Eligibility

PURPOSE

The 1915(i) program allows Medicaid to pay for home and community-based services to support members with behavioral health conditions including mental illness, substance use disorders, and/or brain injury to live in the community rather than an institution.

The policy is for individuals wanting to apply for 1915(i) behavioral health supports and services, individuals assisting applicants, Human Service Zone "Zone" staff, and 1915(i) Care Coordinators. It contains information on 1915(i) eligibility, the application process and how eligibility is determined and redetermined.

APPLICABILITY

ELIGIBLE MEMBERS

Providers are responsible for verifying a member's eligibility before providing services. Eligibility can be verified using the ND Medicaid MMIS Portal or through the through the Automated Voice Response System by dialing 1.877.328.7098.

1915(i) applicants must show a need for 1915(i) services and supports. This policy also describes the two allowed needs-based assessments, qualifying scores, who can administer the assessments, and the requirement that an applicant needs and receives at least one service quarterly.

Eligibility Criteria

The following criteria must be met to be eligible for the 1915(i) program.

- All ages are eligible to Apply. Some services have age limits.
- The applicant must be enrolled in Medicaid or Medicaid Expansion; and
- The applicant's household income must be at or below 150% of the Federal Poverty Level
    - Children in Subsidized Adoption are categorically eligible for Medicaid, so the sub-adopt parents' income is not considered when determining the Federal Poverty Level for purposes of 1915(i) eligibility. The sub-adopt child's income must be at or below 150% of the Federal Poverty Level to be eligible for the 1915(i). If the applicant's categorically needy Medicaid eligibility status changes, then the Medicaid eligibility worker would follow Medicaid policy based on whatever the change of status is; and
- Applicants must possess one or more of the qualified ICD-10 diagnoses, and
- Applicants must need assistance with activities of daily living and/or instrumental activities of daily living due to an impairment as evidenced by one of the following:

- A score of 25 or higher on the World Health Organization Disability Assessment Schedule 2.0 (WHODAS); or
- A score of 5 or lower on the Daily Living Activities-20 (DLA).

  Applicants only need to have one qualifying score and do not need both assessments. However, if an applicant does not receive a qualifying score on the DLA and the DLA is administered first, the applicant must also be assessed with the WHODAS 2.0; and

- Applicants must reside in a compliant home and community-based setting (HCBS). This ensures all individuals have personal choice and are integrated in and have full access to their communities including opportunities to engage in community life, work, attend school in integrated environments, and control their own personal resources.

  Due to duplication of services, applicants residing in the following facilities are not eligible[1] for the 1915(i) program:
  - carceral (jail or prison),
  - nursing facility (NF),
  - Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID),
  - Qualified Residential Treatment Program (QRTP),
  - Psychiatric Residential Treatment Facility (PRTF),
  - Institutions for Mental Disease (IMD, like the State Hospital), and
  - hospitals.

  Individuals in these settings are receiving 24/7 institutional-level services; therefore, 1915(i) services are considered duplication of services.

  Applicants residing in an institution, enrolled in the Program of All-Inclusive Care for the Elderly (PACE), or on Hospice are not eligible to apply for the 1915(i) while receiving these services.

1915(I) APPLICATION PROCESS

Applicants seeking to receive 1915(i) services must submit a completed 1915(i) Eligibility Application (SFN 741).The entire application must be filled out per the directions on the application and contain required signatures prior to submission. Incomplete applications will not be accepted.

[1] Applicants may be "pre-approved" for 1915(i) if the application is submitted with a notation that it is a "PRE-APPROVAL". The application is to be pended for up to 45 days. A member will notify the Customer Support Center/Zone of release and if within the 45-day window the application can be processed for an eligibility determination.

Applicants who are submitting applications on behalf of another individual must have the individual's consent to apply for 1915(i) services, and the individual who will receive services must participate in the eligibility process.

Alternate Contact on an Application

Individuals listed as an alternate contact on an application may not:

- answer any questions about the applicant or their application;
- make any decisions on behalf of the applicant; or
- inquire about the applicant's eligibility status.

