May CM Webinar

Wednesday, May 20th, 2026

Stephanie R. Nickles

Clinical Training Manager

CountyCare
A MEDICAID HEALTH PLAN

Meeting Schedule

Wednesday, May 20th, 2026

1. Kasey Reid-Parker and Estela Estrada-Next step waiver conversion. (35 minutes)
2. Elizabeth Martinez- Serenity Home Healthcare (25 mins)

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Waiver Conversion Training
May 20th, 2026

Estela Estrada

LTSS Program Manager

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Agenda

- Overview of the Home and Community Based Services (HCBS) Program
- Eligibility (IDoA & DRS) and Referral and Referral Triage
- DON Assessment Process / Waiver Application
- Timelines, & Case Examples
- Post-Eligibility Responsibilities & Outreach Requirements

Philosophy of the Home and Community Based Services (HCBS) Program

CountyCare HCBS - Waiver

- Ensure our members have the option to remain at home or live in a community setting as an alternative to institutionalization.
- Support our member's desire to live as independently as possible and in the most integrated, appropriate and chosen setting, for as long as they are able.
- Established in 1979 by Public Act 81-202, the Illinois Department on Aging's Community Care Program helps older adults who might otherwise need nursing home care to remain in their homes by providing in-home and community-based services.
- The Community Care Program aims to assist older adults in maintaining their independence and providing cost-effective alternatives to nursing home placement. These services include comprehensive care coordination, adult day services, in-home services, emergency home response services, and automated medication dispenser service.
- The Community Care Program is available to any person who requests services and meets all current eligibility requirements.
- Eligibility for in-home support services is not based solely on a medical diagnosis. It also considers a member's functional status, including their ability to complete Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).

Eligibility – HCBS Waiver Program

CountyCare – Operates 5 Waiver Programs

Eligibility

- Be at risk of nursing facility placement as measured by the Determination of Need (DON) Assessment
- Estimated cost of community-based care is less than the estimated cost for institutional care

Waiver Programs

1. Aging Waiver (age 60+)
2. Persons with Disabilities (under 60 at time of application)

    **Kids – Customers under age 18*

    - ✓ Home Services Program (HSP) does not have minimum age requirements.
    - ✓ Parents/legal guardians are responsible for providing and/or funding the cost of providing care to their minor child.
    - ✓ HSP is not a resource for families are who are lacking childcare or support systems.

3. Persons living with HIV/AIDS (of any age)
4. Persons with Brain Injury (of any age)
5. Supportive Living Facility Waiver (persons age 22-64 who have a physical disability per SSA or persons age 65+)

Overview of Illinois Department on Aging HCBS Program

IDoA- Aging Waiver

- The Community Care Programs (CCP) core services include homecare aides, adult day services, emergency home response services and automated medication dispensers.
- In-Home Services assist with household tasks such as cleaning, planning and preparing meals, doing laundry, shopping and running errands. Homemakers also assist clients with personal care tasks, such as dressing, bathing, grooming and following special diets.

Overview of Division of Rehabilitation Services HCBS Program

DRS- Persons with Disabilities

- Program provides services to individuals with disabilities so they can remain in their homes and be as independent as possible.
- Independent Living Model- Offers choices and self-directed options for care
  - Persons with disabilities are the best experts on their own needs, particularly in reference to services that impact their day-to-day lives and access to independence.
- Services include Personal Assistant (PA), homemaker, Adult Day Care, Home Delivered Meals, Emergency Response, Assistive Equipment & Environmental Modifications, and Respite.

