

How to Apply for the Aged and Disabled Wavier (ADW) Program

1. What is the ADW Program?

This is an in-home care program that allows staff to come into your home to assist you with your personal needs. This program is for individuals who need the same type of care provided in a nursing home but want to stay in their own home.

2. How do I begin the process to apply for this program?

You must first apply to see if you are financially eligible for this program. You can get an application called the Medical Necessity Evaluation Request (MNER) from one of the following resources and have your physician complete it:

- a. Aging and Disability Resource Network
Toll Free: 1-866-981-2372
Website: www.wnnavigate.org
- b. Bureau of Senior Services
Toll Free: 1-866-767-1575
Website: www.wvseniorservices.gov
- c. Bureau for Medical Services
Telephone: 304-558-1700
Website: www.dhhr.wv.gov/bms/hcbs/ADW/Pages/ADW.aspx

3. What happens after my physician completes the form?

The physician will send the form to KEPRO. KEPRO will send you a letter informing you of the receipt of the MNER and enclosed will be a yellow financial eligibility form along with a Case Management Agency Selection form. If you need or want assistance completing the financial form, you may select a Case Management agency to assist you in the process. Return the completed Case Management agency selection form to KEPRO. Once received, they will notify the agency you selected. The Case Manager should contact you within five days. If not, contact the Bureau of Senior Services at 304-558-3317. If you want to complete the financial eligibility process on your own, you will submit the form and a copy of the letter from KEPRO to your county DHHR office so they may determine financial eligibility based on ADW criteria. If you are deemed financially eligible by the DHHR, they will forward the form onto KEPRO. Once KEPRO receives the financial form with an eligibility designation, KEPRO will contact you to schedule an appointment for the KEPRO RN to come to your house and complete a Pre-Admission Screening (PAS) to determine medical eligibility. You must have substantial needs in at least 5 areas of activities of daily living in order to be medically eligible. Below are some of these activities:

- a. Eating
- b. Bathing
- c. Dressing
- d. Grooming
- e. Mobility

f. Toileting

4. What services are available through this program?

You may receive services through a Traditional ADW provider who will send a staff person to your home. You may also self-direct the Personal Attendant Services (Personal Options) which means your employees work directly for you. Services available include:

- a. Personal Attendant Services – an employee trained to assist you with bathing, dressing, grooming, eating, fixing your meals or other personal care needs.
- b. Case Management Services – a licensed professional who helps you identify your needs and plan for your care as well as advocates for and connects you with services or resources in your community.
- c. Aged and Disable Waiver Non-medical Transportation to and from services on your individual service plan.
- d. Nursing Assessment and Supervision – an RN assesses your needs and writes the plan the Personal Attendant follows when delivering your care.

5. Once you are found to be financially and medically eligible, a funded slot must be available to begin receiving services. You may be placed on a Managed Enrollment List which is a wait list if a funded slot is not available.

**AGED AND DISABLED WAIVER PROGRAM
MEDICAL NECESSITY EVALUATION REQUEST**

ALL INFORMATION MUST BE LEGIBLE, OR THE REQUEST CANNOT BE PROCESSED

Type of Request: Initial. Submit to: KEPRO-ADW | 1007 Bullitt Street, Suite 200, Charleston, WV 25301, FAX: 866-212-5053

Reevaluation. Send completed form to Case Manager:

FAX:

APPLICANT/PARTICIPANT INFORMATION		
Name:	Date of Birth:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
SSN #:	Medicaid #:	Medicare #:
Physical Address:		
Mailing Address:		
Phone #:	County of Residence:	
Signature of Applicant/Participant	X	Date:
CONTACT INFORMATION (REQUIRED IF APPLICANT/PARTICIPANT HAS ALZHEIMER'S, DEMENTIA OR RELATED DIAGNOSES) - ALL APPLICANTS ARE ENCOURAGED TO LIST A CONTACT PERSON		
Name:	Phone #:	
Mailing Address:		
Relationship to Applicant/Participant: (Choose <u>ONLY ONE</u> type of relationship)	<input type="checkbox"/> Guardian <input type="checkbox"/> Committee <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Medical Power of Attorney <input type="checkbox"/> Durable Power of Attorney <input type="checkbox"/> Contact Person	
Signature of Legal Representative (not needed if contact person)	X	Date:
CASE MANAGEMENT AGENCY OR FISCAL EMPLOYER AGENT INFORMATION (Reevaluation Only)		
Agency Name:	Phone #:	Fax #:
Case Manager/Resource Consultant:		
Mailing Address:		
REFERRING PHYSICIAN'S INFORMATION (This information may be shared with the applicant/participant).		
Name: (MD, DO, PA, Nurse Practitioner)	Phone #:	Fax #:
Mailing Address:		
Patient Diagnoses and other Pertinent Medical Conditions:	ICD-10 codes:	
Is the patient terminal? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does the patient have Alzheimer's, brain multi-infarct, senile dementia or a related condition?		
<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please specify:		
Signature of Physician (MD, DO, PA or Nurse Practitioner; original required)	X	Date (valid for 60 days):

How to Apply for the Personal Care (PC) Services Program

1. What is the PC Program?

This is an in-home care program that allows Direct Care Staff to come into your home to assist you with your personal needs. Individuals eligible to receive this service must have a WV Medicaid card. To be eligible, an individual must have needs in at least three areas of activities of daily living.

