IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

H.O.P.E., INC., d/b/a/ HOPE FAIR HOUSING CENTER, an Illinois Not-for-Profit Corporation; KIMBERLY O'CONNOR; and TAMMY MORMINO;

Plaintiffs;

v.

EDEN MANAGEMENT LLC, d/b/a EDEN SUPPORTIVE LIVING; 311 LINCOLNWAY PROPERTIES LLC d/b/a EDEN FOX VALLEY; 222 STATE STREET PROPERTIES LLC, d/b/a EDEN CHAMPAIGN LLC; CHAMPAIGN CAPITAL VENTURE LLC; MICHAEL HAMBLET SR.; MICHAEL HAMBLET JR.; MARIA DROSOS; CARLEEN CURALLI; KIMBERLY CROSS; GOVERNOR PATRICK QUINN, in his official capacity; JULIE HAMOS, in her official capacity as Director of the Illinois Department of Healthcare and Family Services; THERESA EAGLESON, in her official capacity as Acting Medicaid Director for HFS; KELLY CUNNINGHAM, in her official capacity as Chief of DHFS Bureau of Long Term Care; JOHN K. HOLTON, in his official capacity as Director of the Illinois Department on Aging; and MICHELLE R.B. SADDLER, in her official capacity as the Secretary of the Illinois Department of Human Services.

Defendants.

Case No. 13 cv 7391

Judge Joan B. Gottschall
Magistrate Judge Jeffrey T. Gilbert

Jury Trial Demanded

FIRST AMENDED COMPLAINT

Plaintiffs, H.O.P.E., INC., d/b/a/ HOPE FAIR HOUSING CENTER ("HOPE"), KIMBERLY O'CONNOR, and TAMMY MORMINO, on behalf of themselves and similarly situated persons, by and through their attorneys, Soule, Bradtke & Lambert and AARP

Foundation Litigation, file their First Amended Complaint against Defendants EDEN MANAGEMENT LLC, d/b/a EDEN SUPPORTIVE LIVING; 311 LINCOLNWAY PROPERTIES LLC d/b/a EDEN FOX VALLEY; 222 STATE STREET PROPERTIES LLC, d/b/a EDEN CHAMPAIGN LLC; CHAMPAIGN CAPITAL VENTURE LLC; MICHAEL HAMBLET SR.; MICHAEL HAMBLET JR.; MARIA DROSOS, CARLEEN CURALLI (collectively "the Eden Defendants"); GOVERNOR PATRICK QUINN; JULIE HAMOS; THERESA EAGLESON; KELLY CUNNINGHAM; JOHN K. HOLTON; and MICHELLE R.B. SADDLER (collectively "the State of Illinois Defendants," all named in their official capacities); as follows:

Nature of the Action

1. This is an action brought by Plaintiffs O'Connor and Mormino on behalf of themselves and a class of similarly situated persons who were denied a chance to live in Illinois's Medicaid Waiver Supportive Living Program solely because of their mental health diagnosis or disability.

2. Hope Fair Housing Center ("HOPE"), is an organization dedicated to eliminating housing discrimination and segregation that provided assistance to the named plaintiffs and whose investigation confirmed that denial based solely on mental illness or disability is a pattern and practice within Illinois's Supportive Living Program and not isolated to the named Plaintiffs. HOPE also brings this action as a party Plaintiff.

3. The State of Illinois Department of Human Services Division of Mental Health Deputy Director of Systems Rebalancing wrote on March 20, 2014 that the State's criteria used to exclude Supportive Living Facility applicants based on mere diagnosis of mental illness "become buzz words without context."

4. A mental health agency official who contracts with the State to carry out mental health screening testified at a June 26, 2014 deposition that the State of Illinois was applying its mental health screening processes to Supportive Living Facility applicants in a manner contrary to the intended purposes (to ensure residence in the most integrative, least restrictive setting), "and so it made no sense to me." (*See* Paragraph 87, below).

5. The Fair Housing Act ("FHA") prohibits discrimination against "any person in the terms, conditions, or privileges of sale or rental of a dwelling, or in the provision of services or facilities in connection with such dwelling, because of a [disability]." 42 U.S.C. § 3604(f).

6. It is a violation of the FHA to "make, print, or publish, or cause to be made, printed, or published any notice, statement, or advertisement, with respect to the sale or rental of a dwelling that indicates any preference, limitation, or discrimination based upon… [disability]…or an intention to make any such preference, limitation, or discrimination." 42 U.S.C. § 3604(c). For example, a housing provider may not ask whether a prospective applicant has a disability nor inquire as to "the nature and severity of [a disability] of such a person." 24 C.F.R. § 100.202(c).

7. The FHA also prohibits the interference with any person in the exercise or enjoyment of his or her right to obtain housing and related services and facilities free of discrimination. 42 U.S.C. § 3617.

8. Title II of the Americans with Disabilities Act ("ADA") prohibits exclusion on the basis of disability from participation in or denial of the benefits of the services, programs, or activities of a public entity. 42 U.S.C.A. § 12132. It also prohibits discrimination by any such entity. *Id.*

9. Title II of the ADA and Section 504(a) of the Rehabilitation Act require that

public entities administering covered programs such as the Illinois Supportive Living Program must do so in the most integrated setting appropriate to the needs of qualified individuals with disabilities. Both acts seek to avoid unduly segregating people with disabilities. 28 C.F.R. § 35.130(d); 28 C.F.R. pt. 35, App. A, p. 450; 29 U.S.C. § 794(a); 28 C.F.R. §41.51(d); *Olmstead v. L.C. ex re. Zimring*, 527 U.S. 581 (1999).

10. Title III of the ADA prohibits discrimination "on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation." 42 U.S.C.A. § 12182.

11. Section 504 of the Rehabilitation Act ("Section 504"), 29 U.S.C. § 794, states that no person with a disability shall "solely by reason of his or her disability, be excluded from participation in, be denied benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."

12. The Plaintiffs challenge the State Defendants' policies and practices in their Medicaid Waiver Supportive Living Program ("SLP") that discriminate on the basis of mental health diagnosis, illness or disability through their program requirements for Supportive Living Facilities ("SLFs") and their inadequate, confusing, misleading, and sometimes completely incorrect guidance, handbooks, notices, and other communications.

13. The Plaintiffs challenge the Eden defendants' policies and practices of discriminating on the basis of mental health diagnosis, illness, or disability, a history of mental health diagnosis, illness, or disability or their having a perception or belief of a mental health diagnosis, illness, or disability. Eden's discriminatory acts challenged in this lawsuit include: distribution of an oral and widely distributed written "no mental illness" policy that indicates to

the public that people with mental health issues are undesirable; acts to prevent people with mental health disabilities or perceived mental health issues from even applying for housing and services; requests to applicants to falsify records; and improperly intrusive inquiries into an applicant's mental health medical and personal history.

14. Many persons with physical disabilities and suitable for the Supportive Living Program may also have a mental health diagnosis or condition of some kind that does not interfere with their suitability for the program. However, Defendants exclude all persons with mental health diagnoses from the Supportive Living Program.

15. At its core, the claims asserted in this case are straightforward. The individual plaintiffs are Medicaid recipients who believe they are eligible for the Medicaid Waiver Supportive Living Program on the basis of their physical disabilities – the population over which Illinois has authority from the federal government to run this program. Ms. O'Connor and Ms. Mormino assert they are eligible for the Waiver services because the amount and kind of services they need are at the appropriate level to be eligible for the Supportive Living Program to receive Medicaid reimbursement through the State Waiver Program. Both have tenant or resident histories that support participation in the program. Yet, both are being denied both housing and participation in the Medicaid Waiver program solely on the basis of their mental disability in violation of civil rights laws.

16. Plaintiffs challenge the policy and practices of the owners and operators of several Illinois Medicaid Waiver Supportive Living Facilities and their management ("Eden Defendants") to categorically deny all applicants to their facilities who have, have had, or whom they believe to have, any mental health issues, impairments, disabilities, diagnosis or problems,

without any consideration, inquiry, or professional evaluation as to whether or not the applicants are eligible for or qualified for its Supportive Living Facility.

17. This action also arises out of the policies and practices of the State of Illinois Defendants with respect to their Supportive Living Program, in that the State of Illinois Defendants designed and implemented the program in a manner that results in unlawful discrimination based on mental health diagnosis.

18. Plaintiff O'Connor was denied housing by the Eden Defendants on the mere threshold basis of having a "mental health history" or "mental health diagnosis." The Eden Defendants similarly excluded Plaintiff Mormino from housing based on a mental health diagnosis in 2014, even though she had previously been found suitable to live in a Supportive Living Facility.

19. Plaintiff HOPE Fair Housing Center received complaints about Eden's "no mental illness" policy and conducted testing that confirmed the existence of the "no mental illness" policy. Testing at three other SLFs confirmed that the State of Illinois's regulations, policies and procedures materially contribute to discrimination based on disability and mental illness in other Illinois Supportive Living Facilities at intake and admissions.

20. The Eden Defendants intentionally refused supportive living housing and services to Plaintiffs O'Connor and Mormino because of their disability status and membership in a protected class in violation of the FHA.

21. The Eden Defendants receive federal and state funds through the state-administered Medicaid program, and are thus covered by the Rehabilitation Act, 29 U.S.C. § 794 *et seq.*, and their discriminatory denials of services and housing to O'Connor and Mormino violate the Rehabilitation Act's anti-discrimination mandate.

22. The Eden Champaign facility operated by the Eden Defendants was developed and built with the assistance of public funds through Illinois Housing Development Authority's ("IHDA") administration of Affordable Housing programs, which require compliance with federal fair housing laws and practices. *See, e.g., IHDA Low Income Housing Tax Credit Compliance Reference Guide, p. 10, "owners are required under the general use requirement to comply with the Fair Housing Act."* (Exhibit 1).

23. The Eden Defendants operate public accommodations, as defined in Title III of the ADA, 42 U.S.C. § 12181, and their discriminatory denials of services and housing to O'Connor and Mormino violate the anti-discrimination mandates in Title III. In its administration of the Medicaid-funded Supportive Living Program, the State of Illinois must comply with the anti-discrimination and anti-segregation provisions of the ADA and Rehabilitation Act. Moreover, administration of federally funded state programs affecting housing must comport with the FHA.

24. The State of Illinois Defendants have knowingly created and administered the Supportive Living Program, in its entirety, in a manner designed to exclude individuals otherwise qualified who have mental health diagnoses, which has prevented them from receiving full Determination of Needs screening (relating to their physical disability) meaningful mental health screening (and referral for needed mental health services and support), and certain Medicaid-funded services. The State Defendants' actions have prevented these individuals from residing in SLFs and thus increased the likelihood that these rejected persons will be either forced into a more restrictive and segregated living situation or entirely underserved.

25. The actions of the State of Illinois violate the FHA, the ADA, and the Rehabilitation Act, and contravene the principles set forth in *Olmstead.*

26. It is crucial to the purposes of the FHA, ADA, Rehabilitation Act, and other civil rights laws that the Defendants' discriminatory practices be declared illegal and enjoined.

27. The individual Plaintiffs' claims against the State of Illinois Defendants are brought as a class action under F.R.C.P. 23(a) and (b)(2).

28. In addition to being defendants for violations of the above-mentioned laws, the State of Illinois Defendants are also joined under F.R.C.P. 19 because, in their absence, the Court cannot accord the complete injunctive relief sought by the Plaintiffs under the ADA and under the Rehabilitation Act. Appropriate relief must include a requirement that the State revise and issue appropriate guidance, rules, and procedures applicable to SLFs that will ensure non-discrimination. Specifically, to prevent bad actors in the field of SLFs, including, but not limited to, Eden, from implementing blanket, preemptive "no mental illness" policies affecting Medicaid recipients, the Illinois §1915(c) Home and Community-Based Services Waiver application ("HCBS Waiver" or "Waiver," relevant portions of which are attached as Exhibit 2) and Illinois Administrative Code Chapter I, Section 146.220 must be modified to require licensed facilities to adopt a detailed non-discrimination policy concerning persons with disabilities including mental disability, and concerning those perceived to have a disability based on a mental health diagnosis, and to specify that proper screening of prospective residents (including persons with mental health diagnoses) should be done by a proper state official, based on appropriate objective criteria related to suitability and not merely diagnoses, status, or stereotypes, and should fully comply with the Fair Housing Act. Specific injunctive relief Plaintiffs seek as regards State of Illinois regulations, policies, and procedures concerning the Supportive Living Program is set forth more fully below.

29. This is an action for declaratory judgment and permanent injunctive relief against

all Defendants for discrimination on the basis of disability in the provision of housing and supportive services in violation of the Fair Housing Act, Americans with Disabilities Act, and Rehabilitation Act. This is also an action for damages against Eden Defendants for their discriminatory actions.

Jurisdiction and Venue

30. This Court has jurisdiction over the subject matter of this case pursuant to 42 U.S.C. § 3613 and 28 U.S.C. §§ 1331 and 1343.

31. This Court has jurisdiction over Plaintiffs' action for declaratory relief pursuant to 28 U.S.C. § 2201 and F.R.C.P 57. Injunctive relief is authorized by 42 U.S.C. § 3613 and F.R.C.P. 65. The State of Illinois Defendants are also joined as required parties for full relief under F.R.C.P. 19.

32. Venue is proper in the Northern District of Illinois, Eastern Division, pursuant to 28 U.S.C. § 1391 because the Plaintiffs and the Defendants reside within the district and the unlawful events or omissions giving rise to the claims occurred in the district.

Parties

Plaintiffs

33. Plaintiff Kimberly O'Connor is a 59-year-old citizen of the United States who resides in Elgin, Illinois.

34. Ms. O'Connor is a person with a "disability" or "handicap"[1] under the Fair Housing Act, the Americans with Disabilities Act, and the Rehabilitation Act of 1973. She is impaired in her abilities to walk outside, climb stairs, keep house, and prepare meals.

35. Plaintiff Tammy Mormino is a 46-year-old citizen of the United States who

[1] Although the Fair Housing Act uses the term "handicap" throughout the Act, the term "disability" is legally synonymous with "handicap," and "disability" will be used in this Complaint.

resides in Chicago, Illinois.

36. Ms. Mormino is a person with a "disability" or "handicap" under the Fair Housing Act, the Americans with Disabilities Act, and the Rehabilitation Act of 1973. She is impaired in her abilities to walk without an assistive device, climb stairs, keep house, and prepare meals.

37. Plaintiff H.O.P.E., Inc., doing business as HOPE Fair Housing Center ("HOPE") is a private, nonprofit corporation incorporated under the laws of Illinois with its principal place of business located at 245 W. Roosevelt Road, Building 15, Suite 107, in West Chicago, Illinois. HOPE's mission includes promoting equal opportunity in housing and eliminating unlawful discriminatory housing practices. HOPE works to accomplish these goals through education and outreach, public policy initiatives, training, advocacy, investigation of fair housing violations, and enforcement.

38. HOPE's purpose is to eliminate housing discrimination and segregation based on race, color, religion, national origin, sex, disability, familial status, or any other characteristics protected under state or local laws, for all economic levels of society. HOPE serves many counties in Northern and North Central Illinois, including but not limited to: Cook, Kendall, Kane, Grundy, DuPage, McHenry, and Will counties.

39. HOPE counsels both housing seekers and housing providers on their rights and responsibilities under fair housing laws. HOPE also provides complaint investigation services including the use of testers to help identify housing discrimination. All of these services are provided free of charge to the community. HOPE also provides professional and confidential consulting, training, and compliance services to rental housing providers, real estate companies, mortgage lenders, homeowners' insurance companies, municipalities, and governmental agencies.

The Eden Defendants

40. Defendant Eden Management LLC, doing business as Eden Supportive Living ("Eden Management"), is a limited liability company, licensed and doing business within Illinois. Defendant Eden Management manages and operates a state-licensed SLF located at 940 W. Gordon Terrace in Chicago, Illinois 60613 (hereinafter referred to as "Eden Chicago"). Defendant Eden Management's principal office is also located at 940 W. Gordon Terrace in Chicago, Illinois 60613. Defendant Eden Management is licensed by the Illinois Department of Healthcare and Family Services to operate SLFs that provide housing and services for residents between ages 22 and 64 with disabilities.

41. Defendant 311 Lincolnway Properties LLC ("Lincolnway Properties") is a limited liability company, organized and operating under the laws of Illinois with the assumed name "Eden Fox Valley." Lincolnway Properties manages and operates a state-licensed SLF located at 311 S. Lincolnway Hwy, North Aurora, Illinois 60652 (hereinafter referred to as "Eden Fox Valley"). Defendant Lincolnway Properties is licensed by the Illinois Department of Healthcare and Family Services to operate SLFs that provide housing and services for residents between ages 22 and 64 with disabilities.

42. Defendant 222 State Street Properties LLC ("State Street Properties") is a limited liability company, organized and operating under the laws of Illinois with the assumed name "Eden Champaign LLC." State Street Properties manages and operates a state-licensed SLF located at 222 N. State Street, Champaign, Illinois 61820, and doing business as Eden Supportive Living of Champaign (hereinafter referred to as "Eden Champaign"). Defendant State Street Properties is licensed by the Illinois Department of Healthcare and Family Services to operate SLFs that provide housing and services for residents between ages 22 and 64 with disabilities.

43. Defendant Champaign Capital Venture LLC is a limited liability company, organized and operating under the laws of Illinois, with a principal office address of 1404 North LaSalle Street, Chicago, Illinois 60610. Champaign Capital Venture, along with Michael J. Hamblet Jr., owns Defendant State Street Properties.

44. Defendant Michael J. Hamblet Sr. is the owner and co-manager of both Eden Management and Lincolnway Properties. Mr. Hamblet Sr. is also the owner of Champaign Capital Venture LLC, which is an owner of State Street Properties. Mr. Hamblet Sr. is the registered agent for Eden Management, Lincolnway Properties, State Street Properties, and Champaign Capital Venture LLC. Mr. Hamblet Sr. resides at 1226 Grant Road, Northbrook, Illinois 60062.

45. Defendant Michael J. Hamblet Jr. is the co-manager of Eden Management, Lincolnway Properties, and the manager of State Street Properties and Champaign Capital Venture LLC. On information and belief, Mr. Hamblet Jr. also holds an ownership interest in Eden Management, Lincolnway Properties, and State Street Properties. Mr. Hamblet Jr.'s address is listed as 940 West Gordon Terrace, Chicago, Illinois 60613.

46. Defendant Maria Drosos is a Director of Marketing for the Eden Defendants. Ms. Drosos' office is located at the Eden Chicago location. Ms. Drosos provides Eden's policy of "no mental illness" to persons making inquiries about availability of and application for supportive living housing and services provided by Eden.

47. Defendant Carleen Curalli (formerly Carleen Lamaster) is a Director of Marketing for the Eden Defendants. Ms. Curalli's office is located at the Eden Fox Valley location. Ms. Curalli provides Eden's policy of "no mental illness" to persons making inquiries about availability and application for supportive living housing and services provided by Eden.

48. Defendant Kimberly Cross is the Executive Director of the Eden Champaign location. Ms. Cross provides Eden's policy of "no mental illness" to persons making inquiries about availability and application for supportive living housing and services provided by Eden.

49. The Eden Defendants are collectively referred to as "Eden" throughout the Complaint.

The State of Illinois Defendants

50. Defendant Patrick J. Quinn is the Governor of the State of Illinois, a public entity covered by Title II of the ADA. 42 U.S.C. §12131(1). Governor Quinn, sued in his official capacity, is ultimately responsible for ensuring that Illinois operates its service programs in conformity with the ADA and the Rehabilitation Act. 20 ILCS 2407/20(c). His office and the Illinois Department of Healthcare and Family Services ("HFS"), issue Informational Notices to SLFs regarding and governing operation of the State's Supportive Living Program.

51. Defendant Julie Hamos, sued in her official capacity, is the Director of HFS, the state agency responsible for providing health care coverage for the citizens of Illinois and for administering medical assistance programs and other fiscal programs, including the Medicaid Home and Community-Based Services (HCBS) Waiver program at issue in this case. HFS oversees Illinois's Supportive Living Program. Defendant Hamos is responsible for the oversight, supervision and control of HFS and its divisions, and is ultimately responsible for ensuring that HFS' services for people with disabilities are provided in conformance with the law.

52. Defendant Theresa Eagleson, sued in her official capacity, is the Director of HFS's Division of Medical Programs. Defendant Eagleson is HFS's listed signatory on the HCBS Waiver application at issue in this case. (Exhibit 2, p. 12).

53. Defendant Kelly Cunningham, sued in her official capacity, is the Chief of HFS's Bureau of Long Term Care. Defendant Cunningham is HFS's listed contact person on the HCBS Waiver application at issue in this case. (Exhibit 2, p. 11).

54. Defendant Michelle R.B. Saddler, sued in her official capacity, is the Secretary of the Illinois Department of Human Services ("DHS"), the state agency responsible for administering the long-term care system in Illinois for people with disabilities. Secretary Saddler is responsible for the oversight, supervision and control of DHS and its divisions, and is ultimately responsible for ensuring that DHS disability services are provided in conformance with the law.

55. Two divisions within DHS are directly involved in the preadmission screening of SLF applicants – the Division of Rehabilitation Services ("DRS") and the Division of Mental Health ("DMH").

56. DRS, both directly and indirectly through third party agencies under contract with DRS, oversees an early stage of the preadmission screening process for all SLF applicants called the Determination Of Need screening ("DON"). DRS oversees the DON screening process for SLF applicants between the ages of 22 and 59.

57. DMH, both directly and indirectly through third party agencies under contract with DMH, oversees and conducts mental health-related screenings of SLF applicants.

58. Defendant John K. Holton, sued in his official capacity, is the Director of the Illinois Department on Aging ("DoA"), the state agency that, along with DHFS and DHS, is responsible for assessing the performance of contractors and staff performing initial level of care determinations at Supportive Living Facilities.

59. The Department on Aging ("DoA") both directly and indirectly through third

party agencies under contract with DoA oversees the DON screening process for SLF applicants ages 60 and older.

Factual Allegations

The Medicaid Waiver Program

60. Medicaid is a medical assistance program jointly financed by state and federal governments for low income individuals. 42 U.S.C. §1396 et seq. It was first enacted in 1965 as an amendment to the Social Security Act of 1935. Medicaid is administered by the Centers for Medicare and Medicaid Services (CMS).

