06/2024

IDAHO DEPARTMENT OF HEALTH & WELFARE

Region	_____
Rate Code	_____
Date received	_____
Sent to IAC	_____

ELIGIBILITY APPLICATION FOR ADULTS WITH DEVELOPMENTAL DISABILITIES (DD)

This application is for Medicaid participants turning 18 years or older who have been determined financially eligible for Medicaid. If you do not currently have Enhanced Medicaid, you are still encouraged to apply as you may be eligible if you meet level of care eligibility for the DD Waiver and financial criteria.

Name _____ Date of Birth _____
Address _____ Phone _____
Current Living Arrangement _____
Enrolled in Medicaid? ☐ No ☐ Yes If Yes, Medicaid Number _____

What services are you seeking? Choose one:

☐ DD Waiver- **Self Directed Community Supports**
☐ DD Waiver- **Traditional** (if eligible, includes State Plan services below)
☐ **State Plan Services** (Service Coordination, Developmental Therapy)

☐ Family Member ☐ Legal Guardian ☐ Contact
Name _____
Address _____
_____
Phone _____
Email _____

Please provide the following documentation with your application:

- A history and physical that has been completed within the last 365 calendar days.

AND

- Documentation which verifies that your disability was identified before the age of 22,

AND

- Documentation of your disability:
  - For **Cerebral Palsy, Epilepsy, or Traumatic Brain Injury**: A report from a physician

OR

  - For **Intellectual Disability**: Results of an IQ test using the Wechsler Intelligence Scale for Adults – Third Edition (WAIS-III); or Stanford Binet Intelligence Scales, for ages two (2) through adult; or Test of Nonverbal Intelligence, Fourth Edition (TONI-4), for ages six (6) years through eighty-nine (89) years, eleven (11) months. Tests over one (1) year old must be verified to reflect the current status of the individual by an appropriate professional.

OR

  - For **Autism Spectrum Disorder (ASD)**: Documentation supporting this diagnosis from a professional working within their scope of practice.

OR

  - Other condition found to be closely related to, or similar to, one of these impairments that requires similar treatment or services. Provide documentation that can show the causal relationship between the impairing condition and the developmental disability. (Does not include mental illness)

AND

- Documentation demonstrating that guardianship has been registered with the state of Idaho (if applicable)

Submit to email inbox or address listed on page 2 of this application

****For Dept. use only****

☐ State Plan Eligibility ☐ Approved ☐ Denied
☐ ICF/ID LOC Eligibility ☐ Approved ☐ Denied
Reason for Denial: _____
Signature of Authorized Representative of the Department:
_____ Date _____

Return the completed eligibility application for adults with developmental disabilities via email, mail, or to the office nearest you.

Region 1
(Counties served- Benewah, Bonner, Boundary, Kootenai, and Shoshone)

Location- 1120 Ironwood Drive, Suite 102 Coeur d'Alene, ID 83814	Phone- (208) 769-1567 Fax- (208) 666-6856 Email- BDDSQA1@dhw.idaho.gov

Region 2
(Counties served- Clearwater, Idaho, Latah, Lewis, and Nez Perce)

Location- 1118 F Street Mailing- PO Drawer B Lewiston, ID 83501	Phone- (208) 799-4430 Fax- (208) 799-5167 Email- BDDSQA2@dhw.idaho.gov

Region 3
(Counties served- Adams, Canyon, Gem, Owyhee, Payette, and Washington)

Location- **please bring to:** 1720 Westgate Drive, Suite B Boise, ID 83704	Phone- (208) 334-0940 Option #3 Fax- (208) 334-0953 Email- BDDSQA3@dhw.idaho.gov

Region 4
(Counties served- Ada, Boise, Elmore, and Valley)

Location- 1720 Westgate Drive, Suite B Boise, ID 83704	Phone- (208) 334-0940 Option #3 Fax- (208) 334-0953 Email- BDDSQA4@dhw.idaho.gov

