income maintenance agency will review your information to make sure you are still financially eligible for Family Care. If you have a cost share, the income maintenance agency will also make sure you are paying the right amount.

If the income maintenance agency decides you are no longer financially eligible for Family Care, or says your cost share payment will change, the agency will send you a notice with information about your eligibility for Family Care. These notices have the words "About Your Benefits" on the first page. The last page has information about your

right to request a state fair hearing with the Division of Hearings and Appeals.

- If your functional eligibility for Family Care changes, you will receive a written notice.

Filing an appeal with the Division of Hearings and Appeals is the only way to challenge decisions related to financial and functional eligibility for Family Care. This includes decisions about your cost share. See page 100 for more information.

What is the deadline to file an appeal?

- You should file your appeal as soon as possible.
- Inlusa will send you a Notice of Action if we:
 - Plan to stop, suspend, or reduce an authorized service you are getting.
 - Deny a new service you asked for and that service is in the Family Care benefit package.
 - Won't pay for a service that is in the Family Care benefit package.

You must file your appeal no later than 45 days after you receive the Notice of Action. (For example, if you get a notice in the mail on August 1, you must file your appeal on or before September 15.)

If you receive a notification of your appeal rights, you should read this notice carefully. The notice may tell you the deadline for filing your appeal. You can always call one of our member rights specialists for assistance.

What are my options?

If you want to file an appeal, you have three options. You can:

- 1) Start by filing an appeal with Inclusa.
→ See Option 1, page 53.
- 2) Start by asking DHS to review our decision.
→ See Option 2 (page 55) if you want to file with DHS.
- 3) Start by filing an appeal with the State Division of Hearings and Appeals (DHA).
→ See Option 3 (page 56) if you want to file with DHA.

Each option has different rules, procedures, and deadlines.

You cannot file an appeal with Inclusa, or the Wisconsin Department of Health Services (DHS), **and** request a fair hearing from the Division of Hearings and Appeals (DHA) at the **same** time.

You can file a request for a fair hearing instead of, or after, receiving an appeal decision from Inclusa.

If you want **both** Inclusa and DHA to review your issue, then you have to file your appeal with Inclusa **before** you file a request for fair hearing

with DHA. Once you file an appeal with DHA, you cannot file the same appeal with Includa.

An appeal with DHA is the final level of appeal.

Continuing Your Services During Your Appeal

If Includa decides to stop, suspend, or reduce a service you are currently receiving, you have the right to ask Includa, DHS, or DHA to continue your services during your appeal.

If you want your services to continue, you must:

- Postmark or fax your appeal **on or before** the date Includa plans to stop, suspend, or reduce your services; **AND**
- Ask that your services continue throughout the course of your appeal.

No matter which appeal option(s) you use, if you want your services to continue, you must make that request at every level of your appeal. For example, if your services were continued during an appeal with Includa and you lose the appeal, you must once again ask for your services to continue if you file an appeal with DHS and/or DHA.

The final decision of the appeal may not be in your favor. If that happens, **you might have to pay Includa back for the service you got during the appeal process.** If you can show that this would be a substantial financial burden, you may not have to pay us back.

If you want someone to help you file an appeal, you can talk with one of Includa's member rights specialists. An advocate may also be able to help you. An advocate might be a family member, friend, attorney, ombudsman, or any other person willing to help. Ombudsman programs are available to help all Family Care members with appeals. See page 104 for information on how to contact an advocate.

APPEAL OPTION 1: Filing your appeal with Inclusa

To file an appeal with Inclusa you can:

- **Call Inclusa.** If you file your appeal by calling us, we will ask you to send in a written request. If you want, a member rights specialist can help you put your appeal in writing.
- **Mail or fax in a request form.** See Appendix 5 (page 151) for a copy of the request form. Or, you can go online and get the form at:
www.dhs.wisconsin.gov/familycare/mcoappeal.htm.
- **Write your request in a letter or on a piece of paper** and mail or fax it to the address below.

To file an appeal with Inclusa, call:

Member Relations
Toll Free 1-877-622-6700
TTY: 1-715-204-1799

**Or, mail a completed request form,
letter, or written note to:**

Inclusa
Attn: Member Relations
3349 Church Street, Suite 1
Stevens Point, WI 54481
E-mail:
MemberRelations@inclusa.org

What happens next?

If you file an appeal with Includa, we will send you a letter within five business days to let you know we received your appeal. Then, we will try to help informally address your concerns or come up with a solution that satisfies both Includa and you. If we are unable to come up with a solution or if you do not want to work with Includa staff to informally address your concerns, our Grievance and Appeal Committee will meet to review your appeal.

- We will let you know when the committee plans to meet to review your appeal.
- The committee is made up of Includa representatives and at least one “consumer.” The consumer is a person who also receives services from us or represents someone who does. Sometimes other people who specialize in the topic of your appeal might be part of the committee.
- The meeting is confidential. You can ask that the consumer not be on the committee if you are concerned about privacy or have other concerns.
- You have the right to appear in person. You can bring an advocate, friend, family member, or witnesses with you.
- Your care team or other Includa staff will likely be at the meeting.
- The committee will give you a chance to explain why you disagree with your care team’s decision. You or your representative can present information, bring

witnesses, or describe your concerns to help the committee understand your point of view.

- After the committee hears your appeal, Inlusa will send you a decision letter within 20 business days after we first got your appeal. Inlusa may take up to 30 business days to issue a decision if:
 - You ask for more time to give the committee information, or
 - We need more time to gather information. If we need additional time, we will send you a written notice informing you of the reason for delay.

Speeding up your appeal

Inlusa has 20 business days to decide your appeal. If you think waiting that long could seriously harm your health or ability to perform your daily activities, you can ask us to speed up your appeal. We call this an “expedited appeal.” You may ask for an expedited appeal only if you believe waiting for a decision could seriously harm your health or ability to function. If you ask us to speed up your appeal, we will decide if your health requires an expedited appeal. We will let you know as soon as possible if we will expedite your appeal.

In an expedited appeal, you will get a decision on your appeal within 72 hours of your request. However, Inlusa may extend this to a total of 14 days, if additional information is necessary, and if the delay is in your best

interest. If you have additional information you want us to consider, you will need to submit it quickly.

**To request an expedited appeal,
contact:**

Inclusa
Attn: Member Relations
3349 Church Street, Suite 1
Stevens Point, WI 54481
E-mail: MemberRelations@inclusa.org

Or call:

Toll Free 1-877-622-6700
TTY: 1-715-204-1799

What if I disagree with the Grievance and Appeal Committee's decision?

If you disagree, you can request a state fair hearing with the Division of Hearings and Appeals (DHA) or, if you have not already done so, ask for a review by DHS. You must do so within 45 days from the date of the Grievance and Appeal Committee's decision. You can file an appeal with DHA if Inlusa does not issue an appeal decision in a timely manner.

Reviews by the Department of Health Services

APPEAL OPTION 2: Asking the Department of Health Services (DHS) to review Inlusa's decision

DHS is the agency that is in charge of the Family Care program. DHS works with an outside organization called MetaStar to review decisions made by Inlusa. Staff from MetaStar will try to resolve your concerns informally.

MetaStar will not issue a decision. Instead, they will review your concerns and try to come up with an informal solution that is acceptable to you and Inlusa.

A DHS review will not typically result in DHS ordering Inlusa to do what you want. Nor will DHS order you to accept what Inlusa is planning to do. However, if MetaStar tells DHS that we didn't follow certain requirements, DHS may order Inlusa to take steps to correct that.

How do I ask for a DHS review?

You may request a DHS review by calling or e-mailing:

DHS Family Care Appeals

Toll-free: 1-888-203-8338

Email: dhsfamcare@wisconsin.gov

What is the deadline to ask for a DHS review?

You can ask DHS to review Includa's decision before, or instead of, filing an appeal with Includa or DHA.

You should ask DHS to review Includa's decision as soon as possible. You must ask for a DHS review within 45 days after you receive a Notice of Action from Includa. (For example, if you get a notice in the mail on August 1, you must file your request for DHS review on or before September 15.)

You can request to have your services continue during the review if you request the review **on or before** the date Includa plans to stop, suspend, or reduce your services.

What happens next?

- MetaStar will reply in writing to let you know they received your request.
- They will contact you and ask why you disagree with Includa's decision. They will also contact your care

team. MetaStar will try to resolve your concerns informally.

- MetaStar will complete the review and send you a letter with their findings within 20 business days of your request.

What if I disagree with the results of the DHS review?

If you are not happy with the result of the DHS review, you can file an appeal with Inclusa, if you have not already done so, or the Division of Hearings and Appeals. After you receive the letter from MetaStar with their findings, you have up to 45 days to appeal with Inclusa or DHA.

