INSTRUCTIONS
DHS 1180 (Rev. Interim 03/14)

ADRC REFERRAL AND DETERMINATION/RE-DETERMINATION

PURPOSE:

The DHS 1180, ADRC Referral and Determination/Re-determination form, shall be initiated by MQD staff or the health plans when there is a reason to believe that an applicant/beneficiary, to include an individual in the Adult Group requesting Home and Community Based Services (HCBS), may meet the definition of a permanently disabled individual. This form shall not be initiated when an individual in the Adult Group requests for nursing facility services.

GENERAL INSTRUCTIONS:

MQD staff or health plan shall complete Part I of this form to refer an applicant/beneficiary for evaluation. The Med-QUEST Division Clinical Standards Office (MQD/CSO) Medical/Psychiatric Consultant, Medical Director and CSO staff will complete Part II and return the form to the referring party or the MQD Eligibility Worker (EW).

SPECIFIC INSTRUCTIONS:

Part I: Referral to ADRC to be completed by the referring party.

1. Indicate the date a complete ADRC packet is received by the referring party. Inclusion of the DHS 1127 and DHS 1128 forms along with the DHS1180 form constitutes a complete ADRC packet. If either the DHS 1127, DHS 1128 or DHS approved substituted forms (see item 5 below) are missing, the packet should be returned to the referring party.
2. Furnish the following identifying data: the applicant/beneficiary's name, DOB, MQD case # and beneficiary ID #.
3. The type of referral should be indicated by checking the appropriate box. For a re-determination, attach the DHS 1180 of the previous determination.
4. MQD staff or health plan should check the appropriate box and complete the identifying data.
5. Indicate what documents are attached to the referral by checking the appropriate boxes:
    a) DHS 1127 and DHS 1128 **are required** for all ADRC referrals from MQD staff or health plans. Exceptions to submission/completion of DHS 1127 are listed in a separate section at the end of this document.
    b) A HCFA 2728 may be substituted for the DHS 1128 for ADRC referrals on applicants/beneficiaries with end stage renal disease. A DHS 1180 and a DHS 1127 forms are still required.
    c) DHS 1147 is required for sub-acute, long term care and hospice applicant/beneficiary ONLY.
    d) Additional information or supporting evidence for physical or psychiatric disability from the QUEST health plan or applicant's/beneficiary's medical provider.

Part II: Determination by ADRC to be completed by the MQD/CSO Medical/Psychiatric Consultant, MQD/CSO staff or Medical Director.

1. Determination will be addressed to the applicant's/beneficiary's EW, the health plan's contact person or the treating physician.
2. The eligibility key code will be completed by MQD/CSO staff. If the Medicaid beneficiary is in the Modified Adjusted Gross Income (MAGI) Adult Group and has not initialed "D" on the DHS 1127, then the MQD/CSO staff will mark the "unable to determine" box and include in the comment section that beneficiary is in the MAGI Adult group.
3. The result of Gainful Activity Determination will be verified by MQD/HCSB staff based on the applicant's/beneficiary's statement on the DHS 1127 form, verification of the lack of income in the KOLEA system, and other available information sources. If there is incomplete information to make this determination, or if there is question about the information provided, the CSO staff may further investigate. The determination will be marked on the appropriate box.
   a) **"Gainful activity is not possible"** means the education and work experiences of the applicant/beneficiary meets the requirements for the applicant/beneficiary to be considered permanently disabled and unable to do any gainful activity.
   b) **"Gainful activity is possible"** means that information shows that the applicant/beneficiary may be able to perform or is performing gainful activity.
4. MQD/CSO's medical/psychiatric consultant will make the disability determination based on the licensed treating physician/evaluator's statement on the DHS 1128 and the medical records provided. The gainful activity determination will also be used in final determination of disability. The result of the ADRC determination will be indicated by checking the appropriate box(es).
   a) **"Not disabled"** means the applicant/beneficiary does not have a medical or psychological condition that meets the ADRC disability criteria.
   b) **"Temporarily Disabled To __/__/__"** means the applicant has a medical or psychological condition that will last less than a year. The applicant/beneficiary would receive medical coverage under QUEST, as not eligible for QExA. Beneficiary will be referred for a re-evaluation of disability at the end of the disability period.
   c) **"Disabled More Than 12 Months - Meets SSI Disability Criteria-Make Referral to SSA"** means the applicant/beneficiary has a medical or psychological condition that meets the SSI Disability Criteria. The applicant/beneficiary shall be referred to the Social Security Administration by the EW.
   d) **"Condition Requires Re-Evaluation After One Year ___/___/___"** means the applicant/beneficiary has a medical or psychological condition that may resolve after the initial evaluation. The QExA health plan or EW will be sent notification one year after initial disability determination completed requiring the applicant/beneficiary to be re-evaluated for continued disability. Indicate the re-evaluation date in the space provided. (one year from date of determination)
   e) **"Effective Date of QExA Coverage"**. If the applicant/beneficiary has a medical or psychological condition that meets the requirements for the disability to be considered permanent, he/she is eligible for QExA coverage. MQD/CSO medical/psychiatric consultant or Medical Director will certify the determination by signing, dating and designating the effective date of enrollment to a QExA health plan, which is the 1st day of the second month following the date a complete ADRC packet is received.
   f) **"Unable to Determine"** means the MQD/CSO's medical/psychiatric consultant is unable to make a disability determination. The consultant would explain reason(s) why under "Comments".

5. Once gainful activity and disability determinations are completed, MQD/CSO staff will fax the form back to the EW and referring health plan, if a health plan is assigned.

Exceptions to submission/completion of DHS 1127:

1. If an applicant/beneficiary cannot be found, the health plan/evaluator will have to prove good faith effort to locate the applicant/beneficiary by documenting the following:
   a) Attempt to locate the applicant/beneficiary by phone at least five times on different days at different times;
   b) Attempt to locate the applicant/beneficiary by correspondence, including certified letter;
   c) Attempt to locate the applicant/beneficiary in conjunction with a hospitalization or a medical appointment; and
   d) Coordination of efforts with the applicant/beneficiary's primary care physician's office to locate the applicant/beneficiary.
2. If an applicant/beneficiary refuses to complete DHS 1127, the applicant/beneficiary should sign that he/she refuses to complete the form.

In **both** exceptions above, the applicant/beneficiary must be sent a final certified letter from the health plan/evaluator stating that the ADRC process will be moving forward without the applicant's/beneficiary's input, concurrence or signature. The letter must contain Hawaii Administrative Rules language stating the applicant/beneficiary has the right to appeal the disability decision and information on how to file an appeal.

Filing Instructions:

Return complete ADRC packet to:

DHS Med-QUEST Division, Clinical Standards Office
P.O. Box 700190
Kapolei, Hawaii 96709-0190
Attn: ADRC
or
Fax to: (808) 692-8131, Attn: Clinical Standards Office

Part III: Program Eligibility: To be completed by EW, if a program change is required. EW completes this part if beneficiary is determined disabled and will be enrolled into a QExA health plan. This same form is completed if a disabled beneficiary is determined to be no longer disabled and needs to be transitioned from a QExA to a QUEST health plan.

1. The EW completes this section by indicating the date they completed the program eligibility change. The program change must be effective as of the health plan enrollment date as determined by the Medical Consultant in Part II. The form is then faxed back to MQD CSO, (808) 692-8131.
2. If the beneficiary is not eligible for program change, EW must indicate the reason and fax the form back to CSO. Reasons for not eligible for program change could be due to asset or income changes.
3. If the findings of the ADRC do not result in a change of program eligibility, then the EW does not need to complete this portion. No further action is required of the EW.