A 1915(i) provider identified as an alternate contact on an initial eligibility application appears as a conflict or inappropriate relationship but can be overridden in the event no other individuals are available to serve in that capacity.

Authorized Representative

Applicants can give a trusted person permission to talk about:

- their application with the Human Service Zone or 1915i administrators;
- see their information; and
- act for the member on matters related to the member's application, including getting information about the member's application.

This person is called an "authorized representative." If the member ever needs to change their authorized representative they can contact their Human Service Zone office. If a person is a legally appointed representative for someone on the application, proof must be submitted with the application.

Eligibility Determinations

1915(i) applications are processed, and eligibility is determined by qualified Human Service Zone eligibility workers. If a 1915(i) application is received for an applicant who is not enrolled in Medicaid, the Eligibility Worker may assist the applicant with being screened for Medicaid eligibility.

Incomplete Applications

Incomplete applications submitted by Medicaid-enrolled members will be placed in a pended status. In all cases of incomplete applications, zone workers will inform the applicant in writing of what is missing, how to obtain the information, and how to submit it for consideration. Written notices must be uploaded into FileNet and the 1915(i) web system.

If the required information is not received within 45 days of the date of the notice, the Zone will formally deny eligibility in the 1915(i) web system and a denial letter will be sent to the applicant. If an individual wants to re-apply after their application has been denied, a new application will need to be completed and submitted.

If an application is missing or has an incomplete needs-based assessment, the application will be put into pending status and the Zone will administer the WHODAS to ensure eligibility isn't delayed.

In the event of a pending Medicaid determination or redetermination, a 1915(i) application will be pended until there is a Medicaid determination. The Zone will enter the information provided into the web system and place the application in pending status.

REQUIRED APPLICATION INFORMATION

DIAGNOSIS

It is the responsibility of the applicant to provide a proof of diagnosis as part of their application. Section 3 of the application must document the diagnosis, and have the name and signature of the diagnosing professional or verifying staff person; or documentation containing this required information may be attached to the application replacing the diagnosing professional or verifying staff person's signature. The diagnosing professional or verifying staff person's signature, or attached documentation, must be dated within the prior year from the date of application submission.

The Zone will not verify the diagnosing professional's credentials; however, if fraud or abuse is suspected, Zone workers will report findings to the State.

NEEDS-BASED ASSESSMENTS – WHODAS 2.0 or DLA

A needs-based assessment must be completed within 90 days prior to the date of:

- the initial eligibility application submission; and
- each subsequent eligibility redetermination application submission.

WHODAS 2.0 Assessment

The World Health Organization Disability Assessment Schedule 2.0 (WHODAS) Assessment is one of the tools used for assessment of needs-based eligibility. ND Medicaid requires face-to-face administration of the WHODAS 2.0 for 1915(i) eligibility.

The WHODAS 2.0 is used both in determining initial eligibility for 1915(i) and in the development of a member's plan of care for services. The WHODAS 2.0 provides a reliable overall complex score to ensure the individual meets the established needs-based eligibility criteria of the 1915(i), and it assesses an individual's level of need and assign a score in each of the six domains:

- Cognition – understanding and communicating;
- Mobility – moving and getting around;
- Self-care – hygiene, dressing, eating, and staying alone;
- Getting along – interacting with other people;
- Life activities – domestic responsibilities, leisure, work, and school; and
- Participation – joining in community activities.

While developing the person-centered plan of care, the individual domain scores will assist the 1915(i) Care Coordinator with identifying the member's needs to determine which of the 1915(i) services will be authorized.

WHODAS Administration Requirements

WHODAS administrators must be "trained, qualified practitioners" which means the administrator has successfully completed the WHODAS Administration Training Requirements. Human Service Zone eligibility workers can be trained, qualified practitioners for the administration of the WHODAS 2.0.

Allowed methods of WHODAS administration include:

- Face-to-Face Assessment with the applicant
  General interview techniques contained in the WHODAS Instruction Guide are sufficient to administer the interview in this mode.
- Face-to-Face Proxy Assessment with an applicant's representative
  An applicant's representative may provide a third-party view of functioning.

