Title of Proposed Rule: Grant Increase for the Home Care Allowance, Special Populations Home Care Allowance, and Personal Needs Allowance

Rule-making#: 16-04-25-1

Office/Division or Program: Economic Security / Employment and Benefits

Rule Author: Danielle Dunaway

Phone: 303-866-2788
E-Mail: danielle.dunaway@state.co.us

STATEMENT OF BASIS AND PURPOSE

Summary of the basis and purpose for the rule or rule change. *(State what the rule says or does, explain why the rule or rule change is necessary and what the program hopes to accomplish through this rule. How do these rule changes align with the outcomes that we are trying to achieve, such as those measured in C-Stat?)*

Colorado has a Maintenance of Effort (MOE) agreement with the Social Security Administration (SSA). This agreement requires compliance with the Social Security pass-along per 20 CFR 416.2099, which sets a minimum expenditure level on Supplemental Security Income (SSI) recipients as a condition of receiving Colorado's full amount of Federal Financial Participation for Medicaid. The penalty for non-compliance is equal to at least $325 million quarterly and could be as high as at least $1.3 billion annually.

Colorado's MOE claimed include benefits paid directly to SSI recipients in Adult Financial Programs. In order to meet the requirement in 2016 and going forward, the program is proposing an increase to the monthly benefits amounts paid to Home Care Allowance (HCA) and Home Care Allowance – Special Populations (SP-HCA) program recipients.

Additionally, the PNA base amount should be adjusted as described at CRS 25.5-6-202(9)(b)(I). While these statutes are specific to Medicaid, there are Adult Financial recipients whose income is solely or in combination with Supplemental Security Income (SSI) below the Health Care Policy and Financing PNA amount. The additional per diem rate increase for 2016 is three percent (3%).

An emergency rule-making (which waives the initial Administrative Procedure Act noticing requirements) is necessary:

- [ ] to comply with state/federal law and/or
- [ ] to preserve public health, safety and welfare

Explain:

Authority for Rule:

State Board Authority:

26-1-107, C.R.S. (2016) - State Board to promulgate rules; 26-1-109, C.R.S. (2016) - state department rules to coordinate with federal programs; 26-1-111, C.R.S. (2016) - state department to promulgate rules for public assistance and welfare activities.

Program Authority:

26-2-111, C.R.S. (2016) - eligibility for public assistance; 20 CFR 416 et seq. - requires a maintenance of effort with SSA.

		Yes		No
Does the rule incorporate material by reference?		Yes	X	No
Does this rule repeat language found in statute?		Yes	X	No

If yes, please explain.

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The program has sent this proposed rule-making package to which stakeholders?

County Human Services Directors Association; Colorado Commission on Aging; Colorado Legal Services; The Legal Center; Colorado Senior Lobby; Single Entry Point agencies; Community Centered Boards; Economic Security Sub-PAC; Colorado Gerontological Society; All Families Deserve a Chance (AFDC) Coalition; Area Agencies on Aging; Legal Aid of Metropolitan Denver; Colorado Center on Law and Policy; and Colorado Department of Human Services Food Assistance Division, Low-Income Energy Assistance Program, Colorado Refugee Services Program; Colorado Department of Health Care Policy and Financing; and Policy Advisory Committee (PAC)-Subcommittee members

[Note: Changes to rule text are identified as follows: deletions are shown as “strikethrough”, additions are in “all caps”, and changes made between initial review and final adoption are in brackets.]

Attachments:
Regulatory Analysis
Overview of Proposed Rule
Stakeholder Comment Summary

REGULATORY ANALYSIS

(*complete each question; answers may take more than the space provided*)

1. List of groups impacted by this rule:

Which groups of persons will benefit, bear the burdens or be adversely impacted by this rule?

This rule change will impact all HCA and SP-HCA recipients. All HCA and SP-HCA recipients will receive up to a fifty five dollar ($55) increase to their monthly grant. Both the HCA and SP-HCA programs have a three tiered grant system based on the recipient's functional capacity and need for paid care score. The HCA and SP-HCA recipients maximum grant will increase as follows: Tier 1 would increase to two hundred and fifty five dollars ($255), Tier 2 would increase to three hundred and ninety seven dollars ($397) and Tier 3 would increase to five hundred and thirty dollars ($530).

This rule change will also impact recipients that reside in a facility and receive the Adult Financial Personal Needs Allowance. All recipients residing in facilities will receive a two dollar ($2) increase to their monthly allowance.

2. Describe the qualitative and quantitative impact:

How will this rule-making impact those groups listed above? How many people will be impacted? What are the short-term and long-term consequences of this rule?

