FAMILY VOICES OF NORTH DAKOTA®

Accessing and Understanding Health Services In ND

A guide for families of children with special health care needs

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Family Voices of North Dakota
Health Information and Education Center

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ND Department of Human Services
Medical Services Division
Children's Special Health Services
Developmental Disabilities

Information Compiled by Family Voices of North Dakota

Understanding Health Services

Understanding health care, costs and how it affects children with special health care needs is a challenge. Whether you are a new parent or have an older child with special needs, the system is very complex. Families/parents/consumers are looking for ways to get available resources and services to meet their needs. Here are a few tips:

♥ Keep trying! It is about not giving up and it is about asking a lot of questions!

♥Keep calling and asking questions.

♥ Ask for the names and phone numbers of other people to contact.

♥If the recorded voice on the phone is confusing, often you can just stay on the line. Then you will be connected with a person.

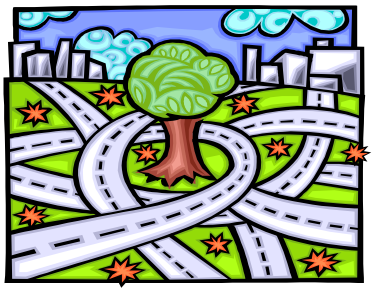
♥A written request or email may result in a prompt response.

♥Get organized! Keep track of who you spoke with, the date of the call, and information you were given. Make special note

of phone numbers, name of the organization or agency, what you agreed to, and ideas about others you can contact. If you do not have a recordkeeping system, contact Family Voices of ND to obtain one for your child.

♥Educate yourself! Get all the information you can. Information can be obtained from providers, the internet, and family organizations. Make sure the information is up to date and share information with health providers and others.

♥It is important to have information at your finger tips. This will help you save valuable time and energy in the long run.



Understanding the differences in public and private programs will assist you in raising your child with special health care needs. Each of us as responsible care givers need to have an understanding of services available for children.

Each child and family is unique as are the services that may be required. The process can be exhausting. Some families in order to meet the needs of their child may utilize both private and public entities to pay for their child's medical expenses.

It is important to understand the systems and how they work. We hope this manual will provide you with the information you need to make the journey a bit smoother.

Information to Have at Your Finger Tips

Many agencies and service providers need basic information when looking at what your family may qualify for. Having this information written out ahead of time can save time and energy.

Legal Name:_____ Date of Birth: _____

Address:_____Town: _____ State: _____ Zip:

_____

Phone numbers- Home: _____ Work: _____ Cell:_____

E-mail address: _____

Child's/family member's SS#: _____

Primary Care Doctor: _____

Address: _____ Tel: _____

Health Insurance Information

Subscriber Name: _____ Policy #: _____

Child/Family Member's Diagnosis: _____

Family Information

Number of members in household: _____

Income (annual gross): _____

Service Providers: who know your family member (physician etc.)

Name: _____ Tel: _____

Name: _____ Tel: _____

Understanding Public Programs

In this day and age programs are constantly changing. Most programs are based on financial eligibility, while others can be based on a child's diagnosis or disability.

An important note In order to streamline the application process for families, the Department of Human Service has developed a joint application for ND Medicaid, ND Healthy Steps and the Caring Program for Children now have a combined application. This is great news for families as it makes this process much easier! This application can be obtained from the ND State Medicaid Office, your local County Social Service Office or online at: http://www.state.nd.us/eforms/Doc/sfn00502.pdf
With the online form, you can fill it out, print it off and send to the State Medicaid office or your local County Social Service Office. (The online form will not save your information, so it is important to print it once it has been filled out.)

Understanding Medicaid

Medicaid is a jointly funded state and federal program for payment of medically necessary services for people who meet certain income and resource guidelines. All states and U.S. territories provide a basic package of benefits. Children under age 21 with Medicaid receive a comprehensive package of services called Early Periodic Screening Diagnosis, and Treatment (EPSDT). In North Dakota EPSDT is called Health Tracks.