A face-to-face assessment may include assessments performed via real-time, two-way communication between the service provider and the member, using secure video conferencing, or another information technology medium. The applicant must receive appropriate support during the assessment and provided with informed consent for this type of assessment. **A telephone is not considered telehealth for WHODAS 2.0 assessments.**

The WHODAS 2.0 Final Revised Complex Scoring guide is required to administer the assessment.

The WHODAS is approved by the World Health Organization for use with individuals across their lifespan. In those cases where a given question may not be applicable, for example in the case of a small child, there is a mechanism outlined in the WHODAS User Manual for how to calculate the score when having dropped a question or two. Another example of a permissible adaptation is using a child's "play" to represent work/school activities in the case of a young child not yet attending school.

WHODAS 2.0 administrators must complete the WHODAS section of the SFN 741.

Applications must contain:

- the overall complex score;
- date administered, and name of the WHODAS administrator;
- the WHODAS 2.0 assessment; and

- 1915(i) score sheet as an attachment; or
  - the summary tab of the 1915(i) score sheet; or
  - The Human Service Center "HSC" Electronic Health Record containing the individual's WHODAS scores may be attached.

See Documentation reference for screenshots showing requirements.

Administration of the WHODAS 2.0 as part of an applicant's initial eligibility is not a billable service. Please refer to the Documentation reference for more information on requirements.

Daily Living Activities -20 (DLA) Assessment

The Daily Living Activities-20 (DLA) Assessment[2] is another tool used for assessment of needs-based eligibility. The DLA contains 20 daily activities that can be affected by mental health and disability. This functional assessment helps behavioral health providers determine the measure of an outcome, showing where treatment is needed.

If the results of the DLA indicate an individual requires a lesser amount of services, the individual's service amounts will not be decreased unless and until the WHODAS 2.0 is administered to confirm the need for a reduction services. The amount of the service reduction will be in accordance with the WHODAS 2.0 if the assessments are in dispute.

If a DLA has already been completed for an individual, a printout can be obtained from a HSC case manager.

DLA administrators must complete the DLA section of the SFN 741.

Applications must contain
- The assessment date; and
- The DLA score

Please refer to the Documentation reference for more information on requirements.

ELIGIBILITY DETERMINATION BY HUMAN SERVICE ZONE

Zone eligibility workers will determine an applicant's 1915(i) eligibility within five (5) days of receiving a completed application. The 1915(i) zone eligibility worker will date receipt of the application and send an eligibility approval or denial letter to the applicant. This letter will contain information on the individual's rights, including their right to appeal the eligibility decision.

[2] If an individual receives a non-qualifying score on the DLA (score of 6 or higher), a WHODAS assessment will be administered. Should the WHODAS demonstrate that the individual is eligible for the 1915(i) (score of 25 or higher), eligibility will be approved or continued participation granted for those already enrolled in the program.

The Eligibility Worker will provide eligible applicants with the Member Rights and Responsibilities form and the Fact Sheet for Individuals Deemed Eligible, as well as the Next Steps sheet, found on the 1915(i) Zone website. These forms will provide information on the services available through the 1915(i) program and inform members of their next steps to accessing 1915(i) services. The Zone will also inform eligible applicants to contact the Care Coordination agency of their choice to begin the person-centered planning process. If assistance is needed in contacting an agency, members may contact the 1915(i) Navigator.

Except in the case of the Community Transition Service, the authorization of services cannot begin before the date eligibility is determined.

When Medicaid is being reviewed at the end of the month, the member's 1915(i) application should be processed as usual. When the applicant's Medicaid closes, 1915(i) staff will suspend the member's case in Dynamics for 90 days to allow time for the applicant to complete their Medicaid redetermination.

ELIGIBILITY REDETERMINATIONS

Eligibility redeterminations follow the same process as initial eligibility determinations. Eligibility redeterminations must be completed at least annually and must take place 30 days or less before the 1915(i) review date. Redeterminations must be completed within five (5) business days from receipt of the completed application.

Applicants and their care coordinators are responsible for submitting completed applications within 30 days of the 1915(i) review date.

