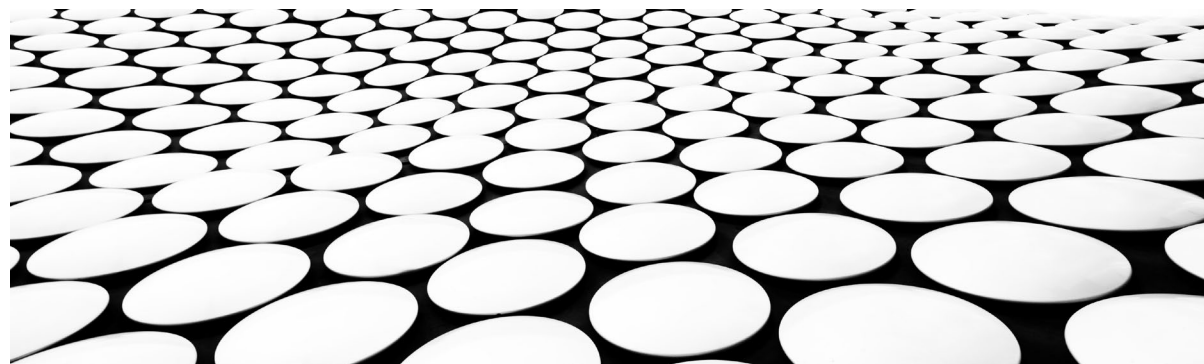


**COMMUNITY
HEALTHCHOICES & OTHER
HOME & COMMUNITY-
BASED SERVICE
PROGRAMS FOR ADULTS
WITH PHYSICAL
DISABILITIES & BRAIN
INJURIES**

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DISABILITY RIGHTS
PENNSYLVANIA



OVERVIEW

- Pennsylvania programs that can provide home and community-based services to adults with physical disabilities and brain injuries
 - Community HealthChoices (“CHC”) Home and Community-Based Services (“HCBS”) Waiver
 - LIFE Program
 - Act 150 Program
 - OPTIONS Program
- Appealing denials of eligibility for the CHC HCBS Waiver, LIFE Program, & Act 150 Program
- Challenging service decisions after enrollment in the CHC HCBS Waiver



**COMMUNITY HEALTHCHOICES
HCBS WAIVER:
ELIGIBILITY AND SERVICES**

COMMUNITY HEALTHCHOICES – OVERVIEW

- CHC consists of two different types of Medicaid waiver programs, which partially – but not completely – overlap
- All Medicaid participants are entitled to certain health care services (e.g., doctors, hospitals, lab tests, prescriptions, home health services, PT/OT/ST)
- In PA, most Medicaid participants receive those services through a Physical Health (“PH”) HealthChoices managed care organization (“MCO”) based on the region where they live
- But some Medicaid participants receive those services through the three statewide Community HealthChoices MCOs rather than through the regional PH HealthChoices MCOs

COMMUNITY HEALTHCHOICES – OVERVIEW

- Medicaid participants ages 21 and older will receive their physical health services through the Community HealthChoices MCOs if they are in one of the following groups:
 - dually eligible for Medicare and Medicaid
 - residing in nursing facilities
 - determined to need a nursing facility level of care and enrolled in the Community HealthChoices HCBS Waiver
- Community HealthChoices HCBS Waiver is a separate Medicaid waiver that provides home and community-based services (not traditional Medicaid physical health services) to eligible individuals
 - Administered by same CHC MCOs
 - Must apply separately for the HCBS Waiver

COMMUNITY HEALTHCHOICES HOME AND COMMUNITY-BASED WAIVER -- ELIGIBILITY CRITERIA

- Ages 21 and older
- Live in Pennsylvania
- Determined to be Nursing Facility Clinically Eligible (“NFCE”)
- Meet financial income and resource requirements
 - Income no more than 300% of Federal Benefit Rate (\$2,523 per month in 2022)
 - Resources no more than \$8,000