Region 5
(Counties served- Blaine, Camas, Cassia, Gooding, Jerome, Lincoln, Minidoka, and Twin Falls)

Location- 601 Pole Line Road, Suite 3 Twin Falls, ID 83301	Phone- (208) 736-3024 Fax- (208) 736-2116 Email- BDDSQA5@dhw.idaho.gov

Region 6
(Counties served- Bannock, Bear Lake, Bingham, Caribou, Franklin, Oneida, and Power)

Location- 1070 Hiline Road, Suite 260 Pocatello, ID 83201	Phone- (208) 239-6260 Fax- (208) 239-6269 Email- BDDSQA6@dhw.idaho.gov

Region 7
(Counties served- Bonneville, Butte, Clark, Custer, Freemont, Jefferson, Lemhi, Madison, and Teton)

Location- 150 Shoup Avenue, Suite 20 Idaho Falls, ID 83402	Phone- (208) 528-5750 Fax- (208) 528-5756 Email- BDDSQA7@dhw.idaho.gov

IDAHO DEPARTMENT OF HEALTH & WELFARE

Acknowledgement of Receipt of the Notice of Privacy Practices

Available in Spanish. We provide interpreter services at no cost. Call 2-1-1 or 1-800-926-2588 for interpretation assistance.
Disponible en espanol. Proveemos servicios de intérprete sin costo alguno. Llame al 2-1-1 ó al 1-800-926-2588 para obtener la ayuda de un intérprete.

Client Name_____
(Please Print your First Name, Middle Initial and Last Name)

By the signature below, I acknowledge that I have received the Notice of Privacy Practices provided by the Idaho Department of Health and Welfare.

Your signature _____ **Date** _____

IDAHO DEPARTMENT OF HEALTH & WELFARE

Idaho Department of Health & Welfare
Authorization for Disclosure

Please complete and return this form to a Department of Health and Welfare office.

Available in Spanish. We provide interpreter services at no cost. Call 2-1-1 or 1-800-926-2588 for interpretation assistance. Disponible en espanol. Proveemos servicios de intérprete sin costo alguno. Llame al 2-1-1 ó al 1-800-926-2588 para obtener la ayuda de un intérprete.

Client Information

Client Name_____ Date of Birth _____ Telephone_____
(First, MI, Last)

Mailing Address_____ State_____ Zip Code_____

Requestor Information
(To be completed if authorization is being made by someone other than the subject of the information. Please provide documentation of your authority).

Requestor Name (if different than client)_____ Telephone _____

Mailing Address_____ State_____ Zip Code_____

Authorization Details

I authorize the following individual, organization or business _____

_____

to disclose my confidential information to: Name_____

Address:_____ State_____ Zip Code_____

for the purpose of _____

*Please describe in detail the information to be disclosed*_____

_____

_____

_____

This authorization will expire in 6 months unless another date or event is specified here_____

_____

I understand that, at my request, a copy of the completed and signed authorization form will be made available to me. I understand that I may revoke this authorization in writing, at any time, except to the extent that action has been taken in reliance upon this authorization. I may submit my written statement of revocation to a Department of Health and Welfare office. I understand that the person or entity who receives my confidential information may not be required to prevent unauthorized use or disclosure.

I understand that this authorization, unless expressly limited by me in writing, will extend to all aspects of my treatment including testing and/or treatment for sexually transmitted diseases, AIDS, or HIV infection, alcohol and/or drug abuse and mental health conditions.

I understand that my signature on this form is not required for treatment, payment, enrollment, or eligibility for benefits, and that a copy of this authorization shall be as valid as the original.

Your signature_____ **Date** _____

Your signature must be notarized if you submit this request by fax, mail or e-mail and we cannot verify it with information already on file.

