3100 Non-Medical Home and Community Based Services (NMHCBS) System

3101 Overview

3101.1 This section provides an outline of the Division of Aging and Adult Services policies and procedures for the NMHCBS System. This policy section is subject to change as additional information and/or regulations are received from the U.S. Department of Health and Human Services, Administration on Aging.

3101.2 The NMHCBS System is designed to establish the necessary support services to retain functionally impaired individuals within their community and avoid premature institutionalization. The NMHCBS System has the following goals:

A. To assist functionally impaired individuals to care for themselves in their home and community.

B. To prevent or delay less desired and more costly institutional placement.

C. To maintain the dignity, autonomy and independence of individuals and their families.

3101.3 The NMHCBS System is a case managed system, where Case Managers use a strength-based approach and integrate client preferences and goals to determine eligibility and need, authorize services, arrange for the provision of services and monitor the services.

3101.4 The NMHCBS System includes, but is not limited to, the following services:

A. Adaptive Aids and Devices.
B. Adult Day Care/Adult Day Health Care.
C. Attendant Care.
D. Case Management.
E. Home Delivered Meals.
F. Home Health Aid.
G. Home Nursing (formerly known as Visiting Nurse Services) and Community Nursing.
H. Home Repair and Adaptation.
I. Housekeeping/Homemaker Services.
J. Personal Care.
K. Respite and Supplemental Services for family caregivers.
L. Other services as defined by Federal and State requirements.

3102 Authority and Statutory Requirement

3102.1 The NMHCBS System is authorized and governed by the following statutes and regulations:

A. Older Americans Act of 1965, as Amended in 2020, P.L. 116-131, §102, §306, §307, §308, §314, §315, §321 and §339. https://acl.gov/sites/default/files/about-acl/2020-04/Older%20Americans%20Act%20Of%201965%20as%20amended%20by%20Public%20Law%20116-131%20on%203-25-2020.pdf

B. A.R.S. Title 46 Chapter 1, Article 8, §46-191, §46-192; Chapter 2, Article 3. https://www.azleg.gov/arsDetail/?title=46

C. Code of Federal Regulations, Title 45 Public Welfare, C.F.R. §1321.63. http://edocket.access.gpo.gov/cfr_2007/octqtr/pdf/45cfr1321.63.pdf

3102.2 The Area Agency on Aging (AAA) must ensure that service providers comply with the following:

A. A fingerprint based criminal background check shall be completed at time of hire, or as a result of reassignment after hire, on employees and volunteers who have direct contact with vulnerable individuals including those who are mentally disabled, frail, or have a chronic disease that puts them at risk for abuse (see A.R.S. § 46-141). See also the Arizona Department of Economic Security Special Terms and Conditions - Professional Services / Optional Auto / Children- Vulnerable Adult / Bonding Area Agency on Aging, Section 5.

3103 Eligibility Requirements

3103.1 The following individuals are eligible to receive NMHCBS based on availability of funding:

A. Individuals 60 years of age or older.

B. Individuals under 60 years of age with a disability.

C. Family Caregivers as defined in the Division of Aging and Adult Services Policy and Procedures Manual Section 3600 – Family Caregiver Support Services.

3103.2 In order to receive NMHCBS (except services identified in section 3103.4), individuals described in 3103.1 shall be assessed as described below, using assessment instruments as defined in Section 3120 - Case Management for the NMHCBS System. See also Exhibit 3100A - Service Eligibility Matrix.

A. For the services of Adult Day Care/Adult Day Health Care, Attendant Care, Personal Care, Home Health Aid and Home Nursing, an individual that enters the NMHCBS System (new clients) shall be determined unable to perform at least three Activities of Daily Living (ADLs) without substantial human assistance including verbal reminding and physical cueing or supervision using assessment instruments as defined in Section 3120. Instrumental ADLs (IADLs) or a combination of ADLs and IADLs cannot be substituted for ADLs. See also Section 3124.3. on the provision of home health aide and home nursing, if there is a medical need.

B. For the services of Housekeeping/Homemaker, an individual that enters the NMHCBS System (new clients) shall be determined unable to perform at least three IADLs without substantial human assistance including verbal reminding and physical cueing or supervision using assessment instruments as defined in Section 3120. The IADLs must be shopping, light housework, meal preparation or heavy housework. One ADL may be substituted for one IADL; the ADL must be either Walking or Transferring.