ND Medicaid, the member's care coordinator, or the member may request a redetermination prior to the annual timeframe if the member's needs change or a change in their circumstances deem it necessary.

No Reasonable Indication of Need for Service

To continue to be eligible for 1915(i) services members must require:

- At least one 1915(i) service, as documented in their person-centered plan and;
- Receive at least one service per quarter or monthly monitoring as noted in their person-centered plan when services are required on a less-than quarterly basis.

Members who do not meet these criteria no longer meet 1915(i) eligibility criteria and will have their 1915(i) Medicaid closed. Members will be sent appropriate written notice of the closure and their appeal rights.

Changes to Medicaid Affecting 1915(i) Eligibility

When a 1915(i) application is received, the Zone will review all contact information in the Self-Service Portal and Combined Eligibility System. (SPACES) and update any necessary information, including any changes in address or contact information.

When Medicaid changes are made in SPACES, a 1915(i) Specialist will check Functional Eligibility System (FES) to for a 1915(i) benefit plan and, if one is found, they must inform the Eligibility Worker of the Medicaid change(s). The 1915(i) Specialist will then update the 1915(i) Web System with any changes that affect 1915(i) eligibility.

Ongoing communication between the 1915(i) Specialist and the Eligibility Worker is essential to ensure all updated information from SPACES gets input into the 1915(i) Web System and vice versa. The information incudes:

- Changes to identifying information including parent/legal guardian and alternate contact, if applicable;
- Changes in address and/or contact information;
- Medicaid date changes including;
  - Transfer from traditional Medicaid to Medicaid Expansion; or
  - Transfer from Medicaid Expansion to traditional Medicaid;
- Medicaid ineligibility;
- Changes in income and/or household size; and
- Transition to a non-compliant Home and Community Based Services (HCBS) setting.

1915(i) Eligibility/Redetermination Start and End Dates

Eligibility for a new applicant will begin the date 1915(i) eligibility was approved by the 1915(i) Zone Eligibility Worker.

If an eligibility redetermination is approved, eligibility will continue with no break in coverage. For example, if prior eligibility was from 2/15/24 – 2/14/25, 1915(i) eligibility would continue and begin on 2/15/25.

If an applicant's 1915(i) eligibility start date is less than 6 months before their Medicaid eligibility redetermination date, then the applicant's 1915(i) end date and 1915(i) review date will be 364 days from the 1915(i) start date. For example, if an applicant's 1915(i) eligibility start date is 2/1/24 and their Medicaid eligibility redetermination date is 5/30/24, the 1915(i) end date and 1915(i) review date would be 364 days from 2/1/24 creating an end date of 1/31/25.

If an applicant's 1915(i) eligibility start date is 6 months or more before their Medicaid eligibility redetermination date, then the applicant's Medicaid eligibility redetermination date is also used as the 1915(i) end date and 1915(i) review date. For example, if an applicant's 1915(i) eligibility start date is 2/1/24 and their Medicaid eligibility redetermination date is 8/31/24, the 1915(i) end date and 1915(i) review date would be the same as the Medicaid eligibility redetermination date, 8/31/24.

1915(i) Eligibility Suspension

When an eligible member enters a non-compliant HCBS setting for 6 months or less, eligibility is suspended, not closed. Services will be paused until the member is discharged. Closure will occur when a member is placed in a non-compliant setting for 6 months or more or when their eligibility expires, whichever occurs first.

1915(i) eligibility dates will remain in the system when a member enters a non-compliant setting. Medicaid remains responsible for the first and last day of an member's residency/incarceration while the member is in a non-compliant HCBS setting. For example, if a Medicaid-eligible member is incarcerated on 4/1/25 and released on 7/17/25, the FES span would run from 4/2/25 through 7/16/25.

1915(i) Eligibility Closure

If a 1915(i) member chooses to close their eligibility, the member or their parent/legal guardian, must contact the Zone and ask to end their eligibility. A request from the member's care coordinator is not sufficient.