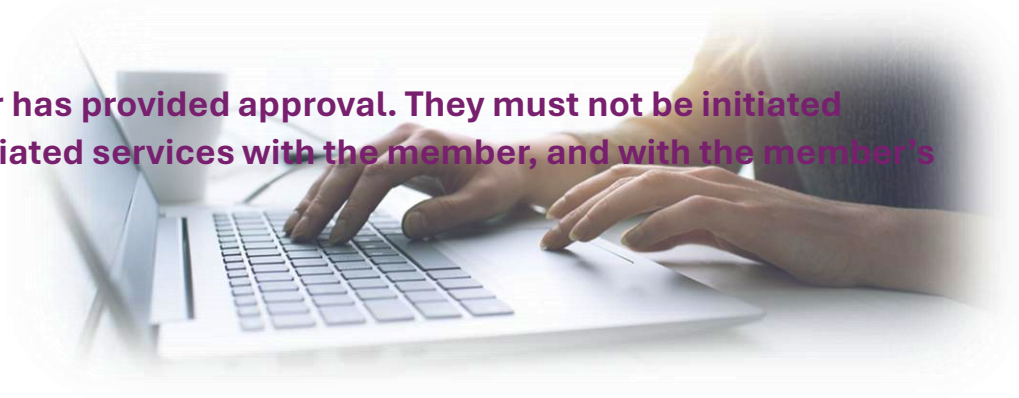
Submitting Referrals to DRS and IDoA

- Referrals to **Division of Rehabilitation Waiver Services (Persons with Disabilities, Brain Injury and HIV waivers)** are made online at: https://wr.dhs.illinois.gov/wrpublic/wr/dynamic/referral.jsf or by calling 1(800)843-6154 – 1(866) 324-5553 TTY
  *Provide MCO Code 56 when referring

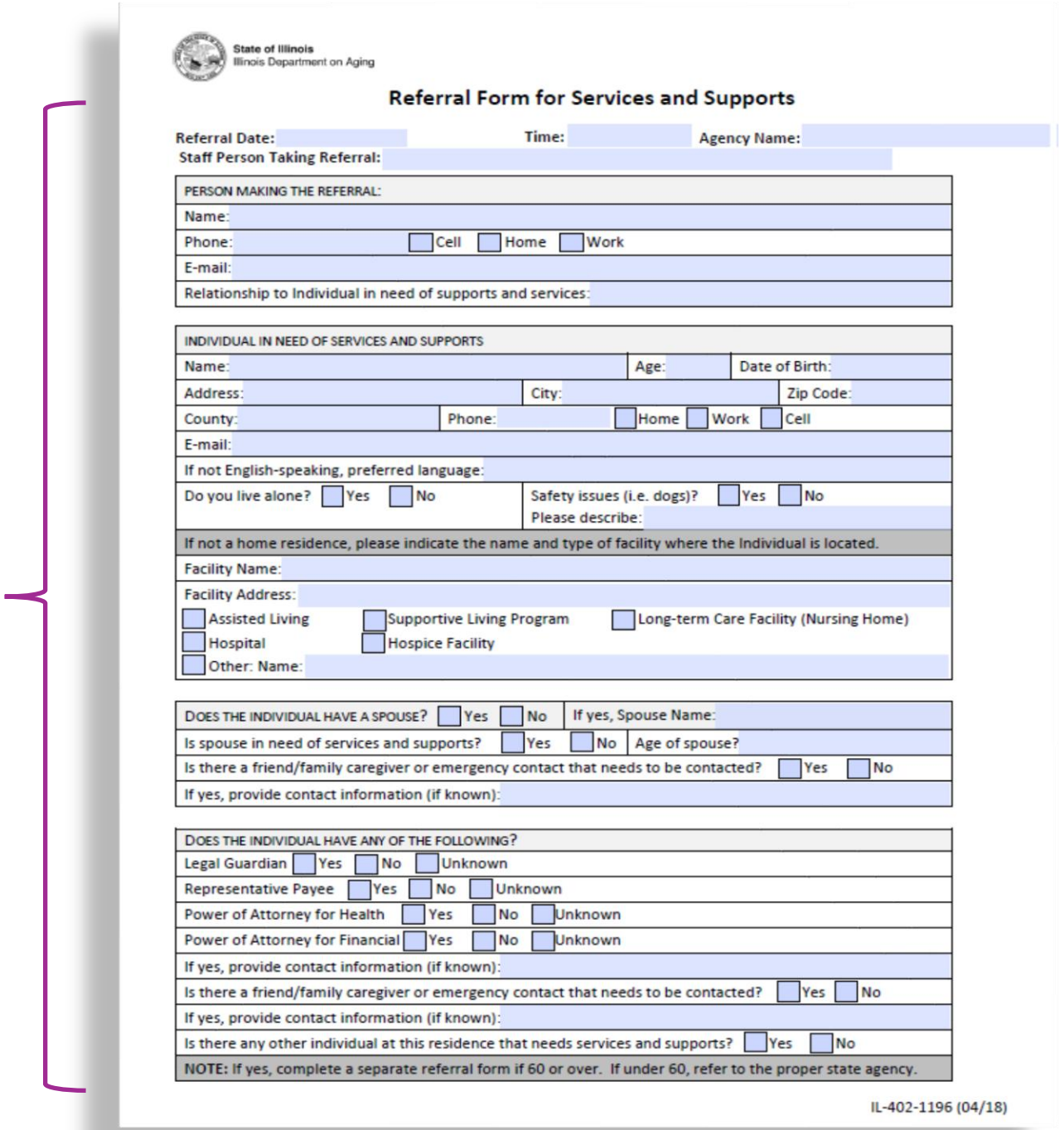
- Referrals to **Department on Aging Waiver Services (Elderly waiver)** MCOs are required to refer all members for **Aging waiver** services directly to the local **Care Coordination Units (CCUs).** Here is the information link for each CCU contact:
  https://webapps.illinois.gov/AGE/ProviderProfileSearch/Search
  Step 1: For Service Type: Select "Care Coordination Unit (CCU)"
  Step 2: Enter geographic location information (in/out Chicago, or township name)
  Step 3: Will populate a page with each CCU contact information

