

Health Care Resources: Access & Funding for Autism

An Informational Guide for Families





Health Care Insurance

Determination Of Eligibility for Services -----	Page 2
Glossary of Terms -----	Page 31
Health Care Contact Information -----	Page 40
Health Care Insurance Checklist -----	Page 45
About Autism New Jersey -----	Page 53

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Determination of Eligibility for Services

Table of Contents

I.	New Jersey Department of Human Services	
<i>a.</i>	New Jersey Division of Developmental Disabilities -----	Page 3
<i>b.</i>	New Jersey Division of Disability Services -----	Page 5
<i>c.</i>	New Jersey Division of Medical Assistance and Health Services ---	Page 9
<i>d.</i>	The Catastrophic Illness in Children Relief Fund -----	Page 11
II.	New Jersey Department of Health and Senior Services	
<i>a.</i>	New Jersey Early Intervention Services -----	Page 13
<i>b.</i>	Pharmaceutical Assistance to the Aged & Disabled -----	Page 15
III.	New Jersey Department of Labor	
<i>a.</i>	New Jersey Division of Vocational Rehabilitation Services -----	Page 17
IV.	New Jersey Department of Children And Families	
<i>a.</i>	New Jersey Division of Child Behavioral Health Services -----	Page 19
V.	New Jersey Medicaid Program -----	Page 21
VI.	Medicare -----	Page 25
VII.	Rx4NJ Program -----	Page 27
VIII.	Charity Care -----	Page 29

New Jersey Department of Human Services (DHS) Determination Of Eligibility for Services

Ia

Determination of Eligibility
for Services

New Jersey Division of Developmental Disabilities (DDD)
Website: www.state.nj.us.humanservices/ddd.index.html

How to become eligible for services funded by DDD

DDD determines who is eligible to receive the services it funds through an application process. In general, to receive these services, individuals must show that they have a severe, chronic physical and/or mental impairment that:

is life-long, and
substantially limits them in at least three of these life activities: self-care, learning, mobility, communication, self-direction, economic self sufficiency and the ability to live independently.

Some conditions that might be considered a developmental disability include mental retardation, cerebral palsy, epilepsy, spina bifida, autism or a neurological impairment.

The complete legal definition is found at NJAC 10:46. In addition to the criteria listed below, there are residence requirements and presumptive eligibility definitions. NJAC refers to the New Jersey Administrative Code.

NJAC 10:46-2.1 General eligibility

- (a) An individual must be determined eligible for services under this chapter before the Division can provide services. In order to receive waiver services (a Federal Medicaid program), the individual and/or representative payee is responsible to make application for all benefits and comply with the requirements to continue eligibility for all benefits for which they are entitled, primarily the Medicaid DDD Community Care Waiver, Social Security and SSI. The individual is also responsible to maintain Medicaid eligibility by ensuring he or she has no more than \$ 2,000 in cash assets.
- (b) The individual is required to apply for these benefits, primarily the Medicaid DDD Community Care Waiver, Social Security and SSI and comply with all the requirements of those programs, for which he or she may be eligible. If the individual is denied benefits and can take no action to become eligible for those benefits, he or she shall provide documentation of the denial to the Division, which shall be part of the client record. Eligibility for waiver services shall not be denied under these instances, if the other eligibility criteria are met.
- (c) Individuals must keep assets below \$ 2,000 in order to remain eligible for waiver services. If eligibility is lost because assets are over \$ 2,000, the individual or representative payee will be notified that they have 30 days to comply with the asset requirement, in order to continue in a waiver program. If the individual or representative payee does not comply, they will receive notification that they will no longer be eligible for waiver services if they do not reduce their assets below \$ 2,000 within an additional 60 days. Loss of eligibility for the Medicaid DDD Community Care Waiver will mean the individual will be eligible for only those State-funded services that are available at that time. If at any time during this period, the individual reestablished eligibility by lowering their assets, the individual will be able to remain in the waiver service.

- (d) When an individual receives residential services from the Division, they are also required to contribute to the cost of care and maintenance. The requirements and financial ability of the individual and that of their legally responsible relatives to contribute to the cost of care and maintenance are set forth in N.J.A.C. 10:46D, Contributions for Care.
- (e) With regard to a child, the substantial functional limitation(s) shall be evaluated according to expectations based upon the child's chronological age.
- (f) With regard to an individual who has entitlements to a free public education pursuant to N.J.S.A. 18A:1-1 et seq., who is otherwise eligible, the expenses of educational and related services shall not be borne by the Division.
- (g) If a determination has been made by a local district board of education or a court of competent jurisdiction that an individual's educational needs can only be appropriately served in a living situation other than the individual's home, then the expenses of that residential placement shall not be borne by the Division.
- (h) For applicants who present documentation of mental retardation, the criteria for establishing the presence of mental retardation shall be an IQ score of less than 70, demonstrated as follows:
 - 1. The person has an IQ score of 60 to 69; and
 - i. There is an impairment in adaptive behavior; and/or
 - ii. There is a chronic medical problem; and/or
 - iii. There is an impairment in behavioral, sensory or motor function and in the ability to perform basic skills; or
 - 2. The person has an IQ score of 59 or below.

Applying for Services

To apply for services from DDD, contact the Community Services Office that serves the county in which the applicant resides. Staff there will guide clients through the process for applying for eligibility. If DDD determines the applicant is eligible to receive services, he or she will receive information on how to access services specific to their situation.

New Jersey Department of Human Services (DHS) Determination Of Eligibility For Services

Ib

Determination of Eligibility
for Services

New Jersey Division Of Disability Services (DDS)

Website: www.state.nj.us/humanservices/dds

The Personal Preference Program (See also Medicaid Personal Care Assistant Services)

The Personal Preference Program (PPP) began as New Jersey's Cash & Counseling Program in 1999, as part of a national research and demonstration project. The project goal was to find new and different ways for individuals to receive their Medicaid Personal Care Assistance (PCA) services, giving them more choice.

Personal Care Assistant (PCA) services are non-emergency, health related tasks. Tasks include help with activities of daily living (ADLs) and with household duties essential to the patient's health and comfort, such as bathing, dressing, meal preparation, and light housekeeping.

Using a "Cash & Counseling" approach, along with the idea of "consumer direction," PPP allows elderly and disabled adult Medicaid recipients to direct and manage their own Medicaid PCA services.

With a monthly cash allowance, participants - or "consumers" - work with a consultant to develop a Cash Management Plan (CMP). This plan helps them decide the services they need and the individuals and/or agencies they can hire to provide those services. Consumers who are cognitively impaired or unable to make their own decisions can choose a representative to make decisions on their behalf.

Eligibility Requirements:

- 18 years of age or older
- Medicaid eligible
- Qualify for Personal Care Assistant Services (PCA) and need PCA services for at least 6 months.
- Be able to self-direct services or choose a representative who can act on your behalf

The New Jersey WorkAbility Program

The NJ WorkAbility Program offers full New Jersey Medicaid health coverage to people with disabilities who are working, and whose earnings would otherwise make them ineligible for Medicaid.

NJ WorkAbility was created by the federal Ticket to Work/Work Incentives Improvement Act of 1999 and Chapter 116 of PL2000 of New Jersey.

Eligibility

- Be between the ages of 16 and 64
- Work part time, full time or be self-employed and have proof of employment
- Have a permanent disability determined by the Social Security Administration (SSA), or the Disability Review Team at the Division of Medical Assistance & Health Services (DMAHS)
- Have an earned income no more than \$ 54,948 per year for eligible individuals, or no more than \$73,644 per year for eligible couples (both with permanent disability, both working)
- Have an unearned income (pensions, child support, interest, etc.) up to \$ 903.00 per month for eligible individuals, or up to \$ 1,215.00 for eligible couples
- Have less than \$20,000 in liquid assets as an individual, or less than \$30,000 as a couple
- Disregarded income: Social Security Disability Benefits and/or Railroad Retirement System Benefits, received by an individual on their own account, are not included in the eligibility criteria.
- Disregarded assets: Retirement accounts like an IRA or 401K, and the value of owned home and car, are also disregarded.

For additional information about NJ WorkAbility or if you would like to apply, please call the County Medicaid Office.

Community Resources for People with Disabilities (CRPD) Waiver

This Medicaid home and community-based services (HCBS) waiver is a five-year, renewable federal program. The purpose of the Community Resources for People with Disabilities (CRPD) Waiver is to help eligible individuals remain in the community or return to the community, rather than be cared for in a nursing facility or a hospital setting.

CRPD serves up to 300 beneficiaries at any one time. It is a statewide program. There are no geographic limitations nor are there limitations on the number of individuals who can be served within any one county. All requests for a reserved slot in the CRPD waiver are managed by the DDS Office of Home and Community Services.

Eligibility Requirements:

- Individuals must be in need of institutional care and meet, at a minimum, the nursing facility (NF) level of care criteria.
- The waiver can serve disabled individuals of any age eligible under SSI, New Jersey Care, Family Care Part A, Division of Youth and Family Services foster care, or if it is an individual not eligible for one of the above full service Medicaid programs, through the institutional Medicaid program administered through the County Board of Social Services
- For children, parental income or resources are not considered in the determination of eligibility when applying for CRPD under the institutional Medicaid program at the County Board of Social Services. For adults applying for CRPD under the same program at the County Board of Social Services the spouse's income is not considered but the spouse's resources are considered in the determination of eligibility. However, up to one-half of the total resources are protected for the use by the spouse.
- Any individual applying for the CRPD waiver must be determined disabled by the Social Security Administration (SSA) or by the Disability Review Section of the DMAHS using SSA disability criteria.
- Individuals must need a minimum of two CRPD waiver services: case management plus another service.
- Any individual applying for the CRPD waiver in order to obtain private-duty nursing (PDN) services must have a live-in primary caregiver (adult relative or significant other adult) who accepts 24-hour responsibility for that applicant's health and welfare.

This waiver is not applied typically to individuals with a developmental disability. See the community care medicaid waiver (ccw).

Medicaid Personal Care Assistant (PCA) Services

The Personal Care Assistant (PCA) Program is an optional statewide service offered to New Jersey Medicaid recipients who are experiencing some functional impairment and need a personal care assistant to help them with some aspects of daily living, such as dressing or bathing.

The purpose of the program is to accommodate long-term chronic or maintenance health care, as opposed to short-term skilled care as is provided under Medicaid's home health program. PCA services are non-emergency health related tasks done by qualified staff in a medically eligible beneficiary's home.

An estimated 21,000 people receive this service at any given time. The program is administered by the Division of Disability Services, Office of Home and Community Services.

Qualifications

- In order to qualify for PCA services recipients must be:
- Participating on Medicaid Plan A or G of the New Jersey FamilyCare program;
- Have a doctor's order to receive this service, but they do not have to be permanently disabled;
- Live in a community-based residence (private home, apartment, rooming house, or boarding home) or group home, skill development home, supervised apartment or other congregate living program where personal care is not provided as a part of the service package included in the living arrangement; and
- Have a documented need for hands-on personal care.

Services

Services include assistance with activities of daily living (ADLs) and household duties essential to the patient's health and comfort. PCA services are performed under the supervision of a registered professional nurse employed by a Medicaid provider.

Services may be provided by community-based home care agencies under contract with Medicaid or by independent clinics under contract to the Division of Mental Health Services (DMHS).

PCA services must be prior authorized by the Division of Disability Services.

Accessing PCA Services

Recipients may contact community-based home care agencies under contract with Medicaid directly in order to select an agency to provide services.

Community-based home care agencies listed by each New Jersey county may be obtained by contacting DDS, Office of Home and Community Services (OHCS) at (609) 292-4800. Information may be sent to requesters by fax, email or regular mail.

Eligibility Determination

- Upon selection of a community-based home care agency by the recipient the following process will occur in order to determine eligibility and award of services:
- Provider agency will obtain necessary personal and medical information to verify Medicaid eligibility;
- A nurse will visit the recipient's home to perform an assessment of need for personal care assistance;
- Provider agency will submit a prior authorization request to the Division of Disability for review upon the results of the assessment; and
- Division staff will review the request and notify the provider agency of the decision on eligibility and number of hours awarded per week.

The final decision on award of service hours is made by the Division of Disability Services professional staff based on the nursing assessment and the recipient's need for personal care assistance.

New Jersey Department of Human Services (DHS) Determination of Eligibility for Services

Ic

Determination of Eligibility
for Services

New Jersey Division of Medical Assistance and Health Services

Website: www.state.nj.us/humanservices/dmahs

New Jersey FamilyCare or NJFC The NJ State Children's Health Insurance Program (S CHIP)

NJ FamilyCare is a federal and state funded health insurance program created to help New Jersey's uninsured children and certain low-income parents and guardians to have affordable health coverage. It is not a welfare program. NJ FamilyCare is for families who do not have available or affordable employer insurance, and cannot afford to pay the high cost of private health insurance.

Eligibility Requirements:

Children 18 and younger may apply for the program, as well as certain low-income parents/guardians. The income eligibility level for children's coverage is 350% of the federal poverty level. For example, children in a family of four with a monthly income of up to \$6,432 could be eligible for coverage. The program is also accepting applications from parents/guardians with work income up to 133% of the federal poverty level – for instance, a family of four making up to \$2,444 per month.