COMMUNITY HEALTHCHOICES HCBS WAIVER - SERVICES

- Residential Services
 - Residential Habilitation
 - Community Transition
 - Pest Eradication
 - Home Adaptations
- Vocational Services
 - Career Assessment
 - Job Coaching
 - Job Finding
 - Employment Skills Development
- Therapies
 - PT, ST, OT
 - Cognitive Rehabilitation Therapy
- Health Services
 - Nursing
 - Home Health Aide
 - Specialized Medical Equipment and Supplies
- Personal Assistance Services
- Community Integration
- Assistive Technology
- Home-Delivered Meals
- Personal Emergency Response System
- Vehicle Modifications
- Respite



LIFE PROGRAM: ELIGIBILITY AND SERVICES

LIFE PROGRAM – ELIGIBILITY CRITERIA

- Ages 55 or older
- Determined to be Nursing Facility Clinically Eligible (“NFCE”)
- Meet the financial income and resource requirements for Medicaid, be dually eligible for Medicaid and Medicare, or able to privately pay
- Reside in an area served by a LIFE provider,
<https://www.palifeprograms.org/locate-a-life-program/>
- Can be safely served in the community

LIFE PROGRAM - SERVICES

- Medical Services
 - Doctors
 - Dental
 - Hospital
 - Laboratory and Radiology
- Therapies (PT, OT, ST)
- Emergency Care
- Prescriptions
- Durable Medical Equipment
- Medical Supplies
- Home modifications
- Personal Emergency Response Systems
- Personal Care Services
- Home Health Aides
- In-Home Nursing
- Recreation and Socialization Activities (LIFE Center)
- Social Services
- Meals
- Hospice
- Transportation to medical appointments and LIFE Center
- Respite
- Rehabilitation and Nursing Facility

ACT 150 PROGRAM: ELIGIBILITY AND SERVICES

ACT 150 PROGRAM – ELIGIBILITY CRITERIA

- Ages 18 through 59, inclusive
- Live in Pennsylvania
- Determined to be Nursing Facility Clinically Eligible (“NFCE”)
- Have a physical impairment that is expected to last a continuous period of not less than 12 months or that may result in death
- Be capable of:
 - Hiring, firing, and supervising their personal assistance worker(s)
 - Managing their own financial affairs
 - Managing their own legal affairs
 - Directing their own care
- Income and/or resources are too high to qualify for the CHC HCBS Waiver or LIFE Program

ACT 150 PROGRAM – SERVICES AND FEES

- Services in the Act 150 Program are limited to:
 - Personal assistance services (formerly called attendant care services)
 - Basic PAS – Assistance with activities of daily living; assistance with therapies; support services (e.g., meal planning, help to keep medical appointments); overnight PAS
 - Ancillary PAS – Homemaker services (e.g., shopping, changing linens, laundry); companion services (e.g., help with transportation); assisting with cognitive tasks (e.g., managing finances); and accompanying person in PAS-related community activities (e.g., food shopping)
 - Personal Emergency Response System (“PERS”)
 - Financial management services
 - Service coordination
- Copays can be charged based on income and number of people in household



**COMMUNITY HEALTHCHOICES HCBS
WAIVER, LIFE PROGRAM, AND ACT 150
PROGRAM: APPLICATION PROCESS**

THE CHC HCBS WAIVER, LIFE PROGRAM, AND ACT 150 PROGRAM – APPLICATION PROCESS

- Contact Independent Enrollment Broker (“IEB”) – Maximus – to apply
 - Phone: 877-550-4227
 - Online - <https://www.paieb.com/>
- IEB will conduct an In-Home Visit
 - IEB staff will discuss the process and provide help to complete the Medical Assistance Application
- An applicant must submit a Physician Certification Form, https://www.paieb.com/doc/Physicians_Certification_Form.pdf,
 - confirms that applicant is Nursing Facility Clinically Eligible (“NFCE”)
 - must be submitted within 86 days of the first in-home visit