There are "required" and "optional" eligibility groups under Medicaid. "Required" eligibility groups are those which must be served by the Medicaid program. "Optional" eligibility groups are those which may be served, with each state determining the benefits package, beyond the basic services in most cases, the eligibility requirements are beyond those not mandated by the federal government.

North Dakota's Medicaid program requires at least basic medical services for any child meeting one of the following descriptions:

- The child's parents receive Aid to Families with Dependent Children, a cash assistance program offered and jointly funded by the federal and state governments.

- The child receives Supplemental Security Income/SSI, a federal cash assistance program for qualifying adults and children with disabilities. Qualifying for SSI may also provide eligibility to Medicaid.

- The child is younger than six years old and the child's family income does not exceed 133% of the federal poverty level.

- The child comes from a two-parent family with low income and limited resources.

- The child receives adoption assistance and foster care in programs administered under the Social Security Act.

- The child is part of a "protected group". Protected groups include children who lose cash assistance for a time period due to higher family income; or children of two-parent unemployed families receiving limited cash assistance. Children in such "protected groups" can receive Medicaid coverage for 12 continuous months.

Basic Medicaid Services

Federal Medicaid laws require each state to offer "Basic Services" to all citizens who qualify for and receive Medicaid. Basic Services include the following:

1. Inpatient hospital services;

2. Outpatient hospital services;

3. Physician services – the services provided by a physician in or out of the hospital;

4. Services in rural health clinics;

5. Laboratory and x-ray services not provided by a hospital or rural health clinic;

6. Care in skilled nursing facilities (commonly known as nursing homes) for individuals 21 years or older;

7. Home-based health care;

8. Family planning services and supplies;

9. Services of a certified nurse practitioner or midwife; and

10. Early Periodic Screening, Diagnosis, and Treatment [EPSDT] Program to screen and treat children for developmental delays.

It is important to note that except for the EPSDT Program, states may set "amount, duration, and scope" of services limits on the benefits offered even under the required Basic Services program. The only limit allowed for the EPSDT Program is that the service must be "medically necessary."

Understanding EPSDT (Early, Periodic Screening Diagnosis and Treatment)/ND Health Tracks

The EPSDT Program or **North Dakota Health Tracks** is available to all Medicaid eligible children below age 21. EPSDT Program's goal is to ensure that all children in the Medicaid program are examined and evaluated on a regular basis and receive any necessary treatment to correct detected delays or problems. This is particularly important for children who have or are at risk for developmental delay.

Under the EPSDT Program, periodic developmental screens are done annually and must include, at a minimum, the following:

- A comprehensive health/developmental history, including health, education, nutrition, immunization, and developmental milestones;
- An unclothed physical examination;
- Laboratory tests;
- Vision and hearing testing; and
- Dental screening.

Additionally, EPSDT requires all children between age 1 and 5 be tested for lead poisoning. The EPSDT Program also provides preventive services normally not included in a state's Medicaid Program. A child enrolled in Medicaid is automatically enrolled in the EPSDT Program. Separate EPSDT program enrollment is not needed.

Who is Eligible?

Effective January 1, 2002, the Medicaid program's children and family coverage group will not have an asset limit.

Income

Depending on the amount of net income, individuals may be eligible for full Medicaid benefits or may be responsible for a portion of their medical bills which is called their recipient liability. Children who are not eligible for full Medicaid benefits may be eligible for Healthy Steps. Medicaid looks at a family's total countable income and subtracts allowed expenses to establish net income.

Some of the more common allowable expenses are:

- Taxes and other work related expenses
- Health insurance premiums
- Dependent care expenses
- Child support paid to a non household member
- Other deductions may apply

How to Apply for Medicaid

Medicaid applications can be requested in person, by phone, online joint application, or by writing to your County Social Service Office. Medicaid applications are also available at certain hospitals. The phone numbers of County Social Service Offices are listed in local telephone directories under "Government Offices - County."