61. Historically, Medicaid covered Long Term Care services, including services related to activities of daily living in Medicaid-defined "institutional settings," such as Nursing Homes, Intermediate Care Facilities for Persons with Mental Retardation, and two types of facilities for mental health care, depending on the age of the patient.

62. In response to pressure from persons with disabilities and those who support them, and to comply with successful litigation they initiated, CMS partnered "with states, consumers and advocates, providers and other stakeholders to create a sustainable, person-driven long-term support system in which people with disabilities and chronic conditions have choice, control and access to a full array of quality services that assure optimal outcomes, such as independence, health and quality of life." http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Long-Term-Services-and-Supports.html.

63. Section 1915(c) of the Social Security Act permits States to offer, under a waiver of statutory requirements, an array of home and community-based services that an individual needs to avoid institutionalization. 24 C.F.R. 441.300. 1915(c) Waiver services can include

homemaker services, assistive technology, personal care, meals, and case management.

64. The HCBS Waiver authority permits a state to offer home and community-based services to individuals who: (a) but for the provision of such services, would require a level of institutional care (hospital, nursing facility, or Intermediate Care Facility for the Mentally Retarded (ICF/MR)) under the state plan; (b) are members of a target group that is included in the waiver; (c) meet applicable Medicaid financial eligibility criteria; (d) require one or more waiver services in order to function in the community; and, (e) exercise freedom of choice by choosing to enter the waiver program in lieu of receiving institutional care. 42 U.S.C. 1396n. It is a state option to offer waiver services through its Medicaid program.

The State of Illinois's Medicaid Waiver Supportive Living Program

65. According to the Illinois Supportive Living Program website:

> Illinois developed the Supportive Living Program as an alternative to nursing home care for low-income older persons and persons with disabilities under Medicaid.
>
> By combining apartment-style housing with personal care and other services, residents can live independently and take part in decision-making. Personal choice, dignity, privacy and individuality are emphasized.
>
> The Department of Healthcare and Family Services has obtained a "waiver" to allow payment for services that are not routinely covered by Medicaid. These include personal care, homemaking, laundry, medication supervision, social activities, recreation and 24-hour staff to meet residents' scheduled and unscheduled needs. The resident is responsible for paying the cost of room and board at the facility.

http://www.slfillinois.com.

66. The Illinois Medicaid Waiver Supportive Living Program, as approved by CMS, is designed for individuals who, but for the waiver, would require a nursing facility level of care.

67. In designing its waiver, a state may choose among the federally designated target

groups set forth in 42 CFR §441.301(b)(6); Illinois chose age (65 and older) and physically disabled. 42 CFR §441.301(b)(6)(i).

68. In Illinois, there are currently 143 operational SLFs with a total of 11,575 units according to the Illinois Supportive Living Program website, with at least 19 more sites approved.

69. Potential SLF residents apply through several routes. They may apply directly to the SLF as they might to any apartment building or community housing in response to a website or advertisement, or through the discharge or transfer process when ready to move on from a hospital or other institutional care setting.

70. To actually become a resident of an SLF, applicants must be approved by two distinct entities: the individual site-based SLF and the Illinois Medicaid Waiver Program. The SLF independently decides if applicants meet the requirements for residency at the site in a manner comparable to other landlords or housing providers: it determines whether applicants can demonstrate based on past objective history their ability to refrain from damaging property or interfering with the rights of other residents (taking into account the services and supports offered at the SLF). The SLF will also determine if the applicant can pay all relevant costs, including the non-Medicaid waiver costs such as room and board.

71. To determine whether an applicant is eligible for the Medicaid Waiver Program, Illinois requires that SLF applicants be "[s]creened by [HFS] or other state agency screening entity and found to be in need of nursing facility level of care and that SLF placement is appropriate to meet the needs of the individual," called a Determination of Need screening ("DON") and must meet the "Resident Participation Requirements," set by Defendant HFS at 89 Ill. Admin. Code § 146.220.

72. The DON screening focuses on the applicant's ability to complete daily activities, like eating, bathing, grooming, dressing, preparing meals, managing money, laundry and housework, and determines if the applicant's "level of care" concerning physical disability is sufficient or appropriate for the SLF Waiver Program.

73. Applying eligibility criteria is the province of the State Defendants, not the individual SLFs.

74. At or before the time an applicant is admitted, an SLF shall conduct a standardized interview geared towards the resident's (or prospective resident's) particular service needs. Within 24 hours after admission, the SLF shall complete an initial assessment and service plan for each resident that identifies needs and potential problems. Within fourteen (14) days after admission, annually, and upon a significant change in the resident's mental or physical status, an SLF must complete a Comprehensive Resident Assessment Instrument ("RAI") and develop a service plan for each resident. 89 Ill. Admin. Code § 146.245.

75. The Illinois Supportive Living Program Waiver and its implementing regulations, notices, guidance, and public materials categorically state that potential participants "must be without a primary or secondary diagnosis of developmental disability and serious and persistent mental illness."

76. The Illinois Supportive Living Program Waiver and its implementing regulations, notices, guidance, and public materials fail to define the terms at issue here in a manner that is internally consistent, grounded in fact or law, or provides sufficient guidance and results in decisions made on the basis of diagnosis.

77. The primary means by which the State carries out its discriminatory policy of banning otherwise qualified people with mental health diagnoses from its Medicaid Waiver SLFs

begins with the same Determination of Needs process that is already required for all SLF applicants. During this process, within a typical and wholly legal Medicaid Waiver framework, all applicants are screened by licensed agents of the State to determine appropriate levels of needed services and the nature of those services. Such an evaluation, by its nature, requires a determination of the applicant's medical needs and ability to perform activities of daily living. In Illinois, if the evaluation reveals suspicion of a mental health diagnosis the applicant will be referred by the DON screener for a mental health screen conducted by the DHS Division of Mental Health, which ordinarily is a full "Level II" screen resulting in a "level of care" Determination designed to support the individual with mental health services in the least restrictive setting.

78. As regards Illinois Supportive Living Facility applicants suspected of mental illness, the State Defendants subject them to a mental health screening ostensibly under the same process it uses for compliance with its federal PASRR requirements, PAS/MH, but with the opposite purpose and outcome. By law, the State is only required to use this mental health screening process for Nursing Facilities, its purpose being to ensure that people with mental illness are not "dumped" or "warehoused" in nursing homes without being provided the necessary services mental illnesses often require or when they can be provided services in a more integrated setting. The State may choose to use the PASRR for other purposes.

79. The PASRR screening in Illinois generally has as its result one of two possible outcomes: an applicant can be found to be eligible for an in-patient mental health facility or for receipt of an array of community mental health services. The Illinois PASRR screening has no option including the Illinois Medicaid Waiver Supportive Living Program. The screening as applied by the State Defendants to Supportive Living Facility applicants is truncated, diagnosis-

based only, and applied without proper guidance to "rule out" mental illness, rather than determine "level of care" akin to or supplemented by community-based mental health services that could include the individual living in a Supportive Living Facility.

80. Thus, once the DON screening determines that a person has a mental health diagnosis, that person cannot be found eligible for the Illinois Medicaid Waiver SLF program, even if he or she meets the physical disability or age requirement, would otherwise benefit from the services the SLF offers, and needs no mental health services because of successful treatment and management.

81. The State Defendants' system of screening Supportive Living Facility applicants to reject them based on confirmation of mental health diagnosis alone materially contributes to Supportive Living Facilities such as Eden adopting blanket (no professional screening) "no mental illness" policies.

82. "No mental illness" policies in state-licensed SLFs receiving funds under the State's administration of Medicaid result in outright exclusion or unjustified institutional segregation or isolation of individuals with mental health issues receiving services from the State of Illinois, an actionable form of discrimination under Title II of the ADA.

83. It is the overwhelming policy and practice of the Illinois Supportive Living Program to determine that individuals who have a diagnosed mental illness are ineligible for SLF placement and should be denied admission even if they are otherwise qualified for the SLF by virtue of their being a member of the physically disabled or aged target groups and having a Medicaid nursing facility level of care need.

84. The Illinois Waiver requires, in Appendix F-1 affording due process after denial, a detailed Pre-Admission Screen ("PAS") by a qualified Department of Human Services

screening agent for "potential participants known or suspected of having a primary or secondary diagnosis of a developmental disability or serious and persistent mental illness." But Appendix F-1 of the Illinois Waiver does not specify compliance with the FHA, the ADA or the Rehabilitation Act.

85. The State of Illinois regulations and §1915(c) Waiver concerning exclusion of persons from Supportive Living Facilities based on a "serious and persistent mental illness," as currently written and applied permit exclusion based on disability status and diagnosis alone, as well as on stereotypes of persons with mental health diagnoses.

86. The Illinois Administrative Code concerning Healthcare and Family Services and, specifically, Supportive Living Facilities (referred to as "The Rule") also omits the FHA nondiscrimination requirements concerning persons with disabilities, with a focus on actual facts relating to suitability. 89 Ill. Admin. Code § 146.220. The Rule requires full screening (which Eden does not do), but also repeats the undefined language that participants must "be without a primary or secondary diagnosis of developmental disability or serious and persistent mental illness."

87. To implement its Rule excluding all persons with mental health diagnoses undefined as "serious and persistent," the State of Illinois incorrectly utilizes existing mental health screening processes otherwise generally undertaken by DHS Division of Mental Health under *Olmstead* to ensure non-segregation and least restrictive settings for persons with mental illnesses. Thus, if Supportive Living Facilities or other facilities do refer a Supportive Living Facility applicant suspected of having a Mental Illness for mental health screening, HFS requires DHS Division of Mental Health to limit its screening to merely "rule out" mental illness diagnosis, resulting in the person being *excluded* from a desirable setting and level of care

screen, to be in most cases left in a more restrictive, segregated, or underserved setting.

88. The State of Illinois procedures discriminatorily apply an undefined term, "serious and persistent mental illness" instead of assessing the actual suitability of the prospective resident to live in a Supportive Living Facility. The State of Illinois rules, policies, and procedures relating to Supportive Living Facility admissions are based on diagnosis alone and not whether, for example, an applicant with a mental health diagnosis is compliant with medications, does not pose a threat to self or others, or has a good rental or residential history.

89. The State of Illinois Supportive Living Program is unlawful under Title II of the ADA, Section 504 of the Rehabilitation Act and the Fair Housing Act, 42 U.S.C. § 3604 and 3617, because it discriminates against individuals with mental health diagnoses who seek to live in Supportive Living Facilities including but not limited to in the following additional particular ways:

a. The State of Illinois, at www.slfillinois.com, states that Supportive Living Facility residents must be "without a primary or secondary diagnosis of developmental disability or serious and persistent mental illness." This statement is unqualified and makes no reference to an actual suitability determination, to non-discrimination based on status, or to well-settled integrative/least restrictive setting principles.

b. The State of Illinois Department of Healthcare and Family Services, at www2.illinois.gov/hfs/medicalprograms, defines eligibility criteria for Supportive Living Facilities to be "no primary or secondary diagnosis of developmental disability or serious and persistent mental illness." This diagnosis-only statement is contrary to the FHA, the ADA, and the

Rehabilitation Act.

c. HFS, along with the Governor's Office, issued an Informational Notice on June 22, 2011, to SLFs stating that if the preadmission screen conducted by a qualified PAS agent determines a person has a serious and persistent mental illness, the person will simply be determined not to be appropriate for Supportive Living Facility admission. (Exhibit 3).

d. HFS failed to consult with DHS Division of Mental Health when it promulgated its Rule to exclude persons with mental health diagnoses from Supportive Living Facilities;

e. Supportive Living Program assessment and screening processes do not address the proper "level of care" analysis and assessment that should apply to persons with or suspected of having mental illnesses who also have physical disabilities and may be suitable to reside in a Supportive Living Facility. Thus, persons who seek to participate in the Supportive Living Program may be denied a wide array of mental health services as well as housing;

f. HFS failed to provide proper guidance or instructions to DHS Division of Mental Health and screening agents under contract with the State of Illinois who may undertake various levels of screenings of SLF applicants;

g. The State of Illinois policies and procedures at issue in this case deny due process in disputing exclusion from a Supportive Living Facility based on actual or perceived mental health conditions;

h. The Illinois Department of Human Services Division of Mental Health has issued a "Contractor's Procedure Manual," for PAS/MH. (Relevant excerpts

of the PAS/MH manual are attached as Exhibit 4). The PAS/MH manual discriminatorily states that persons even "believed" to have "severe" mental illness are "ineligible" to live in Supportive Living Facilities. The PAS/MH manual fails to set forth appropriate standards for nondiscriminatory assessment of whether an individual with a mental health diagnosis is nonetheless suitable to live in a Supportive Living Facility with the services provided or with independently secured additional services. The PAS/MH manual fails to set forth a new process concerning Supportive Living Facility applicants, fails to provide instructions on how screens of Supportive Living Facility applicants are handled or documented, fails to provide any due process safeguards or guidelines regarding denials based on mental illness, and fails to specify the manner in which applicants denied residence and services in the Supportive Living Program based on mental health diagnosis will be notified of their exclusion or any rights, basis or procedures concerning appealing such denials.

i. PAS screening under the State of Illinois Supportive Living Program for persons "suspected" of mental illness is undertaken only to "rule out" "serious" mental illness, which terms are not properly defined or set out in policies or procedures, but no screening is done concerning their suitability for admission into a Supportive Living Facility;

j. The State Defendants fail to properly document and track their purported "screening" of applicants to Supportive Living Facilities who were suspected of mental illness;

k. The present State of Illinois screening system will not allow PAS agents to undertake assessments for suitability for admission to an SLF beyond mere diagnosis;

l. The forms and letters that can be generated by the State Defendants' health screening system that results in exclusion of persons with mental health conditions from Supportive Living Facilities are not applicable or adapted to the Supportive Living Program in particular;

m. The State Defendants' mandatory screening database at issue has no level of care Determination option that applies to SLFs or the Supportive Living Program, and has no information about or choices for Supportive Living Facilities that could admit a person with physical disabilities who may also have a mental health diagnosis;

n. Concerning its Supportive Living Program, the State of Illinois has failed to properly inform, train, monitor or guide SLFs, State agencies who conduct DON/PAS screens, and contractors with the State of Illinois concerning the Supportive Living Program in general, and specifically with regards to non-discrimination concerning mental health issues, proper assessment, proper documentation or due process considerations;

o. The HFS Supportive Living Program Handbook Section C-230 *falsely* states that a person with a mental illness is not necessarily prevented from entering a supportive living facility and *falsely* states that such a person may appeal a determination concerning rejection based on mental illness: this is not included in the Administrative Code or other policies or procedures;

p. Illinois HFS has been aware that SLFs do not conduct any review or proper screening of SLF applicants with mental illnesses and has failed to take corrective action; and

q. The HFS "Interagency Certification of Screening Results" form (HFS 2536) is designed to summarize and document the Determination of Need and "to determine his/her need for nursing facility, supportive living or ICF/DD services and to ascertain if other services might be an acceptable alternative to nursing facility, supportive living or ICF/DD placement." However, no form 2536 or screening paperwork is provided to an SLF if an applicant who is referred for a PAS/MH screen by the DHS Division of Mental Health has a mental illness. The person is simply denied housing and services via an inapplicable form letter.

90. The State of Illinois has failed to take any steps to modify, direct, tailor, track, or adapt its PAS/MH screening processes to determine level of care for persons with mental illnesses regarding State of Illinois SLF program requirements in instances where applicants are suspected of having mental illnesses.

91. The present Illinois scheme of administration of its Medicaid program concerning Supportive Living Facilities increases the likelihood of unduly segregating people with disabilities such as the Plaintiffs, as well as undermining their placement in the "most integrated setting appropriate" as required under Title II and the Rehabilitation Act.

Eden

92. At all times relevant, Eden engaged in common unified management policies and practices throughout and among all Eden Supportive Living locations, including Eden Chicago,

Eden Fox Valley, and Eden Champaign, and among all the principals and employees of all Eden Supportive Living locations.

93. The Eden Defendants jointly engaged in a pattern of discriminatory conduct and programmatic violations as alleged herein towards Plaintiff O'Connor, Plaintiff Mormino, and other similarly situated individuals.

94. At all times relevant, the Eden Defendants maintained a joint website and jointly received applications through its website and on paper.

95. Eden operates all Eden Supportive Living locations, including Eden Chicago, Eden Fox Valley, and Eden Champaign, under a common policy and application process.

96. Eden publishes a "Preliminary Application" on its website and distributes the same Preliminary Application to those who apply in person. (Exhibit 5).

97. Eden requires applicants to either complete the Preliminary Application question that asks, "Any mental diagnosis? If so, explain," in writing, or, in the alternative to answer the question verbally so a representative can record the answer.

98. If the answer is "yes," – if the applicant indicates any "mental diagnosis" -- Eden categorically rejects them. Eden considers no further explanation, conducts no screening, provides no reference for an outside screening or appeal mechanism, never confirms whether the applicant actually has a true or accurate diagnosis, and never determines how or in what manner such a diagnosis may affect the applicant's housing or service needs. In instances where applicants reveal a "mental diagnosis" prior to completing the Preliminary Application, Eden retains no record or documentation of the applicants or the reason for their rejection.

99. Eden's "Preliminary Application" fails to include a list of the services Eden supplies as a Supportive Living Facility and thus fails to inquire whether the prospective resident

needs those services. Instead, Eden's "Preliminary Application" inquiries into the nature and severity of a prospective tenant's disability (both physical and mental).

100. For example, the Preliminary Application inquires about insulin, transferring, showering, memory, medication, and medication reminders. The application asks whether the applicant needs assistance and seeks identification by the applicant of a level of assistance needed.

101. Through their Preliminary Application and overall application and intake processes, the Eden Defendants improperly assert and apply program eligibility criteria that are discriminatory and unauthorized under the Waiver and Supportive Living Program.

102. According to its Director of Marketing, Defendant Drosos, Eden's discriminatory policy is: "Eden is for people 22 through 64, plus physical disability. No mental illness."

103. Eden's "no mental illness" policy is routinely orally communicated to prospective residents.

104. Eden's website states it serves a population with physical disabilities, affirming its "no mental illness" policy. (Exhibit 6).

105. It is the policy and practice of Eden to routinely communicate to prospective residents that no one with a "mental diagnosis" is allowed, as indicated by the information provided in phone calls to Plaintiff O'Connor and the testers, and as demonstrated in Eden's Preliminary Application process.

106. Eden is compensated either by private paying residents, or from capturing funds from a participant's Social Security payment and Illinois Medicaid.

107. Eden's Preliminary Application, improper inquiries, and oral procedures rejecting persons with any mental illness deprive prospective residents of an appropriate level of

suitability screening by a qualified or licensed professional and violate due process protections afforded under state and federal law.

Kimberly O'Connor

108. Ms. O'Connor receives Social Security payments for which she qualifies based on disability.

109. Ms. O'Connor is or would be eligible for Medicaid benefits as administered by the State of Illinois in order to reside in a Supportive Living Facility.

110. Ms. O'Connor is a person with a disability as defined by 42 U.S.C. § 12102 and 42 U.S.C. §§ 3602(h)(1)-(3) in that she has physical and mental impairments which substantially limit one or more of her major life activities, she has a record of such impairments, and Defendants regarded her as having such impairments.

111. Ms. O'Connor's physical disabilities include a severe heart condition, ruptured discs, diabetes, neuropathy, and recurring bleeding ulcers that result in reduction in mobility, equilibrium problems, and physical endurance issues.

112. In particular, her ability to perform the activities of daily living such as food shopping, meal preparation, cooking, and cleaning are impaired.

113. Ms. O'Connor's mental health disabilities include a longstanding disorder that without support and medical management substantially interferes with the major life activities of work, housekeeping, personal care, and relationships.[2]

114. As a result of her physical impairments and following a hospitalization for her physical medical conditions, Ms. O'Connor qualified for and sought out the supportive living services as provided by the Eden Defendants, specifically assistance with nutrition, the provision

[2] Discovery in this case is already underway. Specific information concerning the individual Plaintiffs' mental and physical impairments have been produced under a Protective Order.

of meals, housekeeping, and laundry. She was also interested in other services such as medication reminders concerning a complex array of medications Ms. O'Connor takes relating to her physical disabilities.

115. The Eden Defendants categorically rejected Ms. O'Connor solely on the basis of her mental health diagnosis.

116. In October 2012, Ms. O'Connor had been hospitalized and, upon preparation for discharge, was provided information by the hospital about supportive living facilities, including Eden. Ms. O'Connor utilized the information provided to her by the hospital discharge planner to call Defendant Eden's Fox Valley location to inquire about becoming a resident.

117. During this phone call, Defendant Eden's representative asked Ms. O'Connor several health-related questions. Ms. O'Connor informed Defendant Eden's representative that she had heart problems and diabetes.

118. Ms. O'Connor informed Defendant Eden's representative that she also had a mental health diagnosis.

119. Defendant Eden's representative told Ms. O'Connor that Defendant Eden did not accept residents with her diagnosis and hung up the phone.

120. In approximately November 2012, Ms. O'Connor was hospitalized, for internal bleeding relating to a chronic ulcer condition, and upon discharge again called Defendant Eden's Fox Valley location to ask about becoming a resident, and spoke to a different representative of Defendant Eden.

121. This time, when Defendant Eden's representative inquired into the nature of Ms. O'Connor's disability, Ms. O'Connor told her that she had heart disease and diabetes, which resulted in her need for supportive living services. She did not tell Defendant Eden's

representative that she had a mental health diagnosis.

122. This time, Defendant Eden's representative told Ms. O'Connor that she could view the property after she was prescreened. Defendant Eden's representative provided her with a phone number to arrange the DON prescreening, (630) 892-7417, which is the phone number for a branch of DHS's Division of Rehabilitation Services ("DRS") located in Aurora, Illinois.

123. When Ms. O'Connor called the above-listed phone number, she spoke to two DRS employees, and informed them that she was referred by Eden for prescreening. Both DRS employees were unfamiliar with the screening process concerning the Supportive Living Program and informed Ms. O'Connor that they did not know why she was calling, and she was unable to schedule the screening.

