

**Illinois Department of Human Services
Division of Developmental Disabilities**

**Instructions on Completing the
“Intermittent and Family CILA Support Individual Rate Worksheet”**

(For worksheet revised 7/1/2001)

The Intermittent and Family CILA Support Individual Rate Worksheet must be completed by a licensed CILA agency in cooperation with a PAS/ISSA agency and should represent the conditions applicable to a specific individual for whom CILA Intermittent or “Family” Support funding is being requested. The information provided must be accurate and true to the best of the community provider and PAS/ISSA agencies’ knowledge. Community agencies should report any changes the original information provided to the Department of Human Services, Office of Developmental Disabilities used to set individual CILA rates. Community provider agencies should report such changes to the Department at the time the change occurs.

An “Intermittent and Family CILA Support Individual Rate Worksheet” must be completed by the community provider agency, submitted to the appropriate PAS/ISSA Agency, signed-off on by the Network Facilitator, submitted to the CILA Rates Unit for processing, and an Award Memo must be received, in writing, signed by the Associate Director of the Office of Developmental Disabilities prior to delivery of any services for which reimbursement will be sought from the Department of Human Services. Services delivered before the “Earliest Effective Date” referenced in the CILA Award Memo issued by the Associate Director will not be reimbursed by the Department unless a “Pre-Award Memo” has been issued. A Pre-Award Memo allows retroactive reimbursement up to a maximum of 30 days from the date of the actual CILA Award Memo issued by the Department.

If you have questions while completing the “Intermittent and Family CILA Support Individual Rate Worksheet,” please contact the CILA Rates Unit in the Bureau of Community Reimbursement, or your Network Facilitator. All information on the Worksheet is required and must be completed accurately. If any questions are left blank, the development and implementation of an Intermittent or Family CILA rate will be delayed until missing information can be obtained or explained. The Award Memo signed by the Associate Director of the Office of Developmental Disabilities cannot be issued until the rate is established or a Pre-Award Memo has been issued.

INDIVIDUAL, PROVIDER, AND PAS/ISSA INFORMATION

- 1. Name of the person for whom the rate is being determined** - Enter the last and first name and middle initial (if applicable) of the person for whom the rate packet is being submitted. The name entered on the “Intermittent and Family CILA Support Individual Rate Worksheet” should match exactly with the name as it appears in the Social Security System and in other service or benefit data bases. Differences in spelling or using a nickname on the CILA Support Worksheet and a proper name in other service or benefit systems may delay effective dates or cause related problems.
- 2. Address where the person is/will be living** - Enter the home address, apartment number, etc., of the residence where the person named in Question #1 is/will be living and the services will be delivered. Community agencies must report any client address changes immediately to the CILA Rates Unit or their Network Facilitator.
- 3. Date of Birth** - Enter the numeric date of birth of the person named in Question #1. Dates of birth are useful factors for determining age appropriate services and can be used to differentiate individuals with similar or identical names if the Social Security Numbers or Medicaid Numbers are not available.
- 4. Social Security Number** - Enter the nine digit Social Security Number (SSN) of the person named in Question #1. *NOTE: It is important that the SSN be reported exactly as it appears on the SS card and will be entered into the payment and service systems.* This is one of the most frequent and difficult errors to detect that cause rate change and payment problems. If the Social Security Number has been applied for but not received, or for some other reason is not available, *provide an explanation on a separate attached page. Do not enter “999-99-9999.”* A copy of the individual’s Social Security Card must be included in the CILA rate packet.
- 5. Enter the Medicaid Recipient Identification Number** - Enter the nine digit Medicaid Recipient Identification Number of the person named in Question #1. If the Medicaid Recipient ID Number is not known, provide a brief explanation on a separate attached page. *Do not enter “999-99-999.”*
- 6. CILA Provider Agency Name** - Enter the name of the community agency that will provide the Intermittent or Family CILA supports. If the name of your agency has recently changed, please indicate the old and new name, either on the CILA Rate Worksheet or on a separate page so the change can be made in the DHS agency database and payment system.
- 7. CILA Provider Agency DHS two-digit prefix and four-digit ID No.** - Enter the two-digit prefix and four-digit DHS provider ID number, e.g., 02-0104 or 5A-1912. Although, most new DHS contract, service, and payment systems now use the “FEIN/TIN” as the agency identifier, some former DMHDD systems require the two-digit prefix and four-digit ID numbers.
- 8. CILA Provider Agency FEIN/TIN** - Enter the nine digit “Federal Employer or Taxpayer Identification Number” in the spaces provided. If you don’t know your agency’s FEIN/TIN, please contact the Residential Voucher Section, Office of Clinical, Administrative, and Program Support (OCAPS) at 217/557-9271.