THE CHC HCBS WAIVER, LIFE PROGRAM, AND ACT 150 PROGRAM – APPLICATION PROCESS

- Functional Eligibility Determination to assess whether the applicant is Nursing Facility Clinically Eligible (“NFCE”)
 - County AAA conducts the assessment and completes a written form, https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20LTL/c_288579.pdf, which looks at:
 - Cognition
 - Mood/Behavior
 - Activities of Daily Living
 - Continence
 - Treatments and Procedures

THE CHC HCBS WAIVER, LIFE PROGRAM, AND ACT 150 PROGRAM – APPLICATION PROCESS

- Functional Eligibility Determination to assess whether the applicant is Nursing Facility Clinically Eligible (“NFCE”) (cont.)
 - NFCE Criteria:
 - Applicant has an illness, injury, disability, or medical condition diagnosed by a physician
 - As a result, the applicant requires care and services above the level of room and board
 - The care and services required are either: (1) skilled nursing or rehabilitation services; or (2) health-related care and services that may not be as inherently complex as skilled nursing or rehabilitation, but which are needed and provided on a regular basis in the context of a planned program of health care management and were previously available only through institutional facilities
- Financial Eligibility Determination

CHC HCBS WAIVER, LIFE PROGRAM, AND ACT 150 PROGRAM – ELIGIBILITY DETERMINATIONS

- Eligibility determinations should be made within 90 days of application
- Applicants should receive a written eligibility determination that includes appeal rights
 - NFCE + MA Financial Eligibility + Ages 21-54, inclusive –CHC HCBS Waiver
 - NFCE + MA Financial Eligibility + Age 55 and older – Choice of CHC HCBS Waiver or LIFE Program (if there is a LIFE Program that serves the Applicant’s ZIP code)
 - NFCE + Not Financially Eligible for MA + Under age 60 – Act 150 Program
 - NFCE + Not Financially Eligible for MA + Age 60 or older – Referral to OPTIONS Program
 - Not NFCE + Age 60 or Older – Referral to OPTIONS Program

CHC HCBS WAIVER, LIFE PROGRAM, AND ACT 150 PROGRAM – APPEALING ELIGIBILITY DENIALS

- An Applicant has the right to file an appeal from an adverse eligibility determination, which is called a “Fair Hearing”
- The Applicant must file the appeal within 30 days of the date on the eligibility determination notice with the Bureau of Hearings and Appeals of Pennsylvania’s Department of Human Services (“DHS”)
- If an eligibility determination is not issued within a reasonable time period (usually at least 90 days from the date of application), the Applicant can request a Fair Hearing from DHS’s Bureau of Hearings and Appeals for failure to determine eligibility with “reasonable promptness”



**OPTIONS PROGRAM:
ELIGIBILITY, SERVICES, & APPEALS**

OPTIONS PROGRAM – ELIGIBILITY CRITERIA

- Eligibility Requirements
 - Age 60 or older
 - Be a Pennsylvania resident
 - Have some degree of frailty with respect to physical and/or mental status that impacts daily functioning
 - Are not residing in a personal care home, assisted living residence, nursing home, or correctional facility
- OPTIONS program participants who are determined to be eligible for the CHC HCBS Waiver or the LIFE Program will no longer qualify for the OPTIONS Program
- Apply by contacting the County Area Agency on Aging,
<https://www.aging.pa.gov/local-resources/Pages/AAA.aspx>

OPTIONS PROGRAM - SERVICES

- Services are provided by the County Area Agency on Aging (“AAA”)
- Mandatory services
 - Care management
 - Home-delivered meals
 - Adult day services
 - Personal care services

OPTIONS PROGRAM - SERVICES

- Optional services
 - Emergency services (e.g., overnight shelter or life-sustaining supplies)
 - Home health services (e.g., nursing, home health aides, therapies)
 - Home modifications
 - Home support services (e.g., laundry, shopping, basic housekeeping)
 - Medical equipment, supplies, and assistive devices
 - Personal Emergency Response Systems
 - Pest control/fumigation
 - Medical transportation (if stretcher is required)