Joint application: http://www.state.nd.us/eforms/Doc/sfn00502.pdf

Online applications can be sent to the County Social Service Office or to the address below.

Medical Services Division
North Dakota Department of Human Services
600 E Boulevard Ave, Dept 325
Bismarck, ND 58505-0250
Telephone:(701) 328-2321 Toll-free: 1-800-755-2604

Fax: (701) 328-1544
E-mail: dhsmed@state.nd.us

Medicaid Income Levels Effective April 1, 2005

Family Size	Family Coverage (1931)	Medically Needy	SSI	Children Age 6-19 100% of Poverty	Preg. Women Child to Age 6 133% of Poverty	Transitional Medicaid 185% of Poverty
1	$311	$500	$579	$798	$1061	$1476
2	$417	$516	$869	$1070	$1422	$1978
3	$523	$666		$1341	$1784	$2481
4	$629	$800		$1613	$2145	$2984
5	$735	$908		$1885	$2506	$3486
6	$841	$1008		$2156	$2868	$3989
7	$947	$1083		$2428	$3229	$4491
8	$1053	$1141		$2700	$3590	$4994
9	$1159	$1200		$2972	$3952	$5497
10	$1265	$1250		$3244	$4314	$6000

Services Covered By ND Medical Assistance

Medicaid covers a specific list of medical services. Some covered services have limitations or restrictions. It is a recipient's responsibility to ask a medical provider whether a particular service being provided is covered by Medicaid. Do not assume that all of the medical services you receive are covered and paid by Medicaid. Non-covered medical services are the recipient's responsibility.

The services listed below are a general listing; some covered services have limitations or restrictions.

Hospital

Inpatient: Covers room and board, regular nursing services, supplies and equipment, operating and delivery room, X-rays, lab and therapy.

Outpatient: Covers emergency room services and supplies, lab, X-ray, therapies, drugs and biologicals, and outpatient surgery.

Nursing Facility

Covers room and board, nursing care, therapies, general medical supplies, wheelchairs, and durable medical equipment.

Clinics, Rural Health Clinics

Covers outpatient medical services and supplies furnished under the direction of a doctor.

Hospice

Provides health care and support services to terminally ill individuals and their families.

Physicians

Covers medical and surgical services performed by a doctor; supplies and drugs given at the doctor's office; and X-rays and laboratory tests needed for diagnosis and treatment.

Prescription Drugs

Covers a wide range of, but not all, prescription drugs, insulin, family planning prescriptions, supplies, and devices. Requires a Prescription from a doctor is required. A Pharmacist can tell you if a particular drug is covered by Medicaid.

Chiropractor

Covers X-rays and manual manipulation of the spine for certain diagnosis.

Health Tracks (EPDST)

Covers screening and diagnostic services to determine physical and mental status, and treatment to correct or eliminate defects or chronic conditions and help prevent health problems from occurring for children under 21 years of age. Orthodontia and immunizations may also be covered.

Home Health

Covers nursing care, therapy and medical supplies when provided in a recipient's home. Care must be ordered by a physician and provided by a home health agency.

Durable Medical Equipment and Supplies

Covers medical supplies such as oxygen and catheters and reusable equipment that is primarily medical in nature. Items must be medically necessary and do not include exercise equipment, personal comfort or environmental control equipment.

Dental

Covers exams, X-rays, cleaning, fillings, surgery, extractions, crowns, root canals, dentures (partial and full) and anesthesia.

Family Planning

Covers diagnosis and treatment, drugs, supplies, devices, procedures and counseling for persons of child bearing age.

Sterilization

Covers sterilization procedures if: (1) The recipient is at least 21 years old; (2) The recipient is legally competent; (3) The recipient signs an informed consent form; and (4) At least 30 days but not more than 180 days have passed between the signing of the consent form and the sterilization.