3103.3 Additional eligibility criteria apply for the following services:

Home Health Aid and Home Nursing

1. Documentation of medical need from a health care practitioner of one of the following: insulin set-up, medication set-up, vital monitoring, nursing assessment, teaching by nurse, medication management/ monitoring, wound care and catheter/colostomy care.
2. Documentation that the individual has no other resources available for obtaining the needed care; for example, the individual resides alone or the spouse or caregiver of the individual is incapacitated and unable to assist the individual with the medically related function.

3103.4 Operational procedure 3103.2 does not apply to the following:

A. Adaptive Aids and Devices, Home Repair and Adaptation
   1. An assessment for ADLs or IADLs is not required for NMHCBS.
      Note: For FCSP, different requirements apply; see section 3103.4.B.
   2. Although not required by the Older Americans Act for NMHCBS, the Division of Aging and Adult Services recommends that an assessment be conducted prior to providing the service to ensure the best use of limited resources.

B. Family Caregiver Support Program (FCSP) Services.
   1. Refer to the Division of Aging and Adult Services Policy and Procedure Manual, Section 3600 – Family Caregiver Support Program, sections 3603 and 3604.3.

C. Home Delivered Meals
   1. Refer to the Division of Aging and Adult Services Policy and Procedure Manual, Section 3200 – Nutrition Programs, section 3203.1 Eligibility.

3120 Case Management for the NMHCBS System

3121.1 This section provides an outline of the Division of Aging and Adult Services operational principles and procedures for Case Management. This policy section is subject to change as additional information and/or regulations are received from the U.S. Department of Health and Human Services, Administration on Aging.

3121.2 Case Management is provided to any individual entering the NMHCBS System. Case Management is a service provided by experienced or trained Case Managers to an individual who is older, frail and/or disabled, at the direction of the individual, family member, or caregiver. For the individual eligible for Case Management, a strength-based approach is used and appropriate services and/or

benefits are identified and comprehensively assessed, planned and coordinated with formal and informal resources, obtained and provided, recorded and monitored, modified, or terminated with follow-up provided where and when appropriate. The Area Agency on Aging, or entity that such agency has contracted with, is required to maintain a comprehensive Case Management System wherein an older, frail and/or disabled adult is determined eligible to receive services from the NMHCBS System within the Planning and Service Areas. If Home Delivered Meals is the only service being authorized, a Non-Case Management provider may be authorized to provide assessment and service monitoring.

3122 Operational Procedures for Provision of Case Management

3122.1 Area Agency on Aging shall develop Case Management to facilitate the coordination of non-medical home and community-based services designed to enable older, frail and/or disabled individuals to remain in their home. Case Management shall be an integrated system that accomplishes the following:

A. Provide access to the NMHCBS System through a single point of entry utilizing approved eligibility assessment instruments.

B. Apply a strength-based, client-centered approach in determining needed services.

C. Utilize a holistic assessment of the client's (and caregiver's) situation and address the problems contributing to the client's situation.

D. Promote networking to ensure the coordination of service and development of a cost-effective service plan.

E. Involve LTC providers in the coordination of such services.

F Evaluate and promote informal supports and private pay options where appropriate.

3122.2 The Area Agency on Aging shall ensure that Case Management is provided through the following:

A. Public or non-profit agencies that:

1. Give each individual seeking services a list of agencies that provide similar services within the jurisdiction of the Planning and Service Area.

2. Give each individual the right to make an independent choice of service providers, if available, and document the receipt by such individual of such a statement.

3. Ensures case managers, or authorized Non-Case Management providers, act as agents for an individual receiving the services and not as promoters for the agency providing services.

4. Provide a written complaint resolution procedure to clients.

B. The Area Agency on Aging providing Case Management directly.

3122.3 In providing Case Management, the Area Agency on Aging, or entity that such agency has contracted with, shall comply with the following:

A. Not duplicate Case Management provided through other Federal and State programs, such as the Arizona Long Term Care System (ALTCS), Division of Developmental Disabilities (DDD), Department of Veteran's Affairs (VA) and the Arizona Department of Health Services (ADHS). Efforts shall be made, to the extent possible, to ensure that coordination with other service systems do not result in services being duplicated and that the client's goals and objectives are not compromised between service systems.
B. Conduct a functional assessment of all clients entering the NMHCBS System to determine eligibility. This may include assessment of the primary family caregiver to determine eligibility for services within the FCSP (see sections 3123 and 3600).