Or by calling 1(800) 252-8966, after choosing language, press #4 or by calling 1(888) 206-1327 (TTY)

***Referrals may only be made after the member has provided approval. They must not be initiated without prior discussion of the referral and associated services with the member, and with the member's family when appropriate.**



IDoA Referral Form



State of Illinois
Illinois Department on Aging

Referral Form for Services and Supports

Referral Date: **Time:** **Agency Name:**
Staff Person Taking Referral:

PERSON MAKING THE REFERRAL:
Name:
Phone: ☐ Cell ☐ Home ☐ Work
E-mail:
Relationship to Individual in need of supports and services:

INDIVIDUAL IN NEED OF SERVICES AND SUPPORTS		
Name:	Age:	Date of Birth:
Address:	City:	Zip Code:
County:	Phone: ☐ Home ☐ Work ☐ Cell	
E-mail:		
If not English-speaking, preferred language:		
Do you live alone? ☐ Yes ☐ No	Safety issues (i.e. dogs)? ☐ Yes ☐ No Please describe:	
If not a home residence, please indicate the name and type of facility where the Individual is located.		
Facility Name:		
Facility Address:		
☐ Assisted Living ☐ Supportive Living Program ☐ Long-term Care Facility (Nursing Home) ☐ Hospital ☐ Hospice Facility ☐ Other: Name:		

DOES THE INDIVIDUAL HAVE A SPOUSE? ☐ Yes ☐ No	If yes, Spouse Name:
Is spouse in need of services and supports? ☐ Yes ☐ No	Age of spouse?
Is there a friend/family caregiver or emergency contact that needs to be contacted? ☐ Yes ☐ No	
If yes, provide contact information (if known):	

DOES THE INDIVIDUAL HAVE ANY OF THE FOLLOWING?
Legal Guardian ☐ Yes ☐ No ☐ Unknown
Representative Payee ☐ Yes ☐ No ☐ Unknown
Power of Attorney for Health ☐ Yes ☐ No ☐ Unknown
Power of Attorney for Financial ☐ Yes ☐ No ☐ Unknown
If yes, provide contact information (if known):
Is there a friend/family caregiver or emergency contact that needs to be contacted? ☐ Yes ☐ No
If yes, provide contact information (if known):
Is there any other individual at this residence that needs services and supports? ☐ Yes ☐ No
NOTE: If yes, complete a separate referral form if 60 or over. If under 60, refer to the proper state agency.

IL-402-1196 (04/18)

DRS Online Referral

DHS: Rehabilitation Services: Apply Online

If you live in Illinois and have a disability, the Division of Rehabilitation Services may be able to help you find a job or live at home independently.