Eligibility is based on family size and monthly income. Family size includes children under 21, adoptive and natural parents and their spouses. If a child is living in a household with a grandparent, guardian, or caretaker, that person is not included in the family size, and their income is not taken into consideration when calculating eligibility for NJ FamilyCare, unless the guardian is also requesting coverage. Only monthly income, not assets, is considered for eligibility. To view income eligibility limits for various family sizes, go to Income Eligibility and Cost on the Division's website.

What if the family makes too much money to qualify for NJ FamilyCare? Parents/guardians at higher income levels can purchase health insurance for their children at reasonable rates through the NJ FamilyCare ADVANTAGE program administered by Horizon NJ Health if they qualify. The cost is \$144 per month for one child; \$288 per month for two children; and \$432 per month for three or more children. To learn more, please visit www.horizonnjhealth.com/members/advantage.html or call 1-800-637-2997.

What if the family has other insurance? Generally, applicants will be eligible for NJ FamilyCare only if they have been uninsured for a period of three months or more. However, there are exceptions to this rule; such as if you lost your insurance because your place of work went out of business or you were laid off. Depending on income, other exceptions may apply for families privately paying for health insurance or for COBRA benefits.

For many families, NJ FamilyCare will be free. Other families will pay a monthly premium based on their income and small co-payments for some services.

Application

Download an application from the Division website, or apply online, or call toll-free 1-800-701-0710 to request an application or to receive more information.

New Jersey FamilyCare Advantage

If the family makes too much money to qualify for NJ FamilyCare, parents/guardians at higher income levels can purchase health insurance for their children at reasonable rates through the NJ FamilyCare ADVANTAGE program administered by Horizon NJ Health if they qualify. The cost is \$144 per month for one child; \$288 per month for two children; and \$432 per month for three or more children. This program provides a wide range of benefits including:

- Doctor visits and regular check-ups
- Immunizations
- Dental care (up to the age of 12)
- Prescriptions
- Hospitalization

Eligibility Requirements:

- Without health insurance for at least six months.
- There is no waiting period if you have recently lost employment due to a reduction in staff or if your child has lost NJ FamilyCare or NJ Medicaid eligibility.
- Your children must be under the age of 19.
- Eligibility is based upon household income and the number of people in your family.

Family Size	Monthly Income	Annual Income
One Person	\$3,160 -	\$37,906
Two People	\$4,251 -	\$50,996
Three People	\$5,342 -	\$64,086
Four People	\$6,433 -	\$77,176
Five People	\$7,524 -	\$90,266
Six People	\$8,614 -	\$103,356
Seven People	\$9,705 -	\$116,446

If your income is less than the amount shown for the size of your family, you may be eligible for another NJ FamilyCare program. Call the Horizon NJ Health Outreach Center at 1-800-637-2997 for more information.

You must be a resident of New Jersey.

New Jersey Department of Human Services (DHS) Determination Of Eligibility For Services

Id

Determination of Eligibility
for Services

The Catastrophic Illness in Children Relief Fund
Website: www.state.nj.us/humanservices/cicrf/home

The Catastrophic Illness in Children Relief Fund is a financial assistance program for New Jersey Families whose children have an illness or condition otherwise uncovered by insurance, State or Federal programs, or other source, such as fundraising. The Fund is intended to assist in preserving a family's ability to cope with the responsibilities which accompany a child's significant health problems.

Eligibility Requirements:

- In any prior, consecutive, 12 month period, dating back to 1988, eligible expenses must exceed 10% of the family's income, plus 15% of any excess income over \$100,000.
- The child must have been 21 years or younger when the medical expenses were incurred.

The family must have lived in New Jersey for 3 months immediately prior to the date of application. Migrant workers may be eligible, temporary residents are not.

The following incurred expenses will be considered and may be eligible for payment/reimbursement if found reasonable. The categories include, but are not limited to:

- Specialized pediatric ambulatory care
- Addictions/mental health services
- Acute or specialized hospital care, both in and outpatient
- Physician care in all settings
- Medical equipment or disposable medical supplies
- Pharmaceuticals
- Medically related home modifications and medical transportation
- Home health care
- Experimental medical treatment or pharmaceuticals following special review

Applying for Services

- Call the toll free Family Information Line: 1-800-335-FUND (3863) for information and an application.
- The completed application is forwarded to the State Office of the Commission for screening and review. All applications to the Fund are confidential.
- The Commission will review the application and make the final determination on eligibility and the amount of assistance.
- Approved grant awards are disbursed directly to the providers to offset outstanding balances.
- Families may be reimbursed for their out-of-pocket expenses.

New Jersey Department of Health and Senior Services (DHSS) Determination of Eligibility for Services

Early Intervention

Website: www.state.nj.us/health

The New Jersey Early Intervention System (NJEIS), under the Division of Family Health Services, implements New Jersey's statewide system of services for infants and toddlers, birth to age three, with developmental delays or disabilities, and their families. The Department of Health and Senior Services is appointed by the Governor as the state lead agency for the Early Intervention System. If an infant or toddler is experiencing developmental delays, the referral is made by calling the Regional System Point of Entry toll free number at 1.888.653.4463 and following the menu directions based on the county in which the child (or family) lives.

Eligibility Requirements:

In New Jersey, a child is considered eligible for early intervention services if he or she is under the age of three and has at least a 33% delay or a score of at least 2.0 standard deviations below the mean in one functional developmental area or at least a 25% delay or a score of at least 1.5 standard deviations below the mean in two or more of the developmental areas listed below:

- Physical; including gross motor, fine motor, and sensory (vision and hearing)
- Cognitive
- Communication
- Social or emotional
- Adaptive

Eligibility for early intervention services is determined using clinical opinion, parent report, and standardized evaluation/assessment and criterion referenced measures. The percentages listed above for a developmental delay are calculated on the basis of corrected age for infants born before 38 weeks gestation and applying until 24 months of age. Corrected age is based on 40 weeks term. For infants born at or after 38 weeks of gestation there shall be no correction in age.

Conditions with High Probability

1. This category of eligibility includes children who have identified conditions but who may not be exhibiting delays in development at the time of eligibility.
2. Children are eligible who have a diagnosed physical and/or mental condition that has a high probability of resulting in developmental delay. This eligibility must be documented by a signed statement or report from a physician; advanced practice nurse; or licensed clinical psychologist in the child's record that confirms:
 - (a) The high probability diagnosed condition; and
 - (b) That the diagnosed condition for this child has a high probability of developmental delay.
3. Examples of high probability conditions noted in 34 CFR Part 303.16 include:
 - (a) Chromosomal abnormalities
 - (b) Genetic or congenital disorders
 - (c) Severe sensory impairments, including vision and hearing

- (d) Untreated inborn errors of metabolism
- (e) Disorders reflecting disturbance of the development of the nervous system
- (f) Congenital infections
- (g) Disorders secondary to exposure to toxic substances, including fetal alcohol syndrome
- (h) Severe attachment disorders
- (i) Autism Spectrum Disorders

4. NJEIS has selected the following ten diagnoses that are known to result in developmental delay and have designated these as “Presumptive Eligibility Diagnoses”. The child’s early intervention record must clearly document the presence of the condition. A high probability statement or report from a physician; advanced practice nurse; or licensed clinical psychologist is not required for the following conditions:

- (a) Down Syndrome
- (b) Fetal Alcohol Syndrome
- (c) Hearing Impairment
- (d) Vision Impairment
- (e) Autism/PDD
- (f) Spina Bifida
- (g) Cerebral Palsy
- (h) Trisomy 13, 18, etc
- (i) Fragile X
- (j) Hydrocephalus

Early intervention services, provided to eligible infants and toddlers and their families, are financed through multiple funding sources. Sources which may be available to finance individualized services, as appropriate, may include, but are not limited to, the following:

- Title XIX of the Social Security Act (Medicaid).
- New Jersey FamilyCare.
- Third party payers. Third party payers, such as health insurance companies, may be accessed by families to cover the costs of early intervention services.
- Any medical program administered by the Secretary of the United States Department of Defense.
- Part C, Individuals with Disabilities Education Act (IDEA).
- State appropriation, Early Childhood Intervention Program.
- Cost participation by the family of an eligible child that receives direct early intervention services through the implementation of an Individualized Family Service Plan (IFSP).

In accordance with these policies and procedures, DHSS-NJEIS has established and implemented family cost participation procedures for charges and fees for early intervention services provided under an IFSP by NJEIS approved early intervention program provider agencies.

New Jersey Department of Health and Senior Services (DHSS) Determination of Eligibility for Services

IIb

Determination of Eligibility
for Services

Pharmaceutical Assistance to the Aged and Disabled (PAAD) Website: www.state.nj.us/health/seniorbenefits/paad.shtml

Pharmaceutical Assistance to the Aged and Disabled (PAAD) is a New Jersey Department of Health and Senior Services, Division of Senior Benefits and Utilization Management program, the Pharmaceutical Assistance to the Aged and Disabled program helps eligible New Jersey residents pay for prescription drugs, insulin, insulin needles and syringes and needles for injectable medicines used for the treatment of multiple sclerosis. Only drugs approved by the Food and Drug Administration are covered.

Eligibility Requirements:

- A New Jersey resident;
- 65 years of age or older or 18 years of age or older and receiving Social Security Title II disability benefits; and
- Annual income for 2010 of less than \$24,432 if single or less than \$29,956 if married; and
- Medicare-eligible PAAD beneficiaries are also required to enroll in a standard Medicare Part D Prescription Drug Plan in New Jersey with a monthly premium below the regional benchmark. These plans will cover medically necessary prescription medications under Medicare Part D. The federal Medicare Plan and PAAD will pay any costs above the PAAD copayment of \$6 for each covered generic drug or \$7 for each covered brand name drug, including premiums. However, if a Medicare Part D plan does not pay for a medication because the drug is not on its formulary, PAAD beneficiaries will have to switch to drug on their Part D plan's formulary, or their doctor will have to request an exception due to medical necessity directly to their Part D plan. Medicare Advantage participants must add a prescription benefit to their coverage, and PAAD will contribute up to the regional benchmark amount towards the prescription portion of their total premium.

Contact: 1.800.792.9745

New Jersey Division of Vocational Rehabilitation Services (DVRS) Determination Of Eligibility for Services

New Jersey Department Of Labor
Website: www.state.us/labor/dvrs

The New Jersey Division of Vocational Rehabilitation Services (DVRS) provides services that enable individuals with disabilities to find jobs or keep their existing jobs. Any physical or mental impairment that is a substantial impediment to employment may qualify an individual for vocational rehabilitation services. While DVRS is not a direct healthcare service provider, the services it provides for employment can be a defining determiner of healthcare coverage.

Client Services

1. **Vocational Counseling & Guidance** – Providing assistance to the consumer in handling the job search issues that impact employability, job maintenance strategies, and developing the overall techniques needed to be successful in a work environment.
2. **Placement Services** - Development of job leads both with and for the consumer and support during the job search; could include On the Job Training (OJT), Supported Employment (SE) or Time Limited Placement and Coaching (TLPC)
3. **Job Seeking Skills** - Guidance in work search activities such as resume writing, interviewing skills, job search organization
4. **Supported Employment** - Through referral to an SE provider, one-on-one assistance in job searching, interviewing, applying for jobs; followed by coaching on the job to facilitate learning job duties and adjusting to the work environment; followed by periodic follow-up to ensure job retention
5. **Time Limited Placement and Coaching** - The first two categories of Supported Employment Services without periodic follow-along
6. **Job Accommodations** - Guidance on changing the worksite's physical environment or adding equipment that will allow an individual to do more work tasks independently, effectively, and safely
7. **Skills Training** - Vocational school, technology or trade School, business school, etc.
8. **College Training** - 2 or 4 year programs leading to a degree
9. **Physical Restoration** - Equipment or therapies which improve physical or cognitive functioning so that a person is able to work; examples could be physical, occupational, or speech therapy; cognitive therapy which includes those modalities; prosthetics or orthotics such as artificial limbs, braces, special shoes, hearing aides, and eyeglasses (in some instances)
10. **Emotional Restoration Services** – Short-term individual, group or other types of counseling to reduce symptoms of mental health problems and improve work-tolerance and the ability to get and keep a job.

11. **Mobility Equipment**
12. **Driver Training** - Assessment of driving ability and equipment needed to drive safely; assistance in purchasing driver training lessons if needed to reach a specific work goal.
13. **Vehicle Modification**
14. **Home Modifications** – services if needed to reach a specific work goal

A student within two years of graduation or exit from the school system with a defined disability, who will need further assistance after graduation in order to maintain employment in the adult community, is a transition student. A student may be determined eligible with DVRS if due to their disability they have difficulty working without specific services and/or accommodations. A student may apply to DVRS within two years of the anticipated graduation. The rehabilitation counselor will meet with the student and evaluate eligibility for DVRS.