OPTIONS PROGRAM - SERVICES

- Monthly cap on costs of services: \$765 (averaged over 12 months)
- Services are dependent on the availability of funding and eligibility can be prioritized on need
- Copays (cost sharing) can be charged based on client's and, if applicable, spouse's income

OPTIONS PROGRAM – APPEALING DECISIONS

- Individuals can appeal decisions that:
 - determine an individual is not eligible for the OPTIONS Program
 - decisions to deny, reduce, or terminate OPTIONS Program services
- Individuals cannot appeal:
 - placement on a waiting list for the OPTIONS Program
 - termination due to non-payment of the copayments
- Individuals have the right to receive a notice that states the basis for a decision about eligibility or services and includes information about how to appeal (“Notice of Adverse Action”)

OPTIONS PROGRAM – APPEALING DECISIONS

- To appeal an OPTIONS Program decision, the individual must first file an Informal Complaint with the AAA within 30 days of receipt of the Notice of Adverse Action
 - If the appeal relates to reduction or termination of OPTIONS Program services, the individual will continue to receive services at the existing level pending resolution of the Informal Complaint process
 - The AAA will recommend a resolution of the Informal Complaint within 10 days
- If the individual does not agree to the recommended resolution, they can request a formal hearing by writing to the Secretary of Aging within 30 days after receipt of the recommended resolution
 - The hearing will be conducted by DHS’s Bureau of Hearings and Appeals (“BHA”)
 - The hearing should be conducted within 45 days
 - The BHA Administrative Law Judge will send a proposed report to the Department of Aging, which will then issue a final order within 30 business days from the date of the hearing

**CHALLENGING DENIALS, REDUCTIONS,
AND TERMINATIONS OF COMMUNITY
HEALTHCHOICES SERVICES:
COMPLAINTS, GRIEVANCES, AND
EXTERNAL REVIEW**

COMPLAINTS VS. GRIEVANCES

- Complaints and grievances are not different names for the same thing
- A **complaint** is a dispute or objection regarding either:
 - a health care provider or
 - coverage, operations, or management of the MCO
- A **grievance** is a request to have the MCO reconsider a decision concerning medical necessity and/or appropriateness of a service or item that can be covered

COMPLAINTS VS. GRIEVANCES

- Examples of complaints:
 - the MCO denies a requested service or item on the basis that it is not covered
 - the MCO approves a requested service or item, but does not timely provide it
 - the MCO does not decide one way or the other whether to approve a request for service in a timely way
 - the MCO does not decide a complaint or grievance within the required time periods
 - dissatisfaction with a provider's services
 - inability to identify a qualified, willing provider in the MCO's network
 - dispute about a financial charge for a service or item

COMPLAINTS VS. GRIEVANCES

- Examples of grievances
 - the MCO denied, completely or in part, a requested service or item on the basis that it is not medically necessary or is inappropriate
 - the MCO issues only a limited authorization for the service
 - the MCO denies a requested service or item, but approves a different one
 - the MCO reduces the amount of, suspends, or terminates a service or item that it had previously authorized

GENERAL RULES FOR COMPLAINTS AND GRIEVANCES

- Complaints and grievances can be filed by phone or in writing
 - If done by phone, it must be reduced to writing and signed
- Complaints and grievances can be filed before the MCO provides a written notice of its decision
- An individual can have a representative file the complaint or grievance if they provide written consent
 - If the individual needs someone to help them because of a disability, they should ask for a reasonable accommodation and should not be compelled to provide written consent for such assistance

GENERAL RULES FOR COMPLAINTS AND GRIEVANCES

- An individual who files a complaint or grievance has the right to receive information from the MCO at no cost
 - medical records
 - documents or records the MCO relied on to make the decision, including medical necessity criteria or information about coverage limits
 - new or additional evidence the MCO considered, relied on, or generated in connection with the complaint or grievance
- An individual who files a complaint or grievance has the right to present evidence and argument
 - MCO should be flexible in scheduling the complaint/grievance to enable the individual to participate
 - should have at least 10-days' notice unless it is expedited