State Fair Hearings

APPEAL OPTION 3: Filing your appeal with the Wisconsin Division of Hearings and Appeals (DHA)

If you file an appeal with the Wisconsin Division of Hearings and Appeals (DHA), you will have a state fair hearing with an independent administrative law judge. Administrative law judges do not have any connection to Inclusa. You can find more information about fair hearings online at www.doa.state.wi.us/Divisions/Hearings-Appeals.

An appeal with DHA is the final level of appeal. If you go to DHA first, you cannot file the same appeal with Inclusa or ask for a DHS review. However, if you request a state fair hearing, DHS will automatically review your appeal.

How do I request a state fair hearing?

To ask for a state fair hearing, you can either:

- **Send a request form to DHA.** A copy of the form you can use is in Appendix 5. You can also get a copy from one of Inclusa's member rights specialists or from one of the advocacy organizations listed in this handbook (see page 104). Or, go to the Web to download the form at www.dhs.wisconsin.gov/forms/f0/f00236.doc.
- **Mail a letter.** Include your name and contact information, and explain what you are appealing. If you received a Notice of Action or other notification of your appeal rights, it's a good idea to include a copy of that notice with your request for a state fair hearing. Do not send your original copy.

A member rights specialist or an advocate can help you

To request a State Fair Hearing

Send the completed request form or a letter asking for a hearing to:

Family Care Request for Fair Hearing
c/o Wisconsin Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875
(Or fax your request to 608-264-9885)

put your appeal in writing. To contact an advocate, see page 104.

What is the deadline to file an appeal with DHA?

You should file your appeal as soon as possible. You must file your appeal within 45 days after you receive a Notice of Action or other notification of your appeal rights. (For example, if you get a notice in the mail on August 1, you must file your appeal on or before September 15.) If you began the appeal process by filing an appeal with Inlusa and you received a decision you didn't agree with, you have 45 days from the date you receive that decision to file a request for a state fair hearing.

You can request to have your services continue during the fair hearing process if you file your appeal **on or before** the date Inlusa plans to stop, suspend, or reduce your services. See page 93 for more information about continuing your services.

What happens next?

- After you send in your request for a state fair hearing, DHA will mail you a notice with the date, time, and location of your hearing.
- The hearing will be at an office in your county or may be done by telephone.
- An administrative law judge will run the hearing.
- You have the right to participate in the hearing. You can bring an advocate, friend, family member, or witnesses with you.
- Your care team or other Inlusa staff will be present at the hearing to explain their decision.

- You will have a chance to explain why you disagree with your care team's decision. You or your representative can present information, bring witnesses, or describe your concerns to help the administrative law judge understand your point of view.
- The administrative law judge must issue a decision within 90 days of the date you filed a request for the hearing.

What can I do if I disagree with the administrative law judge's decision?

If you disagree with the administrative law judge's decision, you have two options.

- 1.) Ask for a re-hearing. If you want DHA to reconsider its decision, you must ask within 20 days from the date of the administrative law judge's decision. The administrative law judge will only grant a re-hearing if:
 - You can show that a serious mistake in the facts or the law happened, or
 - You have new information that you were unable to obtain and present at the first hearing.
 - 2.) Take your case to circuit court. If you want to take your case to court, you must file your petition within 30 days from the date of the administrative law judge's decision.
-

Who can help me with my grievance or appeal?

You can contact one of Inclusa's member rights specialists any time you need help with a grievance or appeal, or have questions about your rights. Advocates are also available to answer questions about the grievance and appeal processes. An advocate can also tell you more about your rights and help make sure Inclusa is supporting your needs and outcomes. You can ask anyone you want

to act as an advocate for you, including family members, friends, an attorney, or any other person willing to help.

Below are some places you can contact for assistance. A member rights specialist may be able to give you information about other places that can help you, too.

Ombudsman Programs

Regional ombudsmen programs are available to help all Family Care members with grievances and appeals. They can respond to your concerns in a timely fashion. Both ombudsmen programs will typically use informal negotiations to resolve your issues without a hearing.

Wisconsin Board on Aging and Long Term Care

Ombudsmen from this agency provide advocacy to Family Care members age 60 and older.

Board on Aging and Long Term Care
1402 Pankratz Street, Suite 111
Madison, WI 53704-4001
Toll-free: 1-800-815-0015
Fax: 608-246-7001
<http://longtermcare.state.wi.us>

Disability Rights Wisconsin (DRW)

Ombudsmen from this agency provide advocacy to Family Care members under age 60.

Disability Rights Wisconsin
131 W. Wilson St., Suite 700
Madison, WI 53703

Main: 608-267-0214

TTY: 1-888-758-6049

Fax: 608-267-0368

Madison Toll-free: 1-800-928-8778

Milwaukee Toll-free: 1-800-708-3034

Rice Lake Toll-free: 1-877-338-3724

www.disabilityrightswi.org

Chapter 9. Ending Your Membership in Includa

You can choose to end your membership in Includa at any time. We cannot advise or encourage you to disenroll from Family Care because of your situation or condition.

However, there are limited situations when your membership will end even if that wasn't your choice. For example, your membership will end if you lose eligibility for Medicaid.

You will continue to get your care through Includa until your membership ends. Your membership could end because you are no longer eligible, or because you have decided to get your long-term care services outside of the Family Care program. This would include decisions to enroll in a different long-term care program or different managed care organization, if available.

1.) If you want to end your membership in Family Care.

To end your membership, contact the aging and disability resource center (ADRC) in your area (see page 9 for ADRC contact information). The ADRC can also answer any questions you have about ending your membership. If you decide to disenroll, you should also notify your care team.

You can end your membership at any time of the month or year. You can choose the effective date when you want your membership to end.

2.) Inlusa must report the information listed below to the income maintenance agency.

An income maintenance worker will see if you are still eligible for Family Care. If they determine you are no longer eligible, they will end your membership in Family Care.

- Your financial circumstances change, which might cause a loss of your financial eligibility for Medicaid.
- You are no longer functionally eligible as determined by the Wisconsin Adult Long-Term Care Functional Screen.
- You do not pay your cost share. For more information about cost share, see page 58.
- You permanently move out of Inlusa's service area. If your care team cannot contact you for more than 30 days, we will send a certified letter to your last known address. If you do not respond, we will report this to the income maintenance agency, who will assume you have moved. If you move or take a long trip, you need to contact your care team. If you plan to move within Wisconsin, your team may be able to help you with continued services in your new residence, so you should let them know if you plan to move.
- You are in jail or prison.
- You are admitted to an institute for mental disease (IMD) and lose Medicaid eligibility.

- You stop accepting services for more than 30 days and we don't know why. Includa will send a certified letter to your last known address. If you do not respond, we will report this to DHS. DHS will determine if your membership should end.
- You refuse to participate in care planning and we cannot ensure your health and safety. In this situation, we will work with DHS to determine if your membership should end.
- You intentionally give us incorrect information that affects your eligibility for the program.
- You continuously behave in a way that is disruptive or unsafe to staff, providers, or other members. This makes it difficult for us to provide care for you and other members. Your membership cannot be ended for this reason unless we first get permission from DHS.

Your membership CANNOT be ended because your health declines or you need more services.

You have the right to file an appeal if you are disenrolled from Family Care or your membership in Includa ends. You will get a notice from the income maintenance agency that tells you the reason for ending your membership. This notice will have the words "About Your Benefits" on the first page. The notice will explain how you can file an appeal. See Chapter 8, page 86, for more information.

APPENDICES

1. DEFINITIONS OF IMPORTANT WORDS

Abuse – The physical, mental, or sexual abuse of an individual. Abuse also includes neglect, financial exploitation, treatment without consent, and unreasonable confinement or restraint. See chapter 6 (page 69) for full descriptions of the types of abuse.

Administrative Law Judge – An official who conducts a state fair hearing to resolve a dispute between a member and his or her managed care organization (MCO). See chapter 8 (page 100) for information about state fair hearings.

Advance Directive – A written statement of a person's wishes about medical treatment. An advanced directive is used to make sure medical staff carry out those wishes should the person be unable to communicate. There are different types of advance directives and different names for them. Living will, power of attorney for health care, and do-not-resuscitate (DNR) order are examples of advance directives. See chapter 6 (page 72) for more information on advance directives.

Advocate – Someone who helps members make sure the MCO is addressing their needs and outcomes. An advocate may help a member work with the MCO to informally resolve disputes and may also represent a member who decides to file an appeal or grievance. An advocate might be a family member, friend, attorney,

ombudsman, or any other person willing to represent a member.

Aging and Disability Resource Center (ADRC) –

Service centers that provide information and assistance on all aspects of life related to aging or living with a disability. The ADRC is responsible for handling enrollment and disenrollment in the Family Care program.

Appeal – A request for review of a decision. Members can file an appeal when they want the MCO to change a decision their care team made. Examples include the team deciding to: stop, suspend, or reduce a service the member is currently receiving, deny a covered service the member requests, or not pay for a covered service. Other types of appeals and the process for filing an appeal are in chapter 8 (page 86).