The rule will result an increase of $55 to the HCA and SP-HCA Grant Standard maximums for each tier and will impact all HCA (approximately 1,905) and SP-HCA (approximately 121) recipients. If a recipient's provider also received food assistance with the recipient, this change may slightly decrease the food assistance benefits received by these clients. Approximately every three dollars ($3) additional cash assistance could decrease the Food Assistance amount by one dollar ($1). If an individual receives the full increase of fifty five dollars ($55), his/her Food Assistance amount could decrease by approximately eighteen dollars ($18).

Long-term, increasing the grant standard will assist the State in meeting the SSA MOE. If the State fails to meet the provisions of the MOE, Medicaid Federal Financial Participation (FFP) funds will be placed in jeopardy.
The adjustment to the personal needs allowance quantitatively changes the set $77 personal needs allowance that has not kept up with the cost of living to more equally match the Medicaid personal needs allowance by increasing it to $79. The qualitative impact is enabling the persons who are residents to keep enough of their income to pay for personal needs that are not covered by the nursing facilities such as hygiene supplies and clothing.

The rule will result in an increase of two dollars ($2) to the Personal Needs Allowance ($77 + $2 = $79) and will impact recipients residing in facilities- approximately 609 individuals. The PNA provides a small payment to individuals that are frail elderly or physically or emotionally disabled adults requiring twenty-four (24) hour medical care but who cannot return to their home and need 24 hour medical or non-medical supervision.

3. Fiscal Impact:

For each of the categories listed below explain the distribution of dollars; please identify the costs, revenues, matches or any changes in the distribution of funds even if such change has a total zero effect for any entity that falls within the category. If this rule-making requires one of the categories listed below to devote resources without receiving additional funding, please explain why the rule-making is required and what consultation has occurred with those who will need to devote resources.

State Fiscal Impact *(Identify all state agencies with a fiscal impact, including any Colorado Benefits Management System (CBMS) change request costs required to implement this rule change)*

The cost to the State for the increase for HCA recipients (approximately 1,905) will be $55/recipient/month. This cost will be paid using 100% HCA cash funds. These increased expenditures by the State to HCA recipients are estimated at $419,100 (plus caseload growth) for the remainder of calendar year 2016. No additional appropriation is required as it is included within existing appropriations for HCA.

The cost to the State for the increase for SP-HCA recipients (approximately 121) will be $55/recipient/month. This cost will be paid using 100% HCA cash funds. These increased expenditures by the State to HCA recipients are estimated at $26,620 for the remainder of calendar year 2016. No additional appropriation is required as it is included within existing appropriations for SP-HCA.

The total estimated cost to the State for Personal Needs Allowance recipients (approximately 609) is estimated at $4,872 (plus caseload growth) for the remainder of calendar year 2016. No additional appropriation is required as it is included within the existing appropriations for Old Age Pension, Aid to the Needy Disabled, or Adult Foster Care.

Maintenance hours will be utilized to make the required changes to CBMS.

County Fiscal Impact

No additional appropriation is required as it is included within existing appropriations for the programs impacted by this grant increase.

Federal Fiscal Impact

No impact because there are no federal funds utilized.

Other Fiscal Impact *(such as providers, local governments, etc.)*

No impact because there are no other providers or local governments involved.

4. Data Description:

List and explain any data, such as studies, federal announcements, or questionnaires, which were relied upon when developing this rule?

None.

5. Alternatives to this Rule-making:

Describe any alternatives that were seriously considered. Are there any less costly or less intrusive ways to accomplish the purpose(s) of this rule? Explain why the program chose this rule-making rather than taking no action or using another alternative.

Rule is necessary to be fully in compliance with 20 CFR 416 et seq., which requires a Maintenance of Effort (MOE) between the State of Colorado and the Social Security Administration (SSA). This MOE requires that Colorado spend at least the same amount in the current year as they did in the previous year for specific categories of assistance. Failure to increase the grant could impact the MOE agreement with the SSA. Failure to comply with terms of the MOE could jeopardize Medicaid Federal Financial Participation (FFP) funds as the SSA could impose a sanction of no less than one full quarter FFP match (approximately $300-350 million) for every month Colorado does not meet the MOE requirement.

The personal needs allowance increase is necessary to be more in alignment with the Medicaid PNA and to allow individuals who are frail or elderly to keep enough of their income to pay for personal needs that are not covered by the nursing facilities such as hygiene supplies and clothing. Grant increases require State Human Services Board approval so there is no other action that can be taken.

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Rule-making#: 16-04-25-1

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OVERVIEW OF PROPOSED RULE

Compare and/or contrast the content of the current regulation and the proposed change.