- 9. DHS Network Responsible for Placement** - Check the appropriate DHS network responsible for the CILA agency completing the CILA Rate Worksheet. For example, a community agency's main business office (mailing address) is located in the "North Suburbs" network, but a CILA home is being provided in the "South Suburbs" network, the responsible DHS Network is the "North Suburbs." In this case, the South Suburbs Network should be checked in Question #9. If you do not know your network, you may call the DHS Metro-Chicago Office of Developmental Disabilities at (312) 814-2728 or the Greater Illinois office at (217) 524-2515.
- 10. PAS/ISSA Agency Name** - Enter the name of the community PAS/ISSA agency which will be providing case coordination services. If the name of PAS/ISSA agency has recently changed, please indicate the old and new name, either on the CILA Rate Worksheet or on a separate page so the change can be made in the CILA agency database and payment system.
- 11. PAS/ISSA Agency DHS two-digit prefix and four-digit ID No.** - Enter the two-digit prefix and four-digit DHS Agency identification number of the PAS/ISSA agency, e.g., 02-0104 or 5A-1912.
- 12. PAS/ISSA Agency FEIN/TIN** - Enter the nine-digit "Federal Employer or Taxpayer Identification Number" in the spaces provided. If you don't know the PAS/ISSA agency's FEIN/TIN, please contact the Residential Voucher Section, Office of Clinical, Administrative, and Program Support at 217/557-9271.
- 13. PAS/ISSA Agency DHS Network** - Check the appropriate DHS network in which the central/business office (mailing address) of the PAS/ISSA agency is located. If you do not know your PAS agent's network, you may call the DHS Chicago-Metro Office of Developmental Disabilities at (312) 814-2728 or the Greater Illinois office at (217) 524-2515.

RATE TYPE / RESIDENTIAL LOCATION INFORMATION

- 14. Rate Type** - For the person named in Question #1, indicate what is the most appropriate "rate type," e.g., is the person a Bogard class member? A SODC Discharge? Is the person currently residing in CILA and having their rate redetermined? If you are unsure of the appropriate response, please contact your Network Facilitator.
- 15. Residence Location Prior to CILA Placement** - For the person named in Question #1, indicate their residence location prior to their move to CILA. *NOTE: For persons currently receiving short-term supports such as emergency respite, please indicate the prior residence type.*