3122.4 The Area Agency on Aging shall ensure Case Management providers receive the appropriate orientation and training on Case Management policies and procedures utilizing the following resources:

A. The Arizona Case Management Handbook (see Exhibit 3100B).
B. The Division of Aging and Adult Services Policy and Procedure Manual as posted on the Division of Aging and Adult Services website.
C. Other training material provided by the Division of Aging and Adult Services.

3123 Operational Procedures for Assessing Eligibility for the NMHCBS System

3123.1 The Area Agency on Aging shall be the single point of entry into the NMHCBS System.

3123.2 Case Management is the mechanism used to assess eligibility and authorize services. Individuals shall be assessed for eligibility within **seven** business days after initial screening and referral of the individual to the Case Management provider or authorized Non-Case Management provider.

A. For eligibility criteria and requirements for NMHCBS, refer to section 3103.
B. Referral to Case Management is determined through screening by Area Agency on Aging and / or their contracted providers.

3123.3 Determination of eligibility for entry into the NMHCBS System requires the use of one of the following assessment instruments:

A. The Arizona Standardized Client Assessment Plan (ASCAP), as defined in section 3123.4. Effective July 1, 2011. Caregivers receiving respite services as described in section 3604.2.D shall also be assessed using the Caregiver Assessment Tool (CAT).
B. The Short Form Intake Document (SFID as defined in section 3123.5. Effective July 1, 2011, caregivers receiving respite services as described in section 3604.2.D shall also be assessed using the Caregiver Assessment Tool (CAT).

3123.4 The ASCAP shall be used as described in this section. A home visit is required for all individuals assessed with the ASCAP.

A. The following services require the use of the ASCAP to assess eligibility unless identified in 3123.5 and 3123.6.

1. Adult Day Care/Adult Day Health Care.
2. Attendant Care.
3. Home Delivered Meals.
4. Home Health Aid.
5. Home Nursing.
6. Housekeeping/Homemaker (includes chore and shopping).
7. Personal Care.
8. Respite (in home and group).
9. Supplemental Services for Family Caregivers, including home repair/renovation, adaptive aids and devices, transportation, kinship care support and supplemental provisions.

3123.5 The SFID may be used instead of the ASCAP to assess eligibility for the services described in this section. Unless otherwise identified, a home visit is required for all individuals assessed with the SFID.

A. Home Delivered Meals, if Home Delivered Meals is the **only** service being authorized. A home visit is not required when using the SFID to determine initial eligibility for short-term (up to 90 days) Home Delivered Meals.

B. Family Caregiver Support Services (FCSP): Respite, Group Respite or Adult/Child Day Care, Supplemental Services, including home repair/renovation, adaptive aids and devices, transportation, kinship care support and supplemental provisions.

1. If an individual is being assessed for emergency respite services, a home visit may take place after authorization and service delivery.

C. Tribal Services:
1. Home Delivered Meals
2. Housekeeping/Homemaker
3. Personal Care
4. Respite Care
5. Supplemental Services for Family Caregivers, including Home Repair, Adaptive Aids and Supplemental Provisions
6. Other services as approved by the Division of Aging and Adult Services

3123.6 Qualifiers on the assessment instrument may also be used in determining eligibility.

3123.7 **Re-Determination of Eligibility:** The Case Management provider shall conduct a redetermination based on the following criteria:

A. A change occurs which affects eligibility or the need for service.

B. At least every twelve months unless identified in 3123.8.C.
C. If it is determined that Home Delivered Meals is needed beyond 90 days, a home visit is required to complete a new SFID. The ASCAP must be used if any services are authorized in addition to Home Delivered Meals. The date of the home visit becomes the annual redetermination date, with additional home visits required as specified in section 3127.

3123.8 **Service Denial:** Services may be denied to individuals if one of the following is met:
A. The eligibility criteria described in section 3103 are not met.
B. With the exception of disclosing information on income, information necessary to complete an assessment is not provided.
C. Funding is not available; see also 3103.1.

3124 Operational Procedures for Service Authorization

3124.1 Services may be authorized to individuals meeting the eligibility criteria described in section 3103, documented through assessment as described in section 3123.

3124.2 Services should be authorized based on the following priorities in descending order:

A. Individuals 60 years of age or older, with the greatest social and economic need with particular attention to older individuals who are low-income minority, older individuals residing in rural areas, older individuals with severe disabilities, older individuals with limited English speaking abilities and any individuals with Alzheimer's disease or related dementias.
B. Individuals under 60 years of age with a disability.
C. Eligible individuals accepted in an entitlement program or receiving services through another service system. Services must be non-duplicative.