Assets – Assets include, but are not limited to, motor vehicles, cash, checking and savings accounts, certificates of deposit, money market accounts, and cash value of life insurance. The assets a person has is used, in part, to determine eligibility for Medicaid. An individual must be eligible for Medicaid to be in Family Care.

Authorized Representative – A person who has the legal authority to make decisions for a member. An authorized representative may be court appointed, a person designated as the member's power of attorney for health care, or a person's guardian.

Benefit Package – Services that are available to Family Care members. These include, but are not limited to, personal care, home health, transportation, medical

supplies, and nursing care. The services a member receives must be pre-authorized by the member's care team and listed in the member's care plan. See chapter 4 (page 50) for a complete list of the services in the Family Care benefit package.

Care Plan – An ongoing plan that documents the member's personal experience and long-term care outcomes, needs, preferences, and strengths. The plan identifies the services the member receives from family or friends, and identifies authorized services the MCO will provide. The member is central to the care planning process. The care team and member meet regularly to review the member's care plan.

Care Team – Every Family Care member is assigned a care team. The member is a central part of his or her team. The team includes the member, and at least a Community Resource Coordinator and a Health & Wellness Coordinator. Members can choose anyone else they want involved on their care team, such as a family member or friend. Other professionals, such as an occupational or physical therapist, or mental health specialist, may be involved, depending on the member's needs. The care team works with members to assess needs, identify outcomes, and create care plans. The team authorizes, coordinates, and monitors services.

Choice – The Family Care program supports a member's choice when receiving services. Choice means members have a say in how and when care is provided. Choice also means members are responsible for helping their care team identify services that are cost-effective. Members

can also choose to direct one or more of their services by using the self-directed supports (SDS) option.

Cost Share – A monthly amount that some members may have to contribute toward the cost of their services. Cost share is based on income and is determined by the income maintenance agency. Individuals must pay their cost share every month to remain eligible for Medicaid and Family Care. See chapter 5 (page 58) for information about cost share.

Cost-Effective – The option that effectively supports the member’s identified long-term care outcome at a reasonable cost and effort. The member and the care team use the Resource Allocation Decision (RAD) process to determine ways to support the member’s long-term care outcomes. Then the member and the team look at the options and choose the most cost-effective (not necessarily the cheapest) way to support the member’s outcomes.

Department of Health Services (DHS) – The State of Wisconsin agency that runs Wisconsin’s Medicaid programs, including Family Care.

DHS Review – A review of a member’s grievance or appeal by the Department of Health Services (DHS). DHS works with MetaStar to review grievances and appeals. MetaStar reviews member concerns and tries to come up with informal solutions. A DHS review will not lead to a decision. See chapter 8 (page 69) for information about DHS reviews.

Disenroll/Disenrollment – The process of ending a person’s membership in Family Care. A member can choose to disenroll from Family Care at any time. The MCO has to disenroll a member in certain situations. For example, the MCO would disenroll a member if he or she loses eligibility for Medicaid or permanently moves out of state. Chapter 9 (page 108) explains the disenrollment process in Family Care.

Division of Hearings and Appeals (DHA) – The State of Wisconsin agency that hears Medicaid appeals for Family

Care. Administrative law judges with this Division conduct state fair hearings when a member files an appeal. This Division is independent of the MCO and DHS. See chapter 8 (page 100) for information about fair hearings.

Enroll/Enrollment – Enrollment in Family Care is voluntary. To enroll, individuals should contact their local aging and disability resource center (ADRC). The ADRC determines whether an individual is functionally eligible for Family Care. The income maintenance agency determines whether an individual is financially eligible for Medicaid and Family Care. If the individual is eligible and wants to enroll in Family Care, he or she must complete and sign an enrollment form.

Estate Recovery – The process where the State of Wisconsin seeks repayment for costs of Medicaid services when the individual receives Medicaid-funded long-term care. The State recovers money from an individual's estate after the person and his or her spouse dies. The money recovered goes back to the Medicaid program to be used to care for other Medicaid recipients. See chapter 5 (page 66) for more information about estate recovery.

Expedited Appeal – A process members can use to speed up their appeal. Members can ask the MCO to expedite their appeal if they think waiting the standard amount of time could seriously harm their health or ability to perform daily activities. See chapter 8 (page 96) for information about expedited appeals.

Family Care – A long-term care program for frail elders, adults with developmental/intellectual disabilities, and

adults with physical disabilities. Family Care provides cost-effective, comprehensive, and flexible services tailored to each member's needs. The program strives to foster members' independence and quality of life, while recognizing the need for interdependence and support.

Financial Eligibility – Financial eligibility means eligibility for Medicaid. The income maintenance agency looks at a person's income and assets to determine whether he or she is eligible for Medicaid. An individual must be eligible for Medicaid to be in Family Care.

Functional Eligibility – The Wisconsin Long Term Care Functional Screen determines whether a person is functionally eligible for Family Care. The Functional Screen collects information on an individual's health condition and need for help in such activities as bathing, getting dressed, and using the bathroom.

Grievance – An expression of dissatisfaction about care, services, or other general matters. Subjects for grievances include quality of care, relationships between the member and his or her care team, and member rights. Chapter 8 (page 80) explains grievances, including the process for filing a grievance.

Guardian – The court may appoint a guardian for an individual if the person is unable to make decisions about his or her own life.

Income Maintenance Agency – Staff from the income maintenance agency determine an individual's financial eligibility for Medicaid, Family Care, and other public benefits.

Level of Care – Refers to the amount of help an individual needs to perform daily activities. Members must meet either a “nursing home” level of care or a “non-nursing home” level of care to be eligible for Family Care. The services available to members depend on their level of care. Chapter 4 (page 50) lists the services available at the nursing home level of care and the non-nursing home level of care.

Long-Term Care (LTC) – A variety of services that people may need as a result of a disability, getting older, or having a chronic illness that limits their ability to do the things they need to do throughout their day. This includes such things as bathing, getting dressed, making meals, and going to work. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities.

Long-Term Care Outcome – A situation, condition, or circumstance, that a member or the care team identifies that maximizes a member’s highest level of independence. During the assessment, care teams work with members to assess their physical health needs and ability to perform daily activities. The care team uses this information to determine a member’s long-term care outcomes. The MCO authorizes services based on long-term care outcomes.

Outcomes also include clinical and functional outcomes. A clinical outcome relates to a member’s physical, mental, or emotional health. An example of a clinical outcome is being able to breathe easier. A functional outcome relates

to a member's ability to do certain tasks. An example of a functional outcome is being able to walk down stairs.

Managed Care Organization (MCO) – The agency that operates the Family Care program.

Medicaid – A medical and long-term care program operated by the Wisconsin Department of Health Services (DHS). Medicaid is also known as “Medical Assistance,” “MA,” and “Title 19.” Family Care members must meet Medicaid eligibility requirements to be a member.

Medicare – The federal health insurance program for people age 65 or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or kidney transplant). Medicare covers hospitalizations, physician services, prescription drugs, and other services.

Member – A person who meets functional and financial eligibility criteria and enrolls in Family Care.

Member Rights Specialist – An MCO employee who helps and supports members in understanding their rights and responsibilities. The member rights specialist also helps members understand the grievance and appeal processes and can assist members who wish to file a grievance or appeal. See chapter 8 (page 78) for information about grievances and appeals.

MetaStar – The agency that the Wisconsin Department of Health Services (DHS) works with to review requests of grievances and appeals and conduct independent quality

reviews of MCOs. See chapter 8 (pages 84 and 98) for information about DHS reviews.

Natural Supports – The people in your life who already choose to help you.

Non-Nursing Home Level of Care – Members who are at this level of care have some need for long-term care services, but are not eligible to receive services in a nursing home. A more limited set of Family Care services is available at this level of care. See chapter 4 (page 50) for a list of services available to members who are at a non-nursing home level of care.

Notice of Action – A written notice from the MCO explaining a specific change in service and the reason(s) for the change. The MCO must send the member a Notice of Action if the MCO denies a member's request for a covered service, refuses to pay for a covered service, or plans to stop, suspend, or reduce a member's service. See chapter 8 (page 86) for more information about appeals.

Notification of Appeal Rights – A written notice sent to members explaining their options for filing an appeal. MCOs must send a notification of appeal rights to members if the MCO didn't provide services in a timely way or didn't meet the deadlines for handling an appeal. Other situations when MCOs send this notice include times when members don't like their care plan because it doesn't support their long-term care outcomes or requires members to accept care they don't want. Income maintenance agencies send members a notification of

appeal rights when members lose financial or functional eligibility for Family Care. See chapter 8 (page 86) for more information about appeals.

Nursing Home Level of Care – Members who are at this level of care have needs that are significant enough that they are eligible to receive services in a nursing home. A very broad set of Family Care services is available at this level of care. See chapter 4 (page 50) for a list of services available to members who are at a nursing home level of care.