INDIVIDUAL INFORMATION

- 16. Is the request for “new,” “existing,” or “transferred” CILA capacity?** - Mark “New CILA Capacity” if the person named in Question #1 will be moving into a CILA slot that increases your agency’s capacity. Mark “Existing Capacity” if the person will be filling a funded, but vacant, CILA slot. Mark “Capacity Transferred From Another Community Agency” if the person moving to the CILA is bringing a funded capacity with them from an another agency that currently provides the person’s CILA supports.
- 17. What is the total residential capacity of the home in which the person will be living?** - Enter the number of persons that are anticipated to be living in the CILA home at full capacity. The Department uses the residential capacity of the home rather than the current number of persons living in the home to calculate the individual CILA rate.
- For rate setting, the Department follows the language contained in Rule 115 pertaining to geographic proximity, i.e., if two CILAs are located within 800 feet of each other as measured by the closest driving distance are considered one CILA residence. This holds true for CILA residences located in apartment buildings, duplexes, etc. Distance waivers are sometimes provided by the Department’s Office of Accreditation, Certification, and Licensure for two CILA homes to be located within closer proximity; however, for rate setting purposes the language in Rule 115 is used to establish “residential capacity” regardless of distance waivers granted.
- 18. List the names of all other residents at, or moving to, this location** - In the spaces provided, please list the names of the other persons who either are, or will be, living at the CILA home indicated in Question #2. For each person listed, indicated whether the person is currently living at the home or if the move is yet to be, or has already been, proposed to the Department. Also indicate for each person whether they are currently receiving supports funded by the Department and, if so, under which program name(s).
- 19. In what county is/will the person be living?** Enter the name of the county in which the CILA supports will be provided. Do not enter the county location of the home office of the CILA provider agency.
- 20. What is the person’s two-digit ICAP Score?** Enter the two-digit ICAP Summary Score of the person for whom the rate packet is being submitted. A copy of the three-page ICAP Summary must be attached.
- 21. What is the Date of Evaluation of this ICAP Summary Score?** Enter the date on which the ICAP for the individual was conducted. ICAP scores submitted must be less than one year old and are required to be updated annually.

- 22. Which of the following best describes how supports will be provided?** Indicate whether the CILA Rate Worksheet is being completed for a persons who will be receiving “Intermittent” CILA supports or a CILA supports while residing in a “Family” setting.

Intermittent” CILA - Those settings where the individual lives independently of their family or guardian and will receive less than 24-Hour supports.

“Family” CILA - Those settings where the individual lives with their family or guardian and will receive less than 24-Hour supports.

- 1. Is the person ambulatory (able to walk independently or with assistive devices)?** If the person uses a wheelchair or is unable to walk with assistance devices, mark “No.” If the person is able to walk, does not use a wheelchair, or is able to walk with the use of assistive devices, mark “Yes.” The answer to this Question should be consistent with the information concerning ambulation entered on the individual’s ICAP.

BASE SUPPORT REQUEST

Please indicate the number of hours of staffing support, by type will be provided to the individual named in Question #1. For each staff type requested, indicate (circle) whether the request refers to the supports that will be provided per week, month, or annually.

The number of hours being requested should be supported by the Individual Service Plan (ISP). “Intermittent” and “Family” CILA supports will be approved only if they are substantiated by assessments and/or evaluations by qualified, licensed professionals and are supported through the Goals and Objectives in the person’s ISP as determined by the Interdisciplinary Team (IDT).

All CILA supports are reviewed regularly. The initial rate calculated will remain in effect until the Review Due Date shown on the Individual Rate Worksheet or until the community agency notifies the Department of any new information effecting the individual CILA rate, whichever occurs first.

Community agencies do not need to specify the hourly rate for each staff type. The Intermittent and Family CILA Rate Model uses fixed hourly, Statewide wage rates used in all CILA Individual Rate calculations. For “Other (specify)” staff requests, an hourly rate should be identified if the staff type does not fall into one of the specified staffing categories.

Direct Support, Supervisory, and Coordinating Staff Classifications - If you have questions concerning the training requirements associated with any of the job classifications below, please contact the Bureau of Human Resources Development at 217/782-9438.

Direct Support Personnel - Enter the number of hours of Direct Support Personnel supports, if any, to be provided to the individual. “Direct Support Personnel” are persons who have completed the training requirements associated with the job classification, (i.e., 40 hours of classroom and 80 hours on-the-job). Identify (circle) the time frame for which the number of

hours is being requested.

Supervisor - Enter the number of hours of Supervisory staff supports, if any, to be provided to the individual. Supervisory staff is the agency staff who provides management oversight of the day-to-day operation of Direct Support Personnel and other agency staff. Identify (circle) the time frame for which the number of hours is being requested.

