New Choices Waiver

Division of Medicaid and Health Financing, Bureau of Authorization and Community Based Services
801-538-6155 (option 6) or toll free 800-662-9651 (option 6)

Dear Applicant:

The New Choices Waiver program is a Utah Medicaid program designed to offer a supportive home and community-based services option for people who have been living long term in nursing facilities, assisted living facilities, small health care (Type N) facilities or other licensed Utah medical facilities (excluding institutions for mental disease). The program strives to build upon the strengths and resources of each individual, supporting their ability to return to live in their own home or in another community-based setting.

This application packet is specifically designed for people residing in licensed assisted living facilities or small health care (Type N) facilities. If you are residing in another type of facility, please call to request a different application packet.

Here are a few important things to know about the New Choices Waiver application process:

1. The majority of available program capacity is reserved for residents of hospitals or skilled nursing facilities and this group may apply anytime of the year. People wishing to access one of the limited non-reserved slots (including people living in assisted living facilities or small health care (Type N) facilities) may apply during any of the three open application periods each year. Since each open application period is limited to a predetermined number of available slots, if more applications are received than can be enrolled, applicants are ranked based on length of stay in a qualifying setting and those with the longest stays will be given preference. For this reason, there is no guarantee that everybody who meets the minimum 365-day length of stay requirement will be able to enroll. While it is impossible to predict future ranking cut-off points, applicants should realize that it has historically been much longer than 365 days.
2. The New Choices Waiver program is a Utah Medicaid program. It is only available to individuals who meet the full eligibility criteria for both Utah Medicaid and New Choices Waiver. If the applicant has not already applied for and/or established Utah Medicaid financial eligibility, two different applications will be required:
    a. A New Choices Waiver application must be submitted to the Department of Health, Division of Medicaid and Health Financing, and
    b. An application for Utah Medicaid financial eligibility must be submitted to the Department of Workforce Services (DWS). Applicants must be under the Medicaid asset limit and meet all other financial eligibility criteria before enrollment in the New Choices Waiver program can occur.
3. When an application is received, the New Choices Waiver program office will perform an initial in-house screening. If the applicant passes the screening *and* is among those selected in the length of stay ranking process, a referral will be sent to the external case management agency that the applicant has selected. The case management agency will contact the applicant/representative to schedule a face-to-face assessment. The assessment marks the FIRST POSSIBLE date when waiver enrollment MIGHT occur as long as all other enrollment criteria is met within 60 days of the assessment date. If any of the enrollment criteria remains unmet after 60 days (including Utah Medicaid financial eligibility), a new assessment must be performed and payment for waiver services cannot begin prior to the new assessment date. This cycle repeats as each 60-day period expires. It is very important to respond quickly if additional documents are requested by either the New Choices Waiver program office or by DWS.
4. Applicants whose applications remain incomplete or who do not meet the minimum eligibility criteria by the end of the open application period or whose application is not selected during the length of stay ranking process are welcome to apply again in a future open application period. For more information visit http://health.utah.gov/ltc/NC/NCHome.htm

If you have any questions, please contact the New Choices Waiver program office for assistance. Thank you.

The New Choices Waiver Program Office
(800) 662-9651, option 6

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Screening Checklist for ALF and Type N Residents

(This form must be completed and submitted with the rest of your application.)

A. The New Choices Waiver (NCW) eligibility requirements are complex and require a great deal of analysis and coordination by the NCW intake team. At a minimum, the following four basic requirements must be met during the in-house screening process in order for an application to proceed to the next step:

1. A complete NCW application must be submitted and have an official fax, email, hand delivery or USPS date stamp that falls within the date span of one of the following open application periods:

   March 1 – March 14
   July 1 – July 14
   November 1 – November 14

   Applications that are not submitted timely or that remain incomplete by the end of the open application period will be denied and excluded from consideration during that application period.

2. The applicant must be at least 18 years of age.

3. The applicant must be actively residing in a licensed assisted living facility or in a licensed small health care (Type N) facility and must have reached at least 365 consecutive days by the last day of the open application period. (Remember, this minimum 365-day length of stay requirement is simply the minimum to apply. All applicants will go through the length of stay ranking process and only those with the longest lengths of stay will be processed forward.)