GENERAL RULES FOR COMPLAINTS AND GRIEVANCES

- An individual is entitled to have independent decision-makers decide their complaint or grievance
 - Complaints may be decided by one or more persons who work at the MCO
 - Grievances must be decided by a committee of at least 3 people and at least one-third of the committee must be comprised of individuals who are not employed by the MCO
 - Decision-makers should not include anyone involved in the challenged decision or action
 - Complaints/grievances that involve clinical issues must be decided by a licensed physician who practices in the same or similar specialty area involved in the issues that are raised
- An individual has the right to language interpretation services and disability accommodations
 - can request free language interpretation services
 - can request reasonable accommodations (e.g., large print materials, sign language interpreters, individuals to assist you to present information)

GENERAL RULES FOR COMPLAINTS AND GRIEVANCES

- Individuals can request expedited review of their complaint/grievance if waiting the standard timeframe would jeopardize their life, physical or mental health, or ability to attain, maintain, or regain maximum function
 - Must submit a doctor's certification within 72 hours of your request to expedite to support the request for expedited consideration
 - If the complaint/grievance is expedited, the MCO must issue a decision within 48 hours of receipt of the doctor's certification or 72 hours of receiving the request for expedited review, whichever is shorter
 - The individual can request an extension of up to 14 days if expedited review is granted
 - The individual still has the right to present evidence, but the time for gathering and presenting evidence will be much more limited

GENERAL TIMELINES TO FILE COMPLAINTS & GRIEVANCES

- A complaint must be filed within **60 DAYS** of:
 - the date the individual received a notice from the MCO that it:
 - denied a service or item on the basis that it is not covered
 - denied payment for a service or item that had been provided
 - denied a request to dispute a financial charge
 - the date the MCO should have provided the service
 - the date the MCO should have decided the complaint or grievance
- There are no deadlines to file complaints about other matters (such as complaints about quality of services or treatment)
- A grievance must be filed within **60 DAYS** of the date you receive the notice from the MCO about the decision that you want to challenge

TIMELINES TO MAINTAIN SERVICES PENDING RESOLUTION OF COMPLAINTS AND GRIEVANCES

- If the MCO reduces, suspends, or terminates a service or item it had previously provided, the individual can continue to receive that service or item without change while the MCO is considering the complaint/grievance **ONLY** if you do the following:
 - file a complaint or grievance (whichever is applicable) within **10 days of the date on the written notice** – not the date the individual received the notice
 - verbally (by phone)
 - written complaints/grievances must be hand-delivered or post-marked within the 10-day period

COMPLAINT AND GRIEVANCE DECISIONS AND NEXT STEPS

- The MCO must decide a complaint or grievance within **30 DAYS** after it was filed (unless it was expedited), though the individual can request an extension for up to 14 days
- The MCO must provide a written notice of its decision on a complaint or grievance
- If the MCO decides the complaint or grievance in favor of the individual, the individual should receive the disputed service or item within 72 hours
- If the MCO decides the complaint or grievance against the individual, the individual can:
 - (for Complaints only) file a Second Level Complaint within 45 days of the initial decision
 - file for External Review
 - request a Fair Hearing

SECOND LEVEL COMPLAINTS

- Second Level Complaints
 - another opportunity to present evidence and make arguments
 - must be decided within 45 days of the date filed
 - if dissatisfied, can file for External Review
- It is NOT necessary to file a Second Level Complaint before seeking External Review and/or a Fair Hearing if the complaint involved:
 - denial of a service or item on the basis that it is not covered
 - failure to provide a requested service or item in a timely manner
 - failure to decide a complaint or grievance within the required timeframes
 - denial of payment to a provider for a service or item the MCO later determined to not be covered or because it was delivered before the MCO authorized it
 - a dispute about a financial charge to you for a service or item