To apply for services, begin by completing the form below. Once you have submitted this form, a counselor will contact you to set up an appointment to complete the application process. During this appointment, we will discuss your goals, the nature of your disability, and the services we can provide.

To learn more about the types of services available, please see Rehabilitation Services.

Service
- ☐ I would like help getting or keeping a job
- ☑ I would like help living independently at home

I have the *most* difficulty
First Name
Middle Name
Last Name
Gender at Birth
Date of Birth
Social Security Number
Zip Code
Street Address
Apartment Number
City
County
Phone Number
Phone Mode — Voice
Phone Type — Landline
Email Address
Verify Email Address
Language Preference
Other Language
Are you transitioning from a long term care facility?
Referral Source
Please enter security code25467*

Submit

Managed Care Referrals

Email Address
Verify Email Address
Language Preference
Other Language
Are you transitioning from a long term care facility?
Referral Source — Managed Care Organization
Managed Care ID — MCO Code 56
Medicaid RIN
Primary Impairment
Primary Cause
Referral Source Name
Referral Source Phone
Referral Source TTY
Referral Source Email
Verify Referral Source Email
Please enter security code25467*

Submit

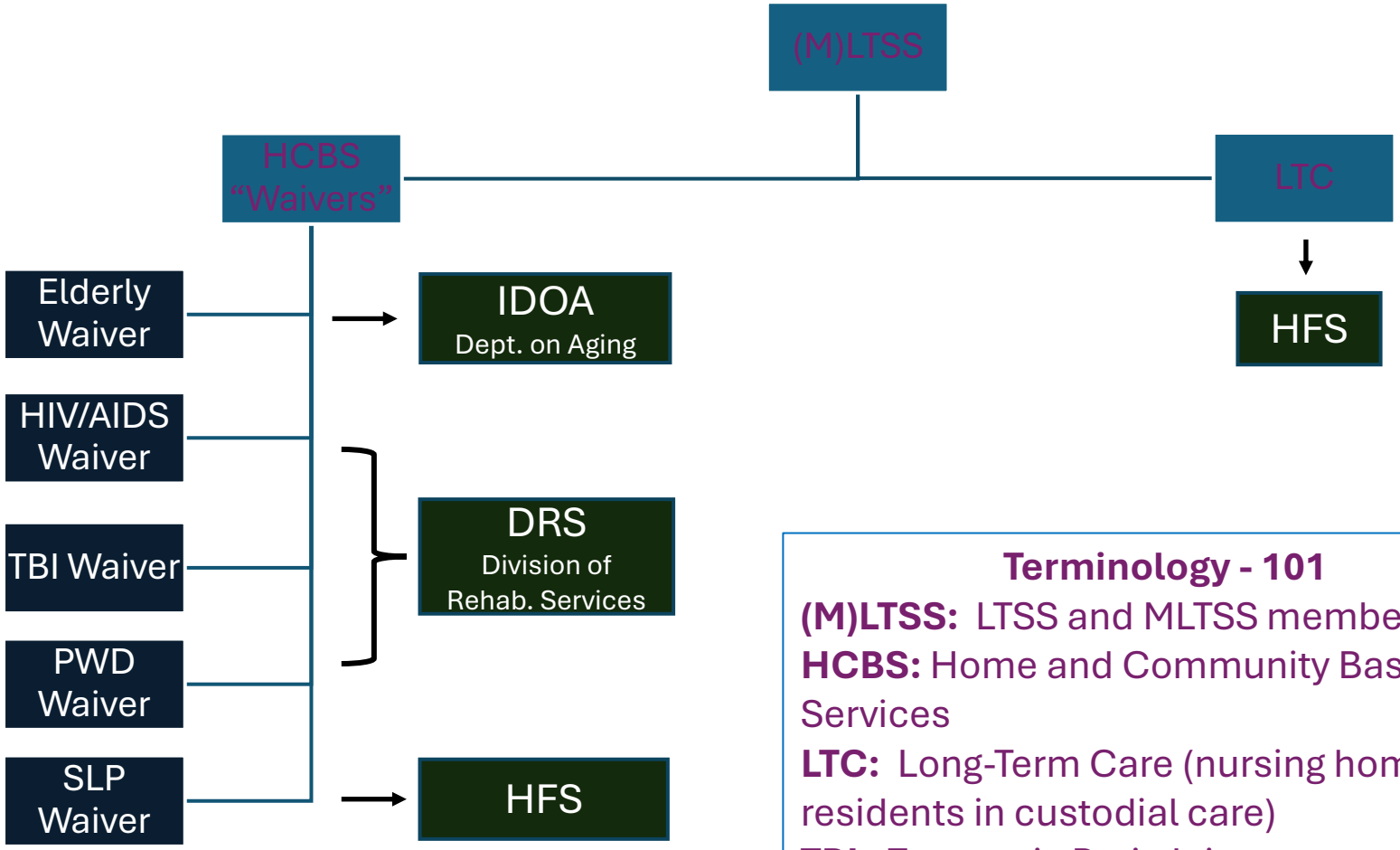
DRS Referral Triage: Assessing Risk and Urgency