124. Ms. O'Connor called Defendant Eden again, and left a voicemail stating that she was unable to schedule the screening.

125. Ms. O'Connor then received a voicemail from Defendant Eden's representative, stating that Eden had scheduled a DON prescreening with DRS for December 6, 2012.

126. Ms. O'Connor contacted a representative from Defendant Eden's Fox Valley location again on approximately December 4, 2012. Ms. O'Connor asked the representative if it would be a problem if she had her particular mental health diagnosis.

127. Defendant Eden's representative said that Defendant Eden could not accept her if she had *any* mental health diagnosis, including, for example, a diagnosis of depression.

128. Ms. O'Connor requires no additional supportive services from Eden as a result of her mental health diagnosis.

129. Ms. O'Connor is able to meet and fulfill all program and residency requirements at Eden, and her mental health diagnosis does not change nor affect her ability to meet or

perform any such program or residency requirements.

130. As a direct result of and after rejection by Eden, Ms. O'Connor became homeless and lived in shelters. While searching the classified advertisements for somewhere to live, she learned about HOPE and contacted HOPE for investigation into Defendants' discriminatory conduct.

131. Ms. O'Connor would benefit from being integrated within a Supportive Living Facility, rather than being excluded altogether from a community setting with services or being required to live in a more restrictive setting.

132. As a direct and proximate result of Defendants' discriminatory policies, practices and actions, Ms. O'Connor suffered and in the future will continue to suffer economic loss, humiliation, embarrassment, and emotional distress.

Tammy Mormino

133. Ms. Mormino receives Social Security payments for which she qualifies based on disability.

134. Ms. Mormino is or would be eligible for Medicaid benefits as administered by the State of Illinois in order to reside in a Supportive Living Facility.

135. Ms. Mormino is a person with a disability as defined by 42 U.S.C. § 12102 and 42 U.S.C. §§ 3602(h)(1)-(3) in that she has physical and mental impairments which substantially limit one or more of her major life activities, she has a record of such impairments, and Defendants regarded her as having such impairments.

136. Ms. Mormino's physical disabilities include chronic obstructive pulmonary disease, hypertension, hypothyroidism, GERD, obstructive sleep apnea, neuropathy, arthropathy, and diabetes.

137. In particular, her ability to perform the activities of daily living such as walking, food shopping, meal preparation, cooking, and cleaning are impaired. Ms. Mormino uses assistive devices for mobility.

138. Ms. Mormino's mental health disabilities include a longstanding disorder that without support and medical management substantially interferes with the major life activities of work, housekeeping, personal care, and relationships.[3]

139. As a result of her physical impairments, Ms. Mormino first qualified for and sought out the supportive living services as provided by the Eden Defendants, in approximately 2005, and was admitted to reside in Eden. The supportive services required by Ms. Mormino included assistance with nutrition, the provision of meals, housekeeping, medication reminders, and laundry.

140. In 2008, Ms. Mormino was considered for transfer from Eden to a nursing facility, and was referred for a Level II Preadmission Mental Health Screening ("PAS/MH") by the State of Illinois DHS Defendants, resulting in a determination of Nursing Facility Level of Care based on her mental health needs *at that time*.

141. Ms. Mormino has resided in a nursing facility since 2008, but in 2013 it was determined and documented by her physician that due to substantial progress in her mental health that her medical issues now superseded her psychiatric issues and she was informed she should apply again to reside at Eden.

142. Ms. Mormino contacted Eden in September of 2013, visited the facility in October 2013, completed an application, and provided to Eden her doctor's verification that her medical issues predominate over her psychiatric issues.

[3] Discovery in this case is already underway. Specific information concerning the individual Plaintiffs' mental and physical impairments have been produced under a Protective Order.

143. On November 20, Eden wrote to Ms. Mormino stating that "one of the resident requirements for the supportive living program is that the individual be without a primary or secondary diagnosis of developmental disability or serious and persistent mental illness."

144. Eden's representative told Ms. Mormino that she needed a more recent PAS/MH screen. The State of Illinois told Ms. Mormino in November 2013 that she did not need another screen and that her prior screen from the transfer in 2008 was sufficient. 89 Ill. Admin. Code 146.220(a)(2) provides that when transferring to a Supportive Living Facility from a nursing facility, a new *DON* screen need not be completed.

145. The discriminatory diagnosis-based approach of Eden and the State Defendants to Ms. Mormino's application to the Supportive Living Program in 2013 failed to take into account changed circumstances, improvement or management of symptoms and conditions that may be related to a mental illness.

146. Eden denied admission to Mormino in January 2014 because it regarded her as having a diagnosis of mental illness, but claimed the pretextual and false basis that she did not provide an updated screen, which is further demonstrated as pretext by Eden's failure to take any steps to cause an updated screening be completed, particularly in light of the Ill. Administrative Code requirement that the Division of Mental Health must screen SLF applicants concerning mental illness.

147. Ms. Mormino complained in writing to Eden about incorrectly denying her admission and about discrimination based on mental health diagnosis on three occasions in November 2013, to no avail.

148. Ms. Mormino requires no additional supportive services from Eden as a result of her mental health diagnosis.

149. Ms. Mormino is able to meet and fulfill all program and residency requirements at Eden, and her mental health diagnosis does not change nor affect her ability to meet or perform any such program or residency requirements.

150. As a direct result of and after rejection by Eden, Ms. Mormino continues to reside in a nursing facility, a more restrictive and segregated setting than is in her best interest, but the only viable option available to her at this time. While researching on the Internet about discrimination and Eden, Ms. Mormino learned about HOPE and Ms. O'Connor from a news article and contacted HOPE for investigation into Defendants' discriminatory conduct.

151. Ms. Mormino would benefit from being integrated within a Supportive Living Facility, rather than being excluded from a community setting with services altogether or being required to live in a more restrictive setting.

152. As a direct and proximate result of Defendants' discriminatory policies, practices and actions, Ms. Mormino suffered and in the future will continue to suffer economic loss, humiliation, embarrassment, and emotional distress.

HOPE Tester #1

153. As a result of complaints concerning Plaintiff O'Connor and as part of a detailed investigation on the part of HOPE that ensued on her behalf, on January 28, 2013, a tester utilized by HOPE ("Tester #1") placed a telephone call to the Eden Chicago location, and requested to speak to someone regarding the facility, its policies, and its available apartments.

154. Tester #1 was transferred to the voicemail of Defendant Maria Drosos, Marketing Director of the Eden Chicago location.

155. On January 29, 2013, Tester #1 placed a telephone call to the Eden Chicago location, and requested to speak to Defendant Drosos. Tester #1 was informed that Defendant

Drosos was not in, so Tester #1 left a voicemail, stating that she was calling to find out more about the facility and asking if any two-bedroom apartments were available.

156. On January 30, 2013, Defendant Drosos returned Tester #1's phone call and left a voicemail, stating in part, "Here at Eden, it's for people 22 through 64, plus physical disability—no mental illness. 24-hour care, housekeeping, laundry service. All their meals are provided for them."

HOPE Tester #2

157. On August 12, 2013, a tester utilized by HOPE ("Tester #2") placed a telephone call to the Eden Champaign location, and stated that she was looking for a Supportive Living Facility in Champaign for her son.

158. Tester #2 was transferred to the phone line of Defendant Kimberly Cross, the Executive Director of the Eden Champaign location.

159. Defendant Cross requested that Tester #2 call her back in ten minutes.

160. Tester #2 called Defendant Cross back ten minutes later. During the phone call, Defendant Cross asked Tester #2 what disability her son had. Tester #2 stated that her son had cerebral palsy.

161. Defendant Cross stated that, even though construction was not yet complete, three floors were already rented. Defendant Cross informed Tester #2 that the Eden Champaign location was the only downstate facility that cared for the 22-64 age range.

162. Later that day, Tester #2 called Defendant Cross again. Tester #2 stated that she looked at Eden's website, and it specified only physical disabilities. Tester #2 stated to Defendant Cross that her son's primary diagnosis was cerebral palsy, but that he had adjustment disorder and depression.

163. Defendant Cross stated that Eden did not rent to people with a mental disability as a primary diagnosis, and that Eden could not accept people with schizophrenia or bipolar disorder.

164. Defendant Cross instructed Tester #2 not to list depression on the application.

HOPE Tester #3

165. On August 20, 2013, a tester utilized by HOPE ("Tester #3) placed a telephone call to the Eden Fox Valley location, and stated that she was looking for information about the property and whether any units were available.

166. Tester #3 was transferred to the voicemail of Defendant Carleen Curalli, Marketing Director for the Eden Fox Valley location.

167. Tester #3 left a voicemail stating that she was calling for information about supportive living and to inquire if any units were available.

168. After an exchange of voicemails, Defendant Curalli called Tester #3 on August 22, 2013.

169. During the conversation, Tester #3 stated that she had multiple sclerosis, that she was in a wheelchair, and that she also had bipolar disorder.

170. Defendant Curalli stated that Eden only serves clients with physical disabilities, and that none of Eden's residents can have a primary or secondary mental illness.

HOPE Tester #4

171. On November 15 and 18, 2013, a tester utilized by HOPE (Tester #4) placed telephone calls to Tabor Hills Supportive Living ("Tabor Hills"), located at 1439 McDowell Road, Naperville, Illinois, a Supportive Living Facility operated under the State of Illinois Supportive Living Program, stating that she was seeking housing for her aunt.

172. Tester #4 informed the agent of Tabor Hills that her aunt's secondary diagnosis was schizophrenia which has been controlled with medication for years. The agent for Tabor Hills responded that it is a written rule of the State of Illinois that supportive living facilities may not take anyone with a psychiatric diagnosis and referred Tester #4 to the County Senior Services agency to find out where else her aunt might be accepted to live.

HOPE Tester #5

173. On November 15, 2013, a tester utilized by HOPE (Tester #5) placed a call to Eastgate Manor ("Eastgate"), located at 101 Eastgate Court, Algonquin, Illinois, a Supportive Living Facility operated under the State of Illinois Supportive Living Program, stating she was seeking housing for her aunt.

174. Tester #5 informed the agent of Eastgate, the Director of Admissions, that her Aunt is partially paralyzed due to a stroke and has mobility issues. In addition, Tester #5 informed the Eastgate agent that her aunt has bipolar disorder with anxiety which is controlled with medication and is not the primary diagnosis.

175. The Eastgate agent told Tester #5 that she had to stop her because they cannot accept anyone who has a diagnosis of mental illness and further stated to Tester #5 that there are very few places that will accept anyone with mental health issues.

Hope Tester #6

176. On November 8, 2013, a tester utilized by HOPE (Tester #6) placed a telephone call to Courtyard Estates Peoria ("Courtyard Estates"), 117 N. Western Avenue, Peoria, Illinois, a Supportive Living Facility operated under the State of Illinois Supportive Living Program, stating that she was seeking residency there for her father, who has bipolar disorder.

177. The agent of Courtyard Estates stated to Tester #6 that a Supportive Living

Facility cannot accept anyone with a primary or secondary diagnosis of mental illness. Tester #6 replied that the bipolar condition is well managed with medication, to which the agent replied that Courtyard Estates "might" be able to make an exception this one time.

Damages

178. Plaintiffs Kimberly O'Connor and Tammy Mormino have suffered loss of their civil rights, emotional injury, humiliation, and embarrassment as a result of the discriminatory conduct of Defendants.

179. Plaintiffs O'Connor and Mormino suffered loss of appropriate housing and were required to live in more restrictive, more segregated, and/or substandard housing, inadequate and inappropriate in general and for their specific needs, as a result of the discriminatory conduct of the Eden Defendants.

180. As a direct and proximate result of the discriminatory actions and statements of the employees and/or agents of the Eden Defendants, Plaintiffs Kimberly O'Connor and Tammy Mormino suffered and continue to suffer deprivation of their rights to equal housing opportunities regardless of their impairment or the perceived extent of their impairment.

181. The Eden Defendants' discriminatory actions have caused and are continuing to cause harm to Plaintiff HOPE by frustrating HOPE's mission of identifying and eliminating discriminatory housing practices in the State of Illinois. HOPE has made substantial efforts and expended considerable resources to ensure equal housing opportunities for all people, including people who have disabilities.

182. The Eden Defendants' refusal to rent to Plaintiff Kimberly O'Connor and Tammy Mormino on the basis of disability status has stifled HOPE's goal of achieving fair housing for all Illinois residents, by impeding HOPE's efforts to educate the public about discriminatory

housing practices and impeding HOPE's efforts to provide counseling and referral services to the public about equal housing opportunities. In addition, Defendants' refusal to rent to Plaintiff Kimberly O'Connor and Tammy Mormino has caused HOPE to divert scarce resources away from its usual education, outreach, counseling, investigation and referral services, in order to investigate and counteract the Defendants' unlawful practices.

183. The Eden Defendants, unless enjoined, will continue to engage in the pattern or practice of discrimination and unlawful conduct described above. Plaintiffs have no adequate remedy at law. Plaintiffs are now suffering and will continue to suffer irreparable injury from Defendants' acts and unlawful conduct unless relief is provided by this Court. Plaintiffs, accordingly, are entitled to permanent injunctive relief.

184. The discriminatory actions of the Eden Defendants were willful, malicious, and taken with reckless disregard for Plaintiffs' rights.

185. The State of Illinois Defendants, unless enjoined in the manner specifically requested herein, will continue to administer programs affecting housing and provision of services to people with disabilities, as alleged herein, in a manner permitting actors such as the Eden Defendants to discriminatorily implement "no mental illness" policies at state-licensed Supportive Living Facilities in violation of the FHA, ADA, and Rehabilitation Act.

Class Action Allegations – State Defendants

186. Plaintiffs O'Connor and Mormino bring this action under the FHA, the ADA, and the Rehabilitation Act against the State of Illinois pursuant to Federal Rule of Civil Procedure 23(a) and 23(b)(2).

187. The class of individuals that the named Plaintiffs seek to represent consists of all persons in the State of Illinois who have been improperly deterred, excluded, or rejected from

SLF housing and services based on mental health diagnosis.

188. The class is so numerous that joinder of all potential class members is impracticable. The exact number of potential class members is not known to Plaintiffs, but is believed to be over 1,000 persons.

189. The claims of the named Plaintiffs are common to those of the class and raise common issues of fact and law, including, but not limited to:

a. Whether State Defendants have rules, policies, and procedures with regards to the SLF Program that serve to interfere with or deny class members the right to housing and services in violation of the FHA, the ADA, and the Rehabilitation Act;

b. Whether the State Defendants have rules, policies, and procedures with regards to the SLF Program that serve to deny class members the right to housing and services in the most integrated setting appropriate to their needs;

c. Whether the State Defendants' rules, policies, and procedures relating to SLF admissions are based on mental health diagnosis alone;

d. Whether the State Defendants' policy to exclude all persons with a primary or secondary diagnosis of "serious and persistent mental illness" from Supportive Living Facilities denies class members the right to services and housing in general and in the most integrated setting appropriate to their needs;

e. Whether the State Defendants' use of the undefined terms "serious and persistent mental illness" and "primary or secondary diagnosis" to exclude class members constitutes a discriminatory policy;

f. Whether the State Defendants' application of the undefined term "serious and persistent mental illness" as it pertains to SLFs discriminates on the basis of disability and leads to the exclusion of class members from services and housing; and

g. Whether the State Defendants adequately determine if class members are eligible for SLF services.

190. Plaintiffs' claims that the State Defendants' rules, policies and procedures with regards to the SLF Program interfere with or deny their right to housing and services in violation of the FHA, the ADA, and the Rehabilitation Act are typical of the claims of the class in that they arise from the same course of conduct and are based upon the same legal theory.

191. The representative Plaintiffs and counsel will fairly and adequately protect the interests of the class. The representative Plaintiffs do not have interests which are antagonistic to or in conflict with the class. The representative Plaintiffs have retained counsel who are competent and experienced in civil rights laws concerning people with disabilities, fair housing, and class litigation.

192. The class can be properly certified under Fed. R. Civ. P. 23(b)(2) in that the State Defendants have acted or refused to act on grounds generally applicable to the class, thereby making appropriate injunctive relief or corresponding declaratory relief with respect to the class as a whole.

193. A class action is superior to other available methods for the fair and efficient adjudication of this controversy. There are no other considerations that would militate against the maintenance of this case as a class action.

194. In the event that a class is not certified as requested, the Court should still enter

systemic injunctive relief to address the unlawful conduct complained of herein.

COUNT I
Fair Housing Act—Damages and Injunctive Relief
O'Connor, Mormino, and HOPE against Eden Defendants

195. Plaintiffs O'Connor, Mormino, and HOPE reallege and incorporate by reference the allegations contained in paragraphs 1-194 as if fully set forth herein.

196. As set forth above, Plaintiff Kimberly O'Connor is a person with a disability as defined in the Fair Housing Act at 42 U.S.C. §§ 3602(h)(1)-(3) in that she has impairments which substantially limit at least one of her major life activities, she has a history of such impairments, and she was regarded by the Eden Defendants as having such impairments.

197. As set forth above, Plaintiff Tammy Mormino is a person with a disability as defined in the Fair Housing Act at 42 U.S.C. §§ 3602(h)(1)-(3) in that she has impairments which substantially limit at least one of her major life activities, she has a history of such impairments, and she was regarded by the Eden Defendants as having such impairments.

198. As set forth above, HOPE engaged in advocacy and investigation of Eden's conduct towards Ms. O'Connor and Ms. Mormino and of Eden's policies and procedures under the Fair Housing Act.

199. By their actions detailed above, the Eden Defendants have violated Ms. O'Connor's rights under the Fair Housing Act, 42 U.S.C. § 3601 *et seq.*, and its implementing regulations, including 24 C.F.R. § 100.202(c), by discriminating in denial or otherwise making unavailable a dwelling to Ms. O'Connor because of her disability in violation of 42 U.S.C. § 3604(f) and interfering in the exercise or enjoyment of her right to obtain housing and related services and facilities free of discrimination in violation of 42 U.S.C. § 3617, including but not limited to in the following ways:

a. Denying Ms. O'Connor the opportunity to complete her application for a desired dwelling based on disability;

b. Denying Ms. O'Connor an opportunity to rent a desired unit based on disability;

c. Making oral statements to Ms. O'Connor with respect to the rental of a dwelling, that indicate a preference, limitation or discrimination on the basis of disability in violation of 42 U.S.C. § 3604(c); and

d. Making improper inquiries through its Preliminary Application and its oral affirmations of its "No Mental Illness" policy not related to a proper determination of suitability of residency in the facility. Eden's inquiries were improper, discriminatory and beyond and contrary to the scope of its authority under the Supportive Living Program, and failed to properly and narrowly discern appropriateness of residency in accord with the Fair Housing Act.

200. By their actions detailed above, the Eden Defendants have violated Ms. Mormino's rights under the Fair Housing Act, 42 U.S.C. § 3601 *et seq.*, and its implementing regulations, including 24 C.F.R. § 100.202(c), by discriminating in denial or otherwise making unavailable a dwelling to Ms. Mormino because of her disability in violation of 42 U.S.C. § 3604(f) and interfering in the exercise or enjoyment of her right to obtain housing and related services and facilities free of discrimination in violation of 42 U.S.C. § 3617, including but not limited to in the following ways:

a. Denying Ms. Mormino an opportunity to rent a desired unit based on disability;

b. Making oral and written statements to Ms. Mormino with respect to the rental

of a dwelling, that indicate a preference, limitation or discrimination on the basis of disability in violation of 42 U.S.C. § 3604(c); and

c. Making improper inquiries through its Preliminary Application and its oral affirmations of its "No Mental Illness" policy not related to a proper determination of suitability of residency in the facility. Eden's inquiries were improper, discriminatory and beyond and contrary to the scope of its authority under the Supportive Living Program, and failed to properly and narrowly discern appropriateness of residency in accord with the Fair Housing Act.

201. The reasons proffered by Eden for denial of housing to Ms. O'Connor and Ms. Mormino are a pretext for unlawful discrimination.

202. As set forth above, the Eden Defendants' conduct resulted in diversion of resources and frustration of HOPE's mission, in violation of the Fair Housing Act.

203. Plaintiffs seek an injunction against the Eden Defendants specifying compliance with the Fair Housing Act, as set forth more fully below in the Prayer for Relief, and including: (a) elimination of Eden's "No Mental Illness" policy; (b) adoption of an appropriate nondiscrimination policy; (c) training of all Eden staff concerning appropriate application and screening process; (d) modification of Eden's "preliminary" and other application and screening process to comply with the FHA; (e) maintenance of adequate documentation of all program and applicant inquiries; and (f) adoption of policies and practices that ensure complete, proper, and qualified screening of all applicants, regardless of actual or perceived mental health issues.

COUNT II
Americans with Disabilities Act (Title III) – Injunctive Relief
O'Connor and Mormino against Eden Defendants

204. Plaintiffs reallege and incorporate by reference the allegations contained in

paragraphs 1-194 as if fully set forth herein.

205. The Eden Defendants own and operate places of public accommodations, as defined in 42 U.S.C. § 12181.

206. By their conduct as set forth above, the Eden Defendants violated Ms. O'Connor and Ms. Mormino's rights under the Americans with Disabilities Act, 42 U.S.C. § 12182, and its implementing regulations including, but not limited to, in the following ways:

a. Denying Ms. O'Connor and Ms. Mormino opportunities to participate in or benefit from certain of its goods, services, facilities, privileges, advantages and accommodations, because of their disabilities;

b. Refusing to serve and accommodate Ms. O'Connor and Ms. Mormino;

c. Improperly imposing application and eligibility criteria that reject prospective participants and tenants like Ms. O'Connor and Ms. Mormino, who have a mental health diagnosis but are nonetheless suitable tenants;

d. Failing to comply with Appendix F: Participant Rights, of the Illinois § 1915(c) Home and Community-Based Services Waiver; and

e. Failing to make reasonable modifications to its policies, practices, and procedures particularly as to admitting residents like Ms. O'Connor and Ms. Mormino when such modification is necessary to afford Ms. O'Connor and Ms. Mormino the opportunity to benefit from the goods, services, privileges, advantages and accommodations at Eden.