IDAHO DEPARTMENT OF
HEALTH & WELFARE

Dear Applicant:

Thank you for your interest in Medicaid adult developmental disability services. The following forms are included in this application packet:

- Eligibility Application for Adults with Developmental Disabilities
- How to Access Adult Developmental Disability Program Services
- Assessment Information
- Service and Support Choices for Adults With a Developmental Disability
- Notice of Privacy Practices and Acknowledgement of Receipt
- Complaint Process
- Language Assistance Services

Prior to completing the Eligibility Application, please review the documentation requirements associated with an adult developmental disability diagnosis. Information about the required diagnosis documentation can be found on the Eligibility Application.

Once you have completed the Eligibility Application and obtained the required disability diagnosis documentation, please forward these documents to your local Health and Welfare Regional Medicaid Adult Developmental Disability office. Contact information for each regional office is listed on the back of the Eligibility Application.

NOTE: It is important that you submit the disability diagnosis documentation requested above at the same time you submit the Eligibility Application for your application to be processed in a timely manner.

Upon receipt of your Eligibility Application, it will be forwarded on to the Independent Assessment Contractor (IAC). Once the IAC has received a complete application, they will schedule an appointment with you to complete the eligibility assessment process.

If you have any questions about the application process or the documents requested above, please contact the IAC at (208) 258-7980.

Sincerely,

Bureau of Developmental Disability Services (BDDS)
Regional Medicaid Services

Applying For and Receiving
Adult Developmental Disability (DD) Services

Step 1:
You may apply for Developmental Disability (DD) services by submitting an ***Eligibility Application for Adults with Developmental Disabilities*** to your local Bureau of Developmental Disability Services (BDDS) office. An application can be mailed to you, or you may print off a copy of the application from: https://healthandwelfare.idaho.gov/services-programs/medicaid-health/apply-adult-developmental-disabilities-programs. When an application is submitted, BDDS staff first verify your financial eligibility for Medicaid. If you do not currently have Enhanced Medicaid, you are still encouraged to apply as you may be eligible for Enhanced Medicaid if you meet level of care eligibility for the DD Waiver and financial criteria.

Step 2:
The IAC will review your documents to see if they have enough information to set up an assessment. If so, they will contact you, your guardian, or other representative to set up an appointment to meet with them for an interview. If not, they will send you a letter that lets you know what else is needed.

Step 3:
It is important that you are available for your scheduled interview. Make sure you ask your guardian, a friend, or another person that knows you very well to be present at the interview.

Step 4:
At the time of your interview:

- The IAC will interview you and the person you bring with you and ask about you and your needs.
- The IAC will complete the Scales of Independent Behavior—Revised (SIB-R) assessment tool with a person who knows you very well.
- The IAC may request signatures on Release of Information forms to gather more information about your disability.
- The IAC will conduct a needs inventory that will help the IAC to calculate your annual budget if you qualify for adult DD services.
- The IAC will have already provided you with an Adult DD Medical Care Form that you can take to your doctor to fill out and return.

After the interview, the IAC will review the information and determine if you're eligible for DD services. A notice will be sent to you about the results.

If you are determined eligible for State Plan only services, you can choose from:

- Service Coordination; and
- Developmental Disability Agency (DDA) services

If you are determined ICF/ID Level of Care eligible, you can choose from both State Plan services and DD Waiver services. DD Waiver services include:

- Residential Habilitation (Certified Family Home or Supported Living)
- Chore Services
- Respite
- Supported Employment
- Transportation

- Environmental Accessibility Adaptations
- Specialized Equipment and Supplies
- Personal Emergency Response System
- Home Delivered Meals
- Skilled Nursing
- Behavior Consultation or Crisis Management
- Adult Day Health

If you are determined ICF/ID Level of Care eligible, you can choose the Consumer Directed Services option to self-direct your services instead of the services listed above.

Step 5:
If you are determined eligible for DD and/or DD Waiver services, the eligibility notice will include the amount of your annual budget and a timeline for submission of a plan.

If you are determined not eligible for either one of these services, you can request an appeal hearing of this decision by submitting an appeal request to Medicaid Appeals. Information about submitting an appeal is included on the denial notice.

IMPORTANT: The assessment process must be completed EACH YEAR if you wish to continue to receive services.