4. The applicant's medical records must demonstrate the medical screening criteria is met. (See item "C" below.)

B. Additional requirements must be met in order to enroll in the NCW program. One of these additional requirements is Utah Medicaid financial eligibility which is determined by the Department of Workforce Services (DWS). Which of the following best describes the applicant's status?

☐ The applicant has already been determined financially eligible for Utah Medicaid by DWS.

☐ The applicant submitted an application to DWS on _____ (date) and it is currently in process.

☐ The applicant has not yet applied for Utah Medicaid. (Please note: the NCW application will not be processed until the applicant has submitted a Utah Medicaid application to DWS.

C. Each applicant must also meet the medical eligibility criteria. This is known as *nursing facility level of care criteria* which is described in administrative rule R414-502-3. In order for the NCW program office to perform an initial screening of the medical criteria, all of the following items must be submitted:

☐ A current list of all diagnoses,
☐ A current list of all medications, including prescriptions and over the counter medicine,
☐ A copy of the current service plan from the facility where the applicant resides,
☐ A copy of the admission face sheet from the facility where the applicant resides,
☐ A copy of the most recent RN assessment from the facility where the applicant resides, and
☐ When applicable, a copy of any other medical records prepared within the last 90 days that document medical conditions and personal care/assistance needs.
☐ If the applicant has a cognitive impairment noted on page 6, please attach records from a licensed physician detailing the applicant's dysfunction in orientation to person, place, and time.

When all New Choices Waiver application forms are complete and all required records have been collected, please follow instructions on page 12 to send the complete application packet to the NCW program office.

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Application
ALF and Type N Residents

Application Date: _____ Date of Admission to Facility: _____

Applicant's Full Name: _____

Date of Birth: _____ Medicaid ID or SSN: _____

Facility Name: _____ Facility Phone#: _____

Facility Address: _____

Applicant's Preferred Mailing Address: _____

_____

_____

Request for Evaluation: (this section can only be completed by the applicant or representative)

By signing below, I am requesting to be evaluated for the New Choices Waiver program. I understand that by requesting this evaluation a representative from the New Choices Waiver program office may contact me and/or my representative to obtain additional information about my current situation. I have willingly submitted copies of the required medical records (listed on page two of this application packet) to enable the New Choices Waiver intake team to perform an initial nursing facility level of care screening. I authorize staff of the facility where I reside and any of my other current medical care providers to speak with representatives from the New Choices Waiver program office if there are any questions about my medical conditions and care needs. I further authorize staff of the facility where I reside to send additional documentation of the services I receive in this facility when requested by the New Choices Waiver program office. I further authorize staff at any previous medical facilities or assisted living facilities that I lived in prior to my admission to the current facility to provide information to the New Choices Waiver program if needed. If my application passes the initial screening and I am among the applicants selected in the length of stay ranking to be processed to the next step in the application flow, I authorize the New Choices Waiver program office to forward my complete application (including medical records) to the case management agency that I have selected on the Freedom of Choice Consent Form.

_____ _____
Signature Date

Who is signing? ☐ Self/Applicant ☐ Family Representative ☐ Legal Representative

Representative's Name (Print): _____

Relationship to Applicant: _____ Preferred contact method: ☐ Phone ☐ Email

Representative's Phone #: _____

Representative's Email: _____

Please list the names of any other family members/representatives that you authorize the NCW program office to speak with:

_____

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Length of Stay Certification

This form can only be completed and signed by staff of the facility where the applicant resides. Evidence that documents the admission date must be attached. Examples of acceptable evidence include a signed lease agreement, official payment ledgers, bank statements or cashed checks. (Signed letters attesting to the length of stay will not be accepted.)

Resident's Name:_____ Date of Birth:_____

Current Facility Name:_____

Individuals who live in an assisted living facility or a small health care (Type N) facility cannot apply to the New Choices Waiver program until they have met the minimum length of stay requirement of at least 365 consecutive days by the end of the open application period in which they apply. Since applicants with the longest length of stay are selected for enrollment, it is important to disclose the current facility's length of stay information as well as any previous facility lengths of stay that this individual experienced immediately prior to moving into this facility.