207. Plaintiffs seek an injunction against the Eden Defendants specifying compliance with the Americans with Disabilities Act, as set forth more fully below in the Prayer for Relief, and including: (a) elimination of Eden's "No Mental Illness" policy; (b) adoption of an

appropriate nondiscrimination policy; (c) training of all Eden staff concerning appropriate application and screening process; (d) modification of Eden's "preliminary" and other application and screening process to comply with the ADA; (e) maintenance of adequate documentation of all program and applicant inquiries; and (f) adoption of policies and practices that ensure complete, proper, and qualified screening of all applicants, regardless of actual or perceived mental health issues.

COUNT III
Section 504 of the Rehabilitation Act of 1973 – Damages and Injunctive Relief
O'Connor and Mormino against Eden Defendants

208. Plaintiffs reallege and incorporate by reference the allegations contained in paragraphs 1-194 as if fully set forth herein.

209. Ms. O'Connor and Ms. Mormino are "individual[s] with a disability" under the Rehabilitation Act.

210. Ms. O'Connor and Ms. Mormino are otherwise qualified for the benefit sought from the Eden defendants.

211. Ms. O'Connor and Ms. Mormino were discriminated against solely by reason of their disabilities.

212. The Eden program in question receives federal financial assistance.

213. By their conduct as set forth above, the Eden Defendants violated Ms. O'Connor and Ms. Mormino's rights under the Rehabilitation Act, 29 U.S.C. § 794(a), and its implementing regulations, including, but not limited to, in the following ways:

a. Denying Ms. O'Connor and Ms. Mormino the opportunity to participate and benefit from living at Eden;

b. Excluding Ms. O'Connor and Ms. Mormino from participation in a program

or activity receiving federal financial assistance based on their disabilities;

c. Denying Ms. O'Connor and Ms. Mormino the right to services, programs, and activities in the most integrated setting appropriate to their needs;

d. Denying Ms. O'Connor and Ms. Mormino enjoyment of a dwelling unit in which she is eligible to reside; and

e. Applying discriminatory criteria to Ms. O'Connor and Ms. Mormino, with the effect of defeating the principal goal of assisting people with disabilities in living full and independent lives.

214. Plaintiffs seek an injunction against the Eden Defendants specifying compliance with the Rehabilitation Act, as set forth more fully below in the Prayer for Relief, and including: (a) elimination of Eden's "No Mental Illness" policy; (b) adoption of an appropriate nondiscrimination policy; (c) training of all Eden staff concerning appropriate application and screening process; (d) modification of Eden's "preliminary" and other application and screening process to comply with the Rehabilitation Act; (e) maintenance of adequate documentation of all program and applicant inquiries; and (f) adoption of policies and practices that ensure complete, proper, and qualified screening of all applicants, regardless of actual or perceived mental health issues.

COUNT IV
Fair Housing Act — Injunctive Relief
O'Connor, Mormino, HOPE, and Class Claims against State Defendants

215. Plaintiffs O'Connor and Mormino, both individually and on behalf of a class of similarly situated individuals, and Plaintiff HOPE reallege and incorporate by reference the allegations contained in paragraphs 1-194 as if fully set forth herein.

216. As set forth above, Plaintiff Kimberly O'Connor is a person with a disability as

defined in the Fair Housing Act at 42 U.S.C. §§ 3602(h)(1)-(3) in that she has impairments which substantially limit at least one of her major life activities, she has a history of such impairments, and she was regarded by the State Defendants as having such impairments.

217. As set forth above, Plaintiff Tammy Mormino is a person with a disability as defined in the Fair Housing Act at 42 U.S.C. §§ 3602(h)(1)-(3) in that she has impairments which substantially limit at least one of her major life activities, she has a history of such impairments, and she was regarded by the State Defendants as having such impairments.

218. As set forth above, HOPE engaged in advocacy and investigation of the State Defendants' conduct towards Ms. O'Connor and Ms. Mormino and of the State's policies and procedures under the Fair Housing Act.

219. By their actions detailed above, the State Defendants have violated the rights of Ms. O'Connor, Ms. Mormino, and a class of similarly situated individuals under the Fair Housing Act, 42 U.S.C. § 3601 *et. seq.*, and its implementing regulations, including 24 C.F.R. § 100.202(c), by discriminating in denying or otherwise making unavailable a dwelling because of their disabilities in violation of 42 U.S.C. § 3604(f) and interfering in the exercise or enjoyment of their rights to obtain housing and related services and facilities free of discrimination in violation of 42 U.S.C. § 3617, including, but not limited to, in the following ways:

a. Enacting policies that discriminatorily exclude all persons with a primary or secondary diagnosis of mental illness from Supportive Living Facilities;
b. Applying the undefined phrase "serious and persistent mental illness" discriminatorily in a manner that results in the discriminatory exclusion of individuals with mental health diagnoses from Supportive Living Facilities;
c. Interfering with the provision of housing and services under the HCBS

Waiver to Plaintiffs O'Connor and Mormino and the class;

d. Effectively denying housing and services to Plaintiffs O'Connor and Mormino and the class based on disability or being "regarded as" disabled;

e. Failing to set any standards or procedures that would permit assessment of the suitability for a Supportive Living Facility of an applicant with a mental health diagnosis who might otherwise be qualified for the Supportive Living Program;

f. Enacting policies and procedures that deny due process in disputing exclusion from Supportive Living Facilities based on mental health diagnosis; and

g. Failing to properly inform, train, monitor or guide Supportive Living Facilities, State agencies who conduct DON/PAS screens, and contractors with the State of Illinois who conduct mental health screens concerning the Supportive Living Program in general, and specifically with regards to non-discrimination concerning mental health diagnosis alone, definitions of "serious," "serious and persistent," or "severe" mental illnesses, proper standards of SLF residency suitability, professional standards required in health or mental health screening (not to be undertaken at the SLF level), documentation, or due process considerations.

220. As set forth above, the State Defendants' conduct resulted in diversion of resources and frustration of HOPE's mission, in violation of the Fair Housing Act.

221. Plaintiffs seek an injunction specifying compliance with the Fair Housing Act by the State of Illinois in administering the Medicaid program and, in particular, concerning Illinois HCBS Waiver and Administrative Code Chapter I, Section 146.220.

222. The Illinois HCBS Waiver, the Administrative Code, and all other applicable State policies and procedures should be modified to ensure nondiscrimination based on disability, including actual or perceived mental illness disability, in provision of housing and services under the Supportive Living Program. The Illinois HCBS Waiver and all other applicable State policies and procedures should also be modified to include guidance adequately ensuring that State agencies and providers of supportive housing funded under the HCBS Waiver conduct outreach, advertising, application processes and residency screening in full accordance and compliance with fair housing, including (a) that no inquiries into the nature and severity of a person's disability are made by the SLF and until the appropriate point in the process for properly determining eligibility and need for supportive services, (b) that informed consent will be elicited and provided, (c) that appropriate preadmission screening must be performed and completed in a nondiscriminatory manner by a trained professional; and (d) that Supportive Living Program housing will not be denied based on mental health conditions where the prospective resident is otherwise qualified. This injunctive relief is necessary to further the goals of federal anti-discrimination laws affecting housing and supportive living services, including as were applied to the Plaintiffs in this case illegally and improperly by the Eden Defendants.

COUNT V
Americans with Disabilities Act (Title II) – Injunctive Relief
O'Connor, Mormino, and Class Claims against State Defendants

223. Plaintiffs O'Connor and Mormino, both individually and on behalf of a class of similarly situated individuals, reallege and incorporate by reference the allegations contained in paragraphs 1-194 as if fully set forth herein.

224. As detailed above, the State Defendants administer Illinois's programs affecting licensee Supportive Living Facilities and their participants, which receive federal funding.

225. Administration of the State of Illinois programs affecting Supportive Living Facilities, applicants and participants must comply with the ADA and its implementing Regulations.

226. By their actions detailed above, the State Defendants have violated the rights of Ms. O'Connor, Ms. Mormino, and a class of similarly situated individuals under Title II of the Americans with Disabilities Act, 42 U.S.C. § 12132, and its implementing regulations, by excluding them from participation in and denying the benefits of the services, programs, and activities of the SLF Program and otherwise discriminating against them because of their disabilities, including, but not limited to, in the following ways:

a. Enacting policies that discriminatorily exclude all persons with a primary or secondary diagnosis of mental illness from Supportive Living Facilities;
b. Applying the undefined phrase "serious and persistent mental illness" discriminatorily in a manner that results in the discriminatory exclusion of individuals with mental health diagnoses from Supportive Living Facilities;
c. Interfering with the provision of housing and services under the HCBS Waiver to Plaintiffs O'Connor and Mormino and the class;
d. Effectively denying housing and services to Plaintiffs O'Connor and Mormino and the class based on disability or being "regarded as" disabled;
e. Failing to set any standards or procedures that would permit assessment of the suitability for a Supportive Living Facility of an applicant with a mental health diagnosis who might otherwise be qualified for the Supportive Living Program;
f. Enacting policies that discriminatorily deny individuals with disabilities from

obtaining services, programs, and activities in the most integrated setting appropriate to their needs;

g. Enacting policies and procedures that deny due process in disputing exclusion from Supportive Living Facilities based on mental health diagnosis; and

h. Failing to properly inform, train, monitor or guide Supportive Living Facilities, State agencies who conduct DON/PAS screens, and contractors with the State of Illinois who conduct mental health screens concerning the Supportive Living Program in general, and specifically with regards to non-discrimination concerning mental health diagnosis alone, definitions of "serious," "serious and persistent," or "severe" mental illnesses, proper standards of SLF residency suitability, professional standards required in health or mental health screening (not to be undertaken at the SLF level), documentation, or due process considerations.

227. Plaintiffs seek an injunction specifying compliance with the Americans with Disabilities Act by the State of Illinois in administering the Medicaid program and, in particular concerning Illinois HCBS Waiver and Administrative Code Chapter I, Section 146.220.

228. The Illinois HCBS Waiver, the Administrative Code, and all other applicable State policies and procedures should be modified to ensure nondiscrimination based on disability, including actual or perceived mental illness disability, in provision of housing and services under the Supportive Living Program. The Illinois HCBS Waiver and all other applicable State policies and procedures should also be modified to include guidance adequately ensuring that State agencies and providers of supportive housing funded under the HCBS Waiver conduct outreach, advertising, application processes and residency screening in full accordance

and compliance with fair housing, including (a) that no inquiries into the nature and severity of a person's disability are made by the SLF and until the appropriate point in the process for properly determining eligibility and need for supportive services, (b) that informed consent will be elicited and provided, (c) that appropriate preadmission screening must be performed and completed in a nondiscriminatory manner by a trained professional; and (d) that Supportive Living Program housing will not be denied based on mental health conditions where the prospective resident is otherwise qualified. This injunctive relief is necessary to further the goals of federal anti-discrimination laws affecting housing and supportive living services, including as were applied to the Plaintiffs in this case illegally and improperly by the Eden Defendants.

COUNT VI
Rehabilitation Act– Injunctive Relief
O'Connor, Mormino, and Class Claims against State Defendants

229. Plaintiffs O'Connor and Mormino, both individually and on behalf of a class of similarly situated individuals, reallege and incorporate by reference the allegations contained in paragraphs 1-194 as if fully set forth herein.

230. As detailed above, the State Defendants administer Illinois's programs affecting licensee Supportive Living Facilities and their participants, which receive federal funding.

231. Administration of the State of Illinois programs affecting Supportive Living Facilities, applicants and participants must comply with the Rehabilitation Act and its implementing Regulations.

232. By their actions detailed above, the State Defendants have violated the rights of Ms. O'Connor, Ms. Mormino, and a class of similarly situated individuals under the Rehabilitation Act, 42 U.S.C. § 794, and its implementing regulations, by excluding them from participation in and denying the benefits of the SLF Program and otherwise discriminating

against them because of their disabilities, including, but not limited to, in the following ways:

a. Enacting policies that discriminatorily exclude all persons with a primary or secondary diagnosis of mental illness from Supportive Living Facilities;

b. Applying the undefined phrase "serious and persistent mental illness" discriminatorily in a manner that results in the discriminatory exclusion of individuals with mental health diagnoses from Supportive Living Facilities;

c. Interfering with the provision of housing and services under the HCBS Waiver to Plaintiffs O'Connor and Mormino and the class;

d. Effectively denying housing and services to Plaintiffs O'Connor and Mormino and the class based on disability or being "regarded as" disabled;

e. Failing to set any standards or procedures that would permit assessment of the suitability for a Supportive Living Facility of an applicant with a mental health diagnosis who might otherwise be qualified for the Supportive Living Program;

f. Enacting policies that discriminatorily deny individuals with disabilities from obtaining services, programs, and activities in the most integrated setting appropriate to their needs;

g. Enacting policies and procedures that deny due process in disputing exclusion from Supportive Living Facilities based on mental health diagnosis; and

h. Failing to properly inform, train, monitor or guide Supportive Living Facilities, State agencies who conduct DON/PAS screens, and contractors with the State of Illinois who conduct mental health screens concerning the Supportive Living Program in general, and specifically with regards to non-

discrimination concerning mental health diagnosis alone, definitions of "serious," "serious and persistent," or "severe" mental illnesses, proper standards of SLF residency suitability, professional standards required in health or mental health screening (not to be undertaken at the SLF level), documentation, or due process considerations.

233. Plaintiffs seek an injunction specifying compliance with the Rehabilitation Act in Illinois's administration of the Medicaid program and, in particular concerning Illinois's HCBS Waiver and Administrative Code Chapter I, Section 146.220.

234. The Illinois HCBS Waiver, the Administrative Code, and all other applicable State policies and procedures should be modified to ensure nondiscrimination based on disability, including actual or perceived mental illness disability, in provision of housing and services under the Supportive Living Program. The Illinois HCBS Waiver and all other applicable State policies and procedures should also be modified to include guidance adequately ensuring that State agencies and providers of supportive housing funded under the HCBS Waiver conduct outreach, advertising, application processes and residency screening in full accordance and compliance with fair housing, including (a) that no inquiries into the nature and severity of a person's disability are made by the SLF and until the appropriate point in the process for properly determining eligibility and need for supportive services, (b) that informed consent will be elicited and provided, (c) that appropriate preadmission screening must be performed and completed in a nondiscriminatory manner by a trained professional; and (d) that Supportive Living Program housing will not be denied based on mental health conditions where the prospective resident is otherwise qualified. This injunctive relief is necessary to further the goals of federal anti-discrimination laws affecting housing and supportive living services, including as

were applied to the Plaintiffs in this case illegally and improperly by the Eden Defendants.

JURY TRIAL DEMAND

Plaintiffs hereby demand a trial by jury on Counts I and III.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs respectfully pray that the Court grant them the following relief:

A. Enter a declaratory judgment that the Eden Defendants' unlawful discriminatory conduct has injured Plaintiffs O'Connor, Mormino, and HOPE in violation of the Fair Housing Act of 1968, as amended, 42 U.S.C. § 3601 *et seq.*;

B. Enter a declaratory judgment that the Eden Defendants' unlawful discriminatory conduct has injured Plaintiffs O'Connor and Mormino in violation of the Americans with Disabilities Act, 42 U.S.C. § 12101 *et. seq.*;

C. Enter a declaratory judgment that the Eden Defendants' unlawful discriminatory conduct has injured Plaintiffs O'Connor and Mormino in violation of the Rehabilitation Act, 29 U.S.C. § 794;

D. Grant a permanent injunction ordering the Eden Defendants, their officers, successors, assigns and all persons in active concert or participating with them, to cease and desist from any of the conduct found by this Court to be discriminatory;

E. Grant a permanent injunction directing that the Eden Defendants take all affirmative steps necessary to remedy the effects of the illegally discriminatory and retaliatory conduct alleged in this Complaint and to prevent repeated occurrences in the future. Such affirmative steps should include but are not limited to the following:

1. Eliminate use and application of Eden's "No Mental Illness" policy;

2. Develop appropriate criteria for pre-admission screening of SLF residents based solely on resident suitability factors (e.g. tenant history, criminal background check, etc.);

3. Adopt a non-discrimination policy prohibiting discrimination based on mental health and/or mental illness;

4. Refrain from inquiring about SLF resident medication lists and diagnoses in the application process;

5. Refrain from applying or inquiring about eligibility criteria that will be evaluated by licensed State officials during the Determination of Needs screening and refer all SLF applicants who appear to need SLF services to proper licensed DON/PAS screening agents, regardless of mental health status;

6. Refrain from requiring individuals transferring from a nursing home to have a duplicate DON/PAS screen; and

7. Accept and fully process the applications of Ms. O'Connor and Ms. Mormino in a nondiscriminatory manner;

F. Enter an order certifying Plaintiffs Kimberly O'Connor and Tammy Mormino as representatives for a class consisting of all persons in the State of Illinois who have been improperly deterred, excluded, or rejected from SLF services and housing based on mental health diagnosis;

G. Enter a declaratory judgment that State Defendants' failure to provide Plaintiffs and the class with housing and services, including but not limited to, in the most integrated setting appropriate to their needs, violates the FHA, ADA, and Rehabilitation Act;

H. Grant a permanent injunction directing that the State Defendants take all affirmative steps necessary to remedy the effects of the illegally discriminatory and retaliatory conduct alleged in this Complaint, including to address incomplete DON and PAS/MH screenings of the rejected and deterred Plaintiffs and class members to ensure nondiscriminatory screenings and suitability determinations occur, to prevent repeated occurrences in the future,

and to require full compliance with the FHA, the ADA, and the Rehabilitation Act. Such affirmative steps should include *but are not limited to* the following:

1. Eliminate all language in Supportive Living Program-related policies and procedures that states or suggests that persons should or may be excluded from an SLF based on diagnosis of mental illness alone, including:
    i. Illinois HCBS SLF Waiver Appendix B-1;
    ii. 89 Ill. Administrative Code §146.220;
    iii. Supportive Living Program Handbook, § C-230;
    iv. Supportive Living Program Website;
    v. June 22, 2011 Informational Notice issued by HFS and Governor Quinn;
    vi. SLF Resident Fact Sheet (HFS, Governor Quinn);
    vii. Preadmission Screen/Mental Health (PAS/MH) Contractor's Procedure Manual (DHS Division of Mental Health); and
    viii. Supportive Living Program Commonly Asked Questions and Answers (HFS);
2. Adopt a nondiscrimination statement applicable to the Supportive Living Program: *The State of Illinois, in the operation of its Home and Community Based Services Waiver Programs, does not discriminate against individuals on the basis of mental illness or being regarded as having a mental illness. A mere diagnosis of mental illness does not automatically preclude an individual from any Waiver Program. Illinois is committed to serving individuals with mental illnesses in the most integrated setting appropriate*;
3. Replace 89 Ill. Adm. Code § 146.220 with: "Potential residents will be screened for (a) residency suitability by the SLF and (b) program suitability (physical disability/determination of needs) by licensed agents of the Department of Human Services Division of Rehabilitation Services (ages 22-59) or Department on Aging (60 or older);
4. Replace language in Illinois-inserted text of SLF Waiver Appendix B-1 with: "Individuals must be found to be in the target group, physical disability, and otherwise be found suitable for residency in an SLF based on their tenant or residential history and background." (See Exhibit 2, p. 23);
5. Replace Section C-230 of the Supportive Living Program Handbook with: "To be eligible for the HCBS Waiver, an individual must be a member of the HCBS

Waiver Target Group because of a physical disability or disabilities (that will require waiver services). An individual who otherwise qualifies for the waiver may not be denied or disqualified from eligibility on the basis of developmental disability or mental health diagnosis, impairment or disability;"

6. Modify Supportive Living Program Website as follows: "To be eligible for the HCBS Waiver, an individual must be a member of the HCBS Waiver Target Group because of a physical disability or disabilities (that will require waiver services). An individual who otherwise qualifies for the waiver may not be denied or disqualified from eligibility on the basis of developmental disability or mental health diagnosis, impairment or disability;"

7. Replace discriminatory language in the June 22, 2011 Informational Notice (Exhibit 3) or issue new Informational Notice as follows: "All applications will be received and processed by SLFs and all applicants will be afforded appropriate screening processes concerning suitability. Potential residents will be screened for (a) residency suitability by the SLF (e.g. tenant history, criminal record, financial need/ability to pay costs, etc.) and (b) program suitability (physical disability determination of needs) by licensed agents of the Department of Human Services Division of Rehabilitation Services (ages 22-59) or Department on Aging (60 or older). SLF staff should not engage in health or mental health screening, only residency-appropriateness screening. SLFs should develop proper tenant and program applications and residential background screening documents and processes, for approval by HFS, in accord with the State's SLF non-discrimination statement. Once an applicant passes the SLF-level initial residency suitability screening, they will be referred based on their age by the SLF to the proper State Department concerning a Determination of Needs/program suitability screening. The fact that an individual has been diagnosed with a mental illness does not automatically prevent that individual from applying to or living in an SLF. The DON/PAS screener should complete the DON for an SLF applicant as regards the applicant's physical disability. If a DON/PAS screener suspects the SLF applicant has a mental illness, they will, once the DON screen is complete, refer the applicant to the DHS Division of Mental Health using the OBRA-1. The Division of Mental Health will undertake a full Level II screen and determine whether the individual may appropriately live in the SLF based on appropriate criteria on a case-by-case basis. DHS Division of Mental Health may determine whether an individual applying to the Supportive Living Program with a mental illness could be linked with other mental health services, in addition to or instead of the Supportive Living Program;"

8. Eliminate the following from the SLF Resident Fact Sheet: "is without a primary or secondary diagnosis of developmental disability or serious and persistent mental illness;"

9. Replace discriminatory language in the DHS Division of Mental Health Contractor's Procedure Manual at p. 8 concerning the Supportive Living Program

with: "PAS/MH Contractors receiving OBRA-1 referrals concerning SLF applicants will determine whether an individual suspected of or having mental illness who also has a physical disability and has received a DON screen may nonetheless be suitable to live in a Supportive Living Facility, using a description of the services provided under the Supportive Living Program. In the event an SLF applicant is deemed by DHS Division of Mental Health suitable or unsuitable for residence in an SLF, and also has a mental illness, DHS Division of Mental Health shall determine whether the individual could be linked with mental health services." (See Exhibit 4);

10. Modify the Response to Question 65 of the Supportive Living Program Frequently Asked Questions and Answers to eliminate language allowing diagnosis-based rejection of SLF applicants with mental health diagnoses and insert language consistent with the modified Informational Notice, Contractor's Procedure Manual, and nondiscrimination statement;

11. Modify the HFS 2536 Interagency Certification of Screening Results form as needed to include certification of the Division of Mental Health concerning suitability for Supportive Living Facility Placement after a Level II mental health screen of an SLF applicant (in addition to the DON screen);

12. Require Supportive Living Facilities to annually certify compliance with all applicable non-discrimination laws as both service and housing providers, including the Fair Housing Act, ADA and Rehabilitation Act;

13. Provide instructional materials and training to DON/PAS screeners and DHS Division of Mental Health-contracted screening agencies concerning Supportive Living Program requirements, and non-discrimination based on mental illness;

14. Implement criteria for DHS Division of Mental Health screeners to determine whether a person with a mental illness who also has a physical disability is suitable for a Supportive Living Facility as a "level of care;"

15. Implement sufficient due process notice and hearing procedures concerning Supportive Living Facility applicants determined unsuitable for the Supportive Living Program, including, but not limited to, on the basis of mental health condition;

16. Modify the UHS System to make applicable to the Supportive Living Program and/or provide instructions for Level II screeners as to how to utilize the existing Illinois UHS data base screens, determinations and form letters, in the context of an SLF applicant suspected of having a mental illness, and/or modify the UHS data base to include: documentation of the application of criteria to determine whether an SLF applicant who also has a mental illness is nonetheless suitable for the SLP Program; a determination of "level of care" that includes Supportive Living Facility; a list of Supportive Living Facilities to which a person screened may be referred; generation of a Determination that applies to suitability or lack

thereof to a Supportive Living Facility that includes a statement of the rationale and notification of appeal rights sufficient to afford due process; and transmittal of screening results for SLF applicants to the referring agency (OBRA -1 referral source) and/or SLF facility (if appropriate); billing for SLF-related screens, and tracking of the numbers of SLF applicants screened and screening outcomes; and

17. Publicize and advertise implementation of the above affirmative relief to all applicable State employees, Illinois Supportive Living Facilities, PAS/MH screeners, referring facilities and institutions, and the public.