DVRS Central Office

LWD Building, 10th Floor
 John Fitch Plaza
 P.O. BOX 398
 Trenton, NJ 08625-0398
 609-292-2919 (TTY) dvradmin@dol.state.nj.us

Northern Region

Hackensack
 Hackettstown
 Jersey City
 Morristown
 Paterson

Central Region

Elizabeth
 Neptune
 New Brunswick
 Newark
 Somerville
 Trenton

Southern Region

Bridgeton
 Camden
 Pleasantville
 Thorofare
 Toms River
 Westampton
 Wildwood

New Jersey Division of Child Behavioral Health Services (DCBHS)

Determination of Eligibility for Services

New Jersey Department of Children & Families
Website: www.nj.gov/dcf/behavioral

The New Jersey Department of Children and Families Division of Child Behavioral Health Services (DCBHS) serves children and adolescents with emotional and behavioral health care challenges and their families. DCBHS is committed to providing these services based on the needs of the child and family in a family-centered, community-based environment.

DCBHS believes that the family or caregiver plays a central role in the health and well being of children. DCF involves families throughout the planning and treatment process in order to create a service system that values and promotes the advice and recommendations of the family, a system that is friendly to families and one which provides them the tools and support needed to create successful life experiences for their children with emotional and behavioral problems.

**For questions about or to access services for children and youth,
call the 24-hour, toll-free Access Line 1.877.652.7624**

PerformCare

- PerformCare is the Contracted System Administrator (CSA) for the Division of Child Behavioral Health Services (DCBHS), within the Department of Children and Families (DCF) for the State of New Jersey.
- PerformCare works for DCBHS to coordinate the care your youth's needs.
- PerformCare is interested in making sure that the services you access for your youth actually work and help your youth to get better.
- You can call PerformCare at any time and count on us to serve as a source of information and referral: 1.877.652.7624 (TDD: 1.866.896.6975). Remember, this is a toll-free call!
- Our clinical staff assesses the needs of your youth and, as appropriate, will send the proper people to your location to do an assessment of your youth's needs.
- Parents, family members, school employees, mental health providers, and other professionals helping children and families may contact PerformCare on behalf of a youth in need of a referral.

Remember, however, the parent/legal guardian of the youth must give consent for services.

Examples of our responsibilities include:

- Providing 24-hour/day, 7 days/week availability.
- Coordinating access to services for all eligible youth.
- Helping youth obtain any necessary specialized behavioral health services.

- Supporting the DCF/DCBHS goals of promoting best practices and assisting the state in assuring compliance with state and federal guidelines.
- Offering complaint, reconsideration, and appeal processes.

Eligibility Requirements:

- Youth eligible for services through PerformCare are primarily between the ages of 5 and 17, reside in the State of New Jersey, and have an emotional or behavioral problem.
- Special consideration for services will be given to youth under age 5.
- Young adults ages 18 to 21 are eligible for services if prior to becoming 18 years of age he or she received services from the child-serving system in New Jersey, including, but not limited to DCBHS, Division of Youth and Family Services (DYFS), the Juvenile Justice Commission, or any other child-serving state agency and demonstrates a clinical need for the continuation of services provided by the DCBHS system of care, as part of the transition into adult services.

**For questions about getting services, call the toll-free number
1.877.652.7624 (TDD: 866.896.6975).**

New Jersey Medicaid Program

Determination of Eligibility for Services

Website: www.cms.gov/MedicaidGenInfo/
 Website: www.state.nj.us.humanservices/dmahs/clients/medicaid/

Medicaid (TitleXIX) is a joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid serves individuals who are poor, blind, aged, disabled or members of families with dependent children (AFDC). Each state has its own standards for qualification. It is a federally aided, state-operated and administered program that provides medical benefits for certain indigent or low-income persons in need of health and medical care. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services, administers Medicaid in the State. Medicaid "Managed Care" delivers services to Medicaid-eligible individuals via a managed care system.

Mandatory services provided for all New Jersey Medicaid clients:

- Inpatient and outpatient hospital treatment
- Laboratory tests and X-rays
- Early and Periodic Screening, Diagnostic and Treatment services
- Home health care
- Physician services
- Nurse-midwife services
- Assistance with family planning and any necessary supplies
- Nursing facilities for people over 21

Optional Services provided to New Jersey Medicaid clients enrolled in specific programs:

- Treatment in residential treatment centers
- Optical appliances
- Dental care
- Optometry services
- Chiropractic services
- Psychologist
- Podiatrist
- Prosthetics and orthotics
- Drugs necessary during long term care
- Drugs at retail cost
- Durable medical equipment
- Hearing aid services
- Hospice care
- Transportation
- Personal care services
- Licensed practitioner services
- Private duty nursing
- Services in a clinic
- Physical, occupational and speech therapy
- Inpatient psychiatric care for individuals under 21 and over 65
- Intermediate care facilities for people with mental retardation

Eligibility Requirements:

New Jersey Medicaid covers persons who are age 65 years or over and persons determined blind or disabled by the Social Security Administration or by the Division of Medical Assistance and Health Services. The individual must be a resident of New Jersey and a citizen of the United States or lawfully admitted for permanent residence. In New Jersey, individuals receiving Supplemental Security Income (SSI) are automatically Medicaid-eligible.

Community Medicaid:

An individual is eligible for community Medicaid in New Jersey if his/her gross monthly income is equal to or less than \$903 (the first \$20 per month of income is excluded). Income includes, but is not limited to, Social

Security income, veterans' benefits, pensions, annuities, interest, dividends, and payments from trust funds, and rental income from real property.

The current Medicaid resource maximum for an individual is \$4,000. Countable resources include, but are not limited to, bank accounts, property other than principal residence, stocks, bonds, certificates of deposit, annuities, and cash surrender value of life insurance which exceeds \$1,500 in face value.

Excludable resources include, but are not limited to, a home which serves as the individual's principal residence, life insurance which does not exceed \$1,500 in face value, burial spaces, and burial funds not exceeding \$1,500 (less excluded cash surrender value of life insurance and/or funds held in an irrevocable burial arrangement), one automobile to the extent that its current market value does not exceed \$4,500, and one wedding and engagement ring.

The income and resources of a parent are not considered when the person with a disability is 18 years or older, even if he or she is living with family.

Institutional Medicaid:

In order to qualify for payment of institutional benefits, for example nursing facility care, under the Medicaid program in New Jersey, an applicant must meet not only the financial criteria, but also the medical necessity requirements. Each of these eligibility processes is complex and must be evaluated according to the applicant's individual circumstances. Considering these complexities, the general information which is being provided should only be used as a guideline. The current Medicaid eligibility income standard for an institutionalized individual is \$2,022 per month. If an individual's gross monthly income exceeds this Medicaid "cap," he or she is income ineligible for Medicaid. Income includes, but is not limited to, Social Security income, veterans' benefits, pensions, annuities, interest, dividends, payments from trust funds, and rental income from real property. Once eligibility is established, full Medicaid coverage is provided. However, the individual's income must be applied to offset the cost of nursing facility care. There are two Medicaid resource eligibility standards depending on the individual's income. If an individual's gross monthly income is below \$903 (the first \$20 per month of income is excluded), the current Medicaid resource maximum is \$4,000. If an individual's gross monthly income is between \$903.01 and \$2,022, the current resource maximum is \$2,000. Countable resources include, but are not limited to, bank accounts, property other than principal residence, stocks, bonds, certificates of deposit, and cash surrender value of life insurance which exceeds \$1,500 in face value.

Excludable resources include, but are not limited to, a home which serves as a principal residence of a spouse or other dependent relative (if a home is not occupied by a dependent relative and the period of institutionalization is expected to be six months or less, the home may also be excluded), life insurance which does not exceed \$1,500 in face value, burial spaces, and burial funds not exceeding \$1,500 (less excluded cash surrender value of life insurance and/or funds held in an irrevocable burial arrangement), one automobile to the extent that its current market value does not exceed \$4,500, and one wedding and engagement ring.

The spousal impoverishment provisions of the Medicare Catastrophic Coverage Act of 1988, effective October 1, 1989, provide that, if the individual requiring institutional services is married, the total countable resources of both members of the couple are counted except for those resources which are protected for the community spouse. The amount of resources which may be protected for the community spouse is the greater of 1/2 of the couple's resources or \$21,912, not to exceed \$109,560. Once eligibility is established for the institutionalized individual, the community spouse's resources are no longer counted. For married individuals whose current period of institutionalization began before September 30, 1989, resources may not be set aside for the community spouse and eligibility will be determined for the institutionalized individual counting only those resources owned by him or her.

The spousal impoverishment provisions of the Medicare Catastrophic Coverage Act of 1988 also provide that a penalty period of ineligibility for only institutional services will be imposed on those individuals who have transferred any resources for less than fair market value prior to the date of application for Medicaid. The look back period for the establishment of a trust is 60 months preceding the date of application for Medicaid.

On February 8, 2006, the provisions of the Deficit Reduction Act of 2005 allowed the period of ineligibility for resource transfers to be determined by dividing the uncompensated value of the transferred resource, which is also, known as the penalty divisor. The monthly penalty divisor is \$7,282. The daily penalty divisor

is \$239.41, which is used to calculate days of ineligibility. There is also a progressive look back period commencing February 2009. Additional months will be added to the look back period until February, 2011, when a full 60 month look back period will be in effect.

In addition, the spousal impoverishment provisions of the Medicare Catastrophic Coverage Act of 1988 provide that a deduction may be made from an eligible institutionalized individual's income, prior to the application of income to the cost of care, for the maintenance of the community spouse. The basic community spouse deduction is \$1,821.25 per month. However, it is reduced by the community spouse's gross income, both earned and unearned. If the community spouse's shelter expenses exceed \$546.36 monthly, the community spouse's maintenance deduction limit will be increased by the amount of the excess. The amount of income made available to the community spouse is limited by the income of the institutionalized spouse, not to exceed \$2,022 per month, less a personal needs allowance of \$35.

Medicaid Community Care Waiver (CCW):

The Medicaid Community Care Waiver (CCW) is a program for individuals with developmental disabilities that pays for the services and supports they need in order to live in the community. The CCW is funded by the State, with assistance from the federal government's Medicaid program. The New Jersey Division of Developmental Disabilities (DDD) administers the CCW. The number of individuals who can be served on the waiver is limited. This limit is based on projections of how much state funding will be available to fund DDD's portion of the cost of providing services to people enrolled on the waiver. ("Waivers" are so named because some of the rules that apply to Medicaid are "waived" or set aside.)

New Jersey Care Special Medicaid programs - Medically Needy segment:

An individual seeking institutional Medicaid whose income exceeds the Medicaid "cap" of \$2,022, may be eligible for limited Medicaid coverage through the Medically Needy component of New Jersey Care...Special Medicaid Programs. The resource standard for Medically Needy for an individual is \$4,000.

The regulations regarding resources and spousal impoverishment provisions of the Medicare Catastrophic Coverage Act of 1988 are equally applicable to the Medically Needy program.

Supplemental Security Income (SSI):

The Supplemental Security Income (SSI) program, administered by the Social Security Administration, is a federal program that provides monthly payments to eligible individuals who are 65 years of age or over and persons determined blind or disabled by the Social Security Administration. In New Jersey, individuals determined to be eligible for SSI will also receive full Medicaid benefits.

An individual may be eligible for SSI in New Jersey if his/her gross monthly income is equal to or less than \$705.25 or \$1,036.36 for a couple (the first \$20 per month of income is excluded). The current resource maximum for an individual is \$2,000 and \$3,000 for a couple.

For more information, please contact the Social Security Administration at 1.800.722.1213.

How and Where To Apply:

The Board of Social Services in the county in which the individual resides is responsible for the determination of eligibility for Medicaid in New Jersey. Below is a listing of the County Boards of Social Services. Please contact the appropriate office for information concerning the application process.

The County Medicaid Offices process applications for New Jersey Family Care, which grants eligibility to those with less than about \$870 per month in income and \$4,000 in resources. The County Office of Special Child Health Services will accept applications for a Split Medicaid Application, a special application for children with disabilities who are not eligible for Medicaid through SSI or otherwise because of parental

income, and who have a non-disabled sibling. Under the “Split Application” analysis, parental income is deemed to the non-disabled child and the child with disabilities is considered on his or her own, so that he or she will meet the income eligibility requirements. The child with disabilities also must meet the SSI disability requirements and the resource limit of \$6,000.

The Division of Medical Assistance and Health Services takes applications and can be reached at 800-356-1561. For more information about the various Medicaid-funded Waivers or to make an application, contact the Division of Developmental Disabilities (DDD) at 800-832-9137; the Division of Disabilities Services at 609-588-2621; or the Department of Health and Senior Services at 800-328-3838.

For further information, you may contact the Office of Eligibility Policy, 5 Quakerbridge Plaza, PO Box 712, Trenton, New Jersey 08625. The telephone number is 609.588.2556.

