TITLE 467 MEDICALLY HANDICAPPED CHILDREN'S PROGRAM

CHAPTER 6 REFERRAL, APPLICATION, ELIGIBILITY, AND SERVICES FOR THE DISABLED CHILDREN'S PROGRAM

001. INTRODUCTION. The Disabled Children's Program serves eligible children with special health care needs and their families by providing medical support services. Family needs are assessed to determine the support services that may be covered based on available funding.

002. REFERRALS. Any individual or agency may refer children who are determined to be eligible for Supplemental Security Income benefits.

003. APPLICATIONS. Upon receiving a referral, the Department verifies Supplemental Security Income current pay status prior to applications being mailed to potential applicants. The Department must receive the completed application within 30 days after the Department mails the application. A legally responsible adult age 19 or older must complete the application. A referral is not a requirement for completing an application.

003.01 WITHDRAWAL. The applicant may voluntarily withdraw an application.

003.02 ELIGIBILITY REQUIREMENTS. The following are the eligibility requirements:

003.02(A) RESIDENT OF NEBRASKA. Applicants and recipients must reside in Nebraska.

003.02(B) CITIZENSHIP OR ALIEN STATUS. Applicants and recipients must be United States citizens or qualified aliens as required by Nebraska Revised Statute §§4-108 to 4-112. Applicants and recipients must sign an attestation form verifying lawful presence in the United States. The Department must be able to verify the status of applicants and recipients.

003.02(C) AGE REQUIREMENT. Applicants and recipients must be age 15 years or younger.

003.02(D) SUPPLEMENTAL SECURITY INCOME. Applicants and recipients must be in current pay status with Supplemental Security Income benefits.

003.02(E) NEED FOR SERVICES. Applicants and recipients must have an identified disability-related need for services.

003.03 CERTIFICATION DATE. The certification date is the date the completed application is received by the Department.

003.04 ELIGIBILITY REVIEWS. Eligibility reviews are completed annually.

004. NOTICES FROM DEPARTMENT. A notice is sent to applicants and recipients in the following instances:

(A) An applicant is determined eligible or ineligible for the program;
(B) A recipient is determined eligible or ineligible at time of redetermination; or
(C) Services are reduced or terminated.

005. NOTICES NOT REQUIRED BY DEPARTMENT. A notice is not sent to applicants or recipients in the following instances:

(A) Services are no longer needed and applicant or recipient requests the closure;
(B) Applicant or recipient has died;
(C) Applicant or recipient becomes institutionalized;
(D) Applicant or recipient whereabouts are unknown; or
(E) Failure to act upon request for redetermination.

006. NEEDS ASSESSMENT. Once the applicant or recipient is determined eligible, a needs assessment is completed to identify the disability-related needs of the family.

007. INDIVIDUAL SERVICE PLAN. An individual service plan is developed for each recipient based upon their needs assessment, service components of the program, and available funds. The plan details the services available to the recipient which are prior approved by the Department.

007.01 LOCATION OF SERVICES. Recipients are encouraged to use medical providers and facilities closest to their place of residence. If a medical provider or facility is available closer to the residence and the recipient chooses one further away, the Department is not obligated to pay for supportive services for that care or treatment.

007.02 SERVICE COMPONENTS. Service components may be covered based on identified needs and available funds.

007.02(A) MEDICAL MILEAGE. Medical mileage reimbursement is a covered service for families who transport recipients to disability-related medical care or treatment. Mileage for routine, general health care is not a covered service. The reimbursement rate for medical mileage follows the annual Internal Revenue Service standard mileage rate per mile driven for medical purposes.

007.02(B) LODGING. Lodging is a covered service for families who travel long distances for disability-related care or treatment for the recipient. If lodging is available through another program at no cost or minimal cost, this service may not be available. The reimbursement rate for lodging follows the annual United States General Services Administration Per Diem Rates based on the location of the lodging. Additional lodging for leisure is optional and not covered.

007.02(C) RESPITE CARE. Respite care is a covered service to provide caregivers a short break from taking care of the recipient with special health care needs. The Department determines the maximum dollar amount of respite care for each recipient based on the needs of the family and available funds, not to exceed $125 per month, which is then included in the individual service plan. Respite care may not be used as child care when a caregiver is working or going to school.

007.02(C)(i) RESPITE PROVIDERS. Parents and legal guardians of recipients are responsible for locating respite providers to care for the recipients. The following are required of all respite providers:

(1) The provider must undergo a child and an adult registry check at least once every twelve (12) months to be enrolled as a provider. The Department may require additional registry checks when the circumstances warrant further investigation. The Department may in its discretion accept a child and an adult registry check completed by another Department program within the previous twelve (12) months. Funds cannot be used to pay providers identified on the Department's child or adult registries as a substantiated perpetrator of abuse or neglect.
(2) The provider must be age 19 years or older.
(3) The provider must not reside in the household with the recipient.
(4) Non-relative providers are encouraged. The Department has the discretion to deny payment for relative providers so long as providers are available in the recipient's residing area.

007.02(D) SPECIAL EQUIPMENT AND ACCESSIBILITY MODIFICATIONS. Special equipment and accessibility modifications are covered services based on the needs of each recipient, available funds, and individual service plans. The maximum dollar amount is $3,600 per recipient's family per 12-month period. Medical necessity must be documented by a health care professional.

008. FRAUDULANT ACTIONS. The Department has the authority to terminate any relationship with a provider who has committed fraud in another government program. The Department has the authority to terminate provider relationships and deny payments to any provider that engages in fraudulent billing.

009. PAYMENTS. Payments are made to the parent or legal guardian of the recipient in specific situations and in other situations payments are made directly to the providers.

009.01 PAYMENTS TO THE PROVIDER. Payments are made directly to the provider for respite care services, special equipment, and accessibility modifications. Billing documents must be completed accurately and received by the Department timely, within 60 days from the date of service, in order to be considered for payment. Billings received by the Department after the 60 days from the date of service will be denied payment. One billing document must be completed for each month for each type of service authorized. Special equipment and accessibility modifications are paid once the purchase or project is complete to satisfaction of the family. Inaccurate or incomplete billing claims may be denied.

009.02 PAYMENTS TO THE RECIPIENT'S PARENT OR LEGAL GUARDIAN. Payments are made as reimbursement to the parent or legal guardian of the recipient for medical mileage and lodging services. Billing documents must be completed accurately and received by the Department timely, within 60 days from the date of service, in order to be considered for payment. Billings received by the Department after the 60 days from the date of service will be denied payment. One billing document must be completed for each month for each type of service authorized. Inaccurate or incomplete billing claims may be denied.