If at any time one of the 1915(i) eligibility criteria is no longer met after a member has been determined eligible, their eligibility must be closed in the 1915(i) Web System as stated below:

- If Medicaid eligibility closes, 1915(i) eligibility closes on the same date. 1915(i) eligibility closes regardless of when the 1915(i) Zone Eligibility Worker is notified. If Medicaid eligibility closes due to not meeting the client share, 1915(i) eligibility closes on the same date Medicaid eligibility is closed. The Zone will send an eligibility closure letter to the member no later than the date of action.
- When any of the following 1915(i) eligibility criteria are not met, (not Medicaid eligibility – see #1 above), 1915(i) eligibility closes on the date the 1915(i) Zone Eligibility Worker was notified. The Zone will send an eligibility closure letter to the member no later than the date of action. The 1915(i) eligibility criteria include:
    - Income exceeds 150% of the FPL;
    - No qualifying diagnosis; or
    - No qualifying needs-based assessment score.
- If a member becomes enrolled in the Program of All-Inclusive Care for the Elderly (PACE), 1915(i) eligibility closes on the day before the member became eligible for PACE. The Zone sends an eligibility closure letter to the member no later than the date of action.
- In the event of a death, 1915(i) eligibility closes on the date of death. The Zone sends an eligibility closure letter to the parent/legal guardian, if applicable, no later than the date of action.

When a member has not connected with a care coordinator or followed through with the annual reevaluation requirements, their 1915(i) eligibility will be closed. The 1915(i) Web

System automatically closes a case when 1915(i) eligibility has expired, and an eligibility closure notice will be sent by the Zone.

Responsibilities and Requirements of the 1915(i) Zone Eligibility Worker

- Providing the applicant with the SFN 741 when requested and instructing them on the process for having the application completed;
- Assisting applicants with enrolling in Medicaid, if needed;
- Informing the applicant of eligibility requirements;
- Signing and dating the SFN 741 under the 1915(i) Eligibility Request section on the date the completed application was received and the date eligibility was determined;
- Verifying the applicant is currently eligible for Medicaid or Medicaid Expansion;
- Verifying the applicant's household income is at or below 150% of the Federal Poverty Level;
- Verifying proof of one or more qualifying 1915(i) diagnoses;
- Verifying proof of a qualifying needs-based assessment and score;
- Entering the eligibility information into the 1915(i) Web System as proof of 1915(i) eligibility and enrollment;
- Informing the applicant or parent/legal guardian, if applicable, of the eligibility decision by providing an approval or denial letter;
- Providing the applicant with the Member Rights and Responsibilities form;
- If eligibility is approved, providing the eligible applicant with the Fact Sheet for Individuals Deemed Eligible and Next Steps flyer;
- Performing redeterminations annually, or earlier when changes occur, or upon request by the member , their care coordinator, or the State;
- Updating information in the 1915(i) web system;
- Informing the applicant or parent/legal guardian, if applicable, of any changes in 1915(i) eligibility by providing a notice; and
- Ongoing communication between the Medicaid Zone Eligibility Worker and the 1915(i) Specialist to ensure updated information from SPACES gets inputted into the 1915(i) Web System and vice versa.

A request of information cannot be attached to an initial eligibility application. However, a request may be attached to an eligibility redetermination.

Zone Responsibility to Provide Notice to 1915(i) Recipients

A notice is a written statement that meets the requirements of CFR § 431.210. A copy of any notice must be uploaded into Filenet and the 1915(i) web system.

Notice of Approval of 1915(i) Eligibility

The Zone will send an eligibility approval letter on the date eligibility is approved. The approval letter informs the eligible member that they must report all future income

exceeding 150% of the federal poverty level to the 1915(i) Zone Eligibility Worker and their rights, including timely and adequate notice of decisions about eligibility; and their right to appeal.

Upon discharge from a non-compliant HCBS setting, 1915(i) eligibility will be reinstated. The Zone will send a notice of approval of eligibility informing the member eligibility has been reinstated.

Notice of Denial of 1915(i) Eligibility
If 1915(i) eligibility is denied, the Zone must send a notice to the individual no later than the date of action. The Zone will send an eligibility denial letter no later than the date eligibility was denied.