Section Numbers	Current Regulation	Proposed Change	Stakeholder Comment
3.532, H	The Old Age Pension personal needs allowance maximum	Revised to increase the maximum to seventy nine dollars ($79), effective September 1, 2016.	Yes X No
3.543, I	The Aid to the Needy Disabled personal needs allowance maximum	Revised to increase the maximum to seventy nine dollars ($79), effective September 1, 2016	Yes X No
3.570.11, B	HCA grant standard maximums	Revised to add a fifty five dollar ($55) increase to each of the three tier levels for Home Care Allowance.	Yes X No
3.570.21, B	SP-HCA grant standard maximums	Revised to add a fifty five dollar ($55) increase to each of the three tier levels for Special Populations Home Care Allowance.	Yes X No
3.583, D	Adult Foster Care eligibility	Revised to increase the maximum to seventy nine dollars ($79), effective September 1, 2016	Yes X No

STAKEHOLDER COMMENT SUMMARY

DEVELOPMENT

The following individuals and/or entities were included in the development of these proposed rules (such as other Program Areas, Legislative Liaison, and Sub-PAC):

None.

THIS RULE-MAKING PACKAGE

The following individuals and/or entities were contacted and informed that this rule-making was proposed for consideration by the State Board of Human Services:

County Human Services Directors Association; Colorado Commission on Aging; Colorado Legal Services; The Legal Center; Colorado Senior Lobby; Single Entry Point agencies; Community Centered Boards; Economic Security Sub-PAC; Colorado Gerontological Society; All Families Deserve a Chance (AFDC) Coalition; Area Agencies on Aging; Legal Aid of Metropolitan Denver; Colorado Center on Law and Policy; and Colorado Department of Human Services Food Assistance Division, Low-Income Energy Assistance Program, Colorado Refugee Services Program; Colorado Department of Health Care Policy and Financing; and Policy Advisory Committee (PAC)-Subcommittee members

Are other State Agencies (such as Colorado Department of Health Care Policy and Financing) impacted by these rules? If so, have they been contacted and provided input on the proposed rules?
Rules were sent to the Colorado Department of Health Care Policy and Financing. No input has been received.

[X] Yes [ ] No

Have these rules been reviewed by the appropriate Sub-PAC Committee?

[X] Yes [ ] No

Date presented May 5, 2016. Were there any issues raised? ____ Yes _X__ No

If not, why.

Comments were received from stakeholders on the proposed rules:

[ ] Yes [X] No

If "yes" to any of the above questions, summarize and/or attach the feedback received, including requests made by the State Board of Human Services, by specifying the section and including the Department/Office/Division response. Provide proof of agreement or ongoing issues with a letter or public testimony by the stakeholder.

(9 CCR 2503-5)

3.532 GRANT DETERMINATION [Em. eff. 1/22/15; Rev. eff. 4/1/15]

A. OAP grants shall be calculated on an individual basis, with just one client per case.

B. When a client has been found eligible based upon eligibility rules as outlined in Sections 3.520.6 and 3.520.71, the amount of the client's authorized OAP benefit shall be determined by deducting the client's total countable income from the OAP grant standard.

1. If determined eligible on the first of the month, the client shall receive his/her authorized benefit in the initial and subsequent months.
2. If determined eligible on any other day of the month, the client's first month benefit shall be prorated according to the number of days remaining in the month; the client shall receive their authorized benefit in subsequent months.
3. If a client is receiving services in another Adult Financial (AF) program in the month he/she turns sixty (60) years of age and is otherwise eligible for OAP, the client shall transition from the other AF program to OAP effective the first day of the client's birth month, and receive his/her authorized benefits for the birthday month and subsequent months.

C. If found eligible, the client's eligibility date shall be determined as follows:

1. If the client returns all verifications within the forty-five (45) day processing time frame, the eligibility date shall be the application date.
2. If the client returns all verifications after the forty-five (45) day processing time frame, but within sixty (60) calendar days of the original application date, the eligibility date shall be the date the verifications were returned.
3. If the client returns all verifications after sixty (60) days from the original application date, the client shall be required to re-apply for benefits.

D. If a client is actively attempting to sell, liquidate, or legally acquire a resource or secure available income, the county department shall not delay action on an application.

1. OAP shall be continued without adjustment until the resource or income is available. The county department is urged to monitor the attempts to access the resource or income.
2. If the client refuses or fails to make a reasonable effort to secure a potential resource or income, such resource or income shall be considered as if available, and timely and adequate notice shall be given regarding a proposed action to deny, reduce, or terminate assistance.
3. If the client secures the potential resource or income prior to the effective action date identified in the notice, the proposed action to deny, reduce, or terminate assistance shall be withdrawn by the county, and the case shall be corrected. Benefits may still be denied, reduced, or discontinued due to a change in income or resources.

E. The OAP benefit shall be made directly to the client or to a legally designated person, such as a representative payee, fiduciary, or conservator.