Podiatry

Covers office visits, supplies, X-rays, glucose and culture checks, and surgery procedures.

Mental Health

Covers psychiatric and psychological evaluations, inpatient services in a psychiatric unit of a hospital, individual-group-family psychotherapy, partial hospitalization services, and inpatient psychiatric and residential treatment centers services for individuals under 21 years of age for the care and treatment of mental illness or disorders.

Ambulance

Covers ground and air ambulance trips, attendant, oxygen, and mileage when medically necessary to transport a recipient to the closest health care facility meeting his needs. House Bill 1282 permits ambulance personnel to refuse transport to an individual where medical necessity cannot be demonstrated and recommend an alternative course of action for the individual. If an ambulance service is not medically necessary, Medicaid will not pay for the service.

Transportation

Covers non-emergency transportation services to and from the recipient's home to the closest medical provider capable of providing a medically necessary examination or treatment. However, it will not pay for a family member to provide that transportation.

Vision

Covers exam, glasses, frames and some hard contact lenses for the correction of certain conditions. Replacement eyeglasses may only be provided after a minimum of 12 months for children under 21 years of age or 24 months for adults if

a lens change is medically necessary. An exception to the replacement limitation may be made if new eyeglasses are required for a significant change in correction and the eyeglasses are prior approved. Lost or broken glasses for individuals over 21 will not be replaced within the first two years.

Therapies

Covers physical, occupational therapy and speech and language pathology.

Waivered Services - Home and Community Based Services, Traumatic Brain Injury

Provides personal care and other services not otherwise covered under the Medicaid program to individuals who are at risk of institutionalization in a nursing facility. The individual would have met the necessary eligibility requirements for the waivered service.

Out-of-State Services

Medically necessary covered services may be provided outside of North Dakota if the services are not available within North Dakota and have been prior approved by the department or if the services are provided in an emergency situation.

Medicaid Managed Care

Eligible Medicaid recipients in Grand Forks County are able to choose between managed care plans. The plans are the AltruCare Plan, which is a Health Maintenance Organization owned and operated by Altru Health System in Grand Forks, or the Primary Care Provider Program, which is a statewide Medicaid program in which each client selects a provider to be their Primary Care Provider.

Home and Community Based Waivers

What is a waiver?

- A waiver is a way the state can use Medicaid funding more flexibly to pay for services for a specific population as an alternative to institutionalized care. States can request that the federal government

waive certain federal restrictions on how Medicaid dollars are spent.

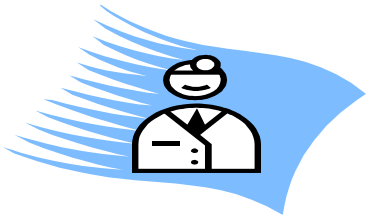
- A child or adult who does not otherwise qualify for Medicaid could be found eligible for Medicaid by receiving one of the five waivers listed below. On the other hand, a child or adult who is eligible for other kinds of Medicaid could get additional services covered under a waiver.
- A child or adult with significant personal assets, such as a trust fund, often cannot receive Medicaid, including a Medicaid waiver, unless the trust is what is known as "Medicaid qualifying" or "special needs".

North Dakota has been approved by the federal government to operate two 1915(c) waivers that allows the delivery of home and community based services for individuals who would ordinarily be admitted to a nursing facility.

The Aged and Disabled Waiver is designed to provide alternative services for individuals with disabilities or individuals over 65 years of age who are eligible for the Medicaid Program and have medical needs that would qualify them to enter a nursing facility. The waiver allows North Dakota to pay for alternative services that permits these individuals to remain in their own homes or community settings.

Likewise, the Traumatic Brain Injured waiver allows North Dakota to pay alternative home and community based services for individuals who have suffered a brain injury and would otherwise be eligible to be admitted to a nursing home.

In the 2005 Legislative Session, the Department of Human Services was directed to apply for a waiver for medically needy children. The Department has begun this process, and it does take some time to complete. When information is available, we will provide families with this information.