County Boards of Social Services

Atlantic County Department of Family & Community Development
1333 Atlantic Avenue
P.O. Box 869
Atlantic City, NJ 08401
609.348.3001

Bergen County Welfare Agency
216 Route 17 North
17 Park Office Center, Bldg. A
Rochelle Park, NJ 07662-3300
201.368.4200

Burlington County Welfare Agency
Human Services Facility
795 Woodlane Road
Mount Holly, NJ 08060-3335
609.261.1000

Camden County Welfare Agency
Aletha R. Wright Administration
Building
600 Market Street
Camden, NJ 08102-8800
856.225.8800

Cape May County Welfare Agency
Social Services Building
4005 Route 9 South
Rio Grande, NJ 08242-1911
609.886.6200

Cumberland County Welfare Agency
275 North Delsea Drive
Vineland, NJ 08360-3607
856.691.4600
Office of Aged/Disabled
856.453.8066

Essex County Department of Citizen Services
Division of Welfare
18 Rector Street – 9th floor
Newark, NJ 07102
973.733.3000

Gloucester County Welfare Agency
400 Hollydell Drive
Sewell, NJ 08080-9198
856.582.9200

Hudson County Division of Social Services Department of Welfare
257 Cornelison Ave.
Jersey City, NJ 07305
201.420.3000

Hunterdon County Division of Social Services
Community Services Center
6 Gauntt Place
Flemington, NJ 08822
Mailing: Hunterdon County Dept. of
Human Services
P.O. Box 2900
Flemington, NJ 08822
908.788.1300

Mercer County Welfare Agency
200 Woolverton Street
P.O. Box 1450
Trenton, NJ 08822-2900
609.989.4320

Middlesex County Welfare Agency
181 How Lane
P.O. Box 509
New Brunswick, NJ 08903
732.745.3500

Monmouth County Division of Social Services
Kozloski Road
P.O. Box 3000
Freehold, NJ 07728
732.431.6000

Morris County Division of Employment and Temporary Assistance Offices of Temporary Assistance Program Services
340 West Hanover Avenue
P.O. Box 900
Morristown, NJ 07963-0900
973.326.7800

Ocean County Welfare Agency
1027 Hooper Ave.
P.O. Box 547
Toms River, NJ 08754-0547
732.349.1500

Passaic County Welfare Agency
80 Hamilton Street
Paterson, NJ 07505-2060
973.881.0100
Pompton Lakes 973.839.5705
Passaic 973.470.5038
Paterson 973.881.2529

Salem County Welfare Agency
147 South Virginia Avenue
Penns Grove, NJ 08069
856.299.7200

Somerset County Welfare Agency
73 East High Street
P.O. Box 936
Somerville, NJ 08876-0936
908.526.8800

Sussex County Division of Social Services
18 Church Street
P.O. Box 218
Newton NJ 07860-0218
973.383.3600

Union County Division of Social Services
342 Westminster Avenue
Elizabeth, NJ 07208-3290
908.965.2700

Warren County Welfare Board
Court House Annex
Second Street
P.O. Box 3000 – 501
Belvidere, NJ 07823-3000
908.475.6301

Medicare (Title XVIII)

Determination of Eligibility for Services

Website: www.medicare.gov
Website: www.cms.gov/home/medicare.asp

Medicare (Title XVIII) is a federal program for the elderly and disabled, regardless of financial status. It is not necessary, as with Medicaid, for Medicare recipients to be poor. It is a U.S. health insurance program for people aged 65 and over, **for persons eligible for social security disability (SSDI) payments for two years or longer**, and for certain workers and their dependents that need kidney transplantation or dialysis. The Centers for Medicare & Medicaid Services (CMS) administers Medicare, the nation's largest health insurance program, which covers nearly 40 million Americans. Medicare is a Health Insurance Program for people age 65 or older, some individuals with disabilities under age 65, and people of all ages with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant). Some people qualify for both Medicare and Medicaid (this is also called "dual eligible"). Medicare has co-payments and deductibles.

A Medicare Approved Charge is the amount Medicare approves for payment to a physician. Typically, Medicare pays 80 percent of the approved charge and the beneficiary pays the remaining 20 percent. Physicians may bill beneficiaries for an additional amount (the balance) not to exceed 15 percent of the Medicare approved charge. There are four parts or components of Medicare:

- **Medicare Part A** - The Medicare component that provides basic hospital insurance to cover the costs of inpatient hospital services, confinement in nursing facilities or other extended care facilities after hospitalization, home care services following hospitalization, and hospice care.
- **Medicare Part B** - The Medicare component that provides benefits to cover the costs of physicians' professional services, whether the services are provided in a hospital, a physician's office, an extended-care facility, a nursing home, or an insured's home.
- **Medicare Part C** - The Medicare component known as Medicare Advantage that combines the coverage of Parts A & B.
- **Medicare Part D** - The Medicare component that provides benefits to cover the costs of prescription drug coverage.

Eligibility Requirements:

- People age 65 or older
- People under age 65 with certain disabilities
- People of any age with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant)

Medicare Basics: Where To Get Your Medicare Questions Answered

1.800.MEDICARE

To get general Medicare information and other important telephone numbers.

1.800.633.4227
TTY 1.877.486.2048

State Health Insurance Assistance Program (SHIP)

To get free Medicare counseling and personalized help making coverage decisions; information on programs for people with limited income and resources; and help with claims, billing, and appeals.

1.800.792.8820 New Jersey

Social Security

To replace a Medicare card; change your address or name; get information about Part A and/or Part B eligibility, entitlement, and enrollment; apply for Extra Help with Medicare prescription drug costs; ask questions about premiums; and report a death.

1.800.772.1213
TTY 1.800.325.0778

Coordination of Benefits Contractor

To get information on whether Medicare or your other insurance pays first and to report changes in your insurance information.

1.800.999.1118
TTY 1.800.318.8782

Department of Defense

To get information about the TRICARE Pharmacy Program.

1.877.363.1303
TTY 1.877.540.6261

Department of Health and Human Services

Office of Inspector General

If you suspect billing fraud.

1.800.447.8477
TTY 1-800-377-4950

Office for Civil Rights

If you think you were discriminated against or if your health information privacy rights were violated.

1.800.368.1019
TTY 1.800.537.7697

Department of Veterans Affairs

If you are a veteran or have served in the U.S. military.

1.800.827.1000
TTY 1.800.8294833

Office of Personnel Management

To get information about the Federal Employee Health Benefits Program for current and retired Federal employees.

1.888.767.6738
TTY 1.800.878.5707

Railroad Retirement Board (RRB)

If you have benefits from the RRB, call them to change your address or name, check eligibility, enroll in Medicare, replace your Medicare card, and report a death.

Local RRB office or
1.877.772.5772

Quality Improvement Organization (QIO)

To ask questions or report complaints about the quality of care for a Medicare-covered service or if you think your service is ending too soon.

Call 1.800.MEDICARE to get the telephone number for your QIO.

RX4NJ

Determination of Eligibility for Services

VII

Website: www.rx4nj.org/

Rx4NJ is a New Jersey program that connects qualified, low-income people with discount prescription drugs, direct from the pharmaceutical manufacturer. Rx4NJ offers a single point of access to public and private patient assistance programs, including more than 150 programs offered by pharmaceutical companies.

Eligibility Requirements:

The Rx4NJ prescription assistance program was created to make it easier for low-income uninsured patients to get free or nearly free prescription medicines through existing patient assistance programs, while providing the highest level of service. Once applicants provide the Web site with some basic information related to prescription medicines, income, and current prescription medicine coverage, Rx4NJ will be able to tell what patient assistance programs they may be eligible for.

The best way to apply for a prescription assistance program is to use the online Rx4NJ program. It will gather all of the information needed to see if you qualify and will then create an application form that you can print out.

Each patient assistance program has its own eligibility criteria. Once applicants complete the step-by-step application process, they should be able to see if you are eligible for one or more patient assistance programs. Patients with questions about the eligibility criteria of a specific program will be transferred directly to the company sponsoring that program. (Note: There are some instances in which Medicaid beneficiaries may be eligible for certain patient assistance programs.)

Information should be prepared to provide facts about the patient, such as:

- Age
- State of residence and ZIP code
- Estimated gross annual household income
- Number of people living in household
- Brand name of prescription medicines they are currently taking or have been prescribed
- Type of health insurance and/or prescription coverage (if applicable)
- Your responses to these questions are completely confidential.

Patients who may be eligible for one or more programs can use the information provided to contact the relevant program sponsors, and in many cases, they can fill out the relevant application forms online and then print out nearly completed forms. Patients must add or attach the required information and bring it to their doctor's office. Healthcare providers must sign the form and include the specific prescription information or simply attach the actual prescription. Either patients or doctors send the necessary forms to the organization sponsoring the specific program.

Charity Care (New Jersey Hospital Care Payment Assistance Program) Determination of Eligibility for Services

VIII

Determination of Eligibility
for Services

1.866.588.5696

The New Jersey Hospital Care Payment Assistance Program (Charity Care Assistance) is free or reduced charge care which is provided to patients who receive inpatient and outpatient services at acute care hospitals throughout the State of New Jersey.

Hospital assistance and reduced charge care are available only for necessary hospital care. Some services such as physician fees, anesthesiology fees, radiology interpretation, and outpatient prescriptions are separate from hospital charges and may not be eligible for reduction.

Eligibility Requirements:

Hospital care payment assistance is available to New Jersey residents who:

1. Have no health coverage or have coverage that pays only for part of the bill: **and**
2. Are ineligible for any private or governmental sponsored coverage (such as Medicaid); **and**
3. Meet **both** the income and assets eligibility criteria listed below.

Hospital assistance is also available to non-New Jersey residents, subject to specific provisions.

Income Criteria	
Income as a Percentage of HHS Poverty Income Guidelines	Percentage of Charge Paid by Patient
less than or equal to 200%	0%
greater than 200% but less than or equal to 225%	20%
greater than 225% but less than or equal to 250%	40%
greater than 250% but less than or equal to 275%	60%
greater than 275% but less than or equal to 300%	80%
greater than 300%	100%
If patients on the 20% to 80% sliding fee scale are responsible for qualified out-of-pocket paid medical expenses in excess of 30% of their gross annual income (i.e. bills unpaid by other parties), then the amount in excess of 30% is considered hospital care payment assistance.	

Assets Criteria
Individual assets cannot exceed \$7,500 and family assets cannot exceed \$15,000.
Should an applicant's assets exceed these limits, he/she may "spend down" the assets to the eligible limits through payment of the excess toward the hospital bill and other approved out-of-pocket medical expenses.

Glossary

Access - The patient's or individual's ability to obtain medical care or appropriate health care services.

Aging and Disability Resource Connection (ADRC) - Administered by the New Jersey Department of Health and Senior Services, it provides information on Services and Resources agencies, including health services and catastrophic illness.

Allowed Charge - The amount Medicare approves for payment to a physician; but may not match the amount the physician gets paid by Medicare (due to co-pay or deductibles) and usually does not match what the physician charges patients.

Appeal - The process that a patient and provider begin to demand that a payer or health plan actually pay for a service that has been denied payment.

Behavioral Health, Behavioral Healthcare - An umbrella term that includes mental health, psychiatric, marriage and family counseling, addictions treatment and substance abuse. Services are provided by a myriad of providers, including social workers, counselors, psychiatrists, psychologists, neurologists, behavior analysts, and even family practice physicians. Many states have "parity" laws that require behavioral health insurance coverage be provided "on par" with physical health coverage.

Beneficiary (Eligible, Enrollee, or Member) - The term for a person who has health care insurance through Medicare, Medicaid, health insurance or a health benefits plan. An individual who is either using or eligible to use insurance benefits, including health insurance benefits, under an insurance contract.

Benefit Package - Aggregate services specifically defined by an insurance policy or HMO that can be provided to patients. The services a payer offers to a group or individual. The package will specify included cost, limitation on the amounts of services, and annual or lifetime spending limits. For example, Medicaid services that state-contracted HMOs are responsible to provide include:

- Primary and Specialty Care
- Preventive Health Care and Counseling, Health Promotion
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
- Emergency Medical Care
- Inpatient Hospital (acute, rehab, and specialty)
- Outpatient Hospital
- Laboratory
- Radiology
- Prescription Drugs
- Family Planning Services and Supplies (in or out of HMO plan)
- Audiology
- Inpatient Rehabilitation
- Podiatrist
- Chiropractor

- Optometrist
- Optical Appliances
- Hearing Aid Services
- Home Health (limited)
- Hospice
- Durable Medical Equipment
- Medical Supplies
- Prosthetics and Orthotics (including shoe)
- Dental
- Organ Transplants
- Transportation (some)
- Post-acute Care
- Mental Health/Substance Abuse

Other services, such as mental health and substance abuse for non-DDD clients, physical, occupational, and speech therapies, some transportation, intermediate care facilities for children with developmental disabilities, medical day care, and nursing home care are covered by Medicaid, but under the fee for service payment system, not under the managed care program.

Benefits - Specific areas of plan coverages, e.g., outpatient visits, hospitalization and so forth, that make up the range of medical services that a payer markets to its subscribers. Also, a contractual agreement, specified in an Evidence of Coverage, determining covered services provided by insurers to members.

Capitation - A specified amount of money paid to a health plan or doctor. This is used to cover the cost of a health plan member's health care services for a certain length of time.