- DRS triages the referrals it receives by reviewing, sorting, and prioritizing them based on urgency.
- This formal triage process helps field offices identify customers who are at the greatest risk of health and safety concerns and/or institutionalization.
- Cases are triaged based on level of need, with the highest priority given to individuals who have recently transitioned from the hospital or have a newly diagnosed terminal illness.

DRS Triage Categories:

- Transition referrals
- Terminal Illness
- Sudden loss of caregiver
- Ventilator Dependent
- Referrals due to abuse/neglect or exploitation
- Persons with HIV/AIDS
- Hospital Referrals
- Must be new to disability
- Other

Who Determines LTSS Eligibility



Terminology - 101

(M)LTSS: LTSS and MLTSS members
HCBS: Home and Community Based Services
LTC: Long-Term Care (nursing home residents in custodial care)
TBI: Traumatic Brain Injury
PWD: Persons with Disabilities
SLP: Supportive Living Provider

Eligibility is based on the Determination of Need Assessment (DON)

Determination of Need (DON) Assessment

- A functional assessment (not a clinical or medical evaluation) that is required for determining waiver eligibility. IDoA/DRS completes the DON assessments.
- Emphasis on the ability to do a task, not the diagnosis, disease, or assumed impairment
- Respite services are available to provide relief to primary care givers.
- Assessors are not medical staff and information regarding an individual's conditions are self-reported (from individual, family/friends, facility staff, etc.)

<u>The DON consists of 2 parts:</u>

1. Mini Mental State Examination (MMSE) which measures cognitive functioning
2. Functional assessment which includes 15 items

<u>The DON & Children</u>

- Children 12 & Under- 10 pts on MMSE
- Developmental Milestones
- Parental responsibilities
- Undue Burden
- Respite services are available to provide relief to primary care givers.

DON score of 29 or higher= waiver eligible

Determination of Need (DON)

The Cognitive Assessment evaluates a member's cognitive abilities, including memory, decision-making, and understanding.

Cognitive Assessment

Functional Assessment

MINI-MENTAL STATE EXAMINATION **Client Name:** _____ **Date** __/__/____

Care Coordinator is to administer all 11 questions equivalent to a score of 30.

____ (5) 1. What is the (year) (season) (day) (date) (month) ?

____ (5) 2. Where are we (state) (county) (town) (nursing facility/hospital) (floor) ?

____ (3) 3. ame 3 objects. Allow 1 second to say each. Ask the client all 3 after you have said them. ive 1 point for each CORRECT answer in the first trial only. Then repeat the 3 objects until the client learns all 3. Count trials and repeat the 3 objects until the client learns all 3. Count trials and record. Trials _____

____ (5) 4. Spell "WORLD" backwards. Score 1 point for each letter in the CORRECT order.

"D" "L" "R" "O" "W"