Developmental Disabilities Services

Developmental Disabilities provides support and training to individuals and families in order to maximize community and family inclusion, independence, and self-sufficiency; to prevent institutionalization; and to enable institutionalized individuals to return to the community.

Case Management

Provides the connection between individuals who receive services and the system of developmental disabilities publicly-funded services. Case managers establish eligibility for services and authorization for federal funding, and assist individuals in accessing needed medical, social, educational, residential, vocational and other services. They also provide ongoing review of client outcomes and satisfaction, and coordinate, monitor and evaluate the services provided.

Corporate Guardianship

A service purchased on behalf of individuals eligible for developmental disabilities case management services when a district court has determined that the individual requires a guardian. When no one else is available to serve as the guardian for an eligible individual age 18 and older, Catholic Family Services, Corporate Guardianship Program will serve as the guardian through a contract with the Disability Services Division. This service is purchased with state general funds.

Family Subsidy

A program that reimburses a family for excess expenses related to their child's disability. Family Subsidy offers support to enable a family to keep their child in their home when lack of financial support would make it very difficult for

the family to keep the child at home. The child may be eligible for Family Subsidy through twenty-one (21) years of age.

Family Support Services

Family centered services which are provided for an eligible client in order for the client to remain in an appropriate home environment. Family Support Services provides: (a) short-term Respite Care when a specialized trained care giver is needed in order to meet the individual's needs. Respite Care is provided when the parents/primary care givers are absent, and can be delivered in the family home or in another location; (b) Supportive Home Care which provides a specialized trained care giver to work with the parents/family when additional help is needed to meet the individual's needs; (c) Family Care Option, out-of-home support which is provided in a licensed family home

Infant Development

A home-based, family-focused service that provides information, support and training for families to assist them in meeting their child's needs. A child may be eligible for Infant Development up to age three (3) years.

Who to Contact in your Region of the State

Northwest Human Service Center
316 Second Avenue West
PO Box 1266
Williston, ND 58801
Phone: (701) 774-4600
Fax: (701) 774-4620
TTY: (701) 774-4692
Toll Free: (800) 231-7724

North Central Human Service Center
400 22nd Avenue NW
Minot, ND 58703-1089
Phone: (701) 857-8500
Fax: (701) 857-8555

TTY: (701) 857-8666
Toll Free: (888) 470-6968

Lake Region Human Service Center
200 Highway 2 SW
Devils Lake, ND 58301
Phone: (701) 665-2200
Fax: (701) 665-2300
TTY: (701) 665-2211

Northeast Human Service Center
151 South 4th Street Suite 401
Grand Forks, ND 58201-4735
Phone: (701) 795-3000
Fax: (701) 795-3050
TTY: (701) 795-3060

Southeast Human Service Center
2624 9th Avenue SW
Fargo, ND 58103-2350
Phone: (701) 298-4500
Fax: (701) 298-4400
TTY: (701) 298-4450
Toll Free: (888) 342-4900

South Central Human Service Center
520 Third Street NW
PO Box 2055
Jamestown, ND 58402
Phone: (701) 253-6300
Fax: (701) 253-6400
TTY (701) 253-6414
Toll Free: (800) 639-6292

West Central Human Service Center
600 South Second Street, Ste 5
Bismarck, North Dakota 58504
Phone: (701) 328-8888
TTY: (701) 328-8802

Fax: (701) 328-8803
Toll Free: (888) 862-7342

DD Program Administrator
Badlands Human Service Center
200 Pulver Hall
Dickinson, ND 58601
Phone: (701) 227-7500
Fax: (701) 227-7575
TTY: (701) 227-7574
Toll Free: (888) 227-7525

Infant Development-Please contact the Human Service Center in your Region as the single point of entry.