Step 6:
You will need to choose a Plan Developer/Support Broker. The IAC can provide you with a list of Service Coordination Agencies if you need help finding a Plan Developer. If you decide to access State Plan and Traditional waiver services, you will use a Plan Developer to help you write your plan. Once you have selected a Plan Developer you will need to fill out the *Plan Developer Choice Form* and submit it to the IAC.

If you decide to self-direct your services through the Consumer Directed Services option, you will use a Support Broker to help you write your plan.

For a list of Plan Developers or Support Brokers, go to:
- Plan Developers: https://healthandwelfare.idaho.gov/services-programs/medicaid-health/traditional-support-services
- Support Brokers: https://healthandwelfare.idaho.gov/services-programs/medicaid-health/self-directed-services

Step 7:
Once you have chosen a Plan Developer/Support Broker, they will help you to identify family and/or other individuals who are important to you to be part of a person-centered planning team.

Step 8:
You and your person-centered planning team will work together to evaluate your needs and goals and help you to develop a plan. For individuals who choose to access State Plan and Traditional waiver services, this plan is called an Individual Support Plan (ISP). For individuals who choose to self-direct their services, this plan is called a Support and Spending Plan (SSP). Once the plan is written, it is submitted to the Bureau of Developmental Disability Services (BDDS) for review. A Care Manager in the BDDS office will be responsible for reviewing your plan.

Step 9:
The Care Manager will make sure your plan meets your assessed needs, allows for your health and safety and is within your budget. You and your Plan Developer/Support Broker will be notified by mail if you plan has been approved.

- If the plan does not meet your assessed needs, allow for your health and safety, and/or is over budget, the Care Manager will contact your Plan Developer/Support Broker to discuss the plan. If adjustments are made to your plan so it meets your needs and is within budget, the Care Manager will be able to authorize the services on the plan.
- However, if your Plan Developer/Support Broker and the Care Manager are not able to agree on the services needed to meet your needs and/or the plan cost continues to exceed your calculated budget, the Care Manager will do one of the following:
    1. Authorize some of the services on your plan; or
    2. Deny all of the services on your plan.

  The Care Manager will send a Notice to you, your Plan Developer/Support Broker and your guardian (if applicable) to let you know what services were approved and/or denied. If you don't agree with the Care Manager's decision to deny some or all of your services, you can request an appeal through Medicaid Appeals. Information about submitting an appeal is included on the notice.

Step 10:
If some or all services on your plan are approved, these services will be authorized in the Medicaid payment system. If you are accessing Traditional DD services, the providers listed on your plan will also be notified they can provide services and the date you can begin receiving those services. If you are self-directing your services, you will need to notify your community support workers when they can begin to provide services.

Step 11:
If your plan needs to be changed during the plan year, this can be done by your Plan Developer/Support Broker. For State plan or traditional waiver services, a Plan Developer will complete an addendum and provide any documents that support the requested changes. For self-directed services, a Support Broker will do a Plan Change Form. An update to a plan must be submitted in the following circumstances:

For a State Plan or Traditional waiver plan:
- A change in provider
- A change in the amount of time you will be receiving a service
- Adding or deleting a service

For a Self-Directed plan:
- Adding or deleting services in a support category
- Moving money from one support category to another

IDAHO DEPARTMENT OF HEALTH & WELFARE

Notice of Privacy Practices

Effective September 23, 2013

HW-0320
Revised 08/2013

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

- If you have any questions about this Notice, please contact the Idaho Department of Health and Welfare's Privacy Office at 208-334-6519 or by email at PrivacyOffice@dhw.idaho.gov.

- You may request a copy of this Notice at any time. Copies of this Notice are available at the Department of Health and Welfare offices. This Notice is also available on the Department of Health and Welfare's website at http://www.healthandwelfare.idaho.gov.