For OAP-C clients, the financial officer of the facility or the client's guardian shall establish a reserve for the client in the amount of the current Personal Needs Allowance (PNA) grant standard for the client's personal needs.

F. The client shall be eligible only for a monthly personal needs allowance when program requirements are met and the client is a resident of a facility at least thirty (30) consecutive days, as follows:

1. In a general medical and surgical hospital~~.~~;
2. In a nursing home, assisted living residence, or, intermediate care facility, group home, host home, or other long-term care facility~~.~~; OR,

3. In a psychiatric facility when sixty-five (65) years of age or older.

G. The following persons are not eligible for a personal needs allowance or OAP benefit:

1. Inmates in a penal institution; or,
2. Residents in an unlicensed private or uncertified public facility.

H. For every full calendar month that the client is a resident in an approved facility, the OAP personal needs allowance maximum shall be ~~seventy seven dollars ($77)~~ **SEVENTY NINE DOLLARS ($79),** effective ~~January 1, 2015~~ **OCTOBER 1, 2016**.

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3.543 GRANT DETERMINATION [Em. eff. 1/22/15; Rev. eff. 4/1/15]

A. AND grants shall be calculated on an individual basis with just one client per case.

B. When a client has been found eligible based upon eligibility rules as outlined in Sections 3.520.6 and 3.520.71, 3.520.72, and 3.520.73, the amount of the client's authorized AND benefit shall be determined by deducting the client's total countable income from the AND grant standard.

1. If determined eligible on the first of the month, the client shall receive his/her authorized benefit in the initial and subsequent months.
2. If determined eligible on any other day of the month, the client's first month benefit shall be prorated according to the number of days remaining in the month; the client shall receive their authorized benefit in subsequent months.

C. If found eligible, the client's eligibility date shall be determined as follows:

1. If the client returns all verifications within the sixty (60) day processing time frame, the eligibility date shall be the application date.
2. If the client returns all verifications after the sixty (60) day processing time frame, but within 90 days of the original application date, the eligibility date shall be the date the verifications were returned.
3. If the client returns all verifications after ninety (90) days from the original application date, the client shall be required to re-apply for benefits.

D. If a client is actively attempting to sell, liquidate, or legally acquire a resource or secure available income, the county department shall not delay action on an application.

1. AND shall be continued without adjustment until the resource or income is available. The county department is urged to monitor the attempts to access the resource or income.
2. If the client refuses or fails to make a reasonable effort to secure a potential resource or income, such resource or income shall be considered as if available, unless the client can show good cause. Timely and adequate notice shall be given regarding a proposed action to deny, reduce, or terminate assistance.
3. If upon receipt of the prior notice, the client secures the potential resource or income prior to the effective action date, the proposed action to deny, reduce, or terminate assistance shall be withdrawn, and the case shall be corrected. Benefits may still be denied, reduced, or discontinued due to a change in income or resources.

E. Except as specified below, the AND benefit shall be made directly to the client.

F. When the client lives in a facility or has a payee, legal fiduciary, or authorized representative, the payment shall be made to the payee, fiduciary, authorized representative, or facility on behalf of the client.

G. The client shall be eligible only for a monthly personal needs allowance when program requirements are met and the client is a resident of a facility at least thirty (30) consecutive days, as follows:

1. In a general medical and surgical hospital;

2. In a nursing home, assisted living residence, or, intermediate care facility, group home, host home, or other long-term care facility.

H. The following persons are not eligible for a personal needs allowance or AND benefit:
1. Inmates in a penal institution; or,
2. Residents in an unlicensed private or uncertified public facility.

I. For every full calendar month that the client is a resident in an approved facility, the AND personal needs allowance maximum shall be ~~seventy seven dollars ($77)~~ **SEVENTY NINE DOLLARS ($79)**, effective ~~January 1, 2015~~ **OCTOBER 1, 2016.**

J. If the Social Security Administration (SSA) is recovering any portion of the client's SSI payment due to an overpayment of benefits, AND-CS shall be calculated based on the gross SSI payment and not the received amount.

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3.570.11 Purpose of Program [Eff. 3/2/14]

A. Home Care Allowance (HCA) is a special cash payment made to a client for the purpose of securing in-home, personal care services.
1. HCA is a non-entitlement program; and,
2. Cannot be received while receiving Home and Community Based Services or Adult Foster Care; and,
3. HCA is designed to serve clients with the lowest functional abilities and the greatest need for paid care.

B. Effective ~~January 1, 2014~~ **OCTOBER 1, 2016**, the HCA grant standard maximums are as follows:
1. Tier 1 - ~~$200.00~~ **$255.00**
2. Tier 2 - ~~$342.00~~ **$397.00**
3. Tier 3 - ~~$475.00~~ **$530.00**

C. The tier grant standard maximums shall be lower for certain clients who have income greater than program limits, as defined in Section 3.570.13, B, or for clients with special circumstances, as defined in Section 3.570.13, D.