I. Award such damages against the Eden Defendants under the Fair Housing Act of 1968, as amended and Section 504 of the Rehabilitation Act as will fully compensate Plaintiffs for their injuries incurred as a result of Eden Defendants' discriminatory housing practices and conduct alleged herein;

J. Award such punitive damages against the Eden Defendants as are proper under law to punish them for their malicious and recklessly indifferent conduct alleged herein and to effectively deter similar conduct in the future, pursuant to 42 U.S.C. § 3613(c)(1);

K. Award Plaintiffs their costs and attorneys' fees incurred herein, pursuant to 42 U.S.C. § 3613(c)(2), 42 U.S.C. § 12205, and 29 U.S.C. § 794a(b);

L. Award Plaintiffs all other applicable relief available to them under the Fair Housing Act, the Americans with Disabilities Act and Section 504 of the Rehabilitation Act; and

M. Grant such other relief as the Court deems appropriate.

Respectfully submitted,

/s/ Jennifer K. Soule
One of Plaintiffs' Attorneys

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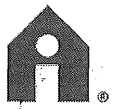
Exhibit 1



ILLINOIS HOUSING
DEVELOPMENT AUTHORITY

ILLINOIS HOUSING DEVELOPMENT AUTHORITY

LOW INCOME HOUSING TAX CREDIT COMPLIANCE REFERENCE GUIDE

Effective 1/01/2002

ILLINOIS HOUSING
DEVELOPMENT AUTHORITY

ILLINOIS HOUSING DEVELOPMENT AUTHORITY LOW INCOME HOUSING TAX CREDIT COMPLIANCE REFERENCE GUIDE

INTRODUCTION

This document is a reference guide for compliance with the Low Income Housing Tax Credit (LIHTC) Program under Section 42 of the Internal Revenue Code of 1986, as amended (*the Code*), for developments allocated Credits by Illinois Housing Development Authority (IHDA). It is intended for the use of owners, developers, management companies, and on-site management personnel. It is a supplement to existing federal law and regulations regarding LIHTC compliance. Questions regarding the content of this document should be directed to:

Illinois Housing Development Authority
401 N. Michigan Avenue, Suite 700
Chicago, Illinois 60611
(312) 836-5200

ATTN: Technical Services Department

DISCLAIMER

This Compliance Reference Guide (The Guide) is intended as a general guide to some of the requirements of the federal LIHTC Program under the Code, which are monitored by (IHDA). It is intended to assist developers, owners, and managers of LIHTC properties which were allocated Credits by IHDA, in understanding their obligations under the LIHTC Program. However, this information is presented as guidance regarding compliance with the Code and is not a substitute for legal and accounting advice as to compliance with Section 42 and applicable Treasury regulations, rulings and issuances. The U.S. Internal Revenue Service (IRS) is responsible for interpreting and applying the Code. IHDA makes no representation as to the, accuracy or completeness of the information contained herein, or in the interpretations provided, and advises all of the LIHTC Program participants to consult with their own tax professionals to assure that they and their projects are in compliance with all applicable federal requirements.

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I. TAX CREDIT REQUIREMENTS

A. General Comments

In 1986, Congress enacted the Tax Reform Act creating the Low Income Housing Tax Credit Program. The Program is authorized and governed by the 1986 Tax Reform Act as amended and Section 42 of the Code. The purpose of the Act is to encourage the construction and rehabilitation of housing for low and moderate-income individuals and families.

The Tax Credit is a dollar for dollar reduction in tax liability to the owner of a qualified low-income housing development for the acquisition, rehabilitation, or construction of low-income rental housing units. The amount of the Credit allocated is based directly upon the number or size of qualified low-income units that meet federal rent and income targeting requirements.

The IRS is responsible for program oversight nationwide. State and local government issuers of Tax Credits are responsible for the actual administration. Under the law, each state is required to designate a Ahousing credit agency@ to allocate and monitor the Credits. In Illinois, the agencies designated are IHDA and the City of Chicago, which has authority within the corporate limits of Chicago.

IHDA is required under Section 42(*m*)(1)(*B*)(*iii*) of the Code, to monitor projects for compliance with the requirements of Section 42 of the Code and report instances of non-compliance to the IRS. This requirement applies to all buildings placed in service for which the LIHTC is, or has been claimed at any time.

Compliance with the Code is the responsibility of the owner of the building for which the Credit is allowable. IHDA's obligation to monitor for compliance with these requirements does not make IHDA liable for the owner's non-compliance.

B. Placed In Service

The owner's responsibilities for Tax Credit compliance begin when a building is placed in service. Placement in service is defined as:

- *New Construction* - when a certificate of occupancy is issued for the first unit in a building;
- *Acquisition* - for an occupied or habitable building, the date of title transfer; and,
- *Rehabilitation* - a date selected by the owner as the last day of a 24-month period within which rehabilitation expenditures are aggregated.

Subsequent to a building being placed in service, IRS Form 8609 for that building is issued to the owner by IHDA.

C. Set-Aside Requirements

Each project that participates in the LIHTC must set-aside a minimum portion of the project units for low or very low-income tenants. The minimum set-asides are as follows:

- 20% of the units must be set-aside for households earning 50% or less of the area median income (very low); or,
- 40% of the units must be set-aside for households earning 60% or less of the area median income (low).

The choice as to which minimum set-aside to satisfy (e.g., 20/50 or 40/60) is made by the project owner and is determined on a project basis. In addition, the owner may elect to set aside additional units, up to 100% of the total units in the project, for low-income tenants, in which event Tax Credits will be based upon the larger proportion of low-income units. An actual percentage of low-income units must be established for each building in a project no later than the time of issuance of IRS Forms 8609. Thereafter, recapture of Tax Credits and other compliance issues are normally determined on a building basis. The project must satisfy both the minimum set-aside requirement and the actual percentage of low-income units selected throughout the compliance period.

D. First Year Requirements

For a property to qualify to claim Credits the owner must have a minimum number of units set aside for low-income tenants and which are rent-restricted. These units are defined as low-income units under the Code. If the project does not meet the minimum set aside at the end of year the building/project was placed in service, the owner must wait until the

next year to claim the credits. Once the minimum set aside has been selected, it is irrevocable.

The first year's compliance is the most critical. Failure to meet the minimum set aside within the initial compliance period disqualifies the project as an LIHTC. Initial compliance with the minimum set aside must be met no later than December 31 of the second year in which the building(s) was placed in service.

II. MANAGEMENT ACTIVITIES

Management Agent

If the owner uses the services of a management agent, the management agent is responsible to the owner for compliance with the LIHTC Program requirements, but this does not relieve the owner from its obligation to assure that all program requirements are met. Persons authorized to lease apartment units to tenants should be familiar with all federal laws and IHDA requirements governing tenant certification, recertification and leasing procedures.

A. Renting Vacant Qualified Units

If an owner elects any set-aside other than 100% of the units, thereby creating market rate units, they are required to adhere to a specific policy concerning the renting of vacant qualified units. When a qualified unit is vacated, the owner must rent the unit or any available unit of comparable or smaller size, whether >qualified or not, to tenants having a qualifying income, and may not rent any units in the project to tenants not having a qualifying income (market rate tenant) until a unit has actually been rented to low-income tenants. When both market rate and low-income apartments are vacant, low-income units (of comparable or smaller size) should be rented first until the project has the correct proportion of low-income units. Managing agents should delay leasing available market rent units until demonstrating reasonable attempts to fill vacant qualified units. This policy is designed to insure that ownership maintains the chosen set-aside throughout the compliance period. (Note that under the current law and Treasury Regulations, the rule governing vacant units applies on a *project* basis, while the rule governing over-income units, discussed below, applies *building-by-building*

B. Certification of Applicants

Owners are required, by the Code regulations, to certify and verify that the income listed on all prospective tenant applications, does not exceed maximum income limitations. Prior to occupancy, the owner must verify the tenant's income and assets (to accurately determine income derived from such assets) by obtaining a written verification of income and assets

and require the tenant to sign a certification. The maximum income limitations, based on HUD median income data, are published yearly by IHDA.

IHDA requires owners to use IHDA Form TST-3 Annual Income Certification/Recertification attachment #4 of this manual to certify tenant income.

C. Recertification of Tenants

Owners are required annually to recertify the eligibility of the household for the low-income unit. The owner must verify the income of all occupants of the unit and the household size. The recertification must be completed within 12 months of the most recent certification.

IHDA requires owners to use IHDA Form TST-3 Annual Income Certification/ Recertification Attachment #4 of this manual in completing tenant recertification.

D. Household's Income Increases Above Income Limit

When any low-income tenant's income rises above 140% of the allowable level, the property agent must lease the next available (comparable or smaller) unit in the building to a qualified person.

1) If a building has fewer than 100% low-income units, a unit in which the tenant exceeded the income limit by more than 140% can cease to be treated as a low-income unit once another unit has been rented to a qualifying tenant and the building has returned to the proper percentage of low-income units. In that case, the over-income tenant can remain in occupancy, but may not be counted in the calculation of low-income units and, subject to lease terms, may be charged market-rate rents. A unit with a tenant whose income does not rise above 140% of the income limit shall continue to be treated as a low-income unit if the income of the occupants initially met such income limit and the unit continues to be rent- restricted.

2) For buildings that are 100% low-income and qualify for Credits on all units, the next available unit must always be rented to an income eligible tenant and all units must be rent-restricted. If a tenant's income rises above 140% of the allowable level, that unit remains rent-restricted also.

E. Change In Household Size

A unit in which tenant incomes exceed the applicable income limit because of a change in household size is treated the same as one in which the tenant exceeds the income limit because of an increase in income. The unit may continue to be counted toward satisfaction of the low-income requirement as long as the unit continues to be rent-

restricted and the next unit in the building of comparable or smaller size is rented to a qualified low-income tenant.

If a tenant has occupied a unit for a length of time and decides to add a roommate, prior to move-in of a new person, management must determine whether the unit may continue to qualify as low-income using the income limits in effect at the time the roommate is to be added. Increases in a lower-income household's aggregate income to greater than 140% of the applicable limit (adjusted for family size) will not result in disqualification as long as the unit continues to be rent-restricted and the next unit in the building of comparable or smaller size is rented to a qualified lower-income tenant.

F. Students

Households where all of the members are full-time students are not eligible tenants and units occupied by these households may not be counted as low-income units. A full-time student is defined by Section 151(c)(4) of the Code as an individual who during at least five calendar months of the year is a full time student at a regular educational institution.

There are four exceptions to the full-time student restrictions; however only one must be met for the household to qualify for the tax credit program.

1. At least one member receiving assistance under Title IV of the Social Security Act (AFDC or its successor under welfare reform).

2. The household consists of single parents and their children and such parents and children are not dependents of another individual.

3. All members of the household are married and file a joint tax return.

4. At least one person of the household is a participant in a job-training program receiving assistance under the Job Training Partnership Act or similar federal, state or local laws

G. Unit Transfers

If a low-income tenant (including an over-income tenant) moves to a new unit within the same building, the new unit assumes the low-income status of the moving tenant. Thus, no recertification or requalification of low-income tenants is required for moves within a building. Should an existing tenant wish to transfer to a unit in a different building, the tenant(s) must be treated as a new move-in, following all application, verification and certification procedures. Income limits (adjusted for family size) at the time of the move will determine if the new unit will be counted as lower-income according to federal regulations.

H. Maximum Rental Charges

1) Developments participating exclusively in the LIHTC Program

In order to be claimed as a *qualified unit*, the gross rent (the rent plus a utility allowance determined as described below) must not exceed 30% of the applicable income limitation. Failure to restrict the rent of a unit will result in ineligibility for the Section 42 Credit, reduction in the amount of the Credit, and/or recapture of previously allocated Credits. Maximum rent limitations, based on HUD median income data, are published yearly by IHDA.

The maximum gross rents, for projects with Tax Credits allocated in calendar years 1987, 1988 and 1989 (pre-1990), are determined using a different formula. In these cases, the maximum gross rent, for a qualified unit, is based on the current tenant's family size and the maximum annual income limit for that size family. Therefore, the gross rent cannot exceed 30% of 1/12th of the maximum qualifying income for a household of the size actually occupying the unit. This means that, for an individual unit, the maximum rent can change each time a new household occupies the unit. (The income limit will be 50% or 60% of median, adjusted for household size, depending upon whether the owner chose the 20/50 minimum set-aside or the 40/60 set-aside.)

Owners of pre-1990 projects were permitted to make a one-time irreversible election, to follow the imputed income limit approach (as described below), rather than the family size convention. This election must have been made by February 7, 1994.

For purposes of post-1989 Tax Credit projects, rent restrictions are based upon 30% of an "imputed income limitation applicable to a unit". The maximum gross rent for a unit is based on the bedroom size. It is calculated by using the maximum household income limit, which would apply to a typical family occupying the unit, and assuming the number of individuals occupying the unit are as follows:

- In the case of a unit which does not have a separate bedroom, e.g. studio or efficiency, = 1 individual;
- In the case of a unit which has 1 or more separate bedrooms, = 1.5 individuals for each separate bedroom.

When the applicable family size is not a whole number, i.e. 1 bedroom = 1.5 or 3 bedroom = 4.5, the maximum annual income limit is determined by adding the two limits for the smaller and larger families (1 bedroom = 1 person limit plus 2 person limit) and dividing by 2. Finally, the applicable maximum annual income limit is divided by 12 and then multiplied by 30%. The resulting answer is the maximum gross rent for all qualified units of that size.

2) Projects participating in the LIHTC Program and other federal housing programs

A) Project Based Section 8 and Section 8 Certificate and/or Voucher holders: The rental payment, calculated using the Section 8 Program formula, is always to be considered the proper and applicable rental payment. This is true even if the household's rental payment exceeds the maximum permissible rent published for the Tax Credit Program. A unit, occupied by a Section 8 tenant, whose rental payment has exceeded the maximum permissible under the Tax Credit program, is still considered a qualified unit.

B) Rural Development or Farmers Home Administration (FmHA) 515: For properties issued Housing Credits in 1991 or later, the owner may charge the higher of the maximum permissible tax credit rent and the FmHA 515 >basic rent. When the higher figure is the FmHA basic rent, it is considered an Aovercharge@ and the difference must be refunded to the FmHA. For properties issued Housing Credits in 1990 and before, only the lower tax credit maximum rent may be charged.

I. Cost Of Services Included In Rent

The cost of any services, that are required to be paid by a tenant as a condition of occupancy, generally must be included in the gross rent for purposes of applying the gross rent limitation of Section 42(*g*)(*2*) of the Code. A service is generally considered to be optional if payment for the service is not required as a condition of occupancy. Payments to owners by persons other than the tenant for certain supportive tenant services in Aspecial needs housing@ will not be considered as part of gross rent or counted against the maximum rents under the tax credit program.

Where multiple services are provided, the owner must decide which services are mandatory and included in the gross rent. All other services must be provided on an optional basis.

J. Utility Allowance Computation

Per Treasury Regulations section 1.42-10, Agross rent@ for tax credit units must include an allowance for the cost of any utilities, other than telephone and cable TV, which are paid directly by the tenant. When a property is participating exclusively in the LIHTC Program, the utility allowance should be based on data obtained from either the local Public Housing Authority or the local utility company.

For projects participating in the LIHTC Program **and** other Federal Programs, which require a utility allowance, Section 42 requires the owner to use the methodology required by the other Federal Program. For example:

- In a HUD regulated building, use the HUD approved utility allowance.
- In an RD (FmHA) regulated building, use the RD approved allowance.

- In a building with both HUD and RD tenants use RD approved allowance.
- In a conventional building with Section 8 Certificates or Vouchers, use PHA approved allowances.

In the case where either the building or any tenant in the building receives FmHA housing assistance, the owner must apply Farmers Home Administration (FmHA) utility allowances to any rent-restricted unit in a building.

Per IRS Notice 89-6, utility allowances should be updated at the time rents are revised and must be put into effect within 90 days of receipts.

K. Fair Housing Act

Under current IRS interpretations, owners are required under the general use requirement to comply with the Fair Housing Act. The Act prohibits discrimination in the sale, rental and financing based on race, color, religion, sex, national origin, familial status, and disability. It also mandates specific design and construction requirements for multifamily housing built for first occupancy after March 13, 1991. The failure of low-income housing credit properties to comply with the requirement of the Fair Housing Act will result in the denial of the tax credits on a per-unit basis.

III. OWNER'S ACTIVITIES

A. Record Keeping

The owner of a low-income housing project must keep records for each qualified low income building in the project that shows for each calendar year in the compliance period:

- The total number of residential rental units in the building (including the number of bedrooms and the size in square feet of each residential rental unit);
- The percentage of residential rental units in the building that are low income units;
- The rent charged on each residential rental unit in the building (including any utility allowances);
- The number of occupants in each low income unit, but only if rent is determined by the number of occupants rather than on the basis of unit size;
- The low income unit vacancies in the building and information that shows when, and to whom the next available units were rented;

- The annual income certification of each low income tenant, per unit;

- Documentation to support each low-income tenant's income certification (*for example, a copy of the tenant's federal tax return, Forms W-2, or verifications of income from third parties such as employees or state agencies paying unemployment compensation*). As shown above, tenant income is calculated in a manner consistent with the determination of annual income under the HUD Section 8 program, not in accordance with the determination of gross income for federal income tax liability. If a tenant receives housing assistance payments under Section 8, the documentation requirement is satisfied if the public housing authority provides a statement to the building owner declaring that the tenant's income does not exceed the applicable income limit under Section 42(*g*) of the Code;

- The eligible basis and qualified basis of the building at the end of the first year of the credit period; and,

- The character and use of the nonresidential portion of the building included in the building's eligible basis under Section 42(*d*) of the Code (*e.g., tenant facilities that are available on a comparable basis to all tenants and for which no separate fee is charged for use of the facilities, or facilities reasonably required by the project*).

B. Record Retention

The owner is required to retain the records described above for each building in the project for at least six (6) years after the due date (with extensions) for filing the federal income tax return for that year. The records for the first year of the credit period, however, must be retained for at least six (6) years beyond the due date (with extensions) for filing the federal income tax return for the last year of the compliance period of the building.

C. Certifications

The owner of a low income housing project must certify, at least annually, to IHDA for the preceding twelve (12) month period, that the project meets and has met the requirements of Section 42 of the Code, and provide such additional information as may be required by Treasury Regulations or IHDA procedures. This certification must be in the format prescribed by IHDA, Forms TST-1 & TST-1A.

IV. ANNUAL INCOME AND ASSETS

Annual income is the anticipated total income from all sources received by the family head and spouse (even if temporarily absent) and by each additional member of the household, including all net income derived from assets for the 12-month period following the effective date of certification of income, exclusive of certain types of income as provided below.

A. Annual Income Includes

A determination of anticipated annual income must include all of the types of income listed below.

- Gross amount (before any payroll deductions) of wages, salaries, overtime pay, commissions, fees, tips, bonuses, and any other compensation for personal services;
- Net income, salaries, and other amounts distributed from a business or profession;
- Gross amount (before deductions for Medicare, etc.) of periodic social security payments. Includes payments received by adults on behalf of minors or by minors for their own support;
- Annuities, insurance policies, retirement funds, pensions, disability or death benefits and other similar types of periodic payments;
- Lump sum payments received because of delays in processing unemployment, social security, welfare or other benefits;
- Payments in lieu of earnings, such as unemployment and disability compensation, workers' compensation, and severance pay. Any payments that will begin during the next twelve months are to be included;
- Welfare Assistance - If the payment includes an amount specifically designated for shelter and utilities that is subject to adjustment by the welfare agency in accordance with the actual cost of shelter and utilities, the amount of welfare assistance income to be included as income shall consist of:
    - the amount of the allowance or grant exclusive of the amount specifically designated for shelter or utilities; plus,

- the maximum amount that the welfare agency could, in fact, allow the family for shelter and utilities. If the family's welfare assistance is ratably reduced from the standard of need by applying a percentage, the amount calculated under this paragraph shall be the amount resulting from one application of the percentage.