2. How do I begin the process to apply for this program?

To start the process, you must get an application called a Personal Care- Medical Necessity Evaluation Request (PC-MNER) from the Bureau of Senior Services (BoSS) website at www.wvseniorservices.gov or on this Bureau for Medical Services website. You may also request the PC-MNER form be sent to you by calling BoSS at 304-558-3317. Have your treating physician (MD or DO), physician's assistant, or nurse practitioner complete, sign and submit it to the following:

KEPRO-PC

100 Capitol Street, Suite 600

Charleston, WV 25301

Toll Free: 1-866-385-8920

Fax: 1-844-794-6729

3. What happens after my PC-MNER form is completed?

You or your treating physician (MD or DO), physician's assistant, or nurse practitioner must mail or fax the PC-MNER form to KEPRO. A KEPRO RN will contact you to schedule a medical eligibility assessment in your home.

4. What services are available through the PC program?

You may receive assistance with activities of daily living from a Direct Care Worker. Activities of daily living include bathing, dressing, grooming, mobility, toileting and feeding.

If you require assistance with some of the activities of daily living mentioned above and are eligible for services, then a Direct Care Worker can also assist you with light housekeeping, laundry and meal preparation. If you only need assistance with these type activities and not activities of daily living you cannot receive Personal Care Services.

You may obtain further information from:

Bureau for Medical Services

Telephone: 304-558-1700

You can get a PC- MNER on this website as well.

Or

Bureau for Senior Services (BoSS)

Telephone: 304-558-3317

Website: <http://www.wvseniorservices.gov/HelpatHome/MedicaidPersonalCare/tabid/78/Default.aspx>



WV PERSONAL CARE PROGRAM MEDICAL NECESSITY EVALUATION REQUEST (PC-MNER)

ALL INFORMATION MUST BE LEGIBLE, OR THE REQUEST CANNOT BE PROCESSED

Type of Request (please check one): Initial Reevaluation Emergency/Facility Discharge
Submit Initial and Emergency PCMNERs to KEPRO-PC | 1007 Bullitt Street, Suite 200 | Charleston, WV 25301 | FAX-844-794-6729
Physicians, submit Reevaluation PC-MNERS to the Personal Care Agency at Fax: _____

APPLICANT/MEMBER INFORMATION			
First Name:	Middle Name:	Last Name:	Suffix:
Date of Birth:	Gender: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	Is the person in a Specialized Family Care Home? <input type="checkbox"/> YES <input type="checkbox"/> NO	
SSN:	Medicaid #:	Medicare #	Dual Services? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, select Type of Waiver: <input type="checkbox"/> IDDW <input type="checkbox"/> TBIW <input type="checkbox"/> ADW
Member's Physical Address (Indicate Facility's name and contact info if the request is for Emergency/Facility Discharge):			
Member's Mailing Address:			
County of Residence (or Facility's County)		Member's Phone # (or Facility's Phone #):	
Signature of Applicant/Member	X		Date:
<input type="checkbox"/> Check if Applicant/Member is his/her own Legal Representative			
LEGAL REPRESENTATIVE, GUARDIAN, OR CONTACT INFORMATION (REQUIRED IF APPLICANT/MEMBER HAS ALZHEIMER'S, DEMENTIA OR RELATED DIAGNOSES OR IS UNDER THE AGE OF 18-- ALL ARE ENCOURAGED TO LIST A CONTACT PERSON TO ASSIST			
Name:		Phone #:	
Mailing Address:			
Relationship to Applicant/Member	<input type="checkbox"/> Guardian <input type="checkbox"/> Committee <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Medical Power of Attorney <input type="checkbox"/> Durable Power of Attorney <input type="checkbox"/> Contact/Other (describe): _____		
Signature of Legal Representative (not needed if contact person)	X		Date:
REFERRING PHYSICIAN'S INFORMATION (This information may be shared with the applicant/member).			
Name (MD, DO, PA, Nurse Practitioner)		Phone #	Fax #
Mailing Address (include city, state, zip):			
Patient Diagnoses			
Other Pertinent Medical Conditions:			
Does the individual have Alzheimer's, brain multi-infarct, senile dementia or a related condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," please specify	
Is the patient terminal?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Signature of Physician (MD, DO PA or Nurse Practitioner; original required)	X		Date (valid for 60 days):