Ombudsman – A person who investigates reported concerns and helps members resolve issues. Disability Rights Wisconsin provides ombudsman services to potential and current Family Care members under age 60. The Board on Aging and Long Term Care provides ombudsman services to potential and current members age 60 and older. Contact information for these agencies is on page 105.

Personal Experience Outcomes – The goals the member has for his or her life. One member's personal experience outcome might be being healthy enough to enjoy visits with her grandchildren, while another member might want to be able to be independent enough to live in his own apartment. See chapter 3 (page 33) for a list of personal outcome areas.

Power of Attorney for Health Care – A legal document people can use to authorize someone to make specific health care decisions on their behalf in case they ever become unable to make those decisions on their own.

Prior Authorization (Prior Approval) – The care team must authorize services before a member receives them (except in an emergency). If a member gets a service, or goes to a provider outside of the network, the MCO may not pay for the service.

Provider Network – Agencies and individuals the MCO contracts with to provide services. Providers include attendants, personal care, supportive home care, home health agencies, assisted living care facilities, and nursing homes. The care team must authorize the member's services before the member can choose a provider from the directory. See chapter 3 (page 40) for information about the MCO's provider network.

Residential Services – Residential care settings include adult family homes (AFHs), community-based residential facilities (CBRFs), residential care apartment complexes (RCACs), and nursing homes. The member's care team must authorize all residential services.

Resource Allocation Decision (RAD) Process – A tool a member and his or her care team use to help find the most effective and efficient ways to meet the member's needs and support his or her long-term care outcomes.

Room and Board – The portion of the cost of living in a residential care setting related to rent and food costs. Members are responsible for paying their room and board expenses. See chapter 5 (page 61) for information about room and board.

Self-Directed Supports (SDS) – SDS is a way for members to arrange, purchase, and direct some of their

long-term care services. Members have greater responsibility, flexibility, and control over service delivery. With SDS, members can choose to have control over, and responsibility for, their own budget for services, and may have control over their providers, including responsibility for hiring, training, supervising, and firing their own direct care workers. Members can choose to self-direct one or more of their services.

Service Area – The geographic area where a member must reside in order to enroll and remain enrolled with Includa. See chapter 2 for a list of Includa's service areas.

State Fair Hearing – A hearing held by an administrative law judge who works for the State of Wisconsin Division of Hearing and Appeals (DHA). Members may file a request for a state fair hearing when they want to appeal a decision made by their care team. Members may also ask for a state fair hearing if they filed an appeal with their MCO and were unhappy with the MCO's decision. Notices of Action and notifications of appeal rights give members information on how to file a request for a fair hearing. See chapter 8 (page 100) for information about state fair hearings.

2. DEFINITIONS OF SERVICES IN THE FAMILY CARE BENEFIT PACKAGE

Home and Community-Based Waiver Service Definitions

Full definitions available upon request
These services are not available to members at the non-nursing home level of care.

Adaptive Aids are controls or appliances that enable people to increase their abilities to perform activities of daily living or control the environment in which they live (including patient lifts, control switches, etc.). Adaptive aids are also services that help people access, participate, and function in their community. This includes vehicle modifications (such as van lifts, hand controls), and may include the initial purchase of a service dog and routine veterinary costs for a service dog. (Excludes food and non-routine veterinary care for service dogs.)

Adult Day Care Services are the provision of services for part of a day in a non-residential group setting to adults who need an enriched social or health-supportive experience or who need assistance with activities of daily living, supervision, and/or protection. Services may include personal care and supervision, light meals, medical care, and transportation to and from the day care site.

Home and Community-Based Waiver Service Definitions

Full definitions available upon request

These services are not available to members at the non-nursing home level of care.

Assistive Technology/Communication Aids means an item, piece of equipment, or product system that increases, maintains, or improves the functional ability of members at home, work, and in the community. Services include devices or services that assist members to hear, speak, or see, such as communication systems, hearing aids, speech aids, interpreters, and electronic technology (tablets, mobile devices, software).

Care Management Services (also known as case management or service coordination) are provided by a care team. The member is the center of the care team. The team consists of, at minimum, a Community Resources Coordinator (CRC) and Health & Wellness Coordinator (HWC), and may also include other professionals, as appropriate to the needs of the member, and family or other natural supports requested by the member. Services include assessment, care planning, service authorization, and monitoring the member's health and well-being.

Home and Community-Based Waiver Service Definitions

Full definitions available upon request
These services are not available to members at the non-nursing home level of care.

Consultative Clinical and Therapeutic Services assist unpaid caregivers and paid support staff in carrying out the member's treatment or support plan. Services include assessments, development of home treatment plans, support plans, intervention plans, training and technical assistance to carry out the plans. Services also include training for caregivers and staff that serve members with complex needs (beyond routine care).

Consumer Education and Training are services designed to help a person with a disability develop self-advocacy skills, support self-determination, exercise civil rights, and acquire skills needed to exercise control and responsibility over other support services. These services include education and training for members, their caregivers, and legal representatives. Covered expenses may include enrollment fees, books and other educational materials, and transportation to training courses, conferences, and other similar events.

Home and Community-Based Waiver Service Definitions

Full definitions available upon request
These services are not available to members at the non-nursing home level of care.

Counseling and Therapeutic Services are services to treat personal, social, physical, medical, behavioral, emotional, cognitive, mental health, or alcohol or other drug abuse disorders. Services may include assistance in adjusting to aging and disability, assistance with interpersonal relationships, recreational therapies, art therapy, nutritional counseling, medical counseling, weight counseling, and grief counseling.

Daily Living Skills Training teaches members and their natural supports the skills involved in performing activities of daily living, including skills to increase the member's independence and participation in community life. Examples include teaching money management, home care maintenance, food preparation, mobility training, self-care skills, and the skills necessary for accessing and using community resources.

Day Services is the provision of regularly scheduled activities in a non-residential setting (day center) to enhance social development and to develop skills in performing activities of daily living and community living.

Home and Community-Based Waiver Service Definitions

Full definitions available upon request
These services are not available to members at the non-nursing home level of care.

Financial Management Services assist members and their families to manage service dollars or manage their personal finances. This service includes a person or agency paying service providers after the member authorizes payment for services included in the member's self-directed support plan. Fiscal Management Services also includes helping members with budgeting personal funds to ensure resources are available for housing and other essential costs.

Home Delivered Meals (sometimes called "meals on wheels") include the costs associated with the purchase and planning of food, supplies, equipment, labor, and transportation to deliver one or two meals a day to members who are unable to prepare or obtain nourishing meals without assistance.

Home and Community-Based Waiver Service Definitions

Full definitions available upon request
These services are not available to members at the non-nursing home level of care.

Home Modifications are the provision of services and items to assess the need for, arrange for, and provide modifications or improvements to a member's living quarters in order to provide accessibility or increase safety. Home modifications may include materials and services, such as ramps, stair lifts, wheelchair lifts, kitchen/bathroom modifications, specialized accessibility/safety adaptations and voice-activated, light-activated, motion-activated and electronic devices that increase the member's self-reliance and capacity to function independently.

Housing Counseling is a service that helps members to obtain housing in the community, where ownership or rental of housing is separate from service provision. Housing counseling includes exploring home ownership and rental options, identifying financial resources, identifying preferences of location and type of housing, identifying accessibility and modification needs, and locating available housing.

Home and Community-Based Waiver Service Definitions

Full definitions available upon request
These services are not available to members at the non-nursing home level of care.

Personal Emergency Response System is a service that provides a direct communications link (by phone or other electronic system) between someone living in the community and health professionals to obtain immediate assistance in the event of a physical, emotional, or environmental emergency.

Prevocational Services involve learning and work experiences where a member can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated, community settings. These services develop and teach general skills, which include the ability to communicate effectively with supervisors, co-workers, and customers, generally accepted community workplace conduct and dress, ability to follow directions, ability to attend to tasks, workplace problem solving skills, general workplace safety, and mobility training. Prevocational services are designed to create a path to integrated community-based employment for which a person is paid at or above the minimum wage, but not less than the usual wage and level of benefits paid for the same or similar work performed by people without disabilities.

Home and Community-Based Waiver Service Definitions

Full definitions available upon request
These services are not available to members at the non-nursing home level of care.

Relocation Services are services and items a member would need in order to move from an institution or a family home to an independent living arrangement in the community. Relocation services may include payment for moving the member's personal belongings, payment for general cleaning and household organization services, payment of a security deposit, payment of utility connection costs and telephone installation charges, the purchase of necessary furniture, telephones, cooking/serving utensils, basic cleaning equipment, household supplies, bathroom and bedroom furnishings, and kitchen appliances.

Residential Care: 1-2 Bed Adult Family Home is a place in which the operator provides care, treatment, support, or services above the level of room and board for up to two adults. Services typically include supportive home care, personal care, and supervision. Services may also include transportation and recreational/social activities, behavior and social support, and daily living skills training.

Home and Community-Based Waiver Service Definitions

Full definitions available upon request
These services are not available to members at the non-nursing home level of care.