The following two questions relate to this resident's length of stay in the current facility:

1. Date of earliest admission to the current facility: _____
2. If a resident is *formally discharged* from a qualifying facility setting and then resides (even short term) in a non-qualifying facility type or in a private home setting, this results in a "break in stay" and the length of stay calculation starts over with the date of readmission to a qualifying facility type. Since this resident's earliest admission in the current facility, has he/she been *formally discharged* for any reason other than for an admission to a hospital, skilled rehab or skilled nursing facility? (Use separate sheets to describe the reasons if needed.)

   ☐ Yes, this resident has had one or more *formal discharges* from the current facility as detailed below:

   Discharge date: _____ Readmit date:_____ Reason for discharge: _____

   Discharge date: _____ Readmit date:_____ Reason for discharge: _____

   ☐ No, this resident has never been *formally discharged* from the current facility since the admission date provided in question #1 above.

To increase the likelihood of this applicant being selected during the length of stay ranking process, it is important to inform the NCW program office of any lengths of stay in other qualifying facilities immediately prior to admission to this facility. To get credit for prior facility stays, evidence must be included (see page 11, item 16).

☐ This applicant did not live in another licensed assisted living facility or small health care (Type N) facility immediately prior to moving into the current facility.

☐ This applicant did live in one or more qualifying facilities prior to moving into the current facility:

Facility Name: _____ Admission/Discharge Dates: _____

Facility Phone Number: _____

Facility Name: _____ Admission/Discharge Dates:_____

Facility Phone Number: _____

I hereby certify that the information provided on this form is correct to the best of my knowledge.

Facility Representative's Name (Print): _____

Signature: _____ Date: _____

Preferred contact method: ☐ Phone ☐ Email

Facility Representative's Phone #: _____ Email: _____

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Pre-enrollment Lease Disclosure Form

Resident's Name: _____ DOB: _____

Facility Name: _____

Facility Address: _____ City: _____ Zip:_____

Facility Phone #:_____

I (resident) have an existing lease contract with this facility and have been paying a total of ($_____) per month for the room, board and care that I've received. I have been paying this amount with my own funds, but now I've reached the point where my assets are depleted or nearly depleted. As of the date of this disclosure the lease contract remains the same, but my ability to meet the financial terms of the contract is diminishing.

Please specify the following lease amounts and sources of contributions, if any:

Current monthly lease amount as stipulated in the formal contract: $_____ (per month)

Monthly amount currently paid by this resident: $_____ (Please note, the amount listed here cannot exceed the resident's monthly income)

Monthly amount paid directly to the facility by other contributors: $_____ (☐ N/A)

Sources of contributions: ☐Family ☐Church ☐Other: _____ (☐N/A)

Amount of monthly lease that is currently unpaid: $_____ (☐N/A)

In the Medicaid financial eligibility determination process performed by DWS, deductions are sometimes permitted for shelter costs and heating/cooling costs. Please ***estimate*** the breakdown of shelter and utility costs below. IMPORTANT: Every line must contain a dollar amount and the sum of the dollar amounts must equal the total amount currently being paid to this facility. **(*This form will be considered incomplete and the application rejected if any of the below items are left blank or list dollar amounts of $0.*)**

Room rate: _____ Gas: _____
Food costs: _____ Water: _____
Electricity: _____ Telephone: _____

If enrolled in the New Choices Waiver program, a new Residential Room and Board Agreement will be negotiated with help from the chosen waiver case management agency. A copy of the new agreement must be sent to the NCW program office who will forward it to DWS.

Resident's Name	Facility Representative's Name
Signature of Resident or Responsible Party	Signature of Facility Representative
Name of Responsible Party	Facility Representative Title / Position
Responsible Party's Relationship to Resident	

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Medical Eligibility Screening

This form serves as a screening tool for the New Choices Waiver program's medical eligibility requirements. It can only be completed by a registered nurse or a physician licensed in Utah, but it is strongly recommended that the day-to-day direct service caregivers (such as a CNA or personal attendant) be consulted, particularly with respect to the amount of hands on physical assistance provided with activities of daily living. The application process will be delayed if this form is not filled out in its entirety, if it is not filled out accurately, or if it contradicts the information provided in the applicant's attached medical records. ***Do not leave any section blank.***

Applicant's Name: _____ Date of Birth: _____

1. **How much assistance does the applicant require with the following activities of daily living (ADLs) on a regular basis (at least 3 times per week)?**