3124.3 Services are authorized using the assessment instruments described in section 3123 and the corresponding instruments in the Division of Aging and Adult Services information management system.

A. If individuals do not meet the criteria for services identified in 3103.2.A, but are determined to be in need of home nursing or home health aid, services may be provided if the following is documented on the assessment tool described in section 3123.8 (the ASCAP): At least one of the eight choices in the section Nursing Services and Treatments is marked.
B. If NMHCBS were authorized through the ASCAP, the SFID shall not be used to authorize additional services.

3124.4 Services are authorized by Case Management providers, who create a service plan for each client.

A. A correlation must be demonstrated between the individual's impairment level(s) and the service(s) authorized.
B. Service authorizations shall not exceed levels required to meet the eligible individual's needs.

C. Service authorizations shall be for a time period determined to meet the eligible individual's need, but shall not exceed a 12-month period. See section 3123.8 for re-determination process.

1. Authorizations for Home Delivered Meals for a significant other (spouse, domestic partner), caregiver or person with a disability under 60 residing with a client age 60 or over, shall coincide with the authorization of Home Delivered Meals for the primary recipient. The assessment tool must reference the corresponding name and social security number of the primary recipient in order for the referenced individual's authorization to be valid.

3124.5 The Area Agency on Aging may identify and authorize Non-Case Management providers within their planning and service area to complete and submit the Short Form Intake Document for an individual requiring only short-term (up to 90 days) Home Delivered Meals. For Home Delivered Meals services beyond 90 days, the designated Non-Case Management providers shall be trained by the Area Agency on Aging to provide the required Case Management services for Home Delivered Meals only. Training must be approved by the Division of Aging and Adult Services and must address the requirements and procedures for referral to a Case Manager.

3125 Operational Procedures for Service Documentation and Provision

3125.1 **The Case Management provider**, or authorized Non-Case Management Provider, shall complete all mandatory fields on the assessment tools and obtain the necessary signatures and comply with the following **time-frames:**

A. The assessment tool shall be submitted to the Area Agency on Aging for input into the Division of Aging and Adult Services information management system within **seven** business days following the completion of the assessment.
B. Service plans must be forwarded to the service providers within **five** business days of authorization.

3125.2 **Service providers** shall comply with the following **time-frames:**

A. Service providers shall initiate service provision authorized by the ASCAP and other approved assessment instruments within **seven** business days after an individual has been assessed for eligibility for the service(s) developed in the service plan.
B. Service provision by the providing agency can commence before receipt of the service plan, but initiation is limited to **five** days before receipt of the plan.

3125.3 The Area Agency on Aging shall ensure that all of the data from the ASCAP and other approved assessment instruments is entered into the Division of Aging and Adult Services information management system within **ten** business days after receipt.

A. If the ASCAP or other approved assessment instruments contains blank mandatory fields, the Area Agency on Aging must establish a process for

completion of blank mandatory fields. **Documentation must exist that the Case Management provider, or authorized Non-Case Management provider, supplied information for completion.**

B. The ASCAP and other approved assessment instruments must be locked in the Division of Aging and Adult Services information management system in order for authorized services to be eligible for reimbursement.

3125.4 Enrollment of clients in services must be completed in the Division of Aging and Adult Services information management system.

3125.5 Case notes and other documents specified in section 3126 must be entered into the Division of Aging and Adult Services information management system, on a regular basis, as close as possible to when updates are made to the client file.

3126 Operational Procedures for Case File Documentation

3126.1 Case files must be maintained in accordance with the requirements for confidentiality outlined in the Division of Aging and Adult Services Policy and Procedures Manual Section 1900.

3126.2 The Area Agency on Aging shall ensure that its Case Management provider completes case files on each individual referred for Case Management.

3126.3 Case files must contain the following documentation:

A. A copy of the assessment/reassessment instrument, including the service plan and documentation that the following have been discussed with the client: client rights and responsibilities, complaint resolution procedure (see 3122.2.A.4), and contributions (see section 2900).

B. Case notes, through regular narrative entries, about the individual and his/her services based on contacts with providers, significant others and the individual. Case notes should address the current functional status of the individual and identify linkages between service plan goals and the services selected and authorized for the client.

C. Copies of the referral forms utilized by Case Management agencies assigning the individual to one or more service providers.

D. Quarterly reviews and updates of the individual's service plan.

E. Documentation of contacts with the client regarding service modification, termination, or client complaints and appeals (see section 1920).