Residential Care: 3-4 Bed Adult Family Home is a place where 3-4 adults who are not related to the licensee reside and receive care, treatment, or services above the level of room and board, and may include up to seven hours per week of nursing care per resident. Services typically include supportive home care, personal care, and supervision. Services may also include behavior and social support, daily living skills training, and transportation.

Residential Care: Community-Based Residential Facility (CBRF) is a homelike setting where five or more adults who are not related to the operator or administrator reside and receive care, treatment, support, supervision, training, transportation, and up to three hours per week of nursing care per resident.

Residential Care: Residential Care Apartment Complex (RCAC) is a homelike, community-based setting where five or more adults reside in their own living units that are separate and distinct from each other. Services include supportive services (laundry, house cleaning), personal care, nursing services (wound care, medication management), and assistance in the event of an emergency.

Home and Community-Based Waiver Service Definitions

Full definitions available upon request
These services are not available to members at the non-nursing home level of care.

Respite Care Services are services provided on a short-term basis to relieve the member's family or other primary caregiver(s) from daily stress and care demands. Respite care may be provided in the member's home, a residential facility, a hospital, or a nursing home.

Self-Directed Personal Care Services are services to assist members with activities of daily living and housekeeping services members need to live in the community. Activities of daily living include help with bathing, eating, dressing, managing medications, oral, hair and skin care, meal preparation, bill paying, mobility, toileting, transferring, and using transportation. The member selects an individual or agency to provide his or her services, pursuant to a physician's order and following his or her member-centered plan.

Skilled Nursing are medically necessary skilled nursing services that may only be provided by an advanced practice nurse, a registered nurse (RN), or a licensed practical nurse (LPN) working under the supervision of an RN. Skilled nursing includes observation and recording of symptoms and reactions, general nursing procedures and techniques, and may include periodic assessment of the member's medical condition and ongoing monitoring of a member's complex or fragile medical condition.

Home and Community-Based Waiver Service Definitions

Full definitions available upon request
These services are not available to members at the non-nursing home level of care.

Specialized Medical Equipment and Supplies are those items necessary to maintain the member's health, manage a medical or physical condition, improve functioning, or enhance independence. Allowable items may include incontinence supplies, wound dressing, orthotics, enteral nutrition (tube feeding) products, certain over-the-counter medications, medically necessary prescribed skin conditioning lotions/lubricants, prescribed Vitamin D, multi-vitamin or calcium supplements, and IV supplies.

Support Broker is a person the member chooses to assist him or her in planning, obtaining, and directing self-directed support (SDS).

Supported Employment Services (individual and small group employment support services) help members who, because of their disabilities, need on-going support to obtain and maintain competitive employment in an integrated community work setting. The outcome of this service is sustained paid employment at or above minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

- Individual employment services are individualized and may include vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, meeting with prospective employers, job analysis, job coaching and training, transportation, career advancement services, or support to achieve self-employment.
- Small group employment services are services and training provided in a business, industry, or community setting for groups of two to eight workers with disabilities. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in the community. Services may include vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, meeting with prospective employers, job analysis, training and systemic instruction, job coaching and training, transportation, career advancement services, or support to achieve self-employment.

Home and Community-Based Waiver Service Definitions

Full definitions available upon request
These services are not available to members at the non-nursing home level of care.

Supportive Home Care (SHC) includes services that directly assist members with daily living activities and personal needs to ensure adequate functioning in their home and community. Services may include help with dressing, bathing, managing medications, eating, toileting, grooming, mobility, bill paying, using transportation, and household chores.

Training Services for Unpaid Caregivers assist the people who provide unpaid care, training, companionship, supervision, or other support to a member. Training includes instruction about treatment regimens and other services included in the member's care plan, use of equipment specified in the service plan, and guidance, as necessary, to safely maintain the member in the community.

Home and Community-Based Waiver Service Definitions

Full definitions available upon request
These services are not available to members at the non-nursing home level of care.

Transportation (specialized transportation) – Community and Other Transportation

- Community transportation services help members gain access to community services, activities, and resources. Services may include tickets or fare cards, as well as transportation of members and their attendants to destinations. Excludes emergency (ambulance) transportation.
- Other transportation services help self-directing members to receive non-emergency, Medicaid-covered medical services. Services may include tickets or fare cards, reimbursement for mileage, as well as transportation of members and their attendants to destinations. Excludes non-medical transportation, which is provided under community transportation-see above. Excludes emergency (ambulance) transportation.

Home and Community-Based Waiver Service Definitions

Full definitions available upon request

These services are not available to members at the non-nursing home level of care.

Vocational Futures Planning and Support is a person-centered, team-based employment planning and support service that provides assistance for members to obtain, maintain, or advance in employment or self-employment. This service may include the development of an employment plan, work incentive benefits analysis and support, resource team coordination, career exploration and employment goal validation, job seeking support and job follow-up, and long-term support.

3. APPLICATION FOR REDUCTION OF COST SHARE

DEPARTMENT OF HEALTH SERVICES
Division of Long Term Care
F-01827 (09/2016)

STATE OF WISCONSIN
Administrative Rule
DHS 10.34

APPLICATION FOR REDUCTION OF COST SHARE

Although completion of this form is voluntary, all the information requested on this form needs to be submitted as part of the approval process. Personally identifiable information is collected on this form for the sole purpose of identifying the program participant and processing the request, and will not be used for any other purpose.

Request for Reduction of Cost Share

- Are you a Family Care, Partnership, or PACE member?
- Do you have to pay a monthly cost share?
- Are you unable to pay your monthly cost share due to your necessary monthly living expenses?

If yes, you may qualify for a reduction of your cost share.

A cost share reduction may make your monthly living expenses more affordable, and allow you to stay enrolled in Family Care, Partnership, or PACE. Necessary monthly living expenses include costs such as mortgage payments, rent, home/renter's insurance, property taxes, utilities, food, clothing, hygiene items, and the cost of operating and maintaining a vehicle.

To request a reduction of your cost share, please complete the attached form, "Application for Reduction of Cost Share," and mail or fax it to the Bureau of Managed Care at:

Member Rights Specialist
Department of Health Services
Bureau of Managed Care
1 West Wilson Street, Room 518
P.O. Box 7851
Madison, WI 53707-7851
Phone: 1-855-885-0287
TTY: 711
Fax: 608-266-5629

Along with the application, you will need to submit proof of your monthly income, your monthly expenses, and the cost share you owe to your MCO each month. The application will tell you what kind of proof is needed and gives examples of the types of documents that provide that proof. The Wisconsin Department of Health Services will review your application to decide if the amount of cost share you pay each month can be reduced. The Department of Health Services will send you a letter approving or disapproving your request. If you have questions, please call 1-855-885-0287.

Who Can Help Me Complete This Form?

If you need help completing this form, you can obtain assistance, free of charge, from the following resources:

Independent Ombudsman Agencies:

For people under age 60:
Disability Rights Wisconsin
Call the office closest to you:
Toll Free Madison 800-928-8778
Milwaukee 800-708-3034
Rice Lake 877-338-3724
TTY 888-758-6049

For people 60 years old and older:
Wisconsin Board On Aging and Long Term Care
Call Toll Free 800-815-0015

Benefit Specialists:

A benefit specialist can help answer your questions. Services are free and confidential. To find a benefit specialist in your county of residence, contact your local Aging and Disability Resource Center or county aging office:
www.dhs.wisconsin.gov/benefit-specialists/counties.htm.

APPLICATION FOR REDUCTION OF COST SHARE

Answer the questions on this form as completely as you can. If you are filling out this form for someone else, answer the questions as they apply to that person. If more space is needed, attach a separate sheet(s) of paper and indicate the number and letter (if any) of the question you are answering.

Section 1—Applicant Information

Last Name	First Name	Middle Initial
Mailing Address—Street	City	State
Telephone Number	Email Address	Zip Code
Name of Managed Care Organization (MCO) Member is Enrolled in		
Date of Birth (mm/dd/yyyy)	Medicaid ID Number or CARES ID	

Section 2—Authorized Representative (complete this section if applicable)

Last Name—Representative	First Name—Representative	Middle Initial
Mailing Address—Street	City	State
Telephone Number	Email Address	Zip Code

A. Source of Authority to Act as Member's Representative:

Check the boxes that apply. *Proof Required:* For any box you have checked, attach a copy of the document that grants you the authority to act as the member's representative. For example, a signed guardianship order or activated power of attorney document.

- ☐ Guardian of Estate
 ☐ Guardian of the Person
 ☐ Power of Attorney for Finances
 ☐ Attorney
☐ Power of Attorney for Health Care
 ☐ Other—Specify:

Section 3—Current Cost Share and Amount of Cost Share Reduction Requested

Answer the questions below. *Proof Required:* Attach a copy of your monthly cost share bill from the MCO or the State of Wisconsin.