Qualified Mental Rehabilitation Professional (QMRP) - Enter the number of hours of QMRP staff supports, if any, to be provided to the individual. A QMRP is the person qualified as a QMRP and provides programmatic oversight, service planning, and quality assurance activities. Identify (circle) the time frame for which the number of hours is being requested.

Other Staffing - Enter the number of hours of “Other Staffing” supports, if any, to be provided to the individual. “Other Staff” is agency staff not meeting the definition of Direct Support Personnel, In-Home Respite Worker, Supervisor, QMRP, or any of the identified NonBase Support staffing classification. Enter staffing hours to be provided directly to the individual only. Do not enter staffing hours for administrative or other non-direct support services. Enter a requested hourly rate for “Other Staffing” and identify (circle) the time frame for which the number of hours is being requested.

TRANSPORTATION REQUEST

Number of Staff-Related Miles - Enter the number of staff-related miles and indicate the time frame for which the mileage refers. *NOTE: Mileage requested should relate only to staff travel to-and-from the individual's home.* Do not include mileage for other services or to and from day programs. The per mile reimbursement used in the Intermittent and Family CILA Rate Model is consistent with the rate used in the CILA Individual Rate Model for 24-Hour supports.

Other Transportation, Not Elsewhere Classified (NEC) - Enter a description and the requested rate or reimbursement amount for “Other Transportation” not included in the staff-related mileage reimbursement in Question #25. “Other Transportation” requested will be reviewed by the Network Facilitator and CILA Unit staff and, therefore, must include an explanation sufficient to make a recommendation for approval or denial. Indicate (circle) the time frame of the request.

DAY PROGRAM AUTHORIZATION

Effective November 1, 2000, the Department of Human Services (DHS) “unbundled” individual CILA rates, i.e., the reimbursement for residential services, day program services, and individual therapy services, were separated in the individual rate and paid directly to the community providers of those component services. The CILA Individual Rate Sheet will show an hourly rate and a maximum number of hours for each day program type that an individual is “authorized” to bill the Department for service reimbursement.

In the “Day Program” section of the CILA Individual Rate Model Worksheet, please mark the day program type that best describes the conditions under which day program supports will be provided.

Developmental Training - Programs must be certified by the DHS Bureau of Accreditation, Licensure and Certification according to the requirements of Rule 119 (DT). Developmental Training programs must also be in compliance with the Department’s requirements for national accreditation. Developmental Training services prepare adults 18 years of age and older to live and function in an integrated social setting. All persons receiving CILA services are authorized for billing in DT upon request by the community agency provider.

Regular Work - A long term employment program carried out in a sheltered work environment. Regular Work programs must be in compliance with the Department’s requirements for national accreditation. All persons receiving CILA services are authorized for billing in DT upon request by the community agency provider.

Supported Employment - All Supported Employment authorizations require a denial of funding to be on record from the Office of Rehabilitation Services (ORS). To have an individual “authorized” to receive reimbursement from DHS for Supported Employment, the community agency provider must first apply to have these supports reimbursed by the ORS. Upon receipt of an ORS denial for funding, DHS staff will “authorize” the individual for billing effective the date of the ORS denial in all four Supported Employment categories:

- 1) Supported Employment Individual, Job Coach Present (SEP/I-JCP);
- 2) Supported Employment Individual, No Job Coach Present (SEP/I-NJCP);
- 3) Supported Employment Group, Job Coach Present (SEP/G-JCP); and,
- 4) Supported Employment Group, No Job Coach Present(SEP/G-NJCP).

Department on Aging Senior Citizen Center Program - The person will not be attending a traditional day program, but rather will attend a program designed for people over working age that is licensed by the Department on Aging. The program is not associated with a Developmental Training program.

Other Day Program - “Other” day program is a category that is used to specify billings for those clients who do not attend a traditional day program and have their day program hours of service that is not delivered by the residential community agency provider. Other day programs must be approved, in writing, by the Associate Director of the Office of Developmental Disabilities.