	Performs Independently	Independent with assistive device or set up	Prompting or Supervision	Minimal Physical Assist	Moderate Physical Assist	Complete Dependence on others
Bathing/Showering	☐	☐	☐	☐	☐	☐
Grooming/Hygiene	☐	☐	☐	☐	☐	☐
Dressing/Undressing	☐	☐	☐	☐	☐	☐
Eating/Self feeding	☐	☐	☐	☐	☐	☐
Transferring	☐	☐	☐	☐	☐	☐
Toileting	☐	☐	☐	☐	☐	☐
Mobility/Ambulation	☐	☐	☐	☐	☐	☐
Bed Mobility	☐	☐	☐	☐	☐	☐

2. **Has a physician formally diagnosed the applicant with a cognitive impairment that results in disorientation to person, place, or time? If yes, please attach medical records from a licensed physician detailing the applicant's cognitive status.**

☐ Yes Diagnosis: _____ ☐ No ☐ Unknown

a. Level of disorientation to <u>person</u>: Does the person consistently know their own name, date of birth and/or age?	☐ N/A	☐ Mild	☐ Moderate	☐ Severe
b. Level of disorientation to <u>place</u>: Does the person consistently know where they are, the name of the facility they reside in, or familiar landmarks they once knew well? If they leave the facility can they find their way back?	☐ N/A	☐ Mild	☐ Moderate	☐ Severe
c. Level of disorientation to <u>time</u>: Can the person consistently recall the date and/or the day of the week? Does he/she refer to past events in the present tense as if they just occurred? Does he/she know which season it is? Does he/she think an hour has passed when it has only been minutes?	☐ N/A	☐ Mild	☐ Moderate	☐ Severe

3. **In the box below, list all of the applicant's medical diagnoses. (New Choices Waiver will not accept "See attached.")**

This form can only be completed by a registered nurse or a physician licensed in Utah.

Name of the person completing the form: _____ ☐ RN ☐ Physician

Phone: _____ Date: _____

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Freedom of Choice Consent Form – Box Elder County

Applicant's Name: _____ DOB: _____

Every participant in the New Choices Waiver (NCW) program must have case management services to help with creation of a person-centered care plan, to coordinate services and service providers and to monitor provision of care. This form is designed to help the applicant select a case management agency. This form should never be completed without the applicant's (or family or legal representative's) involvement, nor should it ever reflect a choice that was made by somebody other than the applicant (or family/legal representative). Please notify the NCW program office if any manipulation of freedom of choice rights is observed.

Applicants (or their family or legal representatives) are free to choose from the list of all case management agencies that are available in the county where the applicant resides or plans to reside. If this applicant is selected during the length of stay ranking process, a referral will be made to the case management agency that is chosen on this form. The case management agency will send a registered nurse and a social worker to meet with the applicant in person. To learn more about these agencies, please visit this website: http://health.utah.gov/ltc/NC/NCCMAContacts.htm.

Select a case management agency from the options available in this county:

- ☐ Advocates for Independence
- ☐ Bear River Area Agency on Aging
- ☐ Adult Case Management
- ☐ FlexCare
- ☐ Roads to Independence
- ☐ Abundant Solutions
- ☐ Utah Case Management
- ☐ Care Advocates
- ☐ Generations Case Management

The case management agency will perform a review of the application and medical records. Case management agencies have the right to decline to serve a new referral. If they do this, they will send the applicant a notice in writing. Under certain circumstances the applicant will have the option to select a different case management agency. The New Choices Waiver program office will advise the applicant as to whether or not this option is available.

If the case management agency decides to move forward to the next step, they have up to 14 days to perform a face-to-face assessment. The date of the assessment is important to remember because it is only valid for up to 60 days. If any of the waiver enrollment criteria (including Medicaid financial eligibility) remains unmet by the end of 60 days, a new assessment must be performed and Medicaid payment for waiver services cannot begin prior to the new assessment date. This cycle repeats as each 60 day window passes. Also, at any point during the assessment process if the case management agency decides to decline to serve the applicant, they may do so by providing notice in writing.

By signing below, I certify that I have read and understand the information in this form. I also certify that I made this case management agency selection of my own free will.