D. The HCA grant is not taxable income to the client. The payment made to the care provider using the HCA grant received by the client is income to the care provider and subject to taxation under State and Federal laws.

E. The HCA grant standards shall be adjusted to stay within available appropriations. Appeals shall not be granted for these adjustments.

F. In addition to the regular monthly HCA grant payments, supplemental payments necessary to comply with the federal Maintenance of Effort (MOE) requirements may be provided. These payments are supplements to regular grant payments, are not entitlements, and do not affect grant standards. Appeals shall not be allowed for MOE payment adjustments.

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3.570.21 Purpose of Program [Eff. 3/2/14]

A. Special Populations Home Care Allowance (SP-HCA) is a special cash payment made to a client for the purpose of securing in-home, personal care services.
1. SP-HCA is a non-entitlement program; and,
2. Cannot be received while receiving benefits from a Home and Community Based Services waiver other than Supportive Living Services (HCBS-SLS) or Children's Extensive Supports (HCBS-CES); and,

3. Is for clients that received Home Care Allowance (HCA) and HCBS-SLS or HCBS-CES services for at least one month between September 2011 and December 2011.

B. Effective ~~January 1, 2014~~ **OCTOBER 1, 2016**, the SP-HCA grant standard maximums are as follows:

1. Tier 1 - ~~$200.00~~ **$255.00**
2. Tier 2 - ~~$342.00~~ **$397.00**
3. Tier 3 - ~~$475.00~~ **$530.00**

C. The SP-HCA grant is not taxable income to the client. The payment made to the care provider using the SP-HCA grant received by the client is income to the care provider and subject to taxation under State and Federal laws.

D. The SP-HCA grant standards shall be adjusted to stay within available appropriations. Appeals shall not be granted for these adjustments.

E. In addition to the regular monthly SP-HCA grant payments, supplemental payments necessary to comply with the federal Maintenance of Effort (MOE) requirements may be provided. These payments are supplements to regular grant payments, are not entitlements, and do not affect grant standards. Appeals shall not be allowed for MOE payment adjustments.

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3.583 ELIGIBILITY [Em. eff. 1/22/15; Rev. eff. 4/1/15]

A. The AFC program provides twenty-four (24) hour care and supervision for clients who are:

1. Frail elderly or physically or emotionally disabled adults age eighteen (18) or older who do not require twenty-four (24) hour medical care but who cannot return to their home and need twenty-four (24) hour non-medical supervision; and,
2. Living in a non-medical facility of no more than sixteen (16) clients that is licensed by the Colorado Department of Public Health And Environment (CDPHE); and,
3. Receiving or eligible to receive Old Age Pension (OAP), Aid to the Needy Disabled-Colorado Supplement (AND-CS), or Supplemental Security Income (SSI).

B. AFC shall not be available to persons:

1. Receiving home care allowance; or,
2. With a developmental disability, as defined in 27-10.5-102, C.R.S.; or,
3. Receiving or eligible to receive behavioral or mental health services pursuant to any provision in Title 27, C.R.S.

C. Eligibility for the Adult Foster Care program shall be based on:

1. Financial eligibility; and,
2. Functional eligibility that includes the client's functional assessment, the client's need for twenty-four (24) hour supervision and assistance, and the client's appropriateness for the AFC program.

D. The county department shall determine financial eligibility for AFC.

1. The client's application shall be processed to determine eligibility for OAP or AND-CS, or the county department shall determine whether the client is receiving SSI benefits.
2. If approved for OAP or AND-CS or the client is receiving SSI, deduct the client's income and the OAP or AND-CS grant standard from the AFC maximum grant standard to determine the client's AFC benefit.
3. If a client is receiving or eligible to receive Home Care Allowance (HCA) or a Home and Community Based Services (HCBS) waiver that provides services for any person receiving or eligible to receive services pursuant to any provision in Title

27, C.R.S., eligibility for AFC cannot begin until the first day of the month following the discontinuation of HCA OR HCBS.

4. The AFC benefit shall be paid to the client. The client shall:
    a. Keep ~~$77.00~~ **$79.00** of the payment for personal needs; and,
    b. Use the remainder of the AFC payment to pay a portion of the fee charged by the AFC provider; ~~and~~,
    c. Pay the remainder of the AFC charges using his/her income from OAP, AND/CS, or SSI.
5. AFC facilities shall charge a standard rate of payment for all AFC clients.
    a. The AFC rate charged by the AFC facility shall be no greater than the current maximum AFC grant standard less ~~seventy seven dollars ($77)~~ **SEVENTY NINE DOLLARS ($79)**, effective ~~January 1, 2015~~ **OCTOBER 1, 2016**, for the client's personal needs.
    b. AFC facilities shall charge private pay clients an amount at least equal to that charged to clients receiving an AFC benefit.