This letter informs the eligible individual of their right to appeal the denial. The State assures that individuals have opportunities for fair hearings and appeals.

Notice of Suspension of 1915(i) Eligibility
Eligibility is suspended when a member goes into non-compliant HCBS setting.

A notice will be sent for cases that have been in suspended status for 5 months. The notice informs the member eligibility will close at 6 months if they remain in a non-compliant setting.

A second notice will be sent for cases that have been suspended for 6 months. This notice informs the member eligibility has been closed due to residing in a non-compliant HCBS setting.

Notice of Closure of 1915(i) Eligibility
When a member's 1915(i) eligibility closes, the Zone must send a notice to the member no later than the date of action. The Zone will send an eligibility closure letter no later than the date of closure.

This letter informs the member they have the right to appeal this action. The State ensure that members have opportunities for fairhearings and appeals in accordance with 42 CFR 431 Subpart E.

The 1915(i) web system automatically closes a case when 1915(i) eligibility has expired. If a case automatically closes due to expiration, an eligibility closure letter will be generated and sent by the State.

Notice of Eligibility Redetermination
Advance notice must also be provided to the member and their parent/legal guardian of the eligibility redetermination date. The Zone will generate and send out the Notice of Upcoming Review Date letter 30 days prior to the member's 1915(i) review date. The

letter includes the 1915(i) Eligibility Application which must be completed and submitted by their review date for redetermination of 1915(i) eligibility.

NOTE: All notices are in the 1915(i) web system. Members have the right to fair hearings and appeals of ND Medicaid decisions to reduce, terminate, or deny their benefits.

Qualifications of 1915(i) Zone Eligibility Workers
The Zone must assure the 1915(i) Zone Eligibility Worker performing 1915(i) determinations/redeterminations:

- Is not related by blood or marriage to the applicant or any paid caregiver of the applicant;
- Is not financially responsible for the applicant;
- Is not empowered to make financial or health-related decisions on behalf of the applicant;
- Has completed initial and ongoing training provided or approved by the State.

Zone Input into the 1915(i) Web System (Dynamics)
The 1915(i) web system is the eligibility system for 1915(i). An entry in the web system is required for all 1915(i) applicants to document approval or denial of eligibility. Any documentation related to 1915(i) eligibility must be uploaded into FileNet and the 1915(i) web system.

The 1915(i) Zone Eligibility Worker is responsible for entering initial and ongoing information into the web system and documenting all contacts with the member in the 1915(i) Web System under the "Notes & Attachments" section.

In certain situations, Medicaid Expansion-eligible members have a choice to be served under Traditional Medicaid rather than Expansion. Please refer to the table of SPACES Category of Eligibility (COE) Codes included in the Web System Cheat Sheet to identify if a member has chosen Traditional or Expansion coverage and input their Traditional or Expansion eligibility dates into the 1915(i) Web System under the appropriate section.

Please see the Web System Cheat Sheet for more information.

FREQUENTLY ASKED QUESTIONS

Q: When should an applicant have the DLA vs WHODAS assessment?
A: The DLA Assessment is provided at a Human Service Center where a professional administrator would decide if the assessment is necessary. Although there are no age specifications for the DLA, it is often administered to member under age 21.

The WHODAS 2.0 can be used for members of any age and can be administered by a wide variety of trained individuals. A WHODAS assessment can be obtained at a Human Service Zone.

Q: Who can be a proxy for the WHODAS?
A: A member can request to have a proxy on their behalf, which can be anyone the member knows and requests. The proxy cannot be the WHODAS Administrator or a 1915(i) provider.

Q: How can I schedule WHODAS 2.0?
A: Contact any Human Service Zone to schedule a WHODAS 2.0. If a member is unable to reach the Zone, they can reach out to nd1915i@nd.gov to receive assistance in scheduling the assessment.

Q: How do I check my 1915(i) application status?
A: An applicant can call the Customer Support Center at 1(866) 614-6005 or (701) 328-1000; 711 (TTY) or can log on to the Self-Service Portal. For questions or assistance with the Self-Service Portal, visit SSP Help | Health and Human Services North Dakota.