_____ _____
Signature Date

Who is signing? ☐ Self/Applicant ☐ Family Representative ☐ Legal Representative

Representative's Name (Print): _____

Freedom of Choice (NF or HCBS)

The New Choices Waiver program is a Medicaid program that serves as an alternative to nursing facility care. Participation in the New Choices Waiver program is completely voluntary. Individuals who meet the eligibility criteria for enrollment in the New Choices Waiver program have the fundamental right to enter a Medicaid certified nursing facility instead of participating in the New Choices Waiver program. Once enrolled in the New Choices Waiver program, participants retain the right to voluntarily disenroll from the program and enter a nursing facility at any time. This form is the formal method for the applicant (or their family or legal representative) to voice preference to receive services in a home or community-based setting through New Choices Waiver program or to receive services in a skilled nursing facility. Please make a selection below:

Applicant's Name: _____ DOB: _____

Please indicate the applicant's choice:

☐ I prefer to receive care in a skilled nursing facility and **not** be considered for enrollment in the New Choices Waiver program.

☐ I prefer to be considered for enrollment in the New Choices Waiver program in hopes of receiving supportive services in my own home or in another community-based setting.

_____ _____
Signature Date

Who is signing? ☐ Self/Applicant ☐ Family Member ☐ Legal Representative

Family Member's or Representative's Name (Print): _____

If the applicant's choice is to be considered for enrollment in the New Choices Waiver program and if the applicant is enrolled in the program, he/she will have the right to choose to live in any available home and community-based setting as long as his/her needs can be safely met in the chosen setting. The case management agency will work with the applicant (and their family/representative) to explore all options which may include:

1. The applicant's own home or apartment,
2. The home or apartment of a friend or family member,
3. A certified independent living facility,
4. A licensed assisted living facility, or
5. A licensed community residential care facility.

No matter which setting the applicant chooses, the applicant will be responsible for the shelter costs. This includes room and board, mortgage payments, rent, and utilities. Please demonstrate ability to cover these costs by providing the applicant's total monthly income:

Total monthly income: _____ (Include the total monthly sum of pension/retirement, social security, disability, and any other sources of monthly income.)

Know your rights:

Applicants have the right to be treated with consideration, respect, and with full recognition of dignity and individuality.

Applicants have the right to be considered for the New Choices Waiver program regardless of race, nationality, disability, gender, sexual orientation or religion.

Applicants have the right to confidentiality of protected health information. Health information cannot be released to any entity without permission, unless it is allowed by law for the provision of treatment or payment and healthcare operation activities.

If the applicant *enrolls* in the New Choices Waiver program, he/she will have the following rights as a program participant:

1. The right to choose where to live. Participants may choose to live in any community-based setting as long as their assessed needs can be met in that setting and as long as they can afford the room and board or rental fees in that setting. Options include:
    a. The participant's own home or apartment
    b. The home or apartment of a friend or family member
    c. An independent living facility
    d. A licensed assisted living facility
    e. A licensed community residential care facility
2. The right to decline New Choices Waiver services or to choose to receive care in a skilled nursing facility instead.
3. The right to choose whether or not to have a roommate. If the participant chooses to have one or more roommates, he/she has the right to select the roommate(s).
4. The right to have visitors including family, friends, and other visitors at any time except when doing so endangers the participant, care providers, or others.
5. The right to a personalized care plan that is based on personal strengths, preferences, goals, and assessed needs. Participants may choose somebody to represent them and to participate in helping with development of the plan of care. Participants have the right to schedule care planning activities at times and locations that are convenient.
6. The right to choose the services that the participant will receive as long as they are assessed to be medically necessary to meet identified goals and to ensure health and safety. Participants may choose to accept or decline any recommended services.
7. The right to select service providers from among the providers available in the participant's county of residence. If the participant chooses to live in a private (non-facility) setting, he/she may also explore the option of hiring service providers through the *self-administered services* option.
8. The right to receive case management services without a conflict of interest.
9. The right to keep a copy of their own care plan and to request changes to the care plan, services, service providers, or living setting at any time. To request changes, the applicant/family may contact your case manager. Your care plan will be reviewed and revised at least yearly and whenever your assessed needs change.
10. The right to voluntarily disenroll from the New Choices Waiver program as a result of declining the observation of care planning activities by New Choices Waiver representatives. The New Choices Waiver program will observe care planning activities as part of quality assurance. Observation is a requirement of enrollment in New Choices Waiver services and may be done in person, via telehealth or phone; personal care services are not included in the observation. Information gathered through the observation may be used to determine ongoing eligibility and/or participation and may also be used in the administrative hearing process.