E. The Single Entry Point (SEP) shall determine functional eligibility.

To be functionally eligible, the client shall have an AFC eligible functional assessment score as outlined in Section 3.584. The functional assessment score is calculated by determining the client's functional capacity score and need for paid care score, as follows:

1. Functional Capacity: determined by assessing the client's ability to complete all activities of daily living (ADLs) and applying a score to his/her ability to complete the ADLs using the functional impairment scale; and,
2. Determining the client's appropriateness of placement in an AFC facility.

F. When the client is determined functionally eligible for the AFC program, the Single Entry Point (SEP) shall notify the county department. The county department shall notify the SEP when the client has been determined financially eligible for the AFC program.

G. The AFC payment effective date shall be the date that the client was admitted to the AFC facility or the date he/she is determined to be financially eligible, whichever is later. If the client is receiving or eligible to receive Home and Community Based Services (HCBS) pursuant to any provision in Title 27, C.R.S, the effective date is the first day of the month following the discontinuation of HCBS.

(9 CCR 2503-5)

3.532 GRANT DETERMINATION [Em. eff. 1/22/15; Rev. eff. 4/1/15]

A. OAP grants shall be calculated on an individual basis, with just one client per case.

B. When a client has been found eligible based upon eligibility rules as outlined in Sections 3.520.6 and 3.520.71, the amount of the client's authorized OAP benefit shall be determined by deducting the client's total countable income from the OAP grant standard.

1. If determined eligible on the first of the month, the client shall receive his/her authorized benefit in the initial and subsequent months.
2. If determined eligible on any other day of the month, the client's first month benefit shall be prorated according to the number of days remaining in the month; the client shall receive their authorized benefit in subsequent months.
3. If a client is receiving services in another Adult Financial (AF) program in the month he/she turns sixty (60) years of age and is otherwise eligible for OAP, the client shall transition from the other AF program to OAP effective the first day of the client's birth month, and receive his/her authorized benefits for the birthday month and subsequent months.

C. If found eligible, the client's eligibility date shall be determined as follows:

1. If the client returns all verifications within the forty-five (45) day processing time frame, the eligibility date shall be the application date.
2. If the client returns all verifications after the forty-five (45) day processing time frame, but within sixty (60) calendar days of the original application date, the eligibility date shall be the date the verifications were returned.
3. If the client returns all verifications after sixty (60) days from the original application date, the client shall be required to re-apply for benefits.

D. If a client is actively attempting to sell, liquidate, or legally acquire a resource or secure available income, the county department shall not delay action on an application.

1. OAP shall be continued without adjustment until the resource or income is available. The county department is urged to monitor the attempts to access the resource or income.
2. If the client refuses or fails to make a reasonable effort to secure a potential resource or income, such resource or income shall be considered as if available, and timely and adequate notice shall be given regarding a proposed action to deny, reduce, or terminate assistance.
3. If the client secures the potential resource or income prior to the effective action date identified in the notice, the proposed action to deny, reduce, or terminate assistance shall be withdrawn by the county, and the case shall be corrected. Benefits may still be denied, reduced, or discontinued due to a change in income or resources.

E. The OAP benefit shall be made directly to the client or to a legally designated person, such as a representative payee, fiduciary, or conservator.

For OAP-C clients, the financial officer of the facility or the client's guardian shall establish a reserve for the client in the amount of the current Personal Needs Allowance (PNA) grant standard for the client's personal needs.

F. The client shall be eligible only for a monthly personal needs allowance when program requirements are met and the client is a resident of a facility at least thirty (30) consecutive days, as follows:

1. In a general medical and surgical hospital~~.~~;
2. In a nursing home, assisted living residence, or, intermediate care facility, group home, host home, or other long-term care facility~~.~~; OR,

3. In a psychiatric facility when sixty-five (65) years of age or older.

G. The following persons are not eligible for a personal needs allowance or OAP benefit:

1. Inmates in a penal institution; or,
2. Residents in an unlicensed private or uncertified public facility.

H. For every full calendar month that the client is a resident in an approved facility, the OAP personal needs allowance maximum shall be ~~seventy seven dollars ($77)~~ **SEVENTY NINE DOLLARS ($79),** effective ~~January 1, 2015~~ **OCTOBER 1, 2016**.

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3.543 GRANT DETERMINATION [Em. eff. 1/22/15; Rev. eff. 4/1/15]

A. AND grants shall be calculated on an individual basis with just one client per case.

B. When a client has been found eligible based upon eligibility rules as outlined in Sections 3.520.6 and 3.520.71, 3.520.72, and 3.520.73, the amount of the client's authorized AND benefit shall be determined by deducting the client's total countable income from the AND grant standard.

