



HCBS Waiver Conversion— Referral Guide

Purpose of HCBS Waiver Programs

- Support members in remaining at home or in the community as an alternative to institutional care
- Focus on independence, safety, and functional need—not diagnosis alone
- 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)

Waiver Programs

- Aging Waiver (60+)- Refer to Illinois Department of Aging (IDoA)
- Persons with Disabilities (under 60 at application)- Refer to Division of Rehabilitation Services
- Brain Injury (no age requirement)- Refer to Division of Rehabilitation Services
- HIV/AIDS (no age requirement)- Refer to Division of Rehabilitation Services

Eligibility Basics

- Members must be at risk of nursing facility placement
- Eligibility determined by the Determination of Need (DON) assessment
- DON score of 29 or higher is required to receive waiver services
- Community care costs must be less than institutional care

What is the DON Assessment

- Functional—not medical—assessment
- Focuses on ability to perform tasks rather than diagnosis
- Includes a cognitive assessment and functional assessment (ADLs and IADLs)

Referral Process

- Members are identified as potentially eligible for waiver services due to health needs or functional limitations with ADL/IADLs
- Referral submitted to IDoA (via CCU)- [Provider Profile Search](#) or DRS (online system) [DHS: Rehabilitation Services: Apply Online](#)

- After referral to DRS or IDoA, care coordinator submits the Automated Online Waiver Conversion Referral/Tracking Form- ***As a reminder, this is the internal referral tracker found on the County Care Coordination website: [Care Coordination – CountyCare Health Plan](#)***
- Application and DON assessment completed
- Eligibility determination made
- CountyCare is notified to begin outreach if member is approved for waiver services within 15 days of notification date
- Member is stratified to “high risk” once deemed eligible

Typical Timeframes

- Timeframes vary based on referral volume, staffing, and triage status at office receiving referral
- **The typical timeframe from referral to service implementation is a minimum of three months**

Member and Current Care Coordinator Responsibilities

- Be available to answer phone calls from IDoA or DRS (member)
- Participate in the in-home visit (member)
- Have required documentation ready: medication list, PCP contact information, income details, medical history (member)
- Request a contact phone number from IDoA or DRS 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. (member and care coordinator)