____ (3) 5. Ask for the three objects repeated in question 3. Give 1 point for each CORRECT answer.

____ (2) 6. Identify a pencil and a watch.

____ (1) 7. Repeat the following: "No ifs, ands or buts."

____ (3) 8. Follow a 3-stage command: "Take a paper in your right hand, fold it in half and put it in your lap."

____ (1) 9. Read and obey the following: CLOSE YOUR EYES.

____ (1) 10. Write a sentence.

____ (1) 11. Copy a design.

Maximum score is 30. er **TOTAL** rrect answer for MMSE score. ____

1. For MMSE box below: e is equal or more than "21"– enter "0"; if score is "20" or less– enter "10"

2. For the MMSE Plus score: s additional 10 points to the total MMSE Box below; if appropriate documentation is provided for ng sted below. (Rule 240:715, d) 1) C))

Court adjudication as incompetent or disabled, Physician/Psychiatrist certifies need for 24 hour supervision; **and,** Physician/Psychiatrist certifies presence of Alzheimer's disease, OBS, or dementia.

A. **NON-COGNITIVE PROBLEM** is affecting the MMSE score ☐ **Yes** ☐ **No** If yes, **check** the correct non-cognitive problem below:
☐ **Vision/Hearing Problem** ☐ **Language Barrier** ☐ **Low Education/Can't Read** ☐ **Physical Impairment** ☐ **Other:** _____

If Mini-Mental State Examination score total is: 21-30, proceed with the DON; informant not needed. 20 points or less: An informant may be needed.
1. Informant Available: ☐ **Yes** ☐ **No** **2. Informant Used:** ☐ **Yes** ☐ **No** **3. Name:** _____ **4. Relationship:** _____

E. DETERMINATION OF NEED (Functional Status - Activities of Daily Living/Instrumental Activities of Daily Living)

FUNCTION	A. LEVEL OF IMPAIRMENT				B. UNMET NEED FOR CARE				A. Case Notes	B. Case Notes
1. Eating	0	1	2	3	0	1	2	3		
2. Bathing	0	1	2	3	0	1	2	3		
3. Grooming	0	1	2	3	0	1	2	3		
4. Dressing	0	1	2	3	0	1	2	3		
5. Transferring	0	1	2	3	0	1	2	3		
6. Continence	0	1	2	3	0	1	2	3		
7. Managing Money	0	1	2	3	0	1	2	3		
8. Telephoning	0	1	2	3	0	1	2	3		
9. Preparing Meals	0	1	2	3	0	1	2	3		
10. Laundry	0	1	2	3	0	1	2	3		
11. Housework	0	1	2	3	0	1	2	3		
12. Outside Home	0	1	2	3	0	1	2	3		
13. Routine Health	0	1	2	3	0	1	2	3		
14. Special Health	0	1	2	3	0	1	2	3		
15. Being Alone	0	1	2	3	0	1	2	3		
TOTAL	0				0					

The Functional Assessment part of the DON evaluates a member's ability to perform **Activities of Daily Living (ADLs)**—personal tasks (Questions 1–6)—and **Instrumental Activities of Daily Living (IADLs)—**non-personal tasks (Questions 7–15).

Waiver Eligible Members

- Notification, no matter which way it comes, starts the clock.
- We have 15 days (and in some cases 2 days for Interim's) from date of notification to:
  - ✓ Conduct a face-to-face visit
  - ✓ Complete an assessment
  - ✓ Establish a service plan that coincides with the care plan

Case Progression

STEP 1

REFERRAL

- Care Coordinator (CC) identifies member who would benefit from waiver services
- CC discusses with member/member family waiver benefits
- Member agrees to referral.
- CC refers member to appropriate agency- IDoA (via CCU referral) or DRS (via the DRS online referral site)
- Time frames for DON assessments can vary on the number of referrals in the queue at the local CCU/DRS office

STEP 2

APPLICATION

- All members are required to complete an application for services
- IDoA/DRS are responsible for gathering all the information needed to complete the application and determine eligibility at the time of the DON assessment
- Members must provide all required documentation at time of assessment to ensure application can be submitted promptly

STEP 3

FORMAL ELIGIBILITY

- While timelines may vary, the eligibility process typically takes at least three months from the time a member is referred for waiver services to the implementation of those services.
- Formal waiver eligibility is achieved when a member has a score of 29 or higher on the DON.
- When a case transitions to formal eligibility, the MCO is notified for outreach to the newly eligible waiver member, and the member's risk level is updated to High Risk.