- Alimony and child support received from persons not residing in the household;

- Interest, dividends, and other income from net family assets (including income distributed from trust funds). On deeds of trust or mortgages, only the interest portion of the monthly payments received by the applicant is included;

- Amounts by which educational grants, scholarships or Veteran's Administration benefits are intended as a subsistence allowance to cover rent, utility costs, and board of a student living away from home;

- Housing allowances for active duty military personnel;

- Lottery winnings paid in periodic payments (a lump sum payment is included in net family assets, not annual income); and,

- Recurring monetary contributions or gifts regularly received from persons not living in the unit, including rent or utility payments regularly paid on behalf of the family. This can include individual rent concessions or payments that are similar to *in-kind* payments for services rendered or to be rendered.

B. Annual Income Excludes

Certain income sources should not be included in annual income such as:

- Employment income of children (including foster children) who are under eighteen. The head of household and spouse are not considered Achildren@ for this purpose. (Unearned income such as social security payments received on behalf of minors must be included as income.);

- Food stamps, meals on wheels or any other program that provides goods for the needy;

- Income for persons who live in the unit but are not household members. Examples include:
  - payments received for care of foster children; and,
  - income of live-in attendants.
- The principal portion of the payments received on mortgages or deeds of trust;
- Scholarships or veteran benefits used for tuition, fees, books or equipment. Student loans are not considered income;
- Hazardous duty pay to a family member in the military;
- Lump sum additions to family assets such as inheritances cash from the sale of assets, one time lottery winnings, workmen's compensation, or settlement for personal or property losses;
- Temporary, nonrecurring or sporadic income;
- Payments, rebates, or credits received under Federal Low-Income Energy Assistance Programs. Includes any winter differentials given to elderly;
- Payments received under training programs funded by HUD;
- Payments received after January 1, 1989, from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation;
- Other forms of income excluded by federal statute;
- Amounts paid by a State Agency to a family with a developmentally disabled family member living at home to offset the cost of services and equipment needed to keep the developmentally disabled family member at home;
- Full amount of Student Financial Assistance;
- Earnings in excess of $480 for each full-time student 18 years old or older (excluding the head of household and spouse/co-head);
- Adoption Assistance Payments in excess of $480 per adopted child;
- Amounts received by the family in the form of refunds or rebates under the state or local law for property taxes paid on the dwelling unit.

- State or Local Employment Training Programs and Training of Resident Management Staff;
- Resident Service Stipends;
- Adult Foster Care Payments;
- Deferred Periodic Payments of SSI and Social Security received in a lump sum; and
- Grants or other amounts received specifically for:
  - auxiliary apparatus for a handicapped person;
  - expenses for attendant care provided by other than a family member living in the household;
  - medical expenses;
  - set aside for use under a Plan to Attain Self Sufficiency (PASS) and excluded for purposes of Supplemental Security Income (SSI) eligibility; and,
  - out of pocket expenses for participation in publicly assisted programs and only to allow participation in these programs. These expenses include special equipment, clothing, transportation, childcare, etc.

C. Assets Include

Assets are items of value, other than necessary personal items, and are considered along with verified income in determining the eligibility of a household. Assets include:

- Cash including amounts held in savings and checking accounts, safety deposit boxes, etc.;
- Trusts - Include the principal value of any trust available to the household. Do not include irrevocable trusts or trusts that no family member can control. An example of an irrevocable trust is a trust fund established for a son or daughter prior to the parent's death. The benefactor receives only the interest from the trust during his/her lifetime and cannot withdraw the principal;

- Equity in Real Estate or other Capital Investments - Include the current market value less any unpaid balance on any loans secured by the property and any reasonable costs that would be incurred in selling the asset such as prepayment penalties or broker fees;

- Stocks, Bonds, Treasury Bills, Certificates of Deposit, and Money Market Funds;

- Individual Retirement (IRA) and Keogh Accounts;

- Retirement and Pension Funds:

  - while the person is employed, include only amounts the family can withdraw without retiring or terminating employment; and,

  - at retirement or termination of employment, if benefits will be received in a lump sum, include the benefits in assets. If benefits are paid in periodic payments, include the benefits in annual income.

- Lump sum receipts should include inheritances, capital gains, one-time lottery winnings, settlements on insurance and other claim (do not include lump sum receipts that must be counted as income);

- Personal property held as an investment such as gems, jewelry, coin collections, antique cars, paintings, etc.;

- Assets owned by more than one person should be prorated according to the percentage of ownership.

D. *Assets Do Not Include*

- Necessary personal property (e.g., clothing, furniture, automobiles, etc.);

- Vehicles specially equipped for the handicapped;

- Interest in Indian Trust Land;

- Life insurance policies;

- Equity in the cooperative unit in which the family lives;

- Assets that are part of an active business (the exception does not include rental of properties that are held as investments and not a main occupation.);

- Assets held in the applicant's name, but are actually owned by someone else including:

  - assets and any earned income that is accrued to the benefit of someone else;

  - another person is responsible for income taxes incurred on income generated by the assets; or,

  - if the applicant is responsible for disbursing someone else's money, such as in the case of having the Power of Attorney, but the money is not his/hers and no benefit is received.

- Assets that are not accessible to the applicant and provide no income to the applicant.

V. *IHDA'S CERTIFICATION & REVIEW PROCESSES*

A. General Reporting Requirements

Compliance monitoring is administered by IHDA's Technical Services Department. Tax Credit projects are typically subject to an annual review of their management activities. Owners will be notified annually as to the extent of their reporting requirements, which will include, at minimum, furnishing of one or more of the documents described below. Projects, which also received mortgage financing from IHDA, may be subject to additional or different reporting requirements. Owners will be informed of these requirements through other communications from IHDA.

- *Certification of Continuing Low Income Housing Tax Credit Compliance (IHDA Form TST-1 & TST-1A).*

- *Low Income Housing Tax Credit Compliance Report (IHDA Form TST-2).*

- *Annual Income Certification (IHDA Form TST-3).* Documentation to support each low-income tenant's income certification must also be submitted with the TST-3.

- *Development Information for Low Income Housing Tax Credit Projects (IHDA Form TST-4).* This form only needs to be completed and submitted once.
- *Tenant Rent Record Information for Low Income Housing Tax Credit Projects (IHDA Form TST-5).*
- *Certification of Student Eligibility (IHDA Form TST-6)*

NOTE: IRS has proposed modifications to the Treasury Regulations governing compliance monitoring. IHDA will implement any changes required by such Regulations, upon their effective date, which may result in changes in the procedures described in this Manual.

B. Tenant Certification & Recertification Reviews

IHDA will perform an in-house desk review of a minimum of 20% of the low-income tenant's files submitted by the owner or his agent. For properties of less than 10 qualified units, 100% of the files will be reviewed. If through the sampling review, significant or sufficient errors are found, a review of 100% of the files will be conducted. For new properties, IHDA will conduct on-site tenant file reviews within one year of buildings being placed in service.

C. Property Inspections

IHDA will perform on-site physical inspections to monitor for habitability standards of at least 33% of the low-income housing tax credit projects annually. Such inspections will include 20% of the low-income units, examination of the grounds, the exterior of the building(s), common areas, and photographs of the project. IHDA will also conduct physical inspections within one year of new buildings being placed in service.

For tax credit projects receiving mortgage financing from IHDA, the inspections may be more frequent and more detailed due to other monitoring requirements.

D. Fees

IHDA may charge an annual compliance-monitoring fee to the owner for undertaking the tax credit compliance monitoring review. Currently, IHDA has established the following fee schedule:

1 - 10 units	$75.00
11 - 19 units	$150.00
20 or more units	$25.00 per tax credit unit

The fee must be paid at the time that compliance monitoring information is supplied to IHDA. Fees should be sent to the lock box address below.

Illinois Housing Development Authority
P.O. Box 93397
Chicago, Il 60673

VI. REPORTING OF NON-COMPLIANCE

A. General Reporting Requirements

IHDA will report all findings of non-compliance, whether corrected or not, to the Internal Revenue Service within 30 days of the end of any correction period. The current IRS Form 8823 allows for IHDA to make a notation concerning the correction of some non-compliance findings.

B. Examples Of Non-Compliance

- Failure to maintain the selected low-income set-aside for the project;
- Charging low income tenants rents in excess of the restricted rents, including improper calculations of utility allowances;
- Failure to maintain and/or provide adequate documentation of low-income occupancy;
  - failure to certify or recertify tenants;
  - improper or incorrect tenant certifications;
  - inadequate, incorrect or improper supporting documentation of tenant certification;
  - failure to meet the next available unit rule; and
  - failure by the owner to submit required documentation to IHDA;
- Changes in the qualified basis of the building;
- Failure to maintain building in safe and habitable condition;
- Failure to permit or provide IHDA access to any low income housing project for the purpose of performing physical inspections;

- Housing ineligibles in qualified units, i.e. over income or certain students;
- Failure to meet selected minimum set-aside (20/50, 40/60) by the end of the first year of the credit period;
- Failure to perform and/or prepare tenant's certification and/or recertification; and
- Failure to comply with any other requirement set out in Code Section 42, Treasury Regulations, IHDA procedures or the extended use agreement.
- State and Local reports of Building Code violations not corrected to filing the annual recertifications.
- Violations of the Fair Housing Amendments Act of 1988 or the 1968 Civil Rights Act

C. Notice to Owner

IHDA will promptly notify the owner, in writing (the *Notice*), as to the nature of the non-compliance and specify a period for correction.

D. Correction Period

The owner will, generally, be given an opportunity to correct most incidents of non-compliance within a *90-day* correction period. This correction period commences on the date of the Notice. During this *90-day* correction period, the owner may be required to submit a detailed report of the actions to be taken to correct the issues of non-compliance. IHDA, in its sole discretion, may extend the correction period for up to 6 months but only if it determines that good cause exists for granting such extension. IHDA will determine whether a particular instance of non-compliance has been satisfactorily corrected within the applicable time period.

Exhibit 2

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Illinois** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. **Program Title:**
Illinois Supportive Living Program

C. **Waiver Number:IL.0326**
Original Base Waiver Number: IL.0326.90

D. **Amendment Number:IL.0326.R03.01**

E. **Proposed Effective Date:** *(mm/dd/yy)*
02/01/13
Approved Effective Date: 02/01/13
Approved Effective Date of Waiver being Amended: 12/13/12

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
Effective February 1, 2013, the State will deliver care coordination and waiver services through a mandatory managed care delivery system for those 1915(c) waiver participants enrolled in the Integrated Care Program (ICP). The program is implemented in the Illinois areas of suburban Cook (all zip codes that do not begin with 606), DuPage, Kane, Kankakee, Lake and Will Counties. The State is implementing the managed care delivery system under the State plan authority (Section 1932(a)), approved effective May 1, 2011.

The ICP is a program for older adults and adults with disabilities, age 19 and over, who are eligible for Medicaid (without a spend down), but not eligible for Medicare. The Medicaid Agency (MA) has contracted with two Managed Care Plans (Plans) to administer the program. Participants have the choice of Plans.

The Medicaid agency implemented the ICP for physical health and other state plan services on May 1, 2011 as Service Package I, in order to establish participant relations and provider networks. Select long term care services, including 1915(c) waivers, are being added under Service Package II of the ICP. As of July 1, 2012, there were 54 Supportive Living Program waiver participants who were enrolled in the ICP under Service Package I. Once Service Package II is effective, all ICP enrollees in these areas will have their waiver services administered through their Plan, to more effectively coordinate and meet the total needs of the participant.

More information is available about the ICP on the SMA website: [www2.illinois.gov/hfs/PublicInvolvement/IntegratedCareProgram/Pages/default.aspx]

The ICP brings together local primary care providers (PCPs), specialists, hospitals, and other providers to provide more coordinated care around the participant's needs.

Tribal Notification of the amendment was sent on September 28, 2012.

The Medicaid agency will continue to meet federal Centers for Medicare and Medicaid Services (CMS) assurances required under the waiver.

Eligibility:
Waiver eligibility determination criteria will remain the same as in the existing waiver and will be the same for all waiver participants, including those being served by the Plans.

Case Management:
Qualified waiver providers will remain responsible for coordinating and delivering waiver services. Overall health care coordination, including waiver services for participants in the ICP or future Managed Care Organizations (MCO), will be the responsibility of the Plans. Plans bring resources to the programs that will more effectively coordinate community based supports and services with physical health and other state plan services to meet the needs of the whole participant. The Plans have the staffing and information technology resources to connect and share information from the many providers that serve participants. These resources will enhance oversight and monitoring of the provision of services and assure that needs are being met.

Service Delivery--Provider Qualifications:
The same approved waiver services are available through the Plans. Service delivery will remain the responsibility of the qualified waiver providers. Plans will recruit providers and are required to contract with any willing and qualified providers currently approved to provide waiver services. Methods for determining provider qualifications for waiver services remain the same as described in the existing waiver. The Plans will be responsible to ensure that providers are qualified and enrolled.

Service Plan Development:
The qualified waiver providers will continue service planning for waiver services for participants enrolled in the ICP or future MCOs, including the development, implementation, monitoring, and updating of the service plan when a participant's needs change. The Plan's care coordinator will be involved with the waiver service planning and implementation. In all aspects of service planning, the participant is the key member of the service planning team. The State will ensure that service plan development is conducted in the best interest of the participant and will be based on individual preferences and assessed needs.

Transition of Service Plans:
In order to provide a more seamless transition for participants who are enrolled in the existing waiver, the Plans will maintain the current service plans for at least 180 days, unless changed with the consent and input of the participant, and only after the completion of a comprehensive needs assessment. Service plans will be transmitted from the Medicaid agency to the Plans prior to the effective date. Eligibility reassessments that are due during this 180 day transition will be conducted by the Medicaid agency as described in the existing waiver.

Health, Safety and Welfare Roles & Responsibilities:
The health, safety and welfare of the waiver participants who are enrolled in the Plans will be the responsibility of the Medicaid agency and the Plans. This will include monitoring the participant to assure needs are being met, assuring providers are qualified, and reporting and following up on critical incidents. The Plan will have established processes and procedures in place to monitor access, quality, and appropriateness of service issues. Critical events and incidents must be reported and identified, issues routed to the appropriate department within the Plans, to the Medicaid agency as required by administrative rule, and when indicated, to the investigating authority described in Appendix G. The procedures will include processes for ensuring participant safety while the appropriate authority conducts its investigation. The Plans will review all incidents to identify trends and patterns and to determine whether individual or systemic changes are needed. The Medicaid agency will oversee Plans to assure compliance with federal waiver requirements and ensure participants' needs are being met.

Quality Improvement Strategy:
For participants enrolled in a MCO, the QIS will be reviewed and modified to assure that the Plans are complying with the waiver assurances in all delegated areas. For example, The Plans will primarily be responsible for overall care coordination, prior authorization of waiver services, qualified provider enrollment, health, safety and welfare and quality assurance and quality improvement activities. Participants enrolled in MCOs will be included in the overall representative sampling

methodology. The Medicaid agency will monitor performance of the Plans through receipt and analysis of reported data, onsite visits, desk audits and interviews. The Plans will submit performance data at least quarterly, and more often as indicated by the contract. The Medicaid agency will schedule onsite reviews and desk audits throughout the waiver year for the representative sample and validation reviews. The Medicaid agency will meet quarterly with the Plans to identify and analyze trends based on scope, severity, changes and opportunities for system improvement.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☑ Waiver Application	1, 2, 6.i., Attachment 1: Transitic
☑ Appendix A – Waiver Administration and Operation	3, 5, 6, 7.a.ii, 7.b.i, QI a.ii, QI b.i
☑ Appendix B – Participant Access and Eligibility	3.f, 6.f, 6.j, 7.a, 8
☑ Appendix C – Participant Services	1.c, 2.f, QI a.ii, QI b.i
☑ Appendix D – Participant Centered Service Planning and Delivery	1.a, 1.c, 1.d, 1.e, 1.f, 1.g, 1.i, 2.a,
☐ Appendix E – Participant Direction of Services	
☑ Appendix F – Participant Rights	1, 3.b, 3.c
☑ Appendix G – Participant Safeguards	1.b, 1.c, 1.d, 1.e, 2.a, 2.b, QI a.ii,
☑ Appendix H	a.i, bi.
☑ Appendix I – Financial Accountability	1, 2.a, 2.b, 2.d, 3.a
☑ Appendix J – Cost-Neutrality Demonstration	2.c.i, 2.c.ii, 2.c.iii, 2.c.iv

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☐ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☐ **Increase/decrease number of participants**
- ☑ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☑ **Other**

Specify:
Revise the delivery system to provide care coordination and waiver services through a mandatory managed care delivery system for those waiver participants enrolled in the Integrated Care Program (ICP).

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Illinois** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):
Illinois Supportive Living Program

C. Type of Request:amendment

Requested Approval Period: *(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: IL.0326
Waiver Number:IL.0326.R03.01
Draft ID: IL.05.03.01

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/12
Approved Effective Date of Waiver being Amended: 12/13/12

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☑ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

- ☐ **§1915(b)(1) (mandated enrollment to managed care)**
- ☐ **§1915(b)(2) (central broker)**
- ☐ **§1915(b)(3) (employ cost savings to furnish additional services)**
- ☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☑ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:
The Illinois' 1932(a) State plan amendment (SPA) to implement mandatory managed care for the adult aged, blind and disabled populations in Cook County and surrounding border counties was approved for the effective date of May 1, 2011.

The State enrolls Medicaid beneficiaries on a mandatory basis into managed care organizations (MCOs) through the Integrated Care Program, which is a full-risk capitated program.

The SPA is operated under the authority granted by section 1932(a)(1)(A) of the Social Security Act. Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness, freedom of choice or comparability. The authority will not be used to mandate enrollment of Medicaid beneficiaries who are Medicare eligible, or who are Indians, except for voluntary enrollment as indicated in D.2.ii of the SPA.

- ☐ **A program authorized under §1915(i) of the Act.**
- ☐ **A program authorized under §1915(j) of the Act.**
- ☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
The Illinois Supportive Living Program (SLP) serves individuals age 65 years and over and persons with physical disabilities ages 22-64 who are in need of assistance with activities of daily living. Supportive living facilities (SLFs) must have a minimum of ten (10) apartments and may have a maximum of 150. Each apartment is private with a locked door and is required to have a living area, bedroom, kitchen and a private bathroom. Participants only share double occupancy apartments by choice. Participants may receive visitors of their choice at any time. They may also come and go from the supportive living facility as they choose. Common areas are required in the building for dining, socializtion and particpant personal use.

The SLP provides participants with individualized services including: medication oversight, regular assessments, well-being checks, nutritious meals, assistance with activities of daily living, laundry and housekeeping services, planned activities and assistance with arranging appointments and other necessary services.

Additionally, access to the larger community is promoted through scheduled activities both on-site and outside of the facility. Opportunities for community involvement are communicated to participants both in writing through activity calendars and newsletters, as well as verbally. Examples of activities that provide an opportunity for community access outside of the supportive living facility include: musical events, religious services, educational opportunities, charity/volunteer opportunities, sporting events, shopping, museum trips, scenic drives and outdoor activities such as fishing. Waiver participants are encouraged to provide input regarding arranged community activities based on their preferences. Supportive living facility staff also encourage individual participation in the community, such as volunteering or

taking college classes. The required comprehensive resident assessment includes a section to identify a resident's individual interests. Additionally, community members are invited into the facility as part of scheduled activities. Medical professionals provide information on health and wellness and children's groups provide musical entertainment and social interaction. Faith-based groups are also common visitors.

The purpose of the SLP is to promote the health and independence of eligible participants by offering the necessary supports and services. The SLP is an alternative to nursing facility care and also to living alone in the community where comprehensive support services may not be available.

The Goals of the SLP include:

Health and Safety
A number of waiver participants enter the program directly from their own home where they might not be receiving regular assistance with supports such as medication oversight, nutritious meals, hygiene, well being checks and overall health monitoring. The SLP provides these services which assists participants in maintaining their health and independence.

Quality of Life
Participants who previously resided in nursing facilities are able to experience more freedom and encouraged to be more independent in a supportive living facility (SLF). For instance, they are free to come and go from the facility, decorate their own apartment, participate in activities of their choosing, cook their own meals or eat in the facility's dining room. Participants also are involved with the development of an individualized service plan, which reflects the services and care they need and choose. Additionally, participants who previously lived in their own homes may have been isolated and not have had regular opportunities for interaction with others and their community. The SLP encourages socialization within the facility and with the community at large.

Increased Service Options
The SLP provides waiver participants with another option for support services that promote health and safety and encourage independence. The licensed Assisted Living Program in Illinois is not subsidized by public funds and therefore is not an affordable option for many elderly people and persons with physical disabilities. Additionally, independent living and subsidized housing do not offer many of the supports waiver participants need, such as medication oversight. Without the SLP, nursing facilities are the only other care option for many people of low income who require more services than they can obtain in their home.

Cost Savings
With a Medicaid reimbursement rate of 60% of the average weighted daily reimbursement rate for nursing facilities (72% for the dementia program), the SLP decreases the State's cost of care for participants who otherwise would be insitutionalized.

The main objective of the SLP is to decrease and deflect the number of individuals in nursing facilities who are not in need of that level of care.

The Department of Healthcare and Family Services (Medicaid agency) is responsible for oversight of the SLP. Services are accessed on the local level at individual supportive living facilities. Applications for Medicaid are also made at the state level at Department of Human Services Family and Community Resource Centers located throughout the state.

Traditional service delivery methods are used, however, participants are encouraged to make their own decisions about the services they receive. The services provided are based on the participant's individual needs and choices.

Effective February 1, 2013, the State will deliver care coordination and waiver services through a mandatory managed care delivery system for those waiver participants enrolled in the Integrated Care Program (ICP). The ICP is implemented in the Illinois areas of suburban Cook (all zip codes that do not begin with 606), DuPage, Kane, Kankakee, Lake and Will Counties. Future areas/MCO plans will affect the population similarly.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. **Participant Access and Eligibility. Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. **Participant Services. Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. **Participant-Centered Service Planning and Delivery. Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. **Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. **Participant Rights. Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. **Participant Safeguards. Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. **Quality Improvement Strategy. Appendix H** contains the Quality Improvement Strategy for this waiver.

I. **Financial Accountability. Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. **Cost-Neutrality Demonstration. Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. **Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. **Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ○ **Not Applicable**
- ◉ **No**
- ○ **Yes**

C. **Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

- ☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

- ☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the

following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.

Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for

this waiver.