Care Manager - A registered nurse or social worker employed by or under contract to an HMO who is responsible for collaborating with enrollees with complex needs to develop and monitor Individual Health Care Plan. Care Managers help coordinate all needed services, including those received outside the HMO, such as PT, OT, Speech Therapy, and transportation.

Carrier - An insurer; an underwriter of risk that finances health care. Also refers to any organization which underwrites or administers life, health or other insurance programs. When an employer has a "self-insured" plan, the carrier (such as Aetna or Blue Cross) may not serve as carrier in this case, but may serve only as "third party administrator".

Case Management - The monitoring and coordination of treatment rendered to patients with a specific diagnosis or requiring high-cost or extensive services. Method designed to accommodate the specific health services needed by an individual through a coordinated effort to achieve the desired health outcome in a cost effective manner.

Case Manager - A nurse, doctor, or social worker who works with patients, providers and insurers to coordinate all services deemed necessary to provide the patient with a plan of medically necessary and appropriate health care.

o f T e r m s

Catastrophic Health Insurance - Policy that provides protection primarily against the higher costs of treating severe or lengthy illnesses or disabilities. Normally these are "add on" benefits that begin coverage once the primary insurance policy reaches its maximum.

Catastrophic Illness in Children Relief Fund (CICRF) – New Jersey agency, run wholly by its CICRF Commission and paid for with the fees gathered from state employers, who contribute \$1.50 per employee to the Fund. This means CICRF is not paid for with tax money; and it independently screens and distributes the bulk of these fees to families facing catastrophic medical expenses for their children.

Centers for Medicare and Medicaid Services (CMS) - The Centers for Medicare & Medicaid Services (CMS) is a Federal agency within the U.S. Department of Health and Human Services. Programs for which CMS is responsible include Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), Health Insurance Portability and Accountability Act (HIPAA) and Clinical Laboratory Improvement Amendments (CLIA).

Centers for Primary Health Care (CPHCs) and Federally Qualified Health Centers (FQHCs) - A program of the New Jersey Department of Health and Senior Services, Centers for Primary Health Care offer a range of primary health care services at locations statewide. Care is affordable. Centers serve the uninsured and underinsured, as well as patients with Medicaid, Medicare and private insurance. If uninsured, the bill will be based on ability to pay and no one is turned away for financial reasons. There are dozens of medical center, community health, and mobile facilities located throughout the State.

Charity Care (New Jersey Hospital Care Payment Assistance Program) - The New Jersey Hospital Care Payment Assistance Program (Charity Care Assistance) is free or reduced charge care which is provided to patients who receive inpatient and outpatient services at acute care hospitals throughout the State of New Jersey. Hospital assistance and reduced charge care are available only for necessary hospital care. All charity care applicants are screened to determine the potential eligibility for any third party insurance benefits or medical assistance programs that might pay towards the hospital bill. The patient or prospective patient must apply for hospital care payment assistance at the hospital from which he/she plans to obtain or has obtained services. The patient should apply at the business office or admissions office of the hospital.

CHIP (The Children's Health Insurance Program) – CHIP is a program that provides health care coverage to children who

need health insurance, live in households with limited income, and don't qualify for Medicaid. Under the CHIP program, there may be copayments required for services. Also, some services may have limitations like covering a maximum number of doctor visits. If eligible, this program offers the many healthcare services. See **FamilyCare**.

Claim - A request by an individual (or his or her provider) to that individual's insurance company to pay for services obtained from a health care professional; an itemized statement of healthcare services and their costs provided by a hospital, physician's office, or other provider facility. Claims are submitted to the insurer or managed care plan by either the plan member or the provider for payment of the costs incurred.

Coding - A mechanism for identifying and defining physicians' and hospitals' services. Coding provides universal definition and recognition of diagnoses, procedures and level of care. Coders usually work in medical records departments and coding is a function of billing. Medicare fraud investigators look closely at the medical record documentation, which supports codes and looks for consistency. Lack of consistency of documentation can earmark a record as "upcoded" which is considered fraud. A national certification exists for coding professionals and many compliance programs are raising standards of quality for their coding procedures.

Co-Insurance (Coinsurance) - A cost-sharing requirement under a health insurance policy that provides that the insured will assume a portion or percentage of the costs of covered services. Health care cost which the covered person is responsible for paying, according to a fixed percentage or amount. A policy provision frequently found in major medical insurance policies under which the insured individual and the insurer share hospital and medical expenses according to a specified ratio. A type of cost sharing where the insured party and insurer share payment of the approved charge for covered services in a specified ratio after payment of the deductible.

Community Health Law Project (CHLP) – New Jersey agency that serves consumers of mental health services, people with physical disabilities, HIV/AIDS, developmental disabilities, and visual impairments, legally representing clients in matters involving Social Security benefits, welfare, food stamps, and other entitlements; Medicaid, Medicare, and other health insurance issues. Its funding is provided by the State of New Jersey, and various county, municipal, and private grants.

Consolidated Omnibus Budget Reconciliation Act (COBRA) - Federal law that continues health care benefits for employees whose employment has been terminated. Employers are required to notify employees of these benefit continuation options and, failure to do so can result in penalties and fines for the employer; an act that allows workers and their families to continue their employer-sponsored health insurance for a certain amount of time after terminating employment.

Coordination of Benefits (COB) - Process for determining the respective responsibilities of two or more health plans that have some financial responsibility for a medical claim. A coordination of benefits, or "non-duplication" clause in either policy prevents double payment by making one insurer the primary payer, and assuring that not more than 100 percent of the cost is covered. Standard rules determine which of two or more plans, each having COB provisions, pays its benefits in full and which becomes the supplementary payer on a claim.

Co-Payment, Copayment, Copay - A cost-sharing arrangement in which the health plan enrollee pays a specified flat amount for a specific service (such as \$15 for an office visit or \$10 for each prescription drug).

Covered Benefit - A medically necessary service that is specifically provided for under the provisions of an Evidence of Coverage. A covered benefit must always be medically necessary, but not every medically necessary service is a covered benefit. For example, some elements of custodial or maintenance care, which are excluded from coverage, may be medically necessary, but are not covered.

Customary, Prevailing, and Reasonable (CPR) - Current method of paying physicians under Medicare. Payment for a service is limited to the lowest of (1) the physician's billed charge for the service, (2) the physician's customary charge for the service, or (3) the prevailing charge for that service in the community. Similar to the Reasonable and Customary (R&C) system used by private insurers.

Deductibles - Amounts required to be paid by the insured under a health insurance contract, before benefits become payable. Different components of a health plan may have separate deductibles. Usually expressed in terms of an "annual" amount.

Definition of Disability (by the Social Security Administration) - The Social Security Administration defines disability differently for adults and children.

Adults: The law defines disability as the inability to engage in any substantial gainful activity (work) by reason of any medically determinable physical or mental impairment(s), which can be expected to result in death or which has lasted or can be expected to last for a continuous period of at least 12 months.

Children: A child under 18 will be considered disabled if he or she has a medically determinable physical or mental impairment or combination of impairments that cause marked and severe functional limitations, that can be expected to cause death or that has lasted or can be expected to last for a continuous period of not less than 12 months.

A medically determinable impairment is one that is established by medical evidence that consists of signs, symptoms and medically acceptable clinical and laboratory diagnostic techniques... not only by the individual's statements.

Dental Clinic Directory (NJ) - A service provided by the Division of Family Health Services, the New Jersey Department of Health and Senior Services, the New Jersey Dental Clinic Directory is a reference tool that provides a central source of information on public dental clinic

services in New Jersey. These clinic services are primarily provided by local health departments, hospitals and Federally Qualified Health Centers (FQHCs). The information contained in the document is from organizations that responded to a "Dental Health Services Survey" and is subject to change. The dental clinic directory may be used to assist people who have difficulty accessing appropriate dental care due to insurance or financial constraints. Many of the clinics have financial and/or residency requirements. Patients should be advised to call for an appointment and ask about required documentation regarding income or residency.

Department of Banking and Insurance (DOBI) - A State of NJ department, it includes the Division of Insurance, which is comprised of units which are charged with the licensing and oversight of the various types of insurance regulated by the State of New Jersey. The Division of Insurance issues licenses to insurance companies, producers and other risk-assuming entities, reviews insurance products and rates for compliance with existing regulations, and monitors the financial solvency of licensees to ensure product availability in the marketplace. The Division also responds to consumer concerns and inquiries and endeavors to educate consumers regarding insurance products and issues. It oversees the Individual Health Coverage Program ("IHC") and the Small Employer Health Benefits Program ("SEH") for the individual and small employer (employers with 2-50 employees) health insurance markets.

Department of Health and Human Services (DHHS) - The federal agency that oversees Medicare, Medicaid and other federal health care programs. The Centers for Medicare and Medicaid (CMS) is a division of DHHS.

Department of Health and Senior Services (DHSS) - State of NJ department established to improve the quality of health care, strengthen the health care delivery system, increase access to health care services, support New Jersey's seniors, promote and protect the public health, and enhance the emergency response infrastructure. The Division of Family Health Services, under DHSS, administers the Special Child Health Services (SCHS) and the New Jersey Early Intervention System (NJEIS) programs.

Department of Justice (U.S. DOJ) - The federal agency that enforces the law and handles criminal investigations. As the nation's largest law firm, the DOJ protects citizens through effective law enforcement, crime prevention and crime detection. It is the agency that prosecutes those in the health care system guilty of proven "fraudulent" activity.

Dependent - Person covered by someone else's health plan. In a payer's policy of insurance, a person other than the subscriber who is eligible to receive care because of a subscriber's contract.

Diagnostic and Treatment Codes - Special codes that consist of a brief, specific description of each diagnosis or treatment and a number used to identify each diagnosis and treatment.

Division of Child Behavioral Health Services (DCBH) - A division of the New Jersey Department of Children and Family Services (NJDCF), it provides services to children and adolescents with emotional and behavioral health care challenges and their families. Based on the needs of the child and family, these services are, in many cases, provided in a family-centered, community-based environment.

Division of Developmental Disabilities (DDD) – A division of the New Jersey Department of Human Services, it provides public funding for services and supports that assist people with developmental disabilities. These services are offered in the community by more than 250 New Jersey agencies and in seven residential developmental centers. There is no entitlement for services funded by DDD. DDD determines through an application process who is eligible to receive services it funds.

Division of Disability Services (DDS) – A division of the New Jersey Department of Human Services, it focuses on serving people who have become disabled as adults, whether through illness or injury. Such conditions are also called late-onset disabilities. The Division serves as a single point of entry for people with disabilities who need information and/or services within the human services system. DDS administers programs that allow people with different types of disabilities to live more independently in the community, and in many cases, avoid the need to move into an institution. These programs include home and community-based service programs, as well as other resource programs, including:

- Community Resources for People with Disabilities (CRPD) Waiver
- Disability Health and Wellness Initiative
- Information and Assistance Services
- Medicaid Personal Care Assistance (PCA)

Division of Medical Assistance & Health Services (DMAHS) - A division of the New Jersey Department of Human Services, it administers the state-and federally-funded Medicaid program for certain groups of low- to moderate-income people. Through these programs, DMAHS serves more than 1,000,000 people with a staff of over 500 people who work both in Trenton and in Medical Assistance Customer Centers (MACCs) throughout the state.

Division of Mental Health Services (DMHS) - A division of the New Jersey Department of Human Services, the Division of Mental Health Services (DMHS) serves adults with serious and persistent mental illnesses.

Division of Vocational Rehabilitation Services (DVRS) - A division of the New Jersey Department of Labor and Workforce Development, it provides services that enable individuals with disabilities to find jobs or keep their existing jobs.

Drug Formulary - Varying lists of prescription drugs approved by a given health plan for distribution to a covered person through specific pharmacies. Health plans often restrict or limit the type and number of medicines allowed for reimbursement by limiting the drug formulary list. The list of prescription drugs for which a particular employer or State Medicaid program will pay. Formularies are either "closed," including only certain drugs or "open," including all drugs. Both types of formularies typically impose a cost scale requiring consumers to pay more for certain brands or types of drugs.

Dual Eligible - A Medicare beneficiary who also receives the full range of Medicaid benefits offered in his or her state. Medicare usually pays the charges for inpatient while Medicaid will pay the co-pay for inpatient care in hospitals. Medicare will be considered the primary insurer for inpatient care for the Care/Caid patient.

Duplication of Benefits - When a person is covered under two or more health plans with the same or similar coverage.

DU31 (Dependent Under 31) – New Jersey insurance provision that allows young adults under 31 years of age to continue coverage or become covered under their parents' group health plan.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) - A Medicaid program for recipients younger than 21 that provides screening, vision, hearing, and dental services at intervals that meet recognized standards of medical and dental practices and at other intervals as necessary to determine the existence of physical or mental illnesses or conditions.