A. What is your current monthly cost share amount? (This is the amount of cost share you must pay to the MCO now.)	\$	per month
B. What is the amount of monthly cost share you can afford to pay? (This is the amount of cost share you would pay the MCO if your request is fully granted.)	\$	per month

Section 4—Why Cost Share Reduction is Necessary

Please explain why you need a reduction in cost share (attach additional pages, if needed):

Section 5—Past Cost Share Amount

A. Do you owe the MCO cost share for past months? ☐ Yes ☐ No

B. If yes, how much do you owe? \$

Section 6—Current Income Amount

List all types of income you receive below. *Proof required:* Attach documentation such as copy of social security statement, annual tax return, statement from a pension or annuity company, paystubs, bank records of deposits into your checking or savings account from social security, pension, or annuity.

A. Total monthly *gross* income (This is income before taxes, Medicare Part B and D premiums, and other deductions are taken out). \$ per month

B. Total monthly *net* income (This is the actual income you receive after taxes, Medicare Part B and D premiums, and other deductions are taken out). Also known as "take-home" pay. \$ per month

C. Source of income

TYPE	AMOUNT
<input type="checkbox"/> Social Security	\$
<input type="checkbox"/> Pension	\$
<input type="checkbox"/> Annuity	\$
<input type="checkbox"/> Other Specify:	\$
<input type="checkbox"/> Other Specify:	\$
<input type="checkbox"/> Other Specify:	\$
<input type="checkbox"/> Other Specify:	\$

Section 7—Current Monthly Living Expenses

A. List your total monthly necessary living expenses below. *Proof required:* Attach documentation such as a copy of a mortgage statement, rental agreement or lease, condo fee invoice, property tax bill, insurance bill, utility bill.

TYPE	AMOUNT
<input type="checkbox"/> Mortgage	\$
<input type="checkbox"/> Rent	\$

<input type="checkbox"/> Home owner's insurance	\$
<input type="checkbox"/> Renter's insurance	\$
<input type="checkbox"/> Property taxes	\$
<input type="checkbox"/> Condo fees	\$
<input type="checkbox"/> Phone	\$
<input type="checkbox"/> Gas	\$
<input type="checkbox"/> Electric	\$
<input type="checkbox"/> Sewer/septic	\$
<input type="checkbox"/> Water	\$
<input type="checkbox"/> Food	\$
<input type="checkbox"/> Clothing	\$
<input type="checkbox"/> Hygiene	\$
<input type="checkbox"/> Maintenance and operation of vehicle	\$
<input type="checkbox"/> Other Specify:	\$
<input type="checkbox"/> Other Specify:	\$
<input type="checkbox"/> Other Specify:	\$
<input type="checkbox"/> Other Specify:	\$
Section 8—Fair Hearing Request	
Have you requested a fair hearing with the Wisconsin Department of Administration, Division of Hearings and Appeals regarding your cost share amount? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, what is the date the hearing occurred or is set to occur? Date (mm/dd/yyyy)	
SIGNATURE – Member or Authorized Representative	Date Signed

4. SAMPLE NOTICE OF ACTION



FAMILY CARE NOTICE OF ACTION

<<Date NOA mailed>>

<<Member's Name>>

<<Member's MA or MCI Number>>

<<Member/Legal Representative's Street Address>>

<<City>> <<State>> <<Zip Code>>

Dear <<Member's Name>>:

This Notice of Action confirms our discussion on <<insert date>>.

The service or support in question is: <<insert service in question>>

After reviewing the options with you using the Resource Allocation Decision (RAD) making process, we have decided to:

☐ **Terminate current service**

Effective date of intended action: _____

☒ **Reduce current service**

Effective date of intended action: _____

Description of current level: <<insert original time or unit limit to authorization>> _____

New level after reduction _____

☐ **Suspend current service**

Effective date of intended action: _____

Expected date service will resume: _____

☐ **Deny request for new service or support**

Date of request: _____

☐ **Limit request for service**

Date of request: _____

Description of requested level: _____

Authorized level of service or support: _____

☐ **Deny payment for service or support**

Date of request: _____

DHS/DMS F-00232 (08/2017)

Page 1 of 4

Date(s) service provided: _____

Provider / Supplier: _____

Payment amount being denied: \$ _____

The reason for our decision, is that:

- ☐ The service or support is not an effective way to support your outcome(s).
- ☐ You do not need this service or level of service or support to support your outcome.
- ☐ We are already supporting your outcome in another way.
- ☐ The service or support you received was not authorized.
- ☐ The service or support you received by out-of-network provider was not authorized.
- ☐ Informal support (or other support) is available to provide this service or support this outcome for you.
- ☐ This service or support is not considered a safe way to support your outcome(s).
- ☐ This service or support is not the most cost-effective way to support your outcome(s).
- ☐ Other: _____

Team staff's explanation of the decision: <<see instruction below>>

This decision is based on the Wisconsin law governing Family Care, Wisconsin Admin. Code, sec. DHS 10.44(2)-(3).

If you disagree with this decision, the following pages describe your options and deadlines that apply.

Sincerely,

<<Community Resource Coordinator Name>>
Community Resource Coordinator
<<Telephone Number>>

<<Health and Wellness Coordinator Name>>
Health and Wellness Coordinator
<<Telephone Number>>

Interpreter and Translation Services. Interpreter and translation services are available free of charge. If you need this form in another language, Braille or large print, please call Inlusa at 1-715-345-5968 or toll-free 1-877-622-6700. TTY users should call 1-715-204-1799.

1. Assistance: Who can help you understand this notice and your rights?

- a. The **Inclusa Member Rights Specialist** can inform you of your rights, attempt to informally resolve your concern, and assist you with filing an appeal. He or she **cannot** represent you at a meeting with your MCO's Grievance & Appeal Committee or a State fair hearing. To contact our MCO's Member Rights Specialist, call 715-204-1805.
- b. The following independent ombudsman agencies may be able to provide you with free assistance. These agencies advocate for Family Care members.

For members age 18 to 59:

Disability Rights Wisconsin Family Care and IRIS Ombudsman Program

Call the office closest to you:

Toll Free Madison: (800) 928-8778

Milwaukee: (800) 708-3034

Rice Lake: (877) 338-3724

TTY (888) 758-6049

For members age 60 and older:

Wisconsin Board on Aging and Long Term Care

Toll Free (800) 815-0015

2. Appealing this Decision. If you disagree with this decision, you have two appeal options:

- a. Inclusa's Grievance & Appeals Committee
- b. State Fair Hearing

You can ask for a State Fair Hearing instead of or after asking <<MCOname>>'s Grievance & Appeals Committee for an appeal. If you choose a State Fair Hearing first, you cannot go back and bring the matter to Inclusa's Grievance & Appeal Committee. You also have the option to request a review from the Department of Health Services; this is not an appeal, for more information see section 5.

Inclusa's Grievance & Appeals Committee

You have the right to request a meeting with Inclusa's Grievance & Appeals Committee. The Committee is made up of Inclusa representatives and at least one person who is also receiving services from us (or represents someone who does). You have the right to appear in person, if you choose. You may bring an advocate, friend, family member or witnesses. You may also present to this committee.

To file an appeal with Inclusa, contact your Member Rights Specialist at 715-204-1805. You can also start the process by sending in a request form or a letter. You can request a form from Inclusa or one of the independent ombudsman agencies listed in this notice. Or you can go online and get a form at:

<http://dhs.wisconsin.gov/LTCare/help.htm>.

You can send the completed request form or a letter asking for a meeting and a copy of this notice to: Member Rights Specialist, Inclusa, 3349 Church Street, Suite 1, Stevens Point, WI 54481

State Fair Hearing

If you request a fair hearing with the State of Wisconsin's Division of Hearings and Appeals, you will have a hearing with an independent judge. You may bring an advocate, friend, family member or witnesses. You may also present evidence at this hearing. If you request a state fair hearing, a Department of Health Services review will automatically review your appeal.

To file a request for a fair hearing, you can ask for a hearing and/or a hearing form from the Member Rights Specialist at 715-204-1805. You can also request a hearing form from one of the independent ombudsman agencies listed or you can go online and get a form at <http://dhs.wisconsin.gov/forms/f0/f00236.doc>.

You can send the completed request form or a letter asking for a hearing and a copy of this notice to: Family Care Request for Fair Hearing, c/o Wisconsin Division of Hearings and Appeals, 5005 University Ave. #201, Madison, WI 53705-5400, or fax it to 608-264-9885.

