State of Illinois
Department of Human Services

DOCUMENTATION FOR MEDICAID WAIVER APPEALS

The information below is to be completed by a Qualified Intellectual Disabilities Professional (QIDP) at an Independent Service Coordination/Individual Service and Support Advocacy (ISC/ISSA) Agency on behalf of an individual seeking to appeal a denial, reduction, suspension, or termination of Medicaid Waiver services for persons with developmental disabilities. Individuals are to be informed of their right to appeal such actions through the Notice of Individual's Right to Appeal Form (IL 462-1202). The appeals and fair hearings policies and procedures are addressed in the Illinois Administrative Code, Title 59, Chapter I, Part 120.110.

Information must be typed and complete or this document and accompanying materials will be returned to the ISC/ISSA agency for additional information. The form must be signed and dated by the QIDP. See accompanying instructions for additional information on completing this form.

Section I:

Individual's Name: _____

Individual's Address: _____

Individual's City/State/Zip: _____

Individual's Phone: _____ Individual's Fax: _____

Individual's E-mail Address: _____

Individual's Social Security Number (Last 4): _____ Individual's Date of Birth: _____

Representative's Name: _____

Representative's Address: _____

Representative's City/State/Zip: _____

Representative's Phone: _____ Representative's Fax: _____

Representative's E-mail Address: _____

Representative's Relationship to Individual: Guardian ☐ Relative ☐ Other ☐

If "Relative" or "Other" is marked above, specify: _____

ISC/ISSA Agency Name: _____

QIDP's Name at ISC/ISSA Agency: _____

QIDP's Phone: _____ QIDP's Fax: _____

QIDP's E-mail Address: _____

Provider Agency Name: _____

Provider Agency Contact: _____

DHS Region: _____

DHS Region Staff: _____

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Section II:

Indicate the type below that best describes the reason for this appeal:

- ☐ Refusal to accept an application
- ☐ Denial of service base on eligibility
- ☐ Termination of service
- ☐ Suspension or reduction of service
- ☐ Denial of one-time funding request(s) (e.g., adaptive equipment or home modifications
- ☐ Other, specify _____

Specify type of service being denied, terminated, reduced or suspended:

Is this appeal related to the submission of a Crisis Transition Plan and Funding Request (Form IL462-1040)?

- ☐ Yes
- ☐ No

Has a Clinical Administrative Review Team (CART), or Service and Support Team (SST) or Short-term Stabilization Home (SSH) been involved with this action or request?

- ☐ Yes ☐ CART ☐ SST ☐ SSH Contract Number: _____
- ☐ No

Section III:

In order for the Division of Developmental Disabilities to complete a review of the action being appealed, attach all applicable documents:

- ☐ A signed request by the individual or guardian for the appeal.
- ☐ A copy of the notice informing the individual or guardian of the action being appealed. (This notice should include the basis for the action being taken.) Include any related documentation (e.g., correspondence between the Independent Service Coordination (ISC) Agency and the Division of Developmental Disabilities.)
- ☐ A copy of the Individual Service Plan. (Applicable for termination, one-time funding denials, and denials of service change requests)
- ☐ A psychological evaluation (meeting the requirements of the Developmental Disabilities Pre-Admission Screening (PAS) Manual) of the individual. (Applicable primarily for eligibility appeals.)
- ☐ The most recent ICAP (Inventory for Client and Agency Planning).
- ☐ Any clinical evaluations of the individual. (Applicable primarily for eligibility appeals and, in some cases, terminations and one-time funding denials.)
- ☐ A copy of the Crisis Transition Plan and Funding Request Form, if checked "Yes" in the previous section.
- ☐ Documentation from the CART, SST, or SSH activity, including the SST evaluation and plan, if checked "Yes" in the previous section. Please include the contact information.
- ☐ Documentation from the direct service provider in support of its actions. (Applicable for terminations, suspensions, and reductions of services.
- ☐ A copy of the entire packet of a One Time Funding Request denial or any other documentation to inform the review.

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Section IV:

☐ What is the basis for the appeal? That is, why does the individual or guardian believe the action to be wrong?

☐ Any Additional comments from the ISC/ISSA Agency that might inform the review.

Section V:

Submit this form and accompanying documentation to:
DHS Division of Developmental Disabilities
Appeals Unit
600 East Ash St., 3rd Floor, Building 400
Springfield, IL 62703

Or via facsimile to 217-558-2799

ISC/ISSA QIDP Name

ISC/ISSA QIDP Signature

Date

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Additional Instructions for Form

The information on the form is to be completed by a Qualified Intellectual Disabilities Professional (QIDP) at an Independent Service Coordination/Individual Service and Support Advocacy (ISC/ISSA) Agency on behalf of an individual seeking to appeal a denial, reduction, suspension, or termination of Medicaid Waiver services for persons with developmental disabilities.

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Information must be typed and complete or this document and accompanying materials will be returned to the ISC/ ISSA agency for additional information.

The form must be signed and dated by the QIDP.

The QIDP must complete all the boxes on the form.

The boxes on the form should be self-explanatory, but specific issues are highlighted below to ensure sufficient information is provided to complete the review in a timely manner:

- In Section II, be specific in specifying the type of service being denied, terminated, reduced, or suspended. Some examples are CILA, Adult HBS, physical therapy, and adaptive equipment. If a one-time funding request for adaptive equipment or home or vehicle modifications is involved, please include the type of request, e.g., ramp, lift, etc.
- In Section III, use the checklist to ensure all necessary documentation is submitted with the appeal. Incomplete submissions will be returned by the Division for additional information without completing the review.
- In Section III, examples of “clinical evaluations” or “other documentation” may include:
    - For eligibility determinations:
        - Psychiatric Evaluation (for persons with Autism)
        - Medical History, Medication Review, and Physical Examination (for persons with Epilepsy or Cerebral Palsy)
    - For terminations due to behavior issues:
        - Psychiatric Evaluation (if individual has a dual diagnosis of mental illness)
        - Behavior Plan and any summary data available of behaviors
    - For terminations due to medical issues:
        - Medical History
        - Medication Review
        - Occupational Therapy and/or Physical Therapy Evaluations
        - Dietitian Recommendations
    - For denials of one-time funding requests:
        - Behavior Plan (if the requested item was to be used to address behavior issues)
        - Occupational Therapy Evaluation (if the requested item was to be used to address sensory needs or fine motor skills)
        - Physical Therapy Evaluation (if the requested item was to be used to address gross motor needs or sensory integration)
        - Speech and Language Assessment (if the requested item was to be used to address communication issues)