Early Intervention System (EIS) - The NJ Early Intervention System (NJEIS) provides services for infants and toddlers, age birth to three years of age, with developmental delays and disabilities, and their families. Services include assistive technology services/devices; audiology services; developmental intervention; family training, counseling and home visits; health services; nursing services; nutrition services; occupational therapy; psychological services; social work services; speech and language therapy; vision services; and other early intervention services. Fees: Family cost share is a progressive monthly fee based on family size and income along the federal poverty guidelines. If a family's income is below 350% of the federal poverty level guidelines, they will not have cost share. Families with an annual income at or above 350% of the federal poverty level guidelines are required to share in the costs of early intervention services provided. Administered under the New Jersey Department of Health and Senior Services

Eligible Expenses - Charges covered under a health plan.

Employee Retirement Income Security Act of 1974 (ERISA) - Also called the Pension Reform Act, this act regulates the majority of private pension and welfare group benefit plans in the U.S. It sets forth requirements governing, among many areas, participation, crediting of service, vesting, communication and disclosure, funding, and fiduciary conduct. Key legislative battleground now, because ERISA exempts most large self-funded plans from State regulation and, hence, from any reform activities undertaken at state level, which is now the arena for continued healthcare reform.

Enrollment - Initial process whereby new individuals apply and are accepted as members of a prepayment plan. The total number of covered persons in a health plan. Also refers to the process by which a health plan enrolls groups and individuals for membership or the number of enrollees who sign up in any one group.

Exclusive Provider Organization (EPO) - A plan that limits coverage of non-emergency care to contracted health care providers. Operates similar to an HMO plan but is usually offered as an insured or self-funded product. Sometimes looks like a managed care organization that is organized similarly to a PPO in that physicians do not receive capitated payments, but the plan only allows patients to choose medical care from network providers. If a patient elects to seek care outside of the network, then he or she will usually not be reimbursed for the cost of the treatment.

Explanation of Benefits (EOB) - A statement sent to covered individuals explaining services provided, amount to be billed, and payments made. A summary of benefits provided subscribers by the carrier. Same as Evidence of Coverage.

FamilyCare (NJFC) - NJ FamilyCare is a federal and state funded health insurance program created to help New Jersey's uninsured children (up to age 19) and certain low-income parents and guardians to have affordable health coverage. NJ FamilyCare is for families who do not have available or affordable employer insurance, and cannot afford to pay the high cost of private health insurance. The entire application process can be completed by mail or online.

Family Health Line - This free hotline operates 24/7 and is available anywhere in New Jersey. Trained telephone counselors provide information and referrals for health screening and treatment. 1.80.328.3838.

Federal Medicaid Managed Care Waiver Program - The process used by States to receive permission to implement managed care programs for their Medicaid or other categorically eligible beneficiaries.

Fee-For-Service (FFS) - Traditional method of payment for health care services where specific payment is made for specific services rendered. Usually people speak of this in contrast to capitation, DRG or per diem discounted rates, none of which are similar to the traditional fee-for-service method of reimbursement. Most Medicaid managed care HMO enrollees still obtain some services outside the HMO that are billed on a fee-for-service basis (e.g., physical, occupational, and speech therapies, and some home health care; and mental health/substance abuse services for people who are not clients of the New Jersey Department of Developmental Disabilities).

Fee Schedule - A listing of accepted fees or established allowances for specified medical procedures. As used in medical care plans, it usually represents the maximum amounts the program will pay for the specified procedures.

Formulary - An approved list of prescription drugs; a list of selected pharmaceuticals and their appropriate dosages felt to be the most useful and cost effective for patient care. Organizations often develop a formulary under the aegis of a pharmacy and therapeutics committee.

Fraud - Intentional misrepresentations that can result in criminal prosecution, civil liability and administrative sanctions. This is a broad definition and can be applied in many different circumstances. In health care, most commonly it refers to hospitals and doctors that are suspected of charging fees for services not provided or have, in some other way, incorrectly documented a medical record in such a way to increase their revenues or avoid scrutiny. Grace Period - Period past the due date of a premium during which coverage may not be cancelled.

Group Health Plan - An insurance plan that provides health coverage to employees, former employees, and their families, and is supported by an employer, employee organization or other organized group.

Group Insurance - Any insurance policy or health services contract by which groups of employees (and often their dependents) are covered under a single policy or contract, issued by their employer or other group entity.

Health - The state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Health has many dimensions (anatomical, physiological, and mental) and is largely culturally defined. The relative importance of various disabilities differs, depending upon the cultural milieu and the role of the affected individual in that culture.

Health Benefits Coordinator (HBC) - individual who can provide information and assistance to persons eligible for Medicaid managed care on how to choose, enroll in, transfer from, or problem-solve about an HMO plan. Enrollment in the Medicaid managed care HMO is through the HBC. The HBC can make home visits. Employed by the organization under contract to the State to provide these services (called Maximus); not employed by the HMO.

Health Care - Care, services, and supplies related to the health of an individual. Health care includes preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, among other services. Health care also includes the sale and dispensing of prescription drugs or devices.

Health Care Provider - Providers of medical or health care or researchers who provide health care are health care providers. Normally, health care providers are clinics, hospitals, doctors, dentists, psychologists and similar professionals.

Health Insurance - Financial protection against the health care costs of the insured person; obtained in a group or individual policy.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) - A federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment relationships.

HealthLink - The website maintained by the New Jersey Office of Information Technology that lists links to information and access to programs that provide financial assistance or reduced fees for health-related services, and to programs that provide information and assistance for people with disabilities. Answers to frequently asked questions about healthcare in New Jersey, such as, "Where can I find information on low-cost health insurance for myself and my children?" "How do I contact Medicaid?" and "How do I contact Medicare?"

Health Maintenance Organization (HMO) - An entity that provides, offers or arranges for coverage of designated health services needed by members for a fixed, prepaid premium. HMOs offer prepaid, comprehensive health coverage for both hospital and physician services. The HMO is paid monthly premiums or capitated (a set fee per person per given period of time) rates by the payers, which include employers, insurance companies, government agencies, and other groups representing covered lives.

Home Health Care - Full range of medical and other health related services such as physical therapy, nursing, counseling, and social services that are delivered in the home of a patient by a provider.

Hospital - An institution that provides medical, surgical, or psychiatric care and treatment for individuals with illnesses and injuries.

Indemnity - Health insurance benefits provided in the form of cash payments rather than services. Insurance program in which covered person is reimbursed for covered expenses.

Individualized Family Service Plan (IFSP) – A plan for services developed by a Special Child Health Services (SCHS) case manager for children under three (3) years of age; a resource under the administration of the New Jersey Department of Health and Senior Services; a statement about the child's development based on an evaluation and assessment.

Individual Plans - A type of insurance plan for individuals and their dependents who are not eligible for coverage through employer or other group coverage.

Life After 21 - Life After 21 is a DDD initiative, a two-part training series addressing the concerns of students with developmental disabilities ages 19 & 21, and their families, as they approach the adult service systems. Life After 21 Part I provides: Skills and tools to plan supports and services based on individual needs; A brief overview of DDD Day Services and Division of Vocational Rehabilitation Services (DVRS); Resource information regarding DDD Day Program/Day Service options; and DVRS contact information, to be distributed to participants. This session also includes "The Provider Marketplace" which is an opportunity for families to become acquainted with Adult Agencies/Service Organizations providing local supports and services.

Lifetime Limit - A cap on the benefits paid under a policy. For example, many policies have a lifetime limit of \$1 million, which means that the insurer agrees to cover up to \$1 million in covered services over the life of the policy.

Long-term Care (LTC) - A set of health care, personal care and social services required by persons who have lost, or never acquired, some degree of functional capacity (e.g., individuals who are chronically ill, aged, disabled, or intellectually-impaired) in an institution or at home, on a long-term basis.

Long-term Care Insurance - Insurance designed to pay for some or all of the costs of long-term care.

Malpractice Insurance - Insurance against the risk of suffering financial damage due to professional misconduct or lack of ordinary skill. Malpractice requires that the patient prove some injury and that the injury was the result of negligence on the part of the professional. A practitioner is liable for damages or injuries caused by malpractice.

Managed Behavioral Health Organization (MBHO) - An organization that provides behavioral health services by implementing managed care techniques.

Managed Care - Systems and techniques used to control the use of health care services; includes a review of medical necessity, incentives to use certain providers, and case management. The body of clinical, financial and organizational activities designed to ensure the provision of appropriate health care services in a cost-efficient manner.

Managed Care Organization (MCO) - A health plan that seeks to manage care. Generally, this involves contracting with health care providers to deliver health care services on a capitated (per member per month) basis. For specific types of managed care organizations, see also Health Maintenance Organization.

Mandated Benefits - Benefits that health plans are required by law to provide.

Maximum Out-of-Pocket Expenses - Limit on total number of co-payments or limit on total cost of deductibles and co-insurance under a benefit plan.

Medicaid (Title XIX) - A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid serves individuals that are poor, blind, aged, disabled or members of families with dependent children (AFDC). Each state has its own standards for qualification. A federally aided, state-operated and administered program that provides medical benefits for certain indigent or low-income persons in need of health and medical care, the New Jersey Department of Human Services, Division of Medical Assistance and Health Services, administers Medicaid in the State. Medicare "Managed Care" delivers services to Medicaid-eligible individuals via a managed care system. Mandatory services for all New Jersey Medicaid clients include:

- Inpatient and outpatient hospital treatment
- Laboratory tests and X-rays
- Early and Periodic Screening, Diagnostic and Treatment services
- Home health care
- Physician services
- Nursing facilities for people over 21

Other services such as long-term prescription drugs and physical, occupational, and speech therapy are optional depending on specific program approval.

Medicaid Community Care Waiver (CCW) - The Medicaid Community Care Waiver (CCW) is a program for individuals with developmental disabilities that pays for the services and supports they need in order to live in the community. The CCW is funded by the state, with assistance from the federal government's Medicaid program. DDD administers the CCW. The number of individuals who can be served on the waiver is limited. This limit is based on projections of how much state funding will be available to fund DDD's portion of the cost of providing services to people enrolled on the waiver.

Medical Code Sets - Codes that characterize a medical condition or treatment. These code sets are usually maintained by professional societies and public health organizations.

Medicare (Title XVIII) - A federal program for individuals that are elderly and disabled, regardless of financial status. It is not necessary, as with Medicaid, for Medicare recipients to be poor. A U.S. health insurance program for people aged 65 and over, for persons eligible for social security disability payments for two years or longer, and for certain workers and their dependents who need kidney transplantation or dialysis.

Medicare Approved Charge - The amount Medicare approves for payment to a physician. Typically, Medicare pays 80 percent of the approved charge and the beneficiary pays the remaining 20 percent. Physicians may bill beneficiaries for an additional amount (the balance) not to exceed 15 percent of the Medicare approved charge.

Medicare Part A - The Medicare component that provides basic hospital insurance to cover the costs of inpatient hospital services, confinement in nursing facilities or other extended care facilities after hospitalization, home care services following hospitalization, and hospice care.

Medicare Part B - The Medicare component that provides benefits to cover the costs of physicians' professional services, whether the services are provided in a hospital, a physician's office, an extended-care facility, a nursing home, or an insured's home.

Medicare Part C - The Medicare component known as Medicare Advantage that combines the coverage of Parts A & B.

Medicare Part D (Medicare Prescription Drug Plan (PDP or MPDP)) - The Medicare component that provides benefits to cover the costs of prescription drug coverage. A stand-alone drug plan, offered by insurers and other private companies to beneficiaries that receive their Medicare Part A and/or B benefits through the Original Medicare Plan; Medicare Private Fee-for-Service Plans that do not offer prescription drug coverage; and Medicare Cost Plans offering Medicare prescription drug coverage. These stand-alone plans add prescription drug coverage to the Original Medicare Plan and to some Medicare Cost Plans and Medicare Private Fee-for-Service Plans.

Medigap - Individual medical expense insurance policies sold by state-licensed private insurance companies. Private health insurance plans that supplement Medicare benefits by covering some costs not paid for by Medicare. Except in Massachusetts, Minnesota, and Wisconsin, there are 12 standardized plans labeled Plan A through Plan L. Medigap policies only work with the Original Medicare Plan. Medigap plans vary from state to state; standardized Medigap plans also may be known as Medicare Select plans.

Mental Health Parity and NJ Mental Health Parity Act - Mental health parity refers to providing the same insurance coverage for mental health treatment as that offered for medical and surgical treatments. The Mental Health Parity Act was passed in 1996 and established parity in lifetime benefit limits and annual limits. A law that prohibits group health plans from applying more restrictive annual and lifetime limits on coverage for mental illness than for physical illness.

Miscellaneous Expenses - Hospital charges, other than room and board, such as those for x-rays, drugs, laboratory fees, and other ancillary services.

New Jersey Care 2000+ - The name of the Medicaid Managed Care program in New Jersey.

Non-Participating Physician (or Provider) - A provider, doctor or hospital that does not sign a contract to participate in a health plan, usually which requires reduced rates from the provider. In the Medicare Program, this refers to providers who are therefore not obligated to accept assignment on all Medicare claims. In commercial plans, non-participating providers are also called out of network providers or out of plan providers. If a beneficiary receives service from an out of network provider, the health plan (other than Medicare) will pay for the service at a reduced rate or will not pay at all.

