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TO: All Home and Community Based Services (HCBS)
Assisted Living for the Elderly (ALE)
Medicaid Waiver (MW) Providers

FROM: Medicaid Waiver Specialists

DATE: January 8, 2010

Ref: 2010 ALE/ACS Reimbursement Worksheet

Enclosed you will find the new "ALE-ACS Reimbursement Worksheet" and the "Share of Cost Worksheet" for 2010. **Please remember that copies of these documents must be kept in your ALW client files for monitoring purposes. Proof of income must be kept in the file for monitoring purposes.**

REMINDERS:

1. Consumers whose income is over $859.00 may not be billed to the ACS program. Any billings found in error during our monitoring visit will be reported to AHCA (Agency for Healthcare Administration).

2. Method II of the "ALE-ACS Reimbursement Worksheet" needs to be used for consumers whose monthly income range between $752.40 and $913.00. Although some of those clients may not be receiving ACS benefits (if their monthly income exceeds $859.00), this worksheet should still be used to determine the ALE – MW daily reimbursable rate.

3. If a consumer's income is higher than $913.00/month, the "2010 Share of Cost Worksheet" attached should be used, not the "ALE-ACS Reimbursement Worksheet". The consumer is responsible for reimbursing the ALF the "share of cost" determined by DCF as indicated on the Notice of Case Action from DCF (Department of Children and Families).

4. A Notice of Case Action is valid for only **one year**. If a consumer's income increases throughout the year, a new Notice of Case Action must be obtained from DCF. You should contact the social worker at DCF every January to obtain the Notice of Case Action for that current year. You MUST not bill the ALE – MW Program until you have received the 2010 Notice of Case Action for each client with a "share of cost". NOTE: Any consumer whose income exceeds $752.40/month should have a share of cost determined by DCF.

If you have any questions regarding these forms, please call your Medicaid Waiver Specialist at 305-670-6500. Thank you very much.

ALE-ACS Reimbursement Worksheet

For January 2010

Facilities participating in the ALE Waiver must bill Medicaid for both the ACS state plan service and the ALE waiver services for those beneficiaries with incomes up to $859.00. Facilities must bill only for ALE waiver services for beneficiaries with incomes over $859.00. **CLIENT WHOSE INCOME IS OVER $859.00 ARE NOT ELIGIBLE FOR ACS.**

Instructions for Worksheet
Facilities are required to use the worksheet to calculate the daily rate to bill for waiver services for each beneficiary.

1. Insert the number of days in the month on Line A.
2. Calculate the Maximum Waiver and ACS for the Month (Lines C and D).
3. Perform the calculations from Line F through Line L to obtain the daily waiver payment (L) to bill for the days the beneficiary received services in the facility.
4. If Line I is "O" (Zero), do not bill for ACS.

A.	Number of Days In Month.	28	30	31
B.	Maximum Daily Waiver Rate.	$32.20	$32.20	$32.20
C.	Maximum Waiver Payment for the Month: A times B.	$901.60	$966.00	$998.20
D.	Assistive Care Service Daily Rate.	$9.28	$9.28	$9.28
E.	ACS for the Month: A times D.	$259.84	$278.40	$287.68
F.	Is Resident's Income Greater Than $859.00 and Less Than $913.00? If Yes, add C plus G and Subtract $54.00. If No, add C plus $859.00.			
G.	Method 1 Recipient Income: Insert Income Social Security: ___________ OSS (State Subsidy) ___________ Other (Income, if any) _________ Total Income ___________ Method II (From Notice of Case Action)-If income is between $752.40 and $913.00. Needs Allowance: ________ Pat. Resp.: ____________ Total Income ____________			
H.	Subtract G From F			
I.	Is Recipient Income (G) more than $859.00? If Yes, Insert "0" (Zero). If No, Insert ACS for the month (Line E).			
J.	Subtract I from H.			
K.	Add Line J plus $54.00.			
L.	Daily Waiver Rate: Divide K by A.			

2010 SHARE OF COST WORKSHEET

(If monthly income exceeds $913.00)

31 DAY MONTH

Capitated rate: $1,911.20
Minus Gross Income: _-___________ (Obtained from Notice of Case Action by adding the needs allowance + share of cost) ***

Bill the Waiver =

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30 DAY MONTH

Capitated rate: $1,879.00
Minus Gross Income: - ____________ (Obtained from Notice of Case Action by adding the needs allowance + share of cost) ***

Bill the Waiver =

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28 DAY MONTH

Capitated rate: $1,814.60
Minus Gross Income: - ____________ (Obtained from Notice of Case Action by adding the needs allowance + share of cost) ***

Bill the Waiver =

*** **These figures are obtained from the Notice of Instruction issued by the Department of Children & Families. The Notices of Instructions are renewed annually when the consumer's benefits increase. DO NOT BILL UNLESS YOU HAVE A NEW SHARE OF COST FOR 2010 FROM DCF.**

The consumer is responsible for paying the ALF the "share of cost" indicated on the Notice of Case Action.