PURPOSE OF THIS NOTICE

This Notice of Privacy Practices describes how the Idaho Department of Health and Welfare (Department) handles confidential information, following state and federal requirements. All programs in the Department may share your confidential information with each other as needed to provide you benefits or services, and for normal business purposes. The Department may also share your confidential information with others outside of the Department as needed to provide you benefits or services.

We are dedicated to protecting your confidential information. We create records of the benefits or services you receive from the Department. We need these records to give you quality care and services. We also need these records to follow various local, state and federal laws.
We are required to:

- Use and disclose confidential information as required by law;
- Maintain the privacy of your information;
- Give you this Notice of our legal duties and privacy practices for your information; and
- Follow the terms of the Notice that is currently in effect.

This Notice of Privacy Practices does not affect your eligibility for benefits or services.

YOUR RIGHTS ABOUT YOUR CONFIDENTIAL INFORMATION

1. Right to Review and Copy

You have the right to ask to review and copy your information as allowed by law.

If you would like to ask to review and copy your information, a "Records Request" form is available at Department offices or its website. You must complete this form and return it to the Department. The Department will respond to your request according to the Idaho Public Records Act and the federal HIPAA Laws.

If you ask to receive a copy of the information, we may charge a fee.

You will be told if there is information we are legally prevented from disclosing to you.

2. Right to Amend

You have the right to ask us to make changes to your information if you feel that the information we have about you is wrong or not complete.

If you would like to ask the Department to change your information, a "Request to Amend Records" form is available at Department offices or its website. You must complete this form and return it to the Department. The Department will respond to your request within 10 days.

We may deny your request if you ask us to change information that:

- Was not created by the Department;
- Is not part of the information kept by or for the Department;
- Is not part of the information which you would be allowed to review and copy; or
- We determine is correct and complete.

3. Right to Restrict Health Information Disclosures

You have the right to ask us not to share your health information for your treatment or services, or normal business purposes. You must tell us what information you do not want us to share and who we should not share it with.

If you would like to ask the Department to not share your information, a "Request to Restrict Health Information Disclosures" form is available at Department offices or its website. You must complete this form and return it to the Department. The Department will respond to your request in writing.

If we agree to your request, we will comply unless the information is needed to give you emergency treatment, or until you end the restriction. In situations where you or someone on your behalf pays for an item or service, and you request that information concerning said item or service not be disclosed to a health insurer, we will agree to the requested restriction.

4. Right to an Alternate Means of Delivery

You have the right to ask that we communicate with you by alternative means or at alternative locations. For example, you can ask that we send your information from one program to a different mailing address from other programs that you receive services or benefits from.

If you would like to ask for an alternate means of delivery for your information, a "Request for Alternate Means of Delivery" form is available at Department offices or its website. You must complete this form and return it to the Department. The Department will respond to your request if it is denied for some reason.

We will not ask you the reason for your request. Reasonable requests will be approved.

5. Right to a Report of Health Information Disclosures

You have the right to ask for a report of the disclosures of your health information. This report of disclosures will not include when we have shared your health information for treatment, payment for your treatment or normal business purposes, or the times you authorized us to share your information.

If you would like to ask for a report of your health information disclosures, a "Request to Receive a Report of Health Information Disclosures" form is available at Department offices or its website. You must complete this form and return it to the Department. The Department will respond to your request according to the Idaho Public Records Act and the federal HIPAA Laws.

The first report you ask for and receive within a calendar year will be free of charge. For additional reports within the same calendar year, we may charge you for the costs of providing the report. We will tell you the cost and you may choose to remove or change your request at that time before any costs are charged to you.

HOW THE DEPARTMENT MAY USE AND SHARE YOUR INFORMATION

Times when your permission is not needed

- **For Treatment**. We may use and share your information to give you benefits, treatment or services. We may share your information with a nurse, medical professional or other personnel who are giving you treatment or services. The programs in the Department may also share your information in order to bring together the services that you may need. We also may share your information with people outside of the Department who are involved in your care or payment of care, such as family members, informal or legal representatives, or others that give you services as part of your care.