Nurse Practitioner (NP) - A registered nurse qualified and specially trained to provide primary care, including primary

health care in homes and in ambulatory care facilities, long-term care facilities, and other health care institutions. Normally, NPs are licensed and possess masters' degrees. Nurse practitioners generally function under the supervision of a physician but not necessarily in his/her or her presence. In some states, NPs are able to provide basic medical services without requiring MD or DO supervision. They are either salaried or reimbursed on a fee-for-service basis.

Office of Public Health Infrastructure (OPHI) - Administered by the New Jersey Department of Health and Senior Services, it manages implementation of NJAC 8:52: Public Health Practice Standards of Performances for Local Boards of Health in New Jersey and maintains data and statistics resources.

Olmstead - Assuring Access to Community Living for the Disabled. On June 22, 1999, the U.S. Supreme Court ruled in *Olmstead v. L.C.* that under the Americans With Disabilities Act (ADA) unjustified institutionalization of a person with a disability, who, with proper support, can live in the community, is discrimination. In its ruling, the Court said that institutionalization severely limits the person's ability to interact with family and friends, to work and to make a life for him or herself. Under the Court's ruling, certain principles emerged: unjustified institutionalization of people with disabilities is discrimination and violates the ADA; states are required to provide community-based services for persons with disabilities otherwise entitled to institutional services when the state's treatment professionals reasonably determine that community placement is appropriate; the person does not oppose such placement; and the placement can reasonably be accommodated, taking into account resources available to the state and the needs of others receiving state-supported disability services; a person cannot be denied community services just to keep an institution at its full capacity; and, there is no requirement under the ADA that community-based services be imposed on people with disabilities who do not desire it.

Ombudsperson or Ombudsman - A person within a managed care organization or a person outside of the health care system (such as an appointee of the state) who is designated to receive and investigate complaints from beneficiaries about quality of care, inability to access care, discrimination, and other problems that beneficiaries may experience with their managed care organization.

Out-of-Network Provider - A health care provider with whom a managed care organization does not have a contract to provide health care services. Because the beneficiary must pay either all of the costs of care from an out-of-network provider or their cost-sharing requirements are greatly increased, depending on the particular plan a beneficiary is in, out-of-network providers are generally not financially accessible to Medicaid beneficiaries.

Out-of-Pocket Expenses, Out-of-Pocket Costs - Dollar amounts set by MCOs that limit the amount a member has to pay out of his or her own pocket for particular healthcare services during a particular time period. Costs borne by the member that are not covered by health care plan. Portion of health services or health costs that must be paid for by the plan member, including deductibles, co-payments and co-insurance. In the age of managed care, out-of-pocket expenses can also refer to the payment of services not covered by or approved for reimbursement by the health plan.

Participating Physician - A primary care physician in practice in the payer's managed care service area who has entered into a contract to provide treatment.

Pathways to Adult Life - Transition, from Graduation to Adult Life - DDD program, partnering with other state agencies to provide current transition-related information. This information is geared specifically to individuals, and their families, who will graduate from the education system in the coming year. The Transition program is called Pathways to Adult Life. Coordinating agencies are:

- DVRS (Division of Vocational Rehabilitation Services)
- DDS (Division of Disability Services)
- DOE (Department of Education-Office of Special Education)
- DDD (Division of Developmental Disabilities)
- The Elizabeth M. Boggs Center – NJ's University Center for Excellence at UMDNJ

Pharmaceutical Assistance to the Aged and Disabled (PAAD) – A New Jersey Department of Health and Senior Services, Division of Senior Benefits and Utilization Management program, the Pharmaceutical Assistance to the Aged and Disabled program helps eligible New Jersey residents pay for prescription drugs, insulin, insulin needles and syringes and needles for injectable medicines used for the treatment of multiple sclerosis. Only drugs approved by the Food and Drug Administration are covered. Drugs purchased outside the State of New Jersey are not covered, nor is any pharmaceutical product whose manufacturer has not agreed to provide rebates to the State of New Jersey. All PAAD participants, if they are eligible for Medicare Part A or enrolled in Medicare Part B, must enroll in a Medicare Part Prescription Drug Plan. All PAAD applicants must also submit information to PAAD to help determine if they may be eligible for a Federal Subsidy to help pay for Medicare Part D. Medicare eligible PAAD participants will use PAAD benefits together with Medicare Part benefits. PHI (Protected Health Information) - Under HIPAA, this refers to individually identifiable health information transmitted or maintained in any form.

Physician Services - Services provided by an individual licensed under state law to practice medicine or osteopathy. Physician services given while in the hospital that appear on the hospital bill are not included in this definition.

Plan Administration - A term often used to describe the management unit with responsibility to run and control a managed care plan - includes accounting, billing, personnel, marketing, legal, purchasing, possibly underwriting, management information, facility maintenance, servicing of accounts. This group normally contracts for medical services and hospital care.

Point-of-Service Plan or Point-of-Service Option (POS) - A health services delivery organization that offers the option to its members to choose to receive a service from participating or a nonparticipating provider. Generally the level of coverage is reduced for services associated with the use of non-participating providers. Managed care plan that specifies that those patients who go outside of the plan for services may pay more out of pocket expenses.

Portability - Requirement that health plans guarantee continuous coverage without waiting periods for persons moving between plans. The ability for an individual to

transfer from one health insurer to another health insurer with regard to pre-existing conditions or other risk factors.

Preadmission Review, Pre-Admission Certification, Pre-Certification, or Pre-Authorization - Review of "need" for inpatient or other care before admission. This refers to a decision made by the payer, MCO or insurance company prior to admission. The payer determines whether or not the payer will pay for the service. Most managed care plans require pre-certification. This is a method of controlling and monitoring utilization by evaluating the need for service prior to the service being rendered.

Pre-Existing Condition - A medical condition developed prior to issuance of a health insurance policy that may result in the limitation in the contract on coverage or benefits. Normally this is defined as a health problem for which the new enrollee received health care services before the date that the new health plan benefit begins.

Preferred Provider Organization (PPO) - Hospitals and physicians who agree to render particular services to a group of people, perhaps under contract with a private insurer. A health care delivery system that contracts with providers of medical care to provide services at discounted fees to members. Members may seek care from non-participating providers at additional costs, such as co-payments and deductibles.

Prescription Drug Plan (PDP) - These plans became more commonplace with the implementation of Medicare Part D in 2006. Everyone with Medicare, regardless of income, health status, or prescription drugs used, can get some sort of prescription drug coverage. These stand-alone plans add prescription drug coverage to the Original Medicare Plan and to some Medicare Cost Plans and Medicare Private Fee-for-Service Plans. Managed by commercial and private entities, these PDPs are a type of managed care. When a person joins a Medicare Prescription Drug Plan, they use the plan member cards that are issued by the plans when they go to the pharmacies to purchase prescriptions.

Preventive Care or Preventive Services - Health care that emphasizes prevention, early detection and early treatment, thereby reducing the costs of healthcare in the long run.

Primary Care Physician (PCP) - A "generalist" such as a family practitioner, pediatrician, internist, or obstetrician. In a managed care organization, a primary care physician is accountable for the total health services of enrollees including referrals, procedures and hospitalization.

Primary Coverage - Plan that pays eligible expenses without consideration of other plans, under coordination of benefits rules.

Privacy Notice - Institution-wide notice describing the practices of the covered entity regarding protected health information (PHI). Health care providers and other covered entities must give the notice to patients and research subjects and should obtain signed acknowledgements of receipt. Internal and external uses of protected health information are explained.

Provider - Usually refers to a hospital or doctor who "provides" care. A health plan, managed care company or insurance carrier is not a healthcare provider. Those entities are called

payers. The lines are blurred sometimes, however, when providers create or manage health plans. At that point, a provider is also a payer. A payer can be provider if the payer owns or manages providers, as with some staff model HMOs.

Qualified Beneficiary - Generally, qualified beneficiaries include covered employees or enrollees, their spouses and their dependent children who are covered under a group health plan. In certain cases, retired employees, their spouses and dependent children may be qualified beneficiaries.

Referral - The process of sending a patient from one practitioner to another for health care services. Health plans may require that designated primary care providers authorize a referral for coverage of specialty services. Normally, this type of referral means a written order from the enrollee's primary care doctor for the enrollee to see a specialist or get certain services.

Rehabilitation - Rehabilitative services are normally ordered by a doctor to help a patient recover from an illness or injury. These services are delivered by nurses and physical, occupational, and speech therapists.

Returning Home New Jersey - DDD initiative with individuals who live in out-of-state residential facilities, and their families, to develop community-based residential options, services and supports for them in New Jersey, thus increasing New Jersey's ability to receive federal matching funds by providing care in New Jersey.

Rx4NJ - Rx4NJ is a New Jersey program that connects qualified individuals with low-income with discount prescription drugs, direct from the pharmaceutical manufacturer. Rx4NJ offers a single point of access to public and private patient assistance programs, including more than 150 programs offered by pharmaceutical companies.

Secondary Coverage - Health plan that pays costs not covered by primary coverage under coordination of benefits rules; any insurance that supplements Medicare coverage. The three main sources for secondary insurance are employers, privately purchased Medigap plans, and Medicaid.

Self-Directed Services - Program of funding through DDD whereby community support services are contracted by eligible participants with developmental disabilities and their families in their homes.

Self-Funding or Self-Funded Plan - Employer or organization assumes complete responsibility for health care losses of its covered employees. This usually includes setting up a fund against which claim payments are drawn and claims processing is often handled through an administrative services contract with an independent organization. In this case, the employer does not pay premiums to an insurance carrier, but, rather pays administrative costs to the insurance company or health plan, and, in essence, treats them as a third party administrator (TPA) only. However, the employee may not be able to notice any difference because the plan description and membership card may carry the name of the insurance company not the employer.

Special Child Health Services (SCHS) - Under the New Jersey Department of Health and Senior Services, Division of

Family Health Services, its programs focus on providing family-centered, community-based, individualized and accessible services to children up to 21 years of age with a broad range of disabilities and chronic illnesses, and to women, infants, children, youth and their families living with HIV and AIDS. There are 21 case management units (one for each county) and they are partially funded by each county board of chosen freeholders. They are housed in community-based organizations and serve as single points of entry into the Early Intervention System (EIS).

State Children's Health Insurance Program (SCHIP) - Under Title XXI of the federal Balanced Budget Act of 1997, the availability of health insurance for children with no insurance or for children from low-income families was expanded by the creation of SCHIP. SCHIPs operate as part of a state's Medicaid program.

State Health Benefits Program (SHBP) and School Employees Health Benefits Program (SEHBP) - Health care plans for New Jersey public employees and administered by Aetna HMO.

State Health Insurance Assistance Program (SHIP) - Administered by the New Jersey Department of Health and Senior Services, it provides free help to NJ Medicare beneficiaries, with funding from the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services. Information and assistance is offered, but not legal advice.

Subscriber - Employment group or individual who contracts with an insurer for medical services. Person or group responsible for payment of premiums, or person whose employment is the basis for membership in a health plan. Usually synonymous with enrollee, covered individual or member.

Supplemental Insurance - Any private health insurance plan held by a Medicare beneficiary or commercial beneficiary, including Medigap policies and post-retirement health benefits. Supplemental usually pays the deductible or co-pay and sometimes will pay the entire bill when the primary carrier's benefits are exhausted.

Supplemental Security Income (SSI) - A federal cash assistance program for individuals who are low-income aged, blind and disabled, established by Title XVI of the Social Security Act. States may use SSI income limits to establish Medicaid eligibility. In many cases, the state of New Jersey adds money to the federal payment. The single payment in the beginning of each month includes both the federal SSI payment and the supplement from New Jersey. If receiving SSI, recipients can get medical assistance (Medicaid) automatically; there is a separate letter of acceptance and Medicaid ID card from the state of New Jersey. For questions about Medicaid, contact the local Medical Assistance Customer Center.

Third-Party Payer - Any organization, public or private that pays or insures health or medical expenses on behalf of beneficiaries or recipients. An individual pays a premium for such coverage in all private and in some public programs; the payer organization then pays bills on the individual's behalf. Such payments are called third-party payments and are distinguished by the separation among the individual receiving the service (the first party), the individual or institution providing it (the second party), and the organization paying for it (third party).

Treatment - The provision of health care by one or more health care providers. Treatment includes any consultation, referral or other exchanges of information to manage a patient's care.

Underwriting - Process of selecting, classifying, analyzing and assuming risk according to insurability. The insurance function bearing the risk of adverse price fluctuations during a particular period. Analysis of a group that is done to determine rates or to determine whether the group should be offered coverage at all.

Universal Application – An application filed on behalf of a child under three (3) years old with a Special Child Health Services (SCHS) case manager that provides access to many services in New Jersey such as Early Intervention, equipment (through the Division of Developmental Disabilities), Medicaid, the New Jersey Family Care program, and the Catastrophic Illness in Children program.

Usual, Customary and Reasonable (UCR) - Referring to charges for medical services, the UCR is the amount a health plan will recognize for payment for a particular medical procedure. It is typically based on what is considered "reasonable" for that procedure in your service area.