3. **Continuing your Services during an Appeal of a Reduction, Suspension or Termination of a Current Service.** You have the right to request to have services continued during your appeal. If you want to request that your benefits be continued during your appeal, your request must be postmarked or faxed **on or before the effective date of the intended action**. You might be responsible for repaying us for the cost of this service if you lose your appeal; however, you may not be required to repay this cost if it would be a significant and substantial financial burden on you.
4. **Deadline to File Your Appeal.** You should file your appeal as soon as possible. Your appeal must be postmarked or faxed within forty-five (45) days of receipt of this notice of action.
IMPORTANT NOTE: If you would like your benefits to continue during your appeal, your appeal must be postmarked or faxed **on or before the effective date of the intended action**.
5. **Department of Health Services Review**
You may choose to have this decision reviewed by MetaStar, the Department of Health Services' external quality review organization. MetaStar will try to resolve your concerns informally. You can request to have your services continued during the review, if you request the review **on or before the effective date of the intended action**. If you request a state fair hearing, MetaStar will automatically review your appeal. *Please note, however, that MetaStar cannot require any MCO to change its decision.*

To request that MetaStar review your case immediately or to learn more about a MetaStar review, call 1-888-203-8338. You may also request a MetaStar review by mail, fax, or email.

DHS Family Care Grievances, C/O MetaStar, 2909 Landmark Place, Madison, WI 53713, or fax it to (608) 274-8340. You can also email MetaStar at dhsfamcare@wisconsin.gov

Speeding up Your Inclusa Appeal. You may ask Inclusa to speed up your appeal. If Inclusa decides that taking the standard amount of time could seriously harm your health or ability to perform your daily activities, it will grant you a faster appeal, called an "expedited appeal." This means that you will receive a decision on your case within 72 hours of your request. If you want to learn more about an expedited appeal, contact Inclusa at 1-715-345-5968.

Copies of Your Records. You or your legal representative have a right to a free copy of your records relevant to your grievance or appeal including, but not limited to medical records. To request copies contact your Member Rights Specialist at 715-204-1805.

5. INCLUSA APPEAL REQUEST FORM

DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00237 (08/2017)

STATE OF WISCONSIN
Wisconsin Statute
§ 46.287(2)(c)

APPEAL REQUEST – INCLUSA

Completion of this form is voluntary. The personally identifiable information collected on this form is used to identify your case and process your request. It will only be used for that purpose.

Name – Member		Today's Date
Mailing Address		
City	State WI	Zip Code

- ☐ Check this box if you would like to appeal Inclusa decision by requesting a meeting with the Inclusa Grievance and Appeal Committee.

Continuing Your Services During an Appeal of a Reduction or Termination of a Current Service

If you request to have your benefits continued, we will continue providing your same service during your appeal if you postmark or fax your appeal **on or before the effective date of the intended action**. You might be responsible for repaying us for the cost of this service if you lose your appeal; however, you may not be required to repay this cost if it would be a significant and substantial financial burden on you.

- ☐ Check this box if you would like to request the same services to continue during your appeal.

You have a right to free copies of your records including but not limited to medical records relevant to your appeal.

- ☐ Check this box if you would like to receive records from Inclusa that apply to your appeal.

If you need this form in another language, Braille, or large print, please call Inclusa at 715-204-1805 or toll-free at 877-622-6700, Monday thru Friday, 8 a.m. to 4:30 p.m. TTY users should call 715-204-1799. Interpreter and translation services are available free of charge.

SIGNATURE – Member

Date Signed

Mail or fax this form to:

Inclusa
Attn: Member Services Department
3349 Church St, Suite 1
Stevens Point WI 54481
Fax: 715-345-5725
Toll Free: 1-877-622-6700
TTY: 711 or 1-715-204-1799
Email: memberrelations@inclusa.org

To start your appeal as soon as possible, you can call Inclusa at 715-204-1805 before mailing this form. Your appeal must be postmarked or faxed within 45 days of receipt of the Notice of Action.

6. STATE FAIR HEARING REQUEST FORM

DEPARTMENT OF HEALTH SERVICES
Division of Long Term Care
F-00236 (03/2012)

STATE OF WISCONSIN
ss 46.287(2)(c)

REQUEST FOR A STATE FAIR HEARING

Completion of this form is voluntary. The personally identifiable information collected on this form is used to identify case and process your request. It will only be used for that purpose.

Name – Member		Telephone Number	Medicaid ID Number
Mailing Address		Program <input type="checkbox"/> Family Care <input type="checkbox"/> Partnership <input type="checkbox"/> PACE	
City	Zip Code	Managed Care Organization	
Today's Date		Effective Date of Action	
Appeal related to: <input type="checkbox"/> eligibility <input type="checkbox"/> cost share <input type="checkbox"/> change to service/support		Briefly describe change to service / support:	

- ☐ Yes ☐ No 1. Did you file an appeal with your MCO's Local Grievance and Appeal Committee?
- ☐ Yes ☐ No 2. If you answered 'yes' to question one (1), did you request the same services to continue during your appeal with the MCO?
- ☐ Yes ☐ No 3. If you answered 'yes' to question one (1), have you appeared before the MCO's Local Grievance and Appeal Committee?
- ☐ Yes ☐ No 4. If you answered 'yes' to question three (3), have you received a decision from the MCO's Local Grievance and Appeal Committee? (Please attach a copy of the decision, if available.)

Continuing Your Services During an Appeal of a Reduction or Termination of a Current Service

If you request to have your benefits continued, we will continue providing your same service during your appeal if you postmark or fax your appeal **on or before the effective date of the intended action**. You might be responsible for repaying us for the cost of this service if you lose your appeal; however, you may not be required to repay this cost if it would be a significant and substantial financial burden on you.

☐ Check this box if you would like to request the same services to continue during your appeal.

You have a right to free copies of your records including but not limited to medical records relevant to your grievance or appeal. To request copies contact your Care Manager or the Member Rights Specialist.

If you need this form in another language, Braille or large print, please call your Care Manager or the Member Rights Specialist. Interpreter and translation services are available free of charge.

SIGNATURE – Member

Date Signed

Mail or fax this form **AND** a copy of the Notice of Action or decision letter to:

Family Care Request for Fair Hearing
c/o Division of Hearings and Appeals
PO Box 7875
Madison WI 53707-7875
Fax: (608) 264-9885

7. NOTICE OF PRIVACY PRACTICES

Notice of Privacy Practices Inclusa

**This Privacy Practices Notice describes how health
care
information about you may be used and disclosed,
and**

**how you can get access to this information.
Please read the notice carefully.**

.

We are required to protect the privacy of health care information about you, to notify you of our legal duties and privacy practices with respect to your protected health information, and to notify you following a breach of unsecured protected health information. This Privacy Notice tells you about your rights regarding information about you that is kept in health care records. You can look at this anytime to see how your health care records are used by Inclusa as part of your care, and who gets to see them.

This Privacy Notice includes answers to the following questions:

1. What is health care information?
2. Who can see health care information about you without your written authorization?

3. Who cannot see health care information about you unless you give written authorization?
4. What are your rights regarding health information about you?

Changes to this Privacy Notice.

We are required to abide by the terms of this notice currently in effect. We reserve the right to change this Privacy Notice. We reserve the right to make the changed Privacy Notice apply to the health care records we already have about you in addition to any information we receive in the future. The Member Handbook will contain the most current Privacy Notice available. You will be offered an updated Member Handbook each year. We will also post a copy of the current Privacy Notice on Inclusa's website. The effective date of the notice can be found in the lower left-hand corner of the first page.

1. What is Health Care Information?

Any information that can identify you and relates to your past, present, or future physical or mental health or condition; the provision of health care to you; or the past, present, or future payment for the provision of health care to you, is considered your protected health care information. Inclusa may have health care information regarding services we provide to you or payment for services provided to you or information about your past, present, or future health condition. We are required by law to protect health care information about you. We are required to follow the policies in the most current Privacy Notice available.

Health care information about you is kept in a health care record. This health care record contains your assessments, your member-centered plan, and other information related to your care. Each time you visit or are visited by your Community Resource Coordinator, Health & Wellness Coordinator, or other professionals on behalf of Inclusa, a record of the visit is made. This health care record serves as:

- a starting point for planning your care, treatment and any needed follow-up care;
- a means of communication among your care team and the many professionals who contribute to your care;
- a means by which you or a third-party payer (for example, insurance carriers, Medicare, Medicaid) can verify that services billed were actually

- provided; and
- a tool that can be used to evaluate and continually improve the care given and progress made.

Understanding what is in your health care record and how your health care information is used helps you to:

- make sure health care information about you in the record is correct;
- better understand who, what, when, where, and why others may access health care information about you; and
- make better-informed decisions when you authorize health care information about you to be shared with others in situations where your consent is required to share the information.

2. Who Can Access Health Care Information About You Without Your Written Authorization?

Listed below are reasons why we use and may share your health information without your written authorization:

- **For Treatment:** We are permitted to use and share health care information about you with health care individuals involved in your care. We are also permitted to share information about you with your health care providers. *For example, your Health & Wellness Coordinator may call your pharmacist to reorder medications for you.* We are permitted to use and share health information about you with providers of service under contract with Includa. *For example, a*

Community Resource Coordinator may need to speak with a transportation provider to arrange transportation for you.