- **For Payment**. We may use and share your information so that the treatment and services you receive through the Department can be paid. For example, we may need to give your medical insurance company information about the treatment or services that you received so that your medical insurance can pay for the treatment or services.

- **For Business Operations**. We may use and share your information for business operational purposes. This is necessary for the daily operation of the Department and to make sure that all of our clients receive quality care. For example, we may use your information to review our provision of treatment and services and to evaluate the performance of our staff in providing services for you.

Times when your permission is needed

- **For reasons other than Treatment, Payment or Business Operations.** There may be times when the Department may need to use and share your information for reasons other than for treatment, payment and business operations as explained above. For example, if the Department is asked for information from your employer or school that is not part of treatment, payment or business operations, the Department will ask you for a written authorization permitting us to share that information. If you give us permission to use or share your information, you may stop that permission at any time, if it is in writing. If you stop your permission, we will no longer use or share that information. You must understand that we are unable to take back any information already shared with your permission.

- **Individuals that are part of your care or payment for your care.** We may give your information to a family member, legal representative, or someone you designate who is part of your care. We may also give your information to someone who helps pay for your care. If you are unable to say yes or no to such a release, we may share such information as needed if we determine that it is in your best interest based on our professional opinion. Also, we may share your information in a disaster so that your family or legal representative can be told about your condition, status and location.

Other uses and sharing of your information that may be made without your permission

- For Appointment Reminders
- For Treatment Alternatives
- As Required by Law
- For Public Health Risks
- To Law Enforcement
- For Lawsuits and Disputes
- To Coroners, Medical Examiners, Funeral Directors
- For Organ and Tissue Donation
- For Emergency Treatment
- To Prevent a Serious Threat to Health or Safety
- To Military and Veterans Organizations
- For Health Oversight Activities
- For National Security and Intelligence Activities
- To Correctional Institutions

SPECIAL REQUIREMENTS

Information that has been received from a federally funded substance abuse treatment program or through the infant and toddler program will not be released without specific authorization from the individual or legal representative.

Affected individuals will be notified following a breach of unsecured health information.

CHANGES TO THIS NOTICE

The Department has the right to change this Notice. A copy of this Notice is posted at our Department offices or at http://www.healthandwelfare.idaho.gov. The effective date of this Notice is shown at the top of each page. If the Department makes any changes to this Notice of Privacy Practices, the Department will follow the terms of the Notice that is currently in effect.

COMPLAINTS

If you believe your confidential information privacy rights have been violated, you may file a written complaint with the Idaho Department of Health and Welfare. All complaints turned in to the Department must be in writing on the "Privacy Complaint" form that is available at Department offices or its website. To file a complaint with the Department, submit your completed Privacy Complaint form to:

Idaho Department of Health and Welfare
Privacy Office
P.O. Box 83720
Boise, ID 83720-0036

If you believe your health information privacy rights have been violated, you may also file a complaint with the U. S. Department of Health and Human Services. Your complaint must be in writing and you must name the organization that is the subject of your complaint and describe what you believe was violated. Send your written complaint to:

Region 10
Office for Civil Rights
U. S. Department of Health and Human Services
2201 Sixth Avenue-Suite 900
Seattle, Washington 98121-1831

For all complaints filed by e-mail send to OCRComplaint@hhs.gov.

A complaint filed with either the Idaho Department of Health and Welfare or the Secretary of Health and Human Services must be filed within 180 days of when you believe the privacy violation occurred. This time limit for filing complaints may be waived for good cause.

You will not be punished or retaliated against for filing a complaint.