TIMELINES TO MAINTAIN SERVICES PENDING RESOLUTION OF EXTERNAL REVIEW AND/OR FAIR HEARINGS

- If the MCO reduces, suspends, or terminates a service or item it had previously provided and the individual was able to maintain services pending the outcome of their complaint/grievance by filing it within 10 days (as described above), the individual can continue to receive that service or item without change if the complaint/grievance was unsuccessful while they pursue External Review or a Fair Hearing **ONLY** if:
 - the individual files a request for External Review and/or a Fair Hearing within **10 days of the date on the written decision on the complaint or grievance** – not the date the individual receives it
 - requests must be hand-delivered or post-marked within the 10-day period
- If the individual may want to seek a Fair Hearing after External Review and maintain services until both processes are done, they must file **BOTH** the request for External Review and for a Fair Hearing within 10 days of the date on the MCO's decision and not wait until the External Review decision is issued

EXTERNAL REVIEW

- An individual whose complaint or grievance is unsuccessful can file a request for External Review
 - Must be filed within 15 days from receipt of the MCO's decision
- A request for External Review is sent to the PA Department of Health or PA Department of Insurance
 - PA Department of Health – Handles issues involving how a provider delivers services
 - PA Insurance Department – Handles issues involving the MCO's decisions, policies, procedures, and practices

EXTERNAL REVIEW

- External Review is conducted by a doctor who is not affiliated with the MCO
- After the request for External Review is made:
 - MCO will submit the file on the complaint/grievance
 - Individual and/or MCO can submit additional information (with copies sent to the other side) within 15 days of filing the request
 - The doctor must decide request for External Review within 60 days

**CHALLENGING DENIALS OF ELIGIBILITY FOR THE
CHC HCBS WAIVER, LIFE PROGRAM, AND ACT
150 AND ADVERSE COMPLAINT AND
GRIEVANCE DECISIONS BY CHC MCOS:
THE FAIR HEARING PROCESS**

FAIR HEARING PROCESS – REQUESTING A FAIR HEARING

- An appeal to DHS’s Bureau of Hearings and Appeals (usually called a “Fair Hearing”) can be filed to challenge:
 - a determination that an applicant is not eligible for the CHC HCBS Waiver, the LIFE Program, or the Act 150 Program
 - failure to receive an eligibility determination for the CHC HCBS Waiver, the LIFE Program, or the Act 150 Program with reasonable promptness (usually within 90 days)
 - decisions on complaints or grievances by a CHC MCO
- Information about how to file an appeal should be on the denial notice or complaint/grievance decision, but should include:
 - reason for appeal
 - type of hearing requested (in person/telephonic)
 - request for accommodations or interpreter services if needed
 - whether the individual has a representative for the fair hearing and, if so, who it is
 - request for expedited review if needed
 - signature of the individual and date

FAIR HEARING PROCESS – GENERAL TIMELINES

- An appeal of a determination that an individual is not eligible for the CHC HCBS Waiver, the LIFE Program, and/or the Act 150 Program must be filed within 30 days of the date on the notice
- An appeal of a CHC MCO's decision on a grievance or complaint must be filed within 120 days of the date on the notice of decision

FAIR HEARING PROCESS – PRE-HEARING CONFERENCE

- After filing an appeal, a prehearing conference may be offered to try to resolve the matter
- Process is optional
- The prehearing process should not delay or replace the Fair Hearing
- If the individual is not satisfied with what is offered at the prehearing conference, the Fair Hearing will go forward

FAIR HEARING PROCESS – PREPARATION

- Individuals are entitled to receive the following information before the Fair Hearing:
 - copies of all information used to make the decision
 - copies of all documents that the other side will present
 - the names of witnesses who will testify for the other side
- Individuals can submit records requests for additional information from:
 - the Independent Enrollment Broker (Maximus) or County Assistance Office, in the case of a Fair Hearing related to an eligibility decision
 - the MCO, in the case of a decision related to services after enrollment in the CHC HCBS Waiver
- Individuals can ask the Bureau of Hearings and Appeals to issue subpoenas to get additional records from other persons or organizations and/or to ensure that witnesses will appear at the hearing