Q: How will I know if a member's eligibility redetermination has been approved?
A: Care coordinators work with the member to complete the 1915(i) application for eligibility redetermination. A Care Coordinator can check a member's eligibility status in MMIS using this how-to document. Additionally, the member will get a letter from the Human Service Zone letting them know the outcome of their application.

Q: Why are non-specific diagnoses not accepted?
A: Non-specific diagnoses are not included in the qualifying diagnosis list. For example, there are several diagnoses for depression, and unspecified depression doesn't identify which depression diagnosis applies.

Q: Is the redetermination process the same as the initial application?
A: Yes, the redetermination process is the same as the initial application process.

Q: When should an eligibility redetermination application be completed?
A: It is recommended a member begins the redetermination application at least 4-6 weeks prior to eligibility ending.

Q: How do I know if a member is in an HCBS compliant facility?
A: Required HCBS settings compliance measures must be completed, and verification of compliance documented in the Plan of Care by the care coordinator prior to submission of the POC and approval of service authorizations. The care coordinator will verify compliance by completing the

person-centered planning and self-assessment process. Each of the identified HCBS settings requirements must be addressed in the member's plan of care.

Q: What happens if a member receiving services moves to a non-compliant setting?
A: Contact the 1915(i) program at nd1915i@nd.gov to request a secure email be sent to you. Once you have received the secure email, respond with the date the member entered the noncompliant setting. Their eligibility will then be suspended. Once the member is back in a compliant setting, email nd1915i@nd.gov requesting a secure email to be sent to you. Respond with the date this occurs, and their eligibility will be reinstated. If they remain in a non-compliant setting for 6 months or longer, their eligibility will be closed and the member will have to reapply.

Q: Who do I contact to notify the program that a member has moved into a facility?
A: Contact the program at nd1915i@nd.gov to request a secure email be sent to you. Once you have received the secure email, respond with the information related to the residence change, and the dates the member will be residing there.

Q: How do providers add members into Therap for support services?
A: Providers don't have the ability to add members to Therap. (see next Q&A for instructions on a member getting added into Therap.)

Q: How does a member get added into Therap?
A: Upon the completion and submission of the Care Coordination Request for Services Form a referral will be made to the provider in Therap.

DEFINITIONS

Alternate contact – an individual, other than the applicant, identified to assist with the application. Alternate contacts may be family members, friends, or someone who is familiar with the applicant. The only purpose of an alternate contact is to assist in providing the applicant's contact information.

Applicant – an individual applying for 1915(i) or "an individual properly seeking services" on behalf of another individual. Individuals seeking services on behalf of a member must be of sufficient maturity and understanding to act responsibly on behalf the member for whom they are applying. "Individuals properly seeking services" may be an applicant's parent or guardian.

Home and Community Based Setting (HCBS) - a member's own home or community. This does not include institutions or other isolated settings.

Institution – nursing facilities (NF), intermediate care facilities for individuals with intellectual disabilities (ICF/IID), Qualified Residential Treatment Programs (QRTPs), Psychiatric Residential Treatment Facilities (PRTF), IMDs, hospitals, and jails/prisons.

Institution for Mental Disease – a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Members residing in IMDs are not eligible for 1915(i) services.

Needs-based assessment – the WHODAS 2.0 or DLA-20 assessment tool.

Non-compliant setting – the setting where services are received that is not a home and community-based setting.

Representative - the individual's legal guardian, parent, authorized representative, family member or advocate (teacher, friend, etc.). A 1915(i) provider cannot act as a representative.

CONTACT

Medical Services
600 East Boulevard Ave Dept. 325
Bismarck, ND 58505-0250
Phone: (701) 328-2310
Email: nd1915i@nd.gov

POLICY UPDATES

September 2025

Section	Summary
Application Process	Added Authorized Representative
WHODAS Administration Requirements	Added link to the WHODAS Administration Training Requirements. Removed billability of WHODAS for redetermination.
1915i Eligibility Suspension	Updated Medicaid responsibility for when a member enters a non-compliant HCBS setting
FAQ	Added directions for secure email.