- **For Payment:** We are permitted to use and share your health care information so that the services you receive through Inlusa may be billed to, and payment collected from, your insurance company, Medicare, and/or Medical Assistance. *For example, Inlusa may use health care information about you to pay a provider who has provided long-term care services to you, or Inlusa, or your care team may work with your Income Maintenance Worker to make sure you maintain financial eligibility for Family Care.*
- **For Health Care Operations:** We can use and share your health care information for our operations. We may use health care records to review our treatment and services and to evaluate the performance of our staff in caring for you. We also may remove all information that identifies you from a set of health care information so that others may use that information to study health care and the health care delivery without learning who the specific people are. *For example, health care information may be collected and analyzed to improve the quality of our services.*
- **To Business Associates for Treatment, Payment and Quality Assurance:** We may use and share your health care information for our business operations.

This using and sharing is necessary to run Inlusa and to make sure that all members receive quality care. We have written agreements with our business associates for administrative purposes, including payment of claims for your services or management of our member-related software system. *For example, Inlusa has a contract with WPS to pay claims on our behalf. WPS is considered a business associate to Inlusa We have a formal written agreement with WPS to protect your health care information.*

Special Situations

- **Individuals Involved in Your Care or Payment of Your Care:** We may use or disclose health care information to a family member, other relative, a close personal friend, or any other person identified by you when you are present and you, based on your participation, do not object to the sharing of health care information. If you are not present, or you are not able to agree because you are hurt or experiencing an emergency, we may use our professional judgment to determine whether sharing your health care information is in your best interest. We may also share health care information about you in order to notify your family member, other relative, a close, personal friend, or an agency involved in disaster relief efforts of your location, general condition, or death.
- **As Required By Law:** We will share your health care record when required to do so by federal, state, or local law. For example, state law requires us to report abuse and neglect. If we believe you are a victim of abuse or neglect, we may share health care information about you to governmental authorities, including protective services as authorized by law to receive such reports. Another example would be during an officially declared disaster or crisis if it is necessary to help ensure your safety or your community's safety or to prevent disease. However, if you have specific preferences on how we disclose

this information under these circumstances, or if you wish to opt out of any disclosure, please let us know and if we agree with the limitations, we will follow your instructions unless there is a specific legal prohibition against it.

- **Health Oversight Activities:** We will share your health care information with a health oversight agency as authorized by the law for audits, investigations, inspections, and licensure. These activities are necessary to monitor the health care system, government programs, and compliance with civil rights laws. *For example, the State of Wisconsin's Department of Health Services contracts with an agency to provide quality oversight of Includa. The oversight agency may conduct file reviews of records to assure compliance with contract requirements.*
- **Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we will share your health care information in response to a court or administrative order. We may also share your health care information in response to a subpoena or other lawful process. *For example, a subpoena may require disclosure, or a judge may order us to disclose health care information about you.*

- **If You Dis-enroll and go to Another Family Care Agency:** Should you leave Inclusa and sign up for Family Care through another agency, we may be asked to provide a copy of your most recent Long Term Care Functional Screen. Once the request has been verified as a legitimate request, Inclusa will release the screen to them without requesting your permission.
- **Other:** If you have given someone medical power of attorney, or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action. Another exception includes organ transplants; we can also share health information about you with organ procurement organizations.

In addition, under some circumstances, we may share your health care information permitted or as required by law:

- to report and/or investigate a death (including sharing information with the coroner, medical examiners, or funeral directors)
- Worker's Compensation claims;
- for judicial and administrative proceedings;
- with protection agencies, advocacy agencies, and ombudsmen programs;
- to a facility to which you may be involuntarily committed;

- to avert a serious threat to health or safety; and
- to a law enforcement or correction agency.

Uses or disclosures of your health care information for other purposes or activities not listed above will be made only with your written permission. If you give us permission to use or share your health care information, you may cancel your permission in writing at any time. If you cancel your permission, we will no longer use or share your health care information for the reasons covered by your written permission. However, we are unable to take back anything we had given already with your permission.

3. Who Cannot See Health Care Information About You Unless You Give Written Authorization?

Other than the uses and disclosures described generally above, we will not use or disclose health care information about you without authorization, or signed permission, from you or your legal decision maker. We would get authorization or signed permission from you, or your legal decision maker, by having you sign an Release of Information for Use and Disclosure of Confidential Information form.

Most uses and disclosures of psychotherapy notes, uses and disclosures of protected health information for marketing purposes, and disclosures that constitute a sale of protected health information, require your written authorization.

Inclusa does not conduct any fundraising, marketing, or medical research. We do not sell any of your information. We do ask members to respond to a survey, provided annually, on their satisfaction with care provided by Inclusa. Participation in the survey is always voluntary and you always have the option to say no.

Inclusa is prohibited from the use or disclosure of protected health information for underwriting purposes, including your genetic information. This is required by the Genetic Information Nondiscrimination Act (GINA) of 2008.

4. What Are Your Rights Regarding Health Care Information about You?

You have the following rights regarding the health care information we maintain about you:

- **The Right to Ask for Limitations:** You have the right to ask for a limitation on the health care information we use or share about you for treatment, payment, or health care operations. You also have the right to ask for a limit on the health care information we share about you to someone who is involved in your care, or the payment for your care, such as a family member or friend. Inclusa must comply with your request to restrict disclosure of your health information to a health plan if:
(A) The disclosure is for the purpose of carrying out payment or health care operations and is not

otherwise required by law; and

(B) The protected health information pertains solely to a health care item or service for which you or a person on your behalf has paid Inlusa in full.

In your request, you must tell us:

- what information you want to limit;
- whether you want to limit Inlusa's use and/or disclosure of the information;
- to whom you want the limits to apply (*for example, sharing information with your spouse*); and
- your contact address and daytime phone number.

We are not required to agree with your request, especially in those situations where your consent is not required before disclosing the information as described above. If we do agree, we will honor your request unless the information is needed to provide you with emergency treatment. Inlusa will notify you in writing with our decision.

- **The Right to Request Confidential Communications:** You have the right to request that we speak with you about your services in a certain way or at a certain location. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests. *For example, you can ask that we only contact you by telephone at work or that we only contact you by mail*

at home.

- **The Right to Inspect and Receive a Copy:** You have the right to inspect and receive a copy of your health care information that may be used to make decisions about your care. Usually, this includes case notes and billing records. Psychotherapy notes may not be seen by others or copied. We will provide you a copy or summary of your health information, usually within thirty (30) days; however, under unique circumstances we do have an option of taking a thirty (30) day extension. If there is a delay, we must notify you in writing why we need the extra time and when we think we will be able to fulfill your request. **All requests for information must be in writing. Your care team can provide you with a request form and help you fill out the request.**

If you request a copy of your health care information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to see or receive a copy in certain very limited circumstances. If you are denied access to your health care information, we will notify you in writing. You may request that the denial be reviewed. The person conducting the review will not be the person who denied your request. We will follow through with the outcome of the review.

- **The Right to Amend:** If you think there is something

wrong or missing in your health care information, you may ask that it be changed. You have the right to request a change to your Inlusa member file. You must include a reason that supports your request. We may say no to your request, but we will tell you why in writing within sixty (60) days.

We may deny your request for a change if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to change information that:

- was not created by Inlusa;
- the person or entity that created the information is no longer available to make the amendment;
- is not part of the health care information kept by or for Inlusa; or
- is accurate and complete.

Inlusa will notify you in writing whether we agree or do not agree with your amendment request.

Additionally, if we grant the request, we will make the correction and distribute it to all necessary recipients as well as those you ask to receive the corrected information. If we deny your request for a change to your health care information, we will notify you how you may file a complaint with Inlusa

- **The Right to be Notified of a Breach of your Personal Health Information:** With the exceptions

outlined under HIPAA Regulations, you have a right to be notified if your information is ever mishandled and a breach (loss) of your personal health information has occurred or has likely occurred.

- **The Right to an Accounting of Disclosures:** You have the right to request an accounting of disclosures that has been made by Inlusa in the past six (6) years. We will include all the disclosures except for those about treatment, payment, and health care operations and certain other disclosures, such as any you asked us to make.

Your request must state a time period not longer than six (6) years and may not include dates before July 1, 2008. The first list you request within a twelve (12) month period will be free of charge. For additional lists, we may charge you for the costs of providing the list. We will also notify you of the cost involved before any costs are incurred.

- **The Right to a Paper Copy of This Notice:** You have the right to receive a paper copy of this Privacy Notice. To obtain a paper copy of this Privacy Notice, contact the Inlusa Privacy Officer at 1-877-622-6700..

- **The Right to Electronic Copy of This Notice:** You may obtain an electronic copy of this Privacy Notice on our website.
- **The Right to File a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with Inlusa's Director of Compliance at (608) 647-1536 or with the Secretary of Health and Human Services at The U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201, or call DHHS at 1-877-696-6775. Inlusa assures that there will be no retaliation for filing a complaint.

For more information visit:

<http://www.hhs.gov/ocr/privacy/hipaa/complaints/>. You may also contact the Inlusa Privacy Officer at 1-877-622-6700.