F. Documentation that clients were provided a list of providers, see 3122.2.A.2.

G. Documentation that clients received a copy of rights and responsibilities and the grievance and appeals procedure.

H. Documentation that service contributions were discussed.

3127 Operational Procedures for Monitoring of Service Plans

3127.1 The Area Agency on Aging shall ensure that service plans for individuals authorized to receive services are monitored at least every 90 days or when a change occurs that affects eligibility or need.

A. Monitoring of the service plan is required to determine the following:

1. That the services authorized meet the individual's needs.
2. That services are being provided in accordance with the service plan.
3. The quality of the services provided.
4. That issues or problems relative to the service delivery process are identified.
5. That a course of action for identified issues or problems are developed.

B. Monitoring of service plans may be accomplished through the following approaches:

1. A telephone contact. A telephone contact may be used for the three-month and nine-month review.
2. Inter-agency monthly or 90-day case conferences held with the service provider to discuss the service plan, service delivery issues and/or problems encountered with the individual.
3. A home visit. A home visit is required every six months.

3127.2 Monitoring of service plans may result in revisions made to the service plan, based upon individual need(s). Revisions may include service **continuation, modification or termination.**

A. Home visits are required when service additions or deletions are made to the individual's service plan.

1. The Case Management provider shall obtain the necessary signatures for services added to or deleted from the service plan. Note: Signatures are not required for service level increases or decreases or when a client voluntarily refuses a service.
2. The assessment tool shall be submitted to the Area Agency on Aging based on the time frames identified in section 3125.

B. Eligibility for services must be re-determined as described in section 3123.8. Home visits are required for services when conducting an annual re-determination.

C. The following applies to short-term Home Delivered Meals as specified in section 3123.5.B:

1. The individual shall be contacted at least **ten** business days **before** the end of the 90 day period to schedule a home visit to determine service continuance or termination.

1a. If Home Delivered Meals only is to be continued, the SFID may be used to continue service authorization. If it is determined that other services are needed, the Case Management provider shall complete the ASCAP.

1b. If service continuance is not warranted, the SFID shall be submitted to the Area Agency on Aging within **seven** business days following the end of the 90 day period so that the services to that individual may be closed in the Division of Aging and Adult Services information management system.

D. The following applies to Family Caregiver Support Program:

1. Monitoring for Caregiver Services includes the care recipient and the caregiver. See 3123.7 for caregiver assessment.
2. If it is determined that services other than Caregiver Services are needed, an ASCAP must be completed.

3127.3 The following applies to service termination:

A. Services may be terminated for the following reasons: voluntarily by the individual, the individual dies, the individual moves out of the planning and service area or the state, the individual is accepted into an entitlement program and receives comparable services, the individual is admitted to an institution for an indefinite stay, or the individual becomes a resident of a LTC facility.

B. Services may also be terminated if the individual has not cooperated with the delivery of service. Examples of lack of cooperation include, but are not limited to, not providing required information, refusing to allow a home visit, or providing incorrect information. The lack of cooperation must be documented with specificity. Documentation in the case file must demonstrate attempts at resolution and subsequent service termination.

C. When the reason for service termination is the individual's death, the Case Management provider must end date the service authorization(s) with the actual date of death. Note: Home-Delivered Meals delivered for the entire week during which the death occurred may be submitted for reimbursement, and case management may complete client case closure after the date of death.

D. Voluntary service termination may occur when the individual and the Case Management provider agree that the service needs of the individual have been met. Documentation in the case file must support the voluntary termination.

E. Services may also be terminated when funding is no longer available.

F. Termination of services within the service plan or case closures must be forwarded by the Case Management provider to provider agencies and the Area Agencies on Aging within **seven** business days after the individual's case is closed.

G. Signatures are not required when all services are terminated and the case is closed.

3128 Operational Procedures for NMHCBS Reporting Requirements

3128.1 The Area Agencies on Aging shall collect data and maintain records relating to the NMHCBS System as defined in the Division of Aging and Adult Services Policy Section 1600.

3129 Non-Medical Home and Community-Based Services Waitlist Policy

3129.1 Overview

This section provides an outline of the Division of Aging and Adult Services (DAAS) operational policies and procedures for maintaining a waitlist of eligible individuals within the Non-Medical Home and Community-Based Services (NMHCBS) system. This policy section is subject to change as additional information and/or regulations are received from the U.S. Department of Health and Human Services, Administration for Community Living (ACL).