1. If determined eligible on the first of the month, the client shall receive his/her authorized benefit in the initial and subsequent months.
2. If determined eligible on any other day of the month, the client's first month benefit shall be prorated according to the number of days remaining in the month; the client shall receive their authorized benefit in subsequent months.

C. If found eligible, the client's eligibility date shall be determined as follows:

1. If the client returns all verifications within the sixty (60) day processing time frame, the eligibility date shall be the application date.
2. If the client returns all verifications after the sixty (60) day processing time frame, but within 90 days of the original application date, the eligibility date shall be the date the verifications were returned.
3. If the client returns all verifications after ninety (90) days from the original application date, the client shall be required to re-apply for benefits.

D. If a client is actively attempting to sell, liquidate, or legally acquire a resource or secure available income, the county department shall not delay action on an application.

1. AND shall be continued without adjustment until the resource or income is available. The county department is urged to monitor the attempts to access the resource or income.
2. If the client refuses or fails to make a reasonable effort to secure a potential resource or income, such resource or income shall be considered as if available, unless the client can show good cause. Timely and adequate notice shall be given regarding a proposed action to deny, reduce, or terminate assistance.
3. If upon receipt of the prior notice, the client secures the potential resource or income prior to the effective action date, the proposed action to deny, reduce, or terminate assistance shall be withdrawn, and the case shall be corrected. Benefits may still be denied, reduced, or discontinued due to a change in income or resources.

E. Except as specified below, the AND benefit shall be made directly to the client.

F. When the client lives in a facility or has a payee, legal fiduciary, or authorized representative, the payment shall be made to the payee, fiduciary, authorized representative, or facility on behalf of the client.

G. The client shall be eligible only for a monthly personal needs allowance when program requirements are met and the client is a resident of a facility at least thirty (30) consecutive days, as follows:

1. In a general medical and surgical hospital;

2. In a nursing home, assisted living residence, or, intermediate care facility, group home, host home, or other long-term care facility.

H. The following persons are not eligible for a personal needs allowance or AND benefit:

1. Inmates in a penal institution; or,
2. Residents in an unlicensed private or uncertified public facility.

I. For every full calendar month that the client is a resident in an approved facility, the AND personal needs allowance maximum shall be ~~seventy seven dollars ($77)~~ **SEVENTY NINE DOLLARS ($79)**, effective ~~January 1, 2015~~ **OCTOBER 1, 2016.**

J. If the Social Security Administration (SSA) is recovering any portion of the client's SSI payment due to an overpayment of benefits, AND-CS shall be calculated based on the gross SSI payment and not the received amount.

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3.570.11 Purpose of Program [Eff. 3/2/14]

A. Home Care Allowance (HCA) is a special cash payment made to a client for the purpose of securing in-home, personal care services.

1. HCA is a non-entitlement program; and,
2. Cannot be received while receiving Home and Community Based Services or Adult Foster Care; and,
3. HCA is designed to serve clients with the lowest functional abilities and the greatest need for paid care.

B. Effective ~~January 1, 2014~~ **OCTOBER 1, 2016**, the HCA grant standard maximums are as follows:

1. Tier 1 - ~~$200.00~~ **$255.00**
2. Tier 2 - ~~$342.00~~ **$397.00**
3. Tier 3 - ~~$475.00~~ **$530.00**

C. The tier grant standard maximums shall be lower for certain clients who have income greater than program limits, as defined in Section 3.570.13, B, or for clients with special circumstances, as defined in Section 3.570.13, D.

D. The HCA grant is not taxable income to the client. The payment made to the care provider using the HCA grant received by the client is income to the care provider and subject to taxation under State and Federal laws.

E. The HCA grant standards shall be adjusted to stay within available appropriations. Appeals shall not be granted for these adjustments.

F. In addition to the regular monthly HCA grant payments, supplemental payments necessary to comply with the federal Maintenance of Effort (MOE) requirements may be provided. These payments are supplements to regular grant payments, are not entitlements, and do not affect grant standards. Appeals shall not be allowed for MOE payment adjustments.

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3.570.21 Purpose of Program [Eff. 3/2/14]

A. Special Populations Home Care Allowance (SP-HCA) is a special cash payment made to a client for the purpose of securing in-home, personal care services.

1. SP-HCA is a non-entitlement program; and,
2. Cannot be received while receiving benefits from a Home and Community Based Services waiver other than Supportive Living Services (HCBS-SLS) or Children's Extensive Supports (HCBS-CES); and,

3. Is for clients that received Home Care Allowance (HCA) and HCBS-SLS or HCBS-CES services for at least one month between September 2011 and December 2011.