_____	_____	_____
Applicant's Name (Please Print)	Signature of Applicant/Representative	Date

Know your responsibilities:

Applicants are responsible to complete the New Choices Waiver application truthfully and to submit all requested documentation in a timely manner. Incomplete or inaccurate applications may result in denial of access to the New Choices Waiver program.

Applicants for the New Choices Waiver program must be found financially eligible for Medicaid and maintain ongoing financial eligibility in order to receive Medicaid coverage of New Choices waiver services. Loss of Medicaid financial eligibility will result in loss of eligibility for the New Choices Waiver program.

Applicants are responsible to provide complete and accurate information about their medical history, health needs and care needs during the medical face-to-face assessment performed by the case management agency.

If *enrolled* in the New Choices Waiver program, participants have the following responsibilities:

1. The responsibility to seek guidance and answers from their manager if they have questions about the New Choices Waiver program, their care plan, the services being received, or if he/she does not understand what action is expected them.
2. The responsibility to drive the development of their own care plan by participating in care planning meetings, communicating strengths, preferences, goals, and needs and communicating their choices. This responsibility can be delegated to a chosen, trusted representative. If a legal representative is designated, the representative is responsible to drive the care planning process on the participant's behalf. When the entire care plan team have come to an agreement about the services and supports to be included in the care plan, the participant (or representative) is responsible to fully engage in those services. If something about the care plan is believed to be ineffective, participants (or representatives) are responsible to contact the case management agency to request a change.
3. The responsibility to notify their case management agency of any changes in their health or circumstances that may impact eligibility for the New Choices Waiver, Medicaid financial eligibility or that may require changes to the comprehensive care plan.
4. The responsibility for any risks or consequences that the client may experience as a result of choosing to decline a recommended service. If a client's decisions result in a dangerous situation for their health and safety or the health and safety of people and the client is unwilling to make adjustments to their plan of care that meets minimal health and safety standards, the client may be disenrolled from the New Choices Waiver program.
5. The responsibility to show respect and consideration to service providers by keeping scheduled appointments or notifying them if unable to keep scheduled appointment times.
6. The responsibility to pay the shelter costs in the client's chosen community-based chosen community-based setting. This includes room and board, mortgage payments, rent and utilities.
7. The responsibility to show respect for the property, comfort, privacy and rights of others.
8. The responsibility to refrain from committing any illegal actions or actions that may result in self-harm or harm against others.

_____	_____	_____
Applicant's Name (Please Print)	Signature of Applicant/Representative	Date

NCW Application Checklist

1. ☐ Application page 2, "Screening Checklist for ALF and Type N Residents"
2. ☐ Application page 3, "Application for ALF and Type N Residents"
3. ☐ Application page 4, "Length of Stay Certification" completed by the facility of residence
4. ☐ Application page 5, "Pre-enrollment Lease Disclosure" completed by the facility of residence
5. ☐ Application page 6, "Medical Eligibility Screening Form" completed by a registered nurse or physician in consultation with day-to-day direct service caregivers
6. ☐ Application page 7, "Freedom of Choice Consent Form"
7. ☐ Application page 8, "Freedom of Choice, NF or HCBS"
8. ☐ Application page 9, "Know Your Rights"
9. ☐ Application page 10, "Know Your Responsibilities"
10. ☐ Application page 11, "NCW Application Checklist"
11. ☐ A current list of all prescribed medications (prescription and over the counter)
12. ☐ A copy of the applicant's current service plan from the facility of residence
13. ☐ A copy of the admission face sheet from the facility of residence
14. ☐ A copy of the applicant's most recent assessment from the facility of residence
15. ☐ When applicable, a copy of any medical records prepared within the last 90 days from other providers such as a home health or hospice agency, attending physician, or hospital
16. ☐ If the applicant has a cognitive impairment noted on page 6, attach records from a licensed physician detailing the applicant's dysfunction in orientation to person, place, and time.
17. ☐ Evidence/records to document the full length of stay in the current facility of residence and any other qualifying facilities prior to the current facility. Include documentation for the current facility AND for any other previous facility. Examples of acceptable evidence includes payment ledgers, cashed monthly checks paid to the facilities of residence, bank statements, official payment ledgers and/or a signed lease agreement. (Signed letters of attestation are not sufficient.)