G. **Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. **Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. **Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. **Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. **Service Plan**. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. **Inpatients**. In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. **Room and Board**. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. **Access to Services**. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. **Free Choice of Provider**. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. **FFP Limitation**. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. **Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. **Quality Improvement**. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. **Public Input.** Describe how the State secures public input into the development of the waiver:
The Affordable Assisted Living Coalition (AALC), an advocacy group for supportive living facilities, was involved with the development of the SLP waiver renewal. Members and staff provided feedback and comments related to care planning, assessments and quality manangment. Conference calls and meetings were conducted in order to promote discussion and obtain input.

The Medicaid Advisory Committee, Long Term Care subcommittee was also consulted as part of the waiver renewal process. Members of the Committee are regularly informed of the status of the waiver and provide input and guidance to the Medicaid agency on issues related to the SLP.

Additionally, staff from the Medicaid agency serve on the Older Adult Services Advisory Committee. This group was established by the Governor and state legislature to develop a more comprehensive system of services for seniors and to create a more robust system of home and community-based services. Ideas and recommendations from the Committee for the development of a statewide vision of long term care were used in the creation of the SLP waiver renewal. Additionally, regular briefings and updates on the SLP program are provided during the Committee's meetings.

Proposed administrative rule changes related to the waiver for the Supportive Living Program are always presented to the AALC and all supportive living facility providers for input and feedback. A public comment period during the rulemaking process also allows interested persons an opportunity to comment.

A notice of the proposed waiver renewal and changes was submitted as required for the Notice of Tribal Governments on April 13, 2012. No response was received.

Integraged Care Program: In compliance with CFR 438.50(b)(4) the State researched various integrated care models through literature and reaching out to other state Medicaid programs. The state held many meetings with clients, client advocates and providers to assist with the development of the program, development of the RFP to solicit the contractors, and to guide the implementation of the program. The list of represented entities included as invitees and attendees is found under B.4. of the approved 1932(a) SPA. The State will continue to have meetings with representatives from the above listed entities throughout implementation and on an on-going basis. These meetings will be through ad-hoc requests and regularly scheduled stakeholder meetings. Public input for future MCOs will be modeled in the same fashion.

A notice of the proposed waiver amendment for ICP was submitted as required for the Notice of Tribal Governments on September 28, 2012.

J. **Notice to Tribal Governments**. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. **Limited English Proficient Persons**. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient

Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Cunningham

First Name: Kelly

Title: Deputy Administrator for Medical Programs

Agency: Department of Healthcare and Family Services

Address: 201 South Grand Avenue

Address 2:

City: Springfield

State: **Illinois**

Zip: 62763

Phone: (217) 782-2570 **Ext:** ☐ **TTY**

Fax: (217) 782-5672

E-mail: kelly.cunningham@illinois.gov

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Illinois**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:	Kelly Cunningham
	State Medicaid Director or Designee
Submission Date:	Feb 1, 2013
	Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:	Eagleson
First Name:	Theresa
Title:	Administrator, Division of Medical Programs
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Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Effective February 1, 2013, the State will deliver care coordination and waiver services through a mandatory managed care delivery system for those waiver participants age 19 and older who are enrolled in the Integrated Care Program (ICP). The program is implemented in the Illinois areas of suburban Cook (all zip codes that do not begin with 606), DuPage, Kane, Kankakee, Lake and Will Counties. The Medicaid Agency contracted with two Managed Care Plans (Plans). Participants have the choice of plans.

The Medicaid agency implemented the ICP for physical health and other state plan services on May 1, 2011 as Service Package I, in order to establish participant relations and provider networks. Select long term care services, including 1915(c) HCBS waivers, are being added under Service Package II of the ICP. Once Service Package II is effective, all ICP enrollees in these areas will have their waiver services administered through their Plan, to more effectively coordinate and meet the total needs of the participant.

In order for the Integrated Care Program to provide a more seamless transition from the existing care coordination processes

and service plans for participants who are currently in the waiver, the Plans will maintain the current service plans for at least 180 days, unless changed with the consent and input of the paricipant, and only after completion of a comprehensive needs assessment. Service plans will be transmitted from the Medicaid agency prior to the effective date of this amendment. Eligibility reassessments that come due during this 180-day transition will be conducted by the Medicaid agency as described in the existing waiver.

Participants will remain in their current waiver program. Responsibility for payment for waiver services will simply shift from the State to the MCO. This will occur for all MCO enrollees on the same date. For existing HCBS eligible enrollees, the Plans will inherit a servcie plan and that plan will remain in place for at least a 180-day transition period unless changed with the consent and input of the enrollee and only after completion of a comprehensive needs assessment. Existing service plans will be transmitted to the MCOs prior to the effective date of this amendemnt. These existing HCBS eligible enrollees will remain eligible for these servcies until the time of the enrollees' redetermination. Plans are expected to assess that the enrollees' needs are being met.

The 180-day period in which enrollees may maintain a current course of treatment with an out-of-network provider also includes HCBS waiver providers. The State will institute an "any willing provider" contractual clause that will require Plans to offer contracts to any willing provider that meets quality and credentialing standards. Therefore there should be little need for transition to a different provider. After the initial contracting period, Plans will be allowed to impose a known quality standard and to terminate contracts with underperforming providers. Finally, during readiness review, the State will only authorize Plans that meet the State's network adequacy determination to move forward. If a transition would be necessary the beneficiary will be consulted in the transition, including the selection of the network provider. If the beneficiary does not agree to the transition, the current provider, including PCPs, may enter into a Single Case Agreement with the Plan. If the provider does not choose to enter into a Single Case Agreement with the Plan, the enrollee will be required to transition to a network provider that is capable of meeting the enrolle's needs.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ◉ **The waiver is operated by the State Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ◉ **The Medical Assistance Unit.**

   Specify the unit name:
   Division of Medical Programs
   (Do not complete item A-2)

   ○ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

   Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

   (Complete item A-2-a).

   ○ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
Local Case Coordination Units perform initial level of care evaluations.

Effective February 1, 2013, the State will deliver care coordination and waiver services through a mandatory managed care delivery system for those waiver participants enrolled in the Integrated Care Program (ICP). The program is being implemented in the Illinois areas of Suburban Cook (all zip codes that do not begin with 606), DuPage, Kane, Kankakee, Lake and Will Counties. The State is implementing the managed care delivery system under the State plan authority [Section 1932(a)]. Future MCOs will be used in a similar fashion over time. They are being designed in the same fashion, but will also serve dual eligibles.

The ICP is a program for older adults and adults with disabilities, age 19 and over, who are eligible for Medicaid, but not eligible for Medicare. The Medicaid agency contracted with two managed care plans (Plans) Aetna Better Health and IlliniCare Health Plan, to administer the program. Participants have the choice of Plans.

For those waiver participants enrolled in a MCO, the Plans will be responsible for care coordination, service plan

oversight, participant safeguards, prior authorization of waiver services, qualified provider enrollment, and quality assurance and quality improvement activities.

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

● **Not applicable**

○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
The Medicaid agency reviews the screening results forms completed by local Case Coordination Units, and Department of Human Services, Division of Rehabilitation Services for all new waiver participants annually, and bi-annually for participants in the dementia program.

The Medicaid agency is responsible for assessing the performance of contracted entities in conducting waiver operational and administrative functions.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
The Medicaid agency reviews the screening results forms of all new waiver participants annually. These forms are completed by Case Coordination Units and Department of Human Services, Division of Rehabilitation Services

staff. Medicaid agency staff audit the forms to verify they are complete and accurate.

Oversight of MCOs:

The State's Quality Improvement System (QIS) has been modified to assure that the plans are complying with the federal assurances and performance measures that fall under the functions delegated to them by the Medicaid agency. The sources of discovery vary, and the sampling methodology for discovery is based on either 100% review or the use of a statistically valid proportionate and representative sample. The type of sample used is indicated for each performance measure. The Medicaid agency's sampling methodolgy is based on a statistically valid sampling methodology that pulls proportionate samples from the enrolled MCOs. The proportionate sampling methodology uses a 95% confidence level and a 5% margin of error. The Medicaid agency will pull the sample annually and adjust the methodology as additional MCOs are enrolled to provide long term services and supports.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	☑	☐
Waiver enrollment managed against approved limits	☑	☐
Waiver expenditures managed against approved levels	☑	☐
Level of care evaluation	☑	☑
Review of Participant service plans	☑	☑
Prior authorization of waiver services	☑	☑
Utilization management	☑	☑
Qualified provider enrollment	☑	☑
Execution of Medicaid provider agreements	☑	☐
Establishment of a statewide rate methodology	☑	☐
Rules, policies, procedures and information development governing the waiver program	☑	☐
Quality assurance and quality improvement activities	☑	☑

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Administrative Authority**
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. **Performance Measures**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
#/% of new waiver participants' screening results forms submitted by CCU or DHS Division of Rehabilitation Services (DRS) as part of the DON process that were complete and accurate. Numerator: Number of new waiver participants with screening results forms submitted by CCU or DRS that were complete and accurate. Denominator: Total number of screening results forms for new waiver particpants.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
#/% of new dementia prog. waiver partic. screening results forms submitted by CCU or DHS Div. of Rehabilitation Svcs. (DRS) as part of the DON process that were complete and accurate. Num: # of new dementia prog. waiver partic. with screening results forms submitted by CCU or DRS that were complete and accurate. Den: Total number of screening results forms for new dementia prog. waiver partic.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Bi-annually	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify:	☑ Annually
	☑ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:
#/% of participant reviews conducted by the EQRO according to sampling methodology specified by the waiver. Num.: # of participant reviews conducted by the EQRO according to the sampling methodology specified in the waiver. Den: Total # of participant reviews by the EQRO required according to sampling methodology.

Data Source (Select one):
Other
If 'Other' is selected, specify:
EQRO Reports

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☑ 100% Review
☐ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☑ Quarterly	☐ Representative Sample Confidence Interval =
☑ Other Specify: EQRO	☐ Annually	☐ Stratified Describe Group:
	☑ Continuously and Ongoing	☐ Other Specify:
	☐ Other	

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: EQRO	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
#/% of supportive living facility providers utilized by the MCO that are an enrolled Medicaid provider. Num.: # of supportive living facility providers utilized by the MCO that continued to maintain certification. Den: Total number of enrolled certified supportive living facility providers utilized by the MCO.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: MCO	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and**	☐ **Other**

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: MCO	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Medicaid agency will conduct routine programmatic and fiscal monitoring for the MCOs.

For those functions delegated to the MCOs, the Medicaid agency is responsible for oversight and monitoring to assure compliance with federal assurances and performance measures. The Medicaid agency monitors both compliance levels and timeliness of remediation by the MCOs.

For the MCO, the Medicaid agency's sampling methodology is based on a statistically valid sampling methodology that pulls proportionate samples from the enrolled MCOs. The proportionate sampling methodology uses a 95% confidence level and a 5% margin of error. The Medicaid agency will pull the sample annualy and adjust the methodology as additional MCOs are enrolled to provide long term services and supports.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
If a new waiver participant's screening results form were found to be incomplete or inaccurate, including those in the dementia program, the Medicaid agency would contact the Department on Aging for local Case Coordination Units or the Department of Human Services, Division of Rehabilitation Services to bring errors to their attention so remediation could occur. The screening results form would be revised by the screening agency or a new form completed. Medicaid agency staff would review the revised or new form to verify remediation had occured. If the problem resulted in a non-payable service period for the participant or a determination that the participant was ineligible for waiver services, the Medicaid agency would recover payments. If persistent problems with a specific local Case Coordination Unit or Department of Human Services employees were identified, the Medicaid agency would seek a meeting with the respective state

agencies to discuss remediation, such as staff training or personnel action. This same process applies to the dementia program.

For the Integrated Care Program (ICP), the EQRO completes case reviews and reviews the case review scheduling/process to determine reasons for reviews not being conducted. If remediation is not within 90 days, the EQRO reviews procedures and submits a plan of correction to the Medicaid agency. The Medicaid agency follows-up for completion.

Upon discovery of a MCO utilizing a provider that is not an enrolled Medicaid provider, the MCO is notified to change the provider. Training will be required for MCO case managers. Remediation shall occur within 60 days.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
◉ **Aged or Disabled, or Both - General**					

	☑	Aged	65		☑
	☑	Disabled (Physical)	22	64	
	☐	Disabled (Other)			
○ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
○ Mental Retardation or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Mental Retardation			☐
○ Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

b. Additional Criteria. The State further specifies its target group(s) as follows:

Potential Supportive Living Program waiver participants must also be screened and found to be in need of nursing facility level of care and appropriate for placement in a supportive living facility. Additionally, individuals must be without a primary or secondary diagnosis of a developmental disability and serious and persistent mental illness.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

○ **Not applicable. There is no maximum age limit**

◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Supportive living facilities serving people with physical disabilities do not have a maximum age limit after a resident is admitted. Although the participant cannot be older than age 64 at the time of admission, participants are able to remain in the facility after that age.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)* Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

◉ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

The limit specified by the State is *(select one)*

- **A level higher than 100% of the institutional average.**

  Specify the percentage:

- **Other**

  Specify:

- **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the State is *(select one)*:

- **The following dollar amount:**

  Specify dollar amount:

  The dollar amount *(select one)*

  - **Is adjusted each year that the waiver is in effect by applying the following formula:**

    Specify the formula:

  - **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**
- **The following percentage that is less than 100% of the institutional average:**

  Specify percent:

- **Other:**

  Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

- ☐ **The participant is referred to another waiver that can accommodate the individual's needs.**
- ☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

- ☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	11700
Year 2	12600
Year 3	13000
Year 4	13400
Year 5	13800

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this

way: *(select one)*:

- **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- **Not applicable. The state does not reserve capacity.**
- **The State reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- **The waiver is not subject to a phase-in or a phase-out schedule.**
- **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. **Allocation of Waiver Capacity.**

Select one:

- **Waiver capacity is allocated/managed on a statewide basis.**
- **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. **Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the

waiver:

The waiver provides for the entrance of all eligible persons.

Participants in the Supportive Living Program waiver must be age 65 years or older, or be ages 22-64 and have a physcical disability, as determined by the Social Security Administration.

Potential participants must also be screened by the Medicaid agency or its designee and found to be in need of nursing facility level of care and appropriate for placement in a supportive living facility (SLF).

All potential participants must be checked against two state and one national sex offender registration websites and have a tuberculin skin test in accordance with the Control of Tuberculosis Code.

Any individual wishing to participate in the Supportive Living Program waiver may not receive services from any other HCBS waiver.

Potential participants must apply and be determined eligible for Medicaid.

Finally, individuals must have the resources to pay for the cost of room and board and to receive a personal allowance, both of which are established by the Medicaid agency.

For participants enrolled in MCOs, State-established policies governing the selection of individuals for entrance to the waiver will remain the same for all participants. Initial waiver eligibility will be conducted by the same persons as designated in the existing waiver and be based on the same objective criteria as for all. Selection of entrants does not violate the requirement that otherwise eligible individuals have comparable access to all services offered in the waiver.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - ○ **§1634 State**
   - ○ **SSI Criteria State**
   - ◉ **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ◉ **No**
   - ○ **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- ☐ **Low income families with children as provided in §1931 of the Act**
- ☐ **SSI recipients**
- ☑ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**

☐ **Optional State supplement recipients**

☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

○ **100% of the Federal poverty level (FPL)**

○ **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**

☑ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

☑ **Medically needy in 209(b) States (42 CFR §435.330)**

☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

○ **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

☐ **A special income level equal to:**

Select one:

○ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☑ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☑ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one):*

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-c (209b State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-c (209b State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-c (209b State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

b. Regular Post-Eligibility Treatment of Income: SSI State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR 435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ◉ **The following standard included under the State plan**

  (*select one*):

  - ○ **The following standard under 42 CFR §435.121**

    Specify:

  - ○ **Optional State supplement standard**
  - ○ **Medically needy income standard**
  - ○ **The special income level for institutionalized persons**

    (*select one*):

    - ○ **300% of the SSI Federal Benefit Rate (FBR)**
    - ○ **A percentage of the FBR, which is less than 300%**

      Specify percentage:
    - ○ **A dollar amount which is less than 300%.**

      Specify dollar amount:
  - ○ **A percentage of the Federal poverty level**

    Specify percentage:
- ◉ **Other standard included under the State Plan**

  Specify:

  The maintenance allowance for the waiver participants equals the maximum income an individual can have and be eligible under 435.217 group.

- **The following dollar amount**

  Specify dollar amount: _____ If this amount changes, this item will be revised.

- **The following formula is used to determine the needs allowance:**

  Specify:

- **Other**

  Specify:

ii. Allowance for the spouse only (*select one*):

- **Not Applicable**
- **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**
  Specify:

  Specify the amount of the allowance (*select one*):

  - **The following standard under 42 CFR §435.121**

    Specify:

  - **Optional State supplement standard**
  - **Medically needy income standard**
  - **The following dollar amount:**

    Specify dollar amount: _____ If this amount changes, this item will be revised.

  - **The amount is determined using the following formula:**

    Specify:

iii. Allowance for the family (*select one*):

- **Not Applicable (see instructions)**
- **AFDC need standard**
- **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

○ **Other**
Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

○ **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*

◉ **The State does not establish reasonable limits.**

○ **The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 4)

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- **SSI standard**
- **Optional State supplement standard**
- **Medically needy income standard**
- **The special income level for institutionalized persons**
- **A percentage of the Federal poverty level**

Specify percentage:

- **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised

- **The following formula is used to determine the needs allowance:**

Specify formula:

- **Other**

Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- **Allowance is the same**
- **Allowance is different.**

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- **The State does not establish reasonable limits.**
- **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level (s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. **Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. **Frequency of services.** The State requires (select one):

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. **Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

- ( ) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- ( ) **By an entity under contract with the Medicaid agency.**

Specify the entity:

- (●) **Other**

Specify:

The Medicaid agency has Intergovernmental Agreements with the the Department on Aging and the Department of Human Services, Division of Rehabilitation Services to perform initial level of care determinations for potential waiver participants. The Medicaid agency conducts reevaluations annually.

c. **Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

As stated in 89 IL Admin. Code, Chap. II, Section 220.605, contractors of the Department on Aging who perform initial level of care evaluations for potential waiver participants must be:

1. A registered nurse, or have a Bachelor of Science in Nursing, or have a Bachelor degree in social science, social work or related field. One year of program experience which is defined as assessment, provision, and/or authorization of formal services for the elderly, may replace one year of college education up to and including four years of experience replacing a baccalaureate degree, OR

2. Be a licensed practical nurse with one year of program experience which is defined as assessment of and provision of formal services for the elderly and/or authorizing service provision.

The Department of Human Services, Division of Rehabilitation Services requires a master's degree with major coursework in rehabilitation, counseling, guidance, psychology or a closely related human services field, OR current licensure in the State of Illinois as a practical nurse, OR a Bachelor degree in social service.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The entry point into the Supportive Living Program waiver, or initial level of care determination, is through the Universal Screening process which become law on July 1, 1996 (Public Act 89-499). This law requires all individuals seeking admission into a nursing facility on or after July 1, 1996 to be screened to determine the need for nursing facility placement prior to being admitted. This screening is required regardless of income, assets or payment source. The standardized screening tool used for assessment is the Determination of Need (DON). Those individuals identified through the screening process as needing nursing facility level of care are afforded the opportunity to select a supportive living facility as long as their needs can be met in that setting.

The necessity for long term care is based on the determined need for a continuum of home and community-based services that ultimately prevent inappropriate or premature placement in a group care facility. The extent and degree of an individual's need for long term care is determined on the basis of consideration of pertinent medical, social and psychological factors as measured by application of the DON (IL-402-1230).

The DON is composed of three parts: demographic, cognitive status and functional status. The Mini-Mental Status Examination (MMSE) Section includes eleven items. The first two items are used to measure a person's orientation. The third question tests the ability of the applicant to register, i.e., learn and remember new information. The fourth item measures the person's ability to attend to a task and perform a mental function. The fifth item measure the person's short term recall. Remaining items is this section test a person's basic ability to use and understand words.

The functional status section assesses the level of assistance a person requires with activities of daily living, including: eating, bathing, grooming, dressing, transferring, continence, managing money, telephoning, preparing meals, laundry, housework, outside home, routine health, special health and being alone.

Reevaluations are performed annually by the Medicaid agency through examination of the Resident Assessment Instrument (RAI). The RAI is a comprehensive assessment tool that is completed by the provider near the time of the waiver participant's admission and annually thereafter. It must also be updated as needed to reflect any significant changes in a participant's condition. The annual Level of Care Determination (LOCD) tool captures scores from specific sections of the RAI, including cognitive patterns, physical functioning and health conditions. Portions of the RAI are scored based on a participant's independence level. For example, a participant who requires no assistance with dressing would be scored as "0", or independent. A participant who needed cuing and reminders for dressing would score a "1", or supervision. Other sections identify health conditions and pain levels.

For the purpose of reevaluation, scores from specific sections of the RAI are examined. The sections reviewed for reevaluation assess independence levels in areas including: cognition, decision making, transferring, dressing, eating, toileting, personal hygiene, bathing, medication management, managing money, preparing meals/snacks, housekeeping and laundry. Assessments of these areas reflect services provided in the Supportive Living Program waiver and used during initial evaluation, which makes them relevant for reevaluation.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- ◉ **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ○ **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. **Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

As described in section B 6 d, the Determination of Need (DON) is the standardized assessment tool used to perform initial level of care evaluations. Assessors complete the DON by asking questions of the potential waiver participant and/or his/her designated representative. Additional information may be gathered from physicians and other health care providers.

Annual reevaluations for waiver participants are performed by the Medicaid agency's Bureau of Long Term Care. As described in section B 6 d, sections of the Resident Assessment Instrument (RAI) are reviewed for each waiver participant. A Level of Care Determination form is then completed to verify the waiver participant continues to require the services provided by the Supportive Living Program waiver. Medicaid agency staff may also interivew the participant, his/her designated representative, other health care providers and facility staff to obtain more information or clarification.

Waiver particpants who do not meet level of care requirements based on the initial or the annual level of care evaluation are provided the opportunity to appeal the decision to the Medicaid agency.