At Home Day Program - “At Home” day program is a category that is used to specify billings for those clients who do not attend a traditional day program and have their day program hours of service delivered by the residential community agency provider. At Home day programs must provide a structured daily program of goal-oriented activities, consistent with the Individual Service Plan (ISP).

THIRD PARTY PAYMENTS

See the CILA Individual Rate Worksheet and for the DHS 403c for details on attaching the information that should be included on the “Community Reimbursement Subsystem Financial Questionnaire.”

INDIVIDUAL (NONBASE) SUPPORT REQUEST

1. Supports Included in the Residential Rate: Those supports that are primarily provided by the community residential service agency. These supports may include:

Medication Administration and RN Oversight - Determined by the information in the individual’s Nursing Services Packet (NSP);

LPN Nursing Treatments and RN Oversight - Determined by the information in the individual’s Nursing Services Packet (NSP);

Dietician - Use NonBase (Individual) Support Form. (See Addendum #13 , CILA Rate Model *User Guide*.)

Other, Not Elsewhere Classified Supports - Use NonBase (Individual) Support Form. (See Addendum #13 , CILA Rate Model *User Guide*.)

2. Supports NOT Included in the Residential Rate, DPA Denial Required: Those supports that are billed directly to DHS, but an Illinois Department Public Aid (IDPA) denial for funding must be on record before “billing authorization” is made. These supports are:

Physical Therapy
Occupational Therapy
Speech Therapy

To have an individual “authorized” to receive reimbursement from DHS for physical therapy (PT), occupational therapy (OT), or speech therapy, the community agency provider must first apply to have these supports reimbursed by the Illinois Department of Public Aid (IDPA). If reimbursement is denied by IDPA, the community agency should forward that notice of denial to DHS and upon its receipt, DHS staff will “authorize” the individual for billing for the annual maximum 52 hours of services, per year. These services are then billed directly to DHS by the licensed professional providing the service, or the representative Medicaid-enrolled agent for the licensed professional.

- 3) Supports NOT Included in the Residential Rate, DPA Denial NOT Required: Those supports that are billed directly to DHS and an Illinois Department Public Aid (IDPA) denial for funding IS NOT required to be on record before “billing authorization” is made. These supports are:

- Behavior Services - Intervention Planning
- Individual Counseling
- Group Counseling
- Individual Therapy
- Group Therapy

All persons receiving CILA supports have been “authorized” to receive 48 annual hours of Behavior Services - Intervention Planning. (See CILA Individual Rate Model User Guide for licensed professional qualification minimums.)

All persons also have been authorized to receive an aggregate total of 60 hours of Individual or Group Counseling, and Individual or Group Therapy. These 60 hours for counseling or therapy supports is the aggregate total number of hours which can be billed, per person, per year. The 60 hour maximum shown does not mean that, for example, 60 hours of Individual Counseling may be billed in addition to 60 hours of Group Therapy.

SIGNATURES

Signatures - Signatures, phone numbers, and dates are required for this worksheet to be processed. Submit the “Intermittent and Family CILA Support Worksheet” with the required attachments to the PAS/ISSA Agency.

If you have any question on completing the CILA “Intermittent and Family CILA Support Worksheet,” please contact the CILA Unit, Bureau of Community Reimbursement, at 217/782-0632.

THE COMPLETE RATE PACKET

A complete individual CILA rate packet includes several pieces of information, in addition to the individual worksheet. Community agencies should include the following into the Individual Rate Packet and submit it to the PAS/ISSA Agency for signature and forwarding to the Network Facilitator:

- Completed Individual Rate Worksheet
- Community Reimbursement Subsystem Financial Questionnaire (DMHDD 403c)
- Copy of the three-page ICAP Summary
- Copy of the Individual Service Plan (ISP)
- Copy of the persons Social Security Card
- Complete Nursing Services Packet (NSP)
- Copy of the person’s psychological evaluation;
- Copy of the person’s psychiatric evaluation (if applicable)
- NonBase Support Documentation Form and Dept. of Public Aid letter of denial for each NonBase Support requested.