At times, limited funding and other capacity challenges may result in the establishment of a waitlist for services by the Area Agency on Aging (AAA).

A NMHCBS waitlist may be imposed for the entire program or for specific services only.

The need for a waitlist will be determined solely at the local level based on both the AAA and service provider ability to provide NMHCBS.

Individuals shall be determined eligible to receive the service(s) before being placed on a waitlist.

3129.2 Maintenance of Waitlist

1. Only one NMHCBS waitlist shall be maintained by each AAA and used to prioritize services for eligible individuals waiting for services.
2. Each AAA shall maintain their respective NMHCBS waitlist in the Division of Aging and Adult Reporting System (DAARS).

3129.3 Management of Waitlist

1. When a particular service is restricted, intake can be processed, and individuals are referred to the appropriate case manager or case management agency for an assessment to determine eligibility utilizing the Arizona Standardized Client Assessment Plan (ASCAP), or Short-Form Intake Document (SFID) where appropriate.
2. When the case management system is at capacity, an initial telephone screening can be conducted to determine initial eligibility of individuals. A completed SFID, at a minimum, is required to complete a telephone screening for eligibility.

    2.1. If the individual appears to be eligible for services from the preliminary information obtained in the telephone screening and SFID, the individual's name can be placed on the waitlist for those services.

2.2. The individual shall be referred to the appropriate case manager or case management agency for an in-home assessment utilizing the ASCAP/SFID at first opportunity, capacity permitting.

3. If eligibility is established, the individual can be opened for unrestricted services and placed on the waitlist for restricted services. The individual must be informed that there are restrictions and that his or her name will be placed on a waitlist.
4. AAAs should not wait until all services that the individual is waitlisted for become unrestricted before serving them.
5. Individuals placed on a waitlist shall be identified in DAARS and their client record shall include, at a minimum, a completed SFID.
6. Regular contact by telephone at a minimum of every 90 days shall occur with individuals on the waitlist and shall be documented in the case notes.
7. While on the waitlist, if an individual's functional needs or supports change, a new ASCAP/SFID shall be completed. Documentation of these changes is required.

3129.4 Prioritization and Waitlist Capitation Limit

1. AAAs shall prioritize waitlists in accordance with DAAS Policy and Procedure Manual Chapter 3000, Operational Procedures for Service Authorization, Section 3124.2, and the AAA's ability to provide NMHCBS.
2. No waitlist capitation limit shall be imposed for individuals determined by the AAA to be of highest priority need for NMHCBS.
3. Individuals determined by the AAA to be of lower priority need for NMHCBS shall be waitlisted for any one service for no longer than twelve months.
4. If an individual determined by the AAA to be of lower priority need for NMHCBS cannot be served at the conclusion of the twelve-month waitlist period, the AAA shall, to every extent practical, assist the individual in finding alternative service(s) to meet their needs before closing waitlist enrollment(s). This shall be documented in the case notes.

3129.5 Adult Protective Services Clients Referred for NMHCBS

1. When an Adult Protective Services (APS) client is referred to the AAA for NMHCBS, the AAA shall review the client assessment information in collaboration with APS to determine service needs and waitlist priority. The outcome of this collaboration shall be documented in the case notes.
2. Final prioritization of APS clients for NMHCBS shall be determined solely at the AAA level based on the outcome of the AAA collaboration with APS, the AAA Case Manager's assessment and the AAA's ability to provide NMHCBS.

3129.6 Reapplying for Services

1. AAAs may allow an individual previously determined to be of lower priority need for NMHCBS and previously removed from waitlist after having reached the waitlist capitation limit to reapply for services at six months from the date of waitlist closure. The decision to allow for reapplication for services will be determined solely at the AAA level based on their ability to provide NMHCBS. This shall be documented in the case notes.

2. If a an individual previously determined to be of lower priority need for NMHCBS and previously removed from a-waitlist after having reached the waitlist capitation limit requests to reapply for services in less than six months from the date of waitlist closure, and the AAA determines that the individual has experienced a life-changing event/emergency that has caused the individual's functional needs or supports to deteriorate, the AAA may allow the individual to reapply for services in less than six months from the date of waitlist closure. The decision to allow for reapplication for services in less than six months from the date of waitlist closure will be determined solely at the AAA level based on the Case Manager's assessment and the AAA's ability to provide NMHCBS. This shall be documented in the case notes.
3. A current assessment utilizing the ASCAP/SFID is required for all individuals reapplying for services.