B. Effective ~~January 1, 2014~~ **OCTOBER 1, 2016**, the SP-HCA grant standard maximums are as follows:

1. Tier 1 - ~~$200.00~~ **$255.00**
2. Tier 2 - ~~$342.00~~ **$397.00**
3. Tier 3 - ~~$475.00~~ **$530.00**

C. The SP-HCA grant is not taxable income to the client. The payment made to the care provider using the SP-HCA grant received by the client is income to the care provider and subject to taxation under State and Federal laws.

D. The SP-HCA grant standards shall be adjusted to stay within available appropriations. Appeals shall not be granted for these adjustments.

E. In addition to the regular monthly SP-HCA grant payments, supplemental payments necessary to comply with the federal Maintenance of Effort (MOE) requirements may be provided. These payments are supplements to regular grant payments, are not entitlements, and do not affect grant standards. Appeals shall not be allowed for MOE payment adjustments.

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3.583 ELIGIBILITY [Em. eff. 1/22/15; Rev. eff. 4/1/15]

A. The AFC program provides twenty-four (24) hour care and supervision for clients who are:

1. Frail elderly or physically or emotionally disabled adults age eighteen (18) or older who do not require twenty-four (24) hour medical care but who cannot return to their home and need twenty-four (24) hour non-medical supervision; and,
2. Living in a non-medical facility of no more than sixteen (16) clients that is licensed by the Colorado Department of Public Health And Environment (CDPHE); and,
3. Receiving or eligible to receive Old Age Pension (OAP), Aid to the Needy Disabled-Colorado Supplement (AND-CS), or Supplemental Security Income (SSI).

B. AFC shall not be available to persons:

1. Receiving home care allowance; or,
2. With a developmental disability, as defined in 27-10.5-102, C.R.S.; or,
3. Receiving or eligible to receive behavioral or mental health services pursuant to any provision in Title 27, C.R.S.

C. Eligibility for the Adult Foster Care program shall be based on:

1. Financial eligibility; and,
2. Functional eligibility that includes the client's functional assessment, the client's need for twenty-four (24) hour supervision and assistance, and the client's appropriateness for the AFC program.

D. The county department shall determine financial eligibility for AFC.

1. The client's application shall be processed to determine eligibility for OAP or AND-CS, or the county department shall determine whether the client is receiving SSI benefits.
2. If approved for OAP or AND-CS or the client is receiving SSI, deduct the client's income and the OAP or AND-CS grant standard from the AFC maximum grant standard to determine the client's AFC benefit.
3. If a client is receiving or eligible to receive Home Care Allowance (HCA) or a Home and Community Based Services (HCBS) waiver that provides services for any person receiving or eligible to receive services pursuant to any provision in Title

27, C.R.S., eligibility for AFC cannot begin until the first day of the month following the discontinuation of HCA OR HCBS.

4. The AFC benefit shall be paid to the client. The client shall:
    a. Keep ~~$77.00~~ **$79.00** of the payment for personal needs; and,
    b. Use the remainder of the AFC payment to pay a portion of the fee charged by the AFC provider; ~~and~~,
    c. Pay the remainder of the AFC charges using his/her income from OAP, AND/CS, or SSI.
5. AFC facilities shall charge a standard rate of payment for all AFC clients.
    a. The AFC rate charged by the AFC facility shall be no greater than the current maximum AFC grant standard less ~~seventy seven dollars ($77)~~ **SEVENTY NINE DOLLARS ($79)**, effective ~~January 1, 2015~~ **OCTOBER 1, 2016**, for the client's personal needs.
    b. AFC facilities shall charge private pay clients an amount at least equal to that charged to clients receiving an AFC benefit.

E. The Single Entry Point (SEP) shall determine functional eligibility.

To be functionally eligible, the client shall have an AFC eligible functional assessment score as outlined in Section 3.584. The functional assessment score is calculated by determining the client's functional capacity score and need for paid care score, as follows:

1. Functional Capacity: determined by assessing the client's ability to complete all activities of daily living (ADLs) and applying a score to his/her ability to complete the ADLs using the functional impairment scale; and,
2. Determining the client's appropriateness of placement in an AFC facility.

F. When the client is determined functionally eligible for the AFC program, the Single Entry Point (SEP) shall notify the county department. The county department shall notify the SEP when the client has been determined financially eligible for the AFC program.

G. The AFC payment effective date shall be the date that the client was admitted to the AFC facility or the date he/she is determined to be financially eligible, whichever is later. If the client is receiving or eligible to receive Home and Community Based Services (HCBS) pursuant to any provision in Title 27, C.R.S, the effective date is the first day of the month following the discontinuation of HCBS.