FAIR HEARING PROCESS – THE HEARING

- Individuals should receive at least 10-days' notice of the Fair Hearing date (unless it was expedited)
- Individuals can represent themselves or have someone else represent them
- Individuals can present evidence – witnesses and documents
- Individuals can cross-examine the other side's witnesses
- Individuals can object to the other side's evidence and should object if:
 - it tries to submit evidence that is related to a reason for the decision that is different than the reason stated in the notice
 - it tries to use documents it did not provide to the individual before the hearing or present witnesses who it did not identify before the hearing
- If necessary, an individual can ask the hearing officer to hold the record open for up to five business days after the hearing to present additional information
- Individuals can ask to submit post-hearing letters to summarize the evidence and argument

FAIR HEARING PROCESS – TIMELINE FOR THE DECISION AND INTERIM ASSISTANCE

- The Bureau of Hearings and Appeals must issue a decision on an appeal within 90 days of the date the appeal was filed (or three business days if your appeal was expedited)
 - If you asked for a postponement or continuation of the Fair Hearing, that time is not counted in calculating the 90-day period
- If the Bureau of Hearings and Appeals does not issue a decision within this timeframe, the individual can request Interim Assistance to get the requested services while the appeal is pending

FAIR HEARING PROCESS – POST-DECISION OPTIONS

■ Reconsideration

- You can ask the Secretary of the Department of Human Services to reconsider the Bureau of Hearings and Appeals' decision
- You must file a request for reconsideration within 15 days of the date of the decision

■ Judicial Review

- You can file an appeal of the Bureau of Hearings and Appeals' decision in Pennsylvania Commonwealth Court
- Your appeal must be filed within 30 days of the date of the decision unless you requested Reconsideration, in which case the deadline is 30 days from the date the Secretary issues a decision on that request

QUESTIONS?



RESOURCES

- DRP's website has a several resources that can provide additional information about some of the programs and services discussed in this presentation, including:
 - *Eligibility for Community HealthChoices ("CHC") and Other Programs that Provide Home and Community-Based Services for Adults as Alternatives to Nursing Facilities*, <https://www.disabilityrightspa.org/wp-content/uploads/2022/03/Eligibility-for-CHC-and-Other-HCBS-Programs-for-Adults-print-version-March-2022.pdf>
 - *Services Available through the Community HealthChoices ("CHC") Home and Community-Based Services Waiver*, <https://www.disabilityrightspa.org/wp-content/uploads/2022/03/Services-Available-Through-the-CHC-HCBS-Waiver-print-version-March-2022.pdf>
 - *Challenging Eligibility and Service Decisions Under the Community HealthChoices ("CHC") Home and Community-Based Services Waiver*, https://www.disabilityrightspa.org/wp-content/uploads/2022/03/Challenging-Eligibility-and-Service-Decisions-Under-The-Community-HealthChoices-HCBS-Waiver_March-2022_CHC-3-.pdf

RESOURCES

- CHC HCBS Waiver (2022), <https://www.dhs.pa.gov/HealthChoices/HC-Providers/Documents/2022%20CHC%20Waiver%200386.R04.07.PDF>
- PA's LIFE Program, <https://www.dhs.pa.gov/Services/Disabilities-Aging/Pages/LIFE.aspx>
- Act 150 Program Guidelines, https://www.dhs.pa.gov/Services/Disabilities-Aging/Documents/Alternatives_to_Nursing%20Homes/ACT%20150%20Guidelines.pdf
- OPTIONS Program information, <https://www.aging.pa.gov/publications/policy-procedure-manual/Documents/Chapter%20IV%20-%20OPTIONS%20Program.pdf>

CONTACT INFORMATION

Disability Rights Pennsylvania

Intake: 800-692-7443, ext. 400 (voice)

Intake: 877-375-7139 (TDD)

Intake: intake@disabilityrightspa.org

Website: www.disabilityrightspa.org