Waiver - Approval that the Centers for Medicare and Medicaid Services (CMS, formerly called HCFA), the federal agency that administers the Medicaid program, may grant to state Medicaid programs to exempt them from specific aspects of Title XIX, the federal Medicaid law. Most federal waivers involve loss of freedom of choice regarding which providers beneficiaries may use, exemption from requirements that all Medicaid programs be operated throughout an entire state, or exemption from requirements that any benefit must be available to all classes of beneficiaries (which enables states to experiment with programs only available to special populations). The following are Medicaid Waivers:

Individuals may be enrolled in only one Medicaid Waiver at a time.

- The Community Resources for People with Disabilities (CRPD) Medicaid Waiver is for children and adults who are blind and disabled, and provides all Medicaid State Plan services, except nursing facility care. CRPD's waiver services are case management and for eligible individuals meeting specific clinical criteria, private duty nursing services of up to 16 hours per day.
- The Traumatic Brain Injury (TBI) Medicaid Waiver is for persons ages 22-65 with an acquired brain injury, and provides all Medicaid State Plan services, except nursing facility care and personal care assistance. The TBI waiver services are case management, counseling, community residential services, therapies, behavioral programs, environmental modifications, day programming, personal care assistant, transportation, respite care, night supervision, chore services and companion services for individuals who qualify. To qualify for the TBI Medicaid Waiver, an individual's injury must have occurred after age 21.
- The Community Care Medicaid Waiver (CCW) is for individuals registered with the Division of Developmental Disabilities (historically, the disability had to have manifested before the age of 22- currently,

this is not a requirement), and provides all Medicaid State Plan services, except ICF/MR (intermediate care facility for people with mental retardation) and personal care assistance in congregate settings. CCW waiver services are case management, habilitation, individual supports, environmental/vehicle accessibility adaptation, personal emergency response system, and respite care.

- The Global Options (GO) for Long-Term Care Medicaid Waiver is for individuals 65 years or older, or between the ages of 21 and 64 who are deemed disabled by the Social Security Administration (SSA) or the Division of Medical Assistance and Health Services, Disability Review Section (individuals who are chronically mentally ill, intellectually-impaired or developmentally disabled are considered ineligible). Services provided through the GO Medicaid Waiver include assisted living/adult family care, respite care, home based supportive care, environmental accessibility adaptations, personal emergency response systems, home delivered meal service, caregiver/participant training, social adult day care, special medical equipment and supplies, chore services, care management, transition services and transitional care management, transportation, and attendant care.
- The Global Options (GO) Nursing Facility Transition (NFT) is part of the above GO initiative, and is for individuals residing in a nursing facility who could potentially transition back to the community.

Workability Program (New Jersey Workability Program) - The NJ WorkAbility Program offers full New Jersey Medicaid health coverage to people with disabilities who are working, and whose earnings would otherwise make them ineligible for Medicaid. This program is available through New Jersey Medicaid. It is funded by the Social Security Administration under the Medicaid Infrastructure Grant. Application is made at each County Board of Social Security (BOSS) office. A sliding scale of fees is utilized, based upon income levels.

WorkFirst (New Jersey State Plan for Temporary Assistance for Needy Families (TANF) – A federal program supervised by the NJ Department of Human Services that provides many family supports, including medical (Medicaid) assistance. It is administered by each county's Board of Social Services.

Organization/Agency Name**Telephone Number**

Aging and Disability Resource Connection (ADRC)	800-367-6543 or 609-292-7837
Boggs Center on Developmental Disabilities	732-235-9300
Catastrophic Illness in Children Relief Fund (CICRF)	800-335-3863 or 609-292-0600
Centers for Medicare and Medicaid Services (CMS) Region 2 Administrator for NJ	877-267-2323 617-565-1188
Charity Care (New Jersey Hospital Care Payment Assistance Program)	800-367-6543
Community Health Law Project (CHLP)	973-275-1175
County Offices for the Disabled	See website index
Dental Clinic Directory (NJ)	732-937-5437 or 856-935-6203
Department of Health and Human Services (US) Region 2 Administrator for NJ	202-690-6060 212-264-4600
Department of Justice	202-514-2000
DCBHS (NJ Division of Child Behavioral Health Services)	877-652-7624 or 609-292-4741
DDD (NJ Division of Developmental Disabilities)	800-832-9137
DDS (NJ Division of Disability Services)	800-285-3036
DHS (NJ Department of Human Services)	-
DHSS (NJ Department of Health and Senior Services)	800-367-6543
DMAHS (NJ Division of Medical Assistance and Health Services)	800-356-1561
DMHS (NJ Division of Mental Health Services)	800-382-6717
DOBI (NJ Department of Banking and Insurance)	800-446-7467
DRNJ (Disability Rights New Jersey)	800-922-7233
DVRS (NJ Division of Vocational Rehabilitation Services)	609-292-5987
Early Interventional System (NJEIS)	888-653-4463
FamilyCare (NJ Family Care or NJFC)	800-701-0710
State Parent Advocacy Network (SPAN)	800-654-SPAN
Family Health Line (NJ Family Health Line)	800-328-3838

Website Address	Key
www.web.doh.state.nj.us/adrcnj/	R
http://rwjms.umdnj.edu/boggscenter	R
www.state.nj.us/humanservices/cicrf/home/	M
www.cms.gov/ROBOSORA@cms.hhs.gov	O
www.state.nj.us/health/charitycare/index/shtml	H
www.chlp.org/	L
www.state.nj.us/humanservices/dds/home/cntyofficeindex.html	R
www.state.nj.us/health/fhs/newborn/documents/dental_directory.pdf	R
www.hhs.gov/	O
www.justice.gov/	O
www.nj.gov/dcf/behavioral	B
www.state.nj.us/humanservices/ddd/index.html	O,B,R,M
www.state.nj.us/humanservices/dds	O,R,M
www.state.nj.us/humanservices	O,R
www.state.nj.us/health	O,E,R,M
www.state.nj.us/humanservices/dmahs	O,R,M
www.nj.gov/humanservices/dmhs/home	O,R,B
www.njdobi.org	O,R
www.drnj.org/	L,R
www.state.nj.us/labor/dvrs	R
www.njeis.org	E
www.njfamilycare.org/	H,R,M,B
www.spannj.org/	R
www.state.nj.us/health/fhs/index.shtml	R

Resource Key

B Behavioral Care	H Hospital Care	M Medical Expense	P Prescription Drugs
E Early Intervention	L Legal Services	O Oversight	R Resource Directory

Organization/Agency Name**Telephone Number**

Family Voices National	888-835-5669
Healthfinder	
HealthLink (NJ HealthLink)	
InsureKidsNow	877-543-7669
Legal Services of New Jersey	888-576-5529
Long-Term and Acute Care Facilities and Services	
Managed Health Care Consumer Assistance Program	888-838-3180
Medicaid	800-356-1561 800-701-0720
Medicare	800-MEDICARE
Medigap	877-267-2323
National Institute of Health	
New Jersey Care 2000+ (NJ Managed Medicaid)	800-701-0710
NJ County and Municipal Websites	
NJ Protection and Advocacy, Inc.	800-922-7233
NJHELPS	
NJ211	
Office of Public Health Infrastructure (OPHI)	800-367-6543
Pharmaceutical Assistance to the Aged and Disabled (PAAD)	800-792-9745
RX4NJ	800-793-6765
Social Security Administration (SSA)	800-772-1213
State Children's Health Insurance Program (SCHIP)	800-701-0710
State Health Benefits Program and School Employees Health Benefits (SHBP)	877-STATENJ
State Health Insurance Assistance Program (SHIP)	800-792-8820
Supplemental Security Income (SSI) in NJ	800-772-1213
The Arc of New Jersey	732-246-2525 x28
Toll-Free Numbers for Health Information	

Website Address	Key
www.familyvoices.org	R
www.healthfinder.gov	R
www.nj.gov/njhealthlink/	R
www.insurekidsnow.gov	R
www.lsnj.org	L
www.nj.us/health/healthfacilities/search.shtml	R
www.managedcarehelpline.org	R
www.state.nj.us/humanservices/dmahs/clients/medicaid/ www.cms.gov/MedicaidGenInfo/	H,M,B,E,P
www.medicare.gov www.cms.gov/home/medicare.asp	H,M,B,P
www.cms.gov/medigap/	H,M,B,P
www.health.nih.gov/	R
www.state.nj.us/humanservices/dmahs/clients/medicaid/	H,M,B,P
www.nj.gov/nj/govinfo/county/localgov.html	R
www.njpanda.org	L
www.njhelps.org/	R
www.nj211.org/	R
www.state.nj.us/health/lh/index.shtml	O
www.state.nj.us/health/seniorbenefits/paad.shtml	P
www.rx4nj.org/	P
www.socialsecurity.gov/	H,M,B,P
www.aap.org/advocacy/washing/SCHIP_factsheets/NewJersey_SCHIP.pdf	H,M,B,P
www.aetna.com/statenj/	H,M,B,P
www.state.nj.us/health/senior/ship.shtml	R
www.ssa.gov/pubs/11148.html	H,M,B,P
www.arcnj.org	R
www.health.gov/NHIC/Pubs/2007tollfreenumbers/2007tollfreenumbers5.htm	R

Resource Key

B Behavioral Care	H Hospital Care	M Medical Expense	P Prescription Drugs
E Early Intervention	L Legal Services	O Oversight	R Resource Directory



Checklists are a practical tool in assisting parents and guardians to access key information about health care resources available to family members affected by autism. With so many other concerns in the areas of education, behavior, and development for parents and caregivers, simple examples of organizing and tracking can be useful. The importance of documentation cannot be understated.

The following pages provide some examples of health care checklists. Your input to the presenters of this workshop on improvements to them would be greatly appreciated.

Healthcare Insurance Checklist	Page 45
Early Intervention Checklist	Page 46
Supplemental Security Income (SSI) Checklist	Page 47
New Jersey Family Care Checklist	Page 48
Medicare Checklist	Page 49
NJ Medicaid Checklist	Page 50
Community Care Waiver (CCW) Checklist	Page 51
Other Healthcare Benefits Checklist	Page 52

Healthcare Insurance Checklist

Name of Patient

Insured's Name

Insurance Carrier

Insurance Type

Insurance Policy ID

Effective Date

Group Number

Member Services Telephone Number

Referral Necessary? Yes No

In-Network Benefits Only? Yes No

Co-Payments Yes No

Co-Payment Amounts:

Office Visit Urgent Care

Specialist Preventive Care

Emergency Room Inpatient Admission

Early Intervention Checklist

First Call (mandatory) 888.653.4463

Call Date

Registration Date

“Universal Application” Date

Individualized Family Service Plan (IFSP) Date

Case Manager Name

Case Manager Telephone Number

Other Information

Supplemental Security Income (SSI) Checklist

Information: 800.722.1213

Call Date

County Board of Social Services Agency Name

Address

Telephone Number

Contact Name(s)

Telephone Number(s)

Other Information

New Jersey Family Care Checklist

NJ Division of Medical Assistance and Health Services

Information: 800.356.1561

Application: 800.701.0710

Horizon NJ Health Outreach Center: 800.637.2997

Application Date

Effective Date

Contact Name

Contact Telephone Number

Policy ID

Co-Payment Amounts

Medicare Checklist

Information: 800.633.4227

Date Social Security Administration Contacted

Medicare ID

Effective Dates: Part A (Hospitalization)

Part B (Physicians Services)

Part C (Medicare Advantage)

Part D (Prescription Drugs)

Policy Administrator Contact

Policy Administrator Telephone Number

Other Information

NJ Medicaid Checklist

Information: 800.356.1561

Providers: AmeriChoice 800.941.4647

AmeriGroup NJ 800.600.4441

HealthFirst NJ 877.464.4365

Horizon NJ Health 877.765.4325

NJ FamilyCare 800.701.0710

County Board of Social Services Agency

Name

Address

Telephone Number

Application Date

Effective Date

Provider

Policy ID

Primary Care Physician

Telephone Number

Community Care Waiver (CCW) Checklist

Division of Developmental Disabilities (DDD): 800.832.9137

Initial Date of Contact

DDD Caseworker Name

Caseworker Telephone Number

Follow-up Call Date

Call Returned? Yes No

Date

Call Returned? Yes No

Date

Call Returned? Yes No

Date of Acceptance (Document Dated)

Other Information

Other Healthcare Benefits Checklist

Program

Effective Date

Program Contact Name

Telephone Number

Policy or Registration Number

Co-Payments? Yes No

Program

Effective Date

Program Contact Name

Telephone Number

Policy or Registration Number

Co-Payments? Yes No

Other Information



Autism New Jersey is the state's leading source of information, support, advocacy and public policy for parents of individuals with autism and the professionals who support them. Considering that the national prevalence rate of autism spectrum disorders is approximately 1% of the population, Autism New Jersey is needed now more than ever to serve the critical needs of the autism community.

*Autism New Jersey is GROUNDED in science,
STRENGTHENED by knowledge,
and DEVOTED to creating a society of compassion and inclusion
for all those touched by autism.*



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