For participants enrolled in a MCO, the re-evaluation will be conducted by the Medicaid agency's Bureau of Long Term Care as described in the existing waiver.

g. **Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ○ **Every twelve months**
- ◉ **Other schedule**

Specify the other schedule:

Reevaluations are conducted by the Medicaid agency every calendar year.

h. **Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ○ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ◉ **The qualifications are different.**

Specify the qualifications:

Medicaid agency staff perform reevaluations. Most are Health Facilities Surveillance Nurses whose qualifications are:

·Current licensure as a Registered Nurse in the State of Illinois.

·Graduation from an approved nursing education program resulting in an associate or a diploma degree in nursing and three years of professional nursing experience OR

·Bachelor's degree in nursing and two years of professional nursing experience, OR

·Master's degree in nursing

Staff may also be Medical Assistance Consultant II's. Their qualifications are:

·Knowledge, skill and mental development equivalent to completion of four years of college with courses in medical social work.

-Two years professional experience in fields related to medical social work.

i. **Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State

employs to ensure timely reevaluations of level of care *(specify):*

Medicaid agency procedures require annual on-site certification reviews be completed for all supportive living facilities (SLF). Policy requires that Level of Care Determination (LOCD) forms be completed for each waiver participant during these reviews. Medicaid agency staff track due dates for annual reviews to ensure they are conducted within 60 days of the original certification date.

A list of all current waiver particpants residing in the supportive living facility is compiled from the long term care database and provided to Medicaid agency regional staff. Additionally, an automated tool with a form designated for each resident on the long term care database list requiring an annual LOCD is provided to Medicaid agency regional staff so that no waiver participant is excluded.

The automated LOCD tool is reviewed after the on-site annual certification review is finished to verify LOCDs were completed for each waiver participant or there is justification indicating why not, such as death.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The records of initial level of care evaluations are be kept by the Case Coordination Units and Department of Human Serivces, Division of Rehabilitation Services for a minimum of three years. Records of reevaluations completed by the Medicaid agency are kept for a minimum of three years by Supportive Living Program providers and are also maintained for a minimum of three years by the Medicaid agency.

For participants enrolled in a MCO, the Plans will also maintain a copy of the forms. The record retention requirements will be the same for the MCOs as required by CMS. The minimum is three years.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number/percent of new waiver applicants who have required initial level of care assessment (DON) prior to admission. Numerator: Number of new waiver applicants who have required initial level of care assessment (DON) prior to admission. Denominator: Total number of new waiver applicants requiring initial level of care evaluation.

Data Source (Select one):

Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☑ 100% Review
☐ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify:	☑ Annually	☐ Stratified Describe Group:
	☑ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Event Reports

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☑ 100% Review
☐ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☑ Other	☐ Annually	☐ Stratified

Specify: MCO		Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Reports from ICP

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: MCOs	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: MCOs	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number/percent of new dementia program waiver applicants who have required initial level of care assessment (DON) prior to admission. Numerator: Number of new dementia program waiver applicants who have required initial level of care assessment (DON) prior to admission. Denominator: Total number of new dementia program waiver applicants requiring initial level of care evaluation.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Bi-annually	

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Event Reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: MCOs	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Reports from ICP

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☑ **Other** Specify: MCOs	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: MCO	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number/percent of enrolled waiver participants evaluated annually as specified in the approved waiver. Numerator: Number of enrolled waiver participants

evaluated annually as specified in the approved waiver. Denominator: Total number of enrolled waiver participants who required annual evaluation.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Level of Care Determination form

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number/percent of enrolled dementia program waiver participants evaluated annually as specified in the approved waiver. Numerator: Number of enrolled dementia program waiver participants evaluated annually as specified in the approved waiver. Denominator: total number of enrolled dementia program waiver participants who required annual reevaluation.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Level of CAre Determination form

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance:*** ***The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number/percent of waiver participants' annual level of care (LOC) determinations completed accurately. Numerator: Number of waiver participants' annual LOC determinations completed accurately. Denominator: Total number of annual LOC determinations reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Level of Care Determination forms and comprehensive assessments.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5

☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number/percent of waiver participants' annual LOC determinations completed by qualified Department staff. Numerator: Number of waiver participants with annual LOC determinations completed by qualified Department staff. Denominator: Total number of waiver participants' LOC determinations completed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Level of Care Determination forms

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number/percent of dementia program waiver participants' annual level of care (LOC) determinations completed accurately. Numerator: Number of dementia program waiver participants' annual LOC determinations completed accurately. Denominator: Total number of dementia program waiver participants' annual LOC determinations reviewed.

Data Source (Select one):

Other
If 'Other' is selected, specify:
Level of Care Determination forms and comprehensive assessments.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number/percent of dementia program waiver participants' annual LOC determinations completed by qualified Department staff. Numerator: Number of dementia program waiver participants with annual LOC determinations completed by qualified Department staff. Denominator: Total number of dementia program waiver participants' LOC determinations completed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Level of Care Determination forms

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The state Medicaid agency is responsible for insuring individual problems are resolved.

Remediation for Initial Level of Care assessments:
When it is discovered that an initial level of care assessment has not been completed for a waiver participant, the LOC assessment is completed. If a participant is found ineligible, he/she is notified in writing by the Medicaid agency and provided appeal rights. Supportive Living Facility staff would assist the person with relocation assistance to another program or setting of the individual's choice.

Regardless of eligibility for waiver services, the Medicaid agency recovers all reimbursements paid for identified non-payable service periods as the result of initial level of care evaluations not being completed prior to admission to the waiver program. Medicaid agency staff change the date of eligibility for waiver services in the MMIS to correspond with the first day of the allowable service period. On-line edits are then posted to the system to recover any reimbursement for waiver services during the non-payable service period.

Additionally the facility may have to develop and implement a plan of correction. The state Medicaid agency performs a follow-up visit to determine compliance with initial level of care assessment requirements. Persistent non-compliance results in sanctions, including but not limited to mandatory in-servicing of staff or termination of the Medicaid provider agreement. If a Medicaid provider agreement was terminated, Medicaid agency staff from the Bureau of Long Term Care would assist waiver participants with identifying possible relocation options, including transferring to another SLF.

Remediation for Annual Level of Care Assessments:
When it is discovered that an annual level of care assessment has not been completed for a waiver participant, the LOC assessment is completed.

If a person is found to be ineligible for waiver services during an annual level of care assessment, he/she is notified in writing by the Medicaid agency and provided appeal rights. Supportive Living Facility staff would assist the person with relocation assistance to another program or setting of the individual's choice.

Accuracy of Level of Care Assessments:
If an annual level of care assessment is not completed accurately by Department staff, the LOC assessment is revised. If the participant in found ineligible after the LOC assessment, he/she is notified in writing by the Medicaid agency and provided appeal rights. Supportive Living Facility staff would assist the person with relocation assistance to another program or setting of the individual's choice.

Additionally, Department supervisory staff also provide technical assistance/training for staff who complete inaccurate assessments. Persistent inaccuracy could result in staff administrative action as appropriate.

Remediation for following approved waiver policies and procedures:
If an annual level of care assessment is not completed by qualified Department staff, the assessment would be completed again by someone who was qualified. If the participant in found ineligible after the LOC assessment, he/she is notified in writing by the Medicaid agency and provided appeal rights. Supportive Living Facility staff would assist the person with relocation assistance to another program or setting of the individual's choice.

Department supervisory staff would be informed of the error and provided a listing of qualified Department staff in their region. Continued completion by unqualified staff could result in staff administrative action as appropriate.

The same processes are followed for the dementia program and participants enrolled with a MCO.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. **Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

At the time of the initial level of care evaluation, all potential waiver participants (or their designated representatives) are informed of feasible service options for either institutional care or waiver services. The Illinois Department on Aging Choices for Care Assessment Form is used for this purpose. Section C., Service Selection and Applicant/Client Certification states, "I have been advised that I may choose community-based services, supportive living facility services or nursing facility placement. I understand that I have the right to change my mind at any time." Services listed are: The Department on Aging's Community Care Program waiver, Department of Human Services waiver for persons with physical disabilities, the Supportive Living Program waiver or nursing facility placement. The participant indicates their service option choice with a check mark and signs his/her name. The Department on Aging's local Case Coordination Units, Department of Human Services, Division of Rehabilitation Services staff and Medicaid agency staff are responsible for the completion of this form.

For participants enrolled in a MCO, preference for institutional or home and community-based services will be documented on a Freedom of Choice form provided by the Plan and approved by the Medicaid agency. The participant must sign the completed form indicating his/her choice and that he/she has made an informed decision.

b. **Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Copies of the Illinois Department on Aging Choices for Care Assessment Form are kept by local Case Coordination Units, caseworkers of the Department of Human Services, Division of Rehabilitation Services and Medicaid agency staff (in cases of private pay residents converting to the waiver). The Medicaid agency maintains copies of forms for private pay residents converting to the waiver.

For participants enrolled in a MCO, the Plans will maintain the Freedom of Choice forms.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
Providers of the Supportive Living Program waiver serving Limited English Proficient (LEP) persons are required take steps to ensure equal access to services for these participants. Acceptable practices include: hiring bi-lingual staff, hiring or contracting with interpreters, engaging community volunteers who are bilingual or hiring staff proficient in American Sign Language and translating written documents.

For participants enrolled in a MCO, the Plan shall make all written materials distributed to English speaking enrollees, as appropriate, available in Spanish and other prevalent languages, as determined by the Medicaid agency. Where there is a prevalent single-language minority within the low income households (5% or more such households) where a language other than English is spoken, the Plans' written materials must be available in that language as well as English.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. **Waiver Services Summary.** *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Other Service	Assisted Living		

Appendix C: Participant Services

Exhibit 3

ILLINOIS DEPARTMENT OF
HFS Healthcare and Family Services

Pat Quinn, Governor
Julie Hamos, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: 1-217-782-0545
TTY: 1-800-526-5812

Informational Notice

Date: June 22, 2011

To: Supportive Living Facilities (SLF)

Re: Preadmission and Conversion Screening

The purpose of this notice is to ensure SLFs understand the processes relating to preadmission screens (PAS) and conversion screens.

Preadmission Screens

The SLF must contact their PAS agent when a person plans to enter a facility. It is best to request a PAS as early as possible in order to not delay the admission due to scheduling problems with the PAS agent. In a non-emergency situation the PAS agent has ten days from the date of the request to complete the screen. A PAS is valid for 90 days from the date it is performed. A resident transferring from a nursing facility (NF) to a SLF, between SLFs or returning from a temporary absence does not require a PAS.

Documentation that a PAS has been performed and the person found appropriate for an SLF is a completed Form HFS 2536 (pdf), Interagency Certification of Screening Results. This form is completed and dated by the agent performing the PAS. Generally, this date must be no later than the date of admission. Exceptions to this requirement are if a person is admitted: on an emergency basis due to loss of a caregiver; from a hospital emergency room/outpatient service; or from out of state. In these cases the SLF should contact the PAS agent as soon as possible. The agent has up to 10 days to perform the post admission screen but payment will begin the date of admission if otherwise eligible. Once the screen is completed the PAS agent must provide the SLF with the completed Form HFS 2536 and the Determination of Need (DON) within 10 days. If a person does not meet one of these requirements and is admitted to a SLF prior to the date recorded on the Form HFS 2536, payment will not begin until the PAS date.

A person must score a minimum of 29 points on the DON portion of the PAS to allow Medicaid payment. DON scores below 29 points indicate the person does not need the level of care provided in a SLF and payment will not be approved.

If the PAS identifies a potential mental illness or developmental disability, a Level II screen must be completed by the Department of Human Services Divisions of Mental Health or Developmental Disabilities. If a Level II screen determines the person has a serious and persistent mental illness or developmental disability the person will be determined to not be appropriate for SLF admission. The completed Form HFS 2536 or OBRA I will indicate if the person is determined appropriate for SLF.

Conversion Screens
A resident who entered a SLF as private pay and converted to Medicaid while in the SLF must have a screen performed at that point in time. This conversion screen will be performed by Healthcare and Family Services' Bureau of Long Term Care (BLTC) field staff. The SLF should contact their BLTC regional office to schedule a conversion screen when the resident becomes Medicaid-eligible. The date of the conversion screen may be later than the date of conversion but must be requested as soon as the SLF becomes aware the resident is Medicaid-eligible. The conversion screen is documented using Form HFS 2536, the same form used when a PAS is completed.

As with the PAS, a conversion screen requires a minimum of 29 points on the DON portion to allow Medicaid payment. Caution should be used when admitting a private pay person who does not score a minimum of 29 points on the DON due to the potential of not meeting the minimum score at the time of conversion after their assets are depleted. If a resident scores less than 29 points on the DON as part of a conversion screen payment will not be approved by HFS.

Transferring Between Facilities
A NF resident transferring to a SLF does not require a PAS. However, a SLF resident transferring to a NF must have a PAS unless a screen was performed within 90 days of the NF admission.

If a SLF is admitting a person from another facility it should attempt to obtain a copy of the original Form HFS 2536 from the discharging facility. If a copy is not available the SLF may use HFS 3864, Screening Verification Form (pdf), to request through their PAS agent verification that a PAS was completed prior to the previous admission.

Noncompliance with the PAS and conversion screening processes detailed above will result in findings and recovery of payments.

Questions regarding this notice may be directed to the Bureau of Long Term Care at 1-217-782-0545.

Theresa A. Eagleson, Administrator
Division of Medical Programs

Exhibit 4

PREADMISSION SCREEN/MENTAL HEALTH (PAS/MH)

CONTRACTOR'S PROCEDURE MANUAL

Illinois Department of Human Services
Division of Mental Health

based upon organic or physical disorder. A severe mental illness is determined by all of the following areas:

1. A diagnosis of schizophrenia; delusional disorder; schizoid-affective disorder; psychotic disorder not otherwise specified; bipolar disorder I – mixed, manic, and depressed; bipolar disorder II; bipolar disorder not otherwise specified; major depression, recurrent.
2. The diagnosis must have been present for at least one year.
3. Self-maintenance: physical functioning; personal care and hygiene, dressing; grooming; toileting; nutrition; speech and language; eating habits; maintenance of personal space or possessions; health maintenance; use of medication; and self-medication.
4. Social Functioning: interaction and involvement with family/significant others; social skills and relationships with friends; peer group involvement; ability to pursue leisure/recreational activities.
5. Community Living Activities: homemaking responsibilities (i.e., cleaning, laundry, meal preparation and service, shopping, financial management, and using telephone); use of transportation; traveling from residence independently.
6. It has been determined that the person's functional abilities are not impaired primarily due to substance abuse problems.
7. The functional disability must be of an extended duration expected to be present for at least a year, which results in substantial limitation in major life activities.

Sheltered Care – A non-medical setting for maintenance and personal care licensed by the Department of Public Health (DPH). This type of setting typically consists of room and board and intermittent personal care.

Skilled Nursing Facility (SNF) – A facility, which provides skilled nursing care, continuous skilled nursing observation, restorative nursing, and other services under professional direction with frequent medical supervision.

Specialized Services – A level of services needed for individuals experiencing an acute episode of severe mental illness and is associated with the level of care provided in a state hospital or an in-patient psychiatric hospital.

Supportive Living Facility (SLF) – Facilities certified by the Illinois Department of Healthcare and Family Services (IDHFS). These are independent apartments within existing nursing facilities or free standing. They are available to persons between the ages of 22 and 64 and physically disable or 65 plus. However, a facility cannot mix this age group within the same facility and persons believed to have severe mental illness (SMI) or a Developmental Disability is ***ineligible.*** Those persons suspected of having a severe an appropriate PAS specialist prior to admission into a SLF to determine if the SLF can meet their needs must screen mental illness or a developmental disability. Referrals for an MH/PAS screening should be forwarded to the PAS Coordinator of PAS Services for consultation.

Exhibit 5

APPLICATION

PRELIMINARY APPLICATION
EDEN SUPPORTIVE LIVING

How did you hear about us? _____

CONTACT INFORMATION

Name: _____ Home Phone: _____ Other Phone: _____

Address: _____ Apartment #: _____

City: _____ State: _____ Zip: _____

Date of Birth: ____ /____/_____ Age: _____ Social Security #: _____-_____-_____

Email Address: _____ OK to call? Yes: _____ No: _____

Emergency Contact Name: _____ Phone: _____

GENERAL INFORMATION

1. What is your yearly income: $_____

   Please indicate sources of income** and medical reimbursement (if any):

   Employer: _____ Phone: _____

   Position: _____ Monthly Salary: $_____

   Social Security (Circle one): SSI / SSDI / SSA Monthly Amount: $_____

   (Circle one): Link Card / Other: _____ Monthly Amount: $_____

   Medicaid? (Circle one): Yes / No Medicare? (Circle one): Yes / No

   Private Insurance: _____ Monthly Amount: $_____

   Pension Provider: _____ Monthly Amount: $_____

   Other: _____ Amount: $_____

   **Income includes, but is not limited to: Social Security, pension, stocks, bonds, interest, annuity, dividends, IRA, rental or other income. The applicant will be required to provide proof of all income sources before being approved.

2. Please list the total cash value of <u>all</u> assets in your name:

   List of Assets: _____

   Total Amount of Assets: $_____

   (To qualify for Medicaid assistance your non-exempt assets may not exceed $2,000)

3. Marital Status: Single: ____ Married: ____ Divorced: _____ Widowed: ____

4. Have you ever been evicted from an apartment? Yes: _____ No: _____

5. Have you ever been convicted of a crime? Yes: _____ No: _____

6. Where do you currently live? (Circle one)

   a. Nursing home: _____
   b. Apartment
   c. Private home
   d. Other: _____

   If you do not live in a care facility, do you currently work with a caregiver? Yes ____ No ____

   Please explain: _____

7. Please indicate **how often you have problems or will need assistance** with the following Activities of Daily Living:

(Circle one on each row)

	Never	Rarely	Sometimes	Always	Explain
Toileting	0	1	2	3	_____
Bathing / Showering	0	1	2	3	_____
Transferring	0	1	2	3	_____
Eating	0	1	2	3	_____
Housecleaning	0	1	2	3	_____
Grooming / Dressing	0	1	2	3	_____
Laundry	0	1	2	3	_____
Memory Loss	0	1	2	3	_____
Taking Medication	0	1	2	3	_____
Medication Reminders	0	1	2	3	_____
Breathing / Swallowing	0	1	2	3	_____
Incontinence	0	1	2	3	_____
If incontinent, are you able to manage it by yourself?					Yes: _____ No: _____
Wounds	0	1	2	3	_____
If you have wounds, are you able to manage it by yourself?					Yes: _____ No: _____
Insulin Dependant	0	1	2	3	_____
If insulin dependant, are you able to manage it by yourself?					Yes: _____ No: _____

8. Current Health Status / Diagnosis: Primary - _____

Secondary - _____

Tertiary - _____

9. Any mental diagnosis? If so, explain: _____

This application is not a rental agreement, contract or lease. All applications are subject to the approval of the owner or managing agent.I (we) certify under penalty of perjury that the information and statements provided above are true and complete to the best of my (our) knowledge. I (we) consent to release this information in order to qualify for Section 42 Housing. I (we) understand that providing false information may be grounds for denial of my (our) application and may subject me (us) to criminal penalties.

I (we) give consent and authorization to have management verify the information contained in this application for the purpose of approving my (our) eligibility for occupancy. I (we) will provide all necessary information to expedite this process. I (we) understand that my (our) occupancy is contingent on meeting management's resident selection criteria and guidelines. I (we) understand and agree that inquiries may include information related to credit, employment, rental and criminal records. I (we) further agree that verification of all information and references regarding sources of income and assets may be conducted and I (we) release all parties for any liability for disclosing factual information obtained by management. I (we) understand and agree that a photocopy or fax of this authorization can be used in lieu of an original.

I (we) agree that any monies I (we) pay to Eden before signing the Resident Contract are not refundable and shall be retained by Eden as liquidated damages if my application is approved and I (we) decide not to rent the Unit. Moreover, Resident's monies paid to Eden are not considered as security deposit until both Eden and Resident have fully executed the Resident contract. At that time only will the specific Resident funds deposited into Eden's Security Deposit Account.

Agreed By: Date:

_____ _____

Eden
SUPPORTIVE LIVING

940 West Gordon Terrace
Chicago, IL 60613

www.LivingInEden.com

Phone: (773) 472-1020
Fax: (773) 472-1907

Exhibit 6

Eden Supportive Living

About Us

Eden Supportive Living is not just a new housing concept. It is a lifestyle designed for people with physical disabilities ages 22 – 64 who expect a better quality of living. At Eden, a person can live amongst their peers in exciting neighborhoods, while taking comfort in knowing there are licensed health professionals available to assist with daily living activities or health emergencies.

Built around the notion everyone is entitled to live with dignity, Eden is the answer for young adults searching for accessible housing with support services, while maintaining a more independent lifestyle (a resident can choose a studio, one or two bedroom apartment). Moreover, each socially-oriented community fosters inter-resident activity without forsaking a person's privacy.

The real secret of Eden's success is its staff. All of its wellness personnel are licensed health care professionals. Annually, the entire organization conducts a rigorous sensitivity training to better serve people with physical disabilities. From maintenance to dining, each employee's goal is to make available the highest level of service while honoring the resident's right to choose how to live their life.

Eden's residences are designed to meet the needs of most disabilities. Eden features fully accessible, professionally planned, apartment layouts with barrier-free bathrooms, adaptable kitchen cabinetry, lower windows for accessible viewing, ample grab bars, high-speed internet service and individually controlled heating and cooling. Eden offers an attractive restaurant with three delicious, well-balanced meals served daily, a state-of-the-art cyber center, an art center, a fully accessible fitness center, movie theatre, free laundry facilities and so much more.

Safety is always a paramount concern at Eden. Every Eden apartment is equipped with at least two emergency pull switches. Staff is available at all times to respond when a cord is pulled.

What's more, for a simple, single monthly fee, everything is covered: rent, utilities, three daily meals, housekeeping, laundry, assistance with transportation, personal care and even medical reminders. Qualified residents eligible for financial assistance under Medicaid may be able to receive financial assistance for their care at Eden. (please ask our marketing representatives for more information).

Eden's continuing mission is to promote a better lifestyle for people with physical disabilities while encouraging self-direction, greater privacy, independence and dignity.

Welcome home!

Learn More Photo Gallery

New & Events

Seasonal and Theme Events

Seasonal and Theme events include holiday parties, cookouts, dances.Everyone at Eden is invited to contribute ideas...

More Information