MEDICAID ADULT DEVELOPMENTAL DISABILITY (DD) SERVICES

DD OPTION – TRADITIONAL SERVICES
AVAILABLE TO EVERYONE WHO QUALIFIES

Plan Development/Targeted Service Coordination

Plan Development

- Assists the participant to decide who to invite, the location, and how to run their person-centered planning meeting
- Assesses participant needs and identifies services to meet those needs
- Completes and submits the participant's Individual Service Plan (ISP)

Targeted Service Coordination

- Monitors the plan, services, and assists with documentation throughout the plan year
- Meets with the participant to monitor progress
- Links the participant to services and supports as needed

Developmental Therapy

- Provided by a Developmental Disability Agency at a center and/or in the community
- Teaches independent living and social skills

Community Crisis Support

- Assists participants to maintain their health and safety during an emergency, such as loss of housing or employment, risk of incarceration, and other emergencies
- Crisis Support is linking and collaborating with other resources, not financial assistance

DD WAIVER OPTION - TRADITIONAL SERVICES
AVAILABLE (IN ADDITION TO SERVICES ABOVE) IF WAIVER ELIGIBLE

Residential Habilitation

Certified Family Home

- Participants who reside in a Certified Family Home receive supports in the home and in the community
- Participants learn independent living skills and receive supervision as necessary
- For more information, visit the Certified Family Home website on https://healthandwelfare.idaho.gov/

Supported Living Services

- Services are provided by a supported living agency in the participant's home and in the community
- Participants learn independent living skills and receive supervision as necessary
- Participants may live with or without roommates

Adult Day Health

- Supervised recreational activities to encourage social interaction

Skilled Nursing

- Professional nursing services or oversight that is within the scope of the Nurse Practice Act

- Develops a plan of care to monitor and address a participant's medical needs

Supported Employment

- Job coaches help a participant learn job skills and maintain competitive employment in community work settings

Non-Medical Transportation

- Transportation to activities and resources within the community

Home Delivered Meals

- Delivers nutritious meals to a participant's home when they are unable to prepare meals without assistance
- Must be home alone for significant parts of the day without a regular caregiver to assist

Respite Care

- Provides supports to participants to allow non-paid caregivers short term breaks or during times when non-paid caregivers are not available

Chore Services

- Contracted services provided to help participants maintain a clean and safe environment when they rent or own their own home
- Participants or others in the home must be unable to provide the services

Specialized Medical Equipment and Supplies

- Medically necessary equipment that is not covered under other insurance plans

Environmental Accessibility Adaptations

- Modifications to the participant's home to allow greater functional independence

Personal Emergency Response System (PERS)

- Portable unit that alerts emergency services
- Not available if a participant is receiving 24-hour services

Behavioral Consultation/Crisis Management

- Services designed to prevent psychological, behavioral and emotional crises
- Emergency backup to provide direct support for individuals in crisis
- Oversight provided by a psychologist

DD WAIVER OPTION – SELF DIRECTED SERVICES
AVAILABLE AS A CHOICE INSTEAD OF TRADITIONAL SERVICES

This option gives you more choice and control over the Medicaid funds used to buy your services and supports. You choose the services and supports that fit your needs.

If you choose self-direction, you will:

- Become the employer and hire, train and manage your workers directly
- Hire a support broker to help you create your plan and monitor your spending
- Hire a Fiscal Employer Agent to help manage your payroll and fiscal responsibilities
- Schedule the type, time, and location you will receive supports
- Be responsible for your choices in the program

Participant Complaint Process

What is a complaint?

A complaint is the process of telling someone when another person's actions or words make you feel unhappy, upset, or in pain.

If you believe you have a complaint, first:

- Discuss the issue with your staff, provider, and/or agency management according to their grievance process. A copy of this process may have been given to you when you started services.

If you feel your complaint is not resolved, follow these guidelines:

- Write down what has happened, when it has happened, and who was involved. If you need help, ask someone to write down this information for you. Some details you could include are:
    - Nature of the complaint or concern
    - Provider/agency name
    - Names of anyone who may have been a witness
    - Is this happening to anyone else?
- Tell your guardian (if applicable), trusted family member, Service Coordinator or Support Broker about your complaint. They can help you decide who to call for more information or to file a complaint.
- If your Service Coordinator or Support Broker is the person you have a concern or complaint about, you can call the Bureau of Developmental Disability Services (BDDS) office yourself and/or have someone you trust help you file the complaint.