PLEASE NOTE: Incomplete applications will not be considered. Please take care to ensure every question of every application form is answered <u>completely</u> and that all items in this checklist are submitted to New Choices Waiver with a fax, email or USPS date stamp that falls within the open application time period. Do not submit the application before the first day or after the last day of the open application period. Any application that remains incomplete by the end of the open application period will be returned/denied.

Application Submission Instructions

When you have completed all of the New Choices Waiver application forms and have obtained copies of all required records, you may send them to the New Choices Waiver program office by fax, secure email, hand delivery or by U.S. postal mail. The New Choices Waiver program office strongly recommends that you send them by **fax** because it is the quickest and the most secure method to transmit your protected health information.

Fax: 801-323-1586
(Faxing is the preferred method of receiving applications.)

Email: **newchoiceswaiver@utah.gov**
(E-mailing protected health information to the New Choices Waiver program office is not permitted unless you can encrypt the message before sending.)

Hand Deliver: Utah Department of Health
288 N. 1460 W.
Salt Lake City, Utah

Mail: Utah Department of Health
Division of Medicaid and Health Financing
New Choices Waiver Program Office
Attn: Intake Team
P.O. Box 143112
Salt Lake City, Utah 84114-3112

(U.S. postal mail is the slowest and the most risky method of sending applications because the State Mail routing system takes an extra 5-7 days beyond the normal U.S. postal mail delivery time. Express Mail, Priority Mail and Certified Mail are even slower because these methods require extra steps and special handling within the State Mail system. Mailed applications must be received by the New Choices Waiver program office no later than 5 state business days after the last day of the open application period in order to be considered. If the application is not received within 5 state business days after the closure of the open application period, the application will be denied even if the date stamp on the envelope was timely.)

Phone: (801) 538-6155, option 6 OR (800) 662-9651, option 6

Following the initial screening and length of stay ranking process, the New Choices Waiver program office will issue a notice of decision letter to every applicant informing them of their application status. If an application is denied, appeal rights will be provided with the notice of decision letter.

The New Choices Waiver program cannot process your NCW application until you have submitted a separate Medicaid financial eligibility application to the Department of Workforce Services (DWS). To find out how to apply or for any other information about Utah Medicaid financial eligibility, please contact DWS:

DWS Phone: 1-866-435-7414

DWS Website: https://medicaid.utah.gov/apply-medicaid OR
http://jobs.utah.gov/mycase

New Choices Waiver Program Office P.O. Box
143112
Salt Lake City, Utah 84114-3112 Fax: (801)
323-1586
Email: newchoiceswaiver@utah.gov

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
New Choices Waiver Program

Participant Name: _____ Medicaid ID#: _____ DOB: _____

Participant Phone Number: _____ Participant Email:_____

I _____ hereby authorize the New Choices Waiver Program (NCW) Office to disclose information, of the above-named participant, indicated below to:

Select all that apply	NCW will release any waiver related information unless otherwise indicated. Please note any restrictions in what can be released below:
☐Senior Planning Agency_____ ☐Family_____ ☐CMA_____ ☐Other	

I understand that:

- I may revoke this authorization at any time by sending written notification to the NCW.
- I may refuse to sign this authorization. The NCW cannot deny services if I refuse to sign this authorization.
- Information used or disclosed under this authorization may be subject to redisclosure by the person or facility receiving it and may no longer be protected by federal or state privacy regulations.
- The authorization cannot be revoked in response to information that has been acted upon by NCW.
- The authorization is valid for **1 year** from the date of signature.

_____ _____
Signature of Participant or Personal Representative* Date

***If signed by a Personal Representative, indicated the authority to act on behalf of the participant.**

☐Legal Guardian (proof of guardianship required)
☐Personal Relationship (state relationship) _____
☐Court Appointed Representative (state type of representative) _____
☐Other