STEP 4

CASE CLOSURE

- An incomplete application can result in case closure
- Possible reasons for case closure are:
  - Inability to locate member
  - Refusal to cooperate with application process
  - Condition improved, services not needed
  - Customer refused services
- Members may request assessment for services at any time, even if they previously declined services

Estimated Timelines (Internal Case Review Findings)

- Timeframes for IDoA referrals depend on the volume of referrals received by the local CCU, as well as factors such as staffing availability to complete assessments.
- Timeframes for DRS referrals vary based on triage status and the number of referrals received by the local DRS office.
- A typical timeframe from the point a referral is made to the implementation of services is approximately 3-4 months, depending on waiver program being applied to.

Case 1: IDoA

- Member referred to CCU on 11/24/2025
- Member assessed by CCU on 2/6/2026
- Eligibility date: 2/1/2026
- HRS completed by health plan on 2/9/2026
- Initial home visit conducted by County Care CC on 2/27/2026

Case 2: DRS

- Member referred to DRS on 10/29/2025
- Member assessed by DRS on 1/30/2026
- Eligibility date: 3/3/2026
- HRS completed by health plan on 3/16/2026
- Initial home visit conducted by County Care CC on 3/19/2026

**Reminder: DRS uses both member need and DON score when triaging cases. Members in hospice or being discharged from rehab will receive the highest priority which can impact timeframes.*

How Members Can Support Their Applications: Member Actions

Be available for call from IDoA or DRS:

It is important members be available to answer their phone, this allows IDoA or DRS to schedule the in-home visit. Being reachable ensures the member can complete the next step in the waiver assessment process.

Have all needed information available:

Have all required documentation ready at time of the IDoA or DRS home visit, including a list of medications, medical history, PCP name and phone number, and income information.

Contact agency (IDoA/DRS) for updates:

Request a contact phone from case worker completing in-home assessment for updates on status of waiver eligibility. Members can also contact assigned CME/HP CC for help with updates on status of waiver applications.

Waiver Conversion Referral Tracker

Kasey Reid-Parker, LCSW, CCM
Manager, Care Management

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Step-by-Step Submission Process

After Care Manager refers member to DRS/IDoA

Access the Waiver Referral Form – Waiver Referral - Clinical Operations

1. Enter the Date of Submission (today's date – M/d/yyyy).
2. Complete all Member Information fields: Member RIN, First and Last Name, Date of Birth, and Zip Code.
3. Select the correct CME Name: HP, MHN, ACCESS, or DSCC.
4. Enter the Care Manager Name and Email Address.
5. Select the referral agency: IDoA (Aging) or DRS (PWD, TBI, HIV).
6. Enter the Date of Referral (actual date referral made to DRS/IDoA – M/d/yyyy).
7. Select the primary Reason for Referral.
8. If 'Other' is selected, clearly explain the reason for referral.
9. Review all required fields for accuracy and click Submit.

The referral form is exported to a spreadsheet and tracked by the CM Oversight Team and CME Leadership during the application process conducted by IDoA or DRS.

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Point of Contact

- Kasey Reid-Parker, Manager- Acct. Mgr. Access

Email: kasey.reid@cookcountyhealth.org

- Daniel Krantz, Senior Manager

Email: Daniel.krantz@cookcountyhealth.org

- Lauren Dillon, Program Manager- Acct. Mgr. MHN

Email: lauren.Dillon@cookcountyhealth.org

- Joanne Leslie, Nurse Coordinator-Acct. Mgr. DSCC

Email: joanne.Leslie@cookcountyhhs.org

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Thank You

CountyCare HEALTH PLAN

Serenity Home Healthcare

SERENITY
Quality Care, Quality Life

- Strengthen the partnership between Serenity Home Healthcare and County Care.
- Provide updates about Serenity's services, communication process, and expansion.
- Gather Feedback to improve collaboration and client care.
- Explore ways to better support clients.

Purpose of the Meeting

SERENITY
Quality Care, Quality Life

Our agency is dedicated to providing high-quality home healthcare services with a focus on compassionate and personalized care. We aim to support patients' health and independence while collaborating closely with case managers in Illinois to ensure seamless care coordination and positive outcomes.