Bureau of Developmental Disability Services (BDDS)	
Region 1 (Coeur d'Alene)	(208) 769-1567 Select Regional Medicaid
Region 2 (Lewiston)	(208) 799-4430 or (877) 799-4430 Select Adult Developmental Disabilities Program
Region 3 (Nampa/Caldwell)	(208) 334-0940
Region 4 (Boise, Meridian, Mountain Home, McCall)	(208) 334-0940
Region 5 (Twin Falls)	(208) 736-3024 or (800) 826-1206
Region 6 (Pocatello)	(208) 239-6260
Region 7 (Idaho Falls)	(208) 528-5750

What will happen with my complaint?

- When you contact BDDS staff to file a complaint, they will need to ask you some questions about the situation. They will then investigate the complaint according to their rules, and/or they will forward the information on to another department or agency if it's important for them to be involved in the investigation.

There are certain types of complaints that are very serious and need to be reported immediately:

- Abuse: Someone is causing you physical pain/injury or mental injury on purpose.
- Neglect: Someone who is supposed to be helping you does not give you the food, clothing, shelter, or medical care you need to stay alive and be healthy or does not allow you to do the things you normally do to take care of yourself.

- Exploitation: Someone is using your money, belongings, or resources for themselves rather than how you want/need it to be used.

If your concern or complaint is about abuse, neglect, or exploitation, it is very important that you report what is going on as soon as possible. You can call directly to Adult Protection Services and let them know what is happening.

Adult Protection Services	
Area 1 (Coeur d'Alene area)	(208) 667-3179 or 1-800-786-5536
Area 2 (Lewiston area)	(208) 743-5580 or 1-800-877-3206
Area 3 (Boise/Caldwell/Nampa/Mountain Home/McCall areas)	(208) 898-7060 or 1-844-850-2883
Area 4 (Twin Falls area)	(208) 736-2122 or 1-800-574-8656
Area 5 (Pocatello area)	(208) 233-4032 or 1-800-526-8129
Area 6 (Idaho Falls area)	(208) 522-5391 or 1-800-632-4813

If you are in immediate danger, have a serious injury, or are experiencing some other emergency, call local law enforcement/emergency medical services at 9-1-1.

Language Assistance Services, Free of Charge, are Available to You

Español (Spanish)	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-926-2588 (TTY: 1-208-332-7205).
繁體中文 (Chinese)	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-926-2588（TTY：1-208-332-7205）。
Srpsko-hrvatski (Serbo-Croatian)	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-926-2588 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-208-332-7205).
한국어 (Korean)	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-926-2588 (TTY: 1-208-332-7205)번으로 전화해 주십시오.
नेपाली (Nepali)	ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-926-2588 (टिटिवाइ: 1-208-332-7205) ।
Tiếng Việt (Vietnamese)	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-926-2588 (TTY: 1-208-332-7205).
العربية (Arabic)	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-926-2588 (رقم هاتف الصم والبكم: 1-208-332-7205).
Deutsch (German)	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-926-2588 (TTY: 1-208-332-7205).
Tagalog (Tagalog/Filipino)	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-926-2588 (TTY: 1-208-332-7205).
Русский (Russian)	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-926-2588 (телетайп: 1-208-332-7205).
Français (French)	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-926-2588 (TTY: 1-208-332-7205).
日本語 (Japanese)	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-926-2588（TTY:1-208-332-7205）まで、お電話にてご連絡ください。
Română (Romanian)	ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-926-2588 (TTY: 1-208-332-7205).
Ikirundi (Bantu-Kirundi)	ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-926-2588 (TTY: 1-208-332-7205).
فارسی (Farsi)	توجه :اگر بهزبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما .بگیرید تماس با .باشد می ف 1-800-926-2588 (TTY: 1-208-332-7205)
English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. 1-800-926-2588 (TTY: 1-208-332-7205).

Source: U.S. Department of Health and Human Services, Office for Civil Rights, August 2016