We value professionalism, reliability, and clear communication to meet and exceed expectations.

Introduction

SERENITY
Quality Care, Quality Life

01

Introduction to Our Home Healthcare Agency

Our mission is to deliver comprehensive and compassionate home healthcare with a patient-centered approach. We strive to enhance quality of life through emphasizing dignity and respect for every individual we serve.

Our vision is to be the trusted partner for case managers and healthcare professionals, driving excellent outcomes in Illinois.

Mission and Vision

LOCATIONS

- NILES
- AURORA
- WAUKEGAN
- SOUTH HOLLAND
- CHATHAM
- BROADWAY
- WEST ENGLEWOOD
- BRIDGEVIEW
- EAST CHICAGO
- ROCKFORD
- NORTH CHICAGO
- BRONZEVILLE
- NORTH RIVERSIDE
- SCHAUMBURG
- MADISON

We provide extensive homecare services throughout Illinois, ensuring prompt access and localized care. Our team is well-versed in the area's needs, allowing us to address diverse patient populations with cultural sensitivity and expertise.

Service Areas

Commitment to Quality and Compassionate Care

The Wellness and Satisfaction Team at Serenity:

-Performs Spot checks and reports any concerns to the Branchmanager.

-Start of care visit.

-Satisfaction survey.

-Educates both new and existing clients on the documentationrequired for Medicaid reassessment eligibility.

The Compliance and Quality Control team Serenity:

-ensure clients hours are utilized.

-visits branches to ensure compliance.

-ensures caregivers are compliant with their certifications andtraining.

02

Services Offered and Support for Case Managers

- Our programs are designed to help clients maintain their daily routines and reduce the risk of hospital readmissions due to falls or changes in health.
- Caregivers diligently report any health changes to our office and monitor for signs that may require intervention.
- Our team includes:
  - Trained caregivers experienced in dementia and Alzheimer's care
  - Certified Nursing Assistants (CNAs) for bed bound clients requiring assistance with diaper changes and Hoyer lifts
- We offer 24/7 call availability and are on-call for urgent needs.
- We accept most private insurance plans, VA, Medicaid, and private pay.
- Our marketing team assists with home care referrals and ensures CCP participants receive the services they need.
- Provide respite care.

Home Care Services

We prioritize open, timely communication with case managers and healthcare providers, ensuring seamless information sharing.

Our care coordination efforts help align treatment plans, schedule regular updates, and reduce hospital readmissions, facilitating better overall patient care management.

Care Coordination and Communication

1. Once authorization is received, the branch manager is notified.
2. The branch manager coordinates and sets up services.
3. Referring partners receive updates and confirmations.
4. Ongoing communication ensures transparency and trust.

Referral & Communication Process

Our skilled nursing team provides expert medical care including wound management, medication administration, and chronic disease monitoring.

We also offer comprehensive physical, occupational, and speech therapy designed to enhance recovery and promote independence, vital for patient progress and satisfaction.

Skilled Nursing and Therapy Services

Caregivers go through background checks and screening interviews.
We focus on trustworthy and reliable caregivers.

Multilingual caregivers available: Spanish, Polish, Ukrainian, Hindi, Urdu, Arabic, Cantonese, Mandarin and more.

Ready-to-start caregivers available for multiple service areas.

Caregiver Hiring & Language Support

- Opened a new branch in Schaumburg and W. Madison.
- Expanded to Ohio, Milwaukee, Minnesota, Indiana, Detroit.
- Focused on increasing accessibility and service coverage.
- Building stronger partnerships with healthcare organizations.

Growth & Expansion

Do you have any questions?

faxes@serenityhhc.com

www.serenityhhc.com

Thank you

SERENITY

Quality Care, Quality Life

Announcements

- Our next webinar is Wednesday June 17th at 2:00pm.
- Slides posted on CountyCare Care Coordination Webpage:
  - http://www.countycare.com/carecoordination
- Have feedback? Ideas for future topics? Please share!
  - https://redcap.link/23k1fzzb
    - Please email questions/concerns: stephanie.nickles@cookcountyhealth.org