Infant Development Program
Northwest Human Service Center
316 - 2nd Avenue West
P.O. Box 1266
Williston, ND 58801
Phone: (701) 774-4600

Minot Infant Development
Minot State University
500 University Avenue W
Minot, ND 58707
Phone: (701) 858-3054

Lake Region Kids
218 SW 4th St.
Devils Lake, ND 58301
Phone: (701) 662-6324

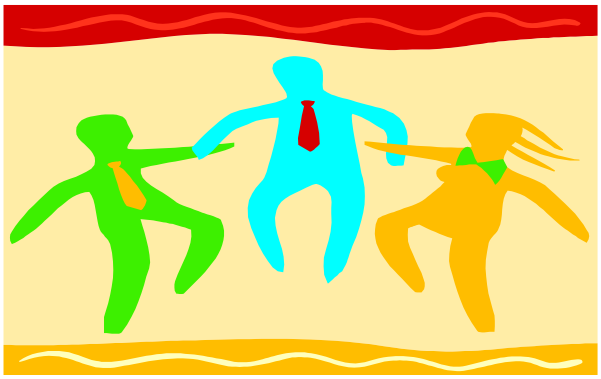
Infant Development Program
Northeast Human Service Center
151 South 4th Street, Ste 401
Grand Forks, ND 58201-4735
Phone: (701) 795-3000

Infant Development Program
Southeast Human Service Center
2624 - 9th Avenue SW
Fargo, ND 58103-2350
Phone: (701) 298-4500

Infant Development Program
South Central Human Service Center
Box 2055
Jamestown, ND 58401
Phone: (701) 253-6300

Bismarck Early Childhood Education Program
806 North Washington Street
Bismarck, ND 58501
Phone: (701) 221-3490

K.I.D.S.
235 Sims, Ste 16
Dickinson, ND 58601
Phone: (701) 483-4394



Children's Special Health Services

Children's Special Health Services (CSHS) is a health program located within the Medical Services Division in the Department of Human Services (DHS). The purpose of CSHS is to provide services for children with special health care needs and their families and promote family-centered, community-based, coordinated services and systems of health care.

Brief History

In 1935, Title V of the Social Security Act authorized federal funding for state Maternal and Child Health programs. It is the key source of support for promoting and improving the health of all the Nation's mothers and children, including children with special health care needs. With the Act, the program known as Crippled Children's Services was established. In July of 1995, the name of the program in ND was changed from Crippled Children's Services to Children's Special Health Services.

Since its original authorization in 1935, Title V of the Social Security Act has been amended several times to reflect the increasing national interest in maternal and child health and well-being. One of the first changes occurred in 1981 when Title V converted to a block grant program. This change resulted in the consolidation of seven categorical programs into a single block grant. Another significant change occurred in 1989 with passage of the Omnibus Budget Reconciliation Act (OBRA). OBRA '89 specified new requirements for Title V accountability.

Services Provided by CSHS

The Specialty Care Program: helps families pay for medical services for eligible children. Generally, eligibility includes the following:

- **Age**: child must be birth to 21 years of age
- **Residency**: child must be a ND resident
- **Special Health Care Need**: child must require health and related services beyond that needed by most children

The Multidisciplinary Clinic Program: is a resource to help families manage their child's chronic health condition. Most clinics supported by Children's Special Health Services (CSHS) provide multidisciplinary team evaluations where families have an opportunity to see many different providers in one place at one time. Reports generated from the clinic visit include recommendations to help direct care for the coming year. There is no charge to families for clinic services; however, insurance or others sources of health care coverage may be used when available. All children who might benefit are eligible to attend.

Clinics make a positive difference in children's overall care. Families' report that clinics provide:

- Information, education, and reassurance
- Coordinated care and treatment
- Follow-up and monitoring
- Access to specialty medical care

Ten different types of clinics are supported by Children's Special Health Services. Some are managed by CSHS in partnership with public and private health care providers across the state. Others are funded through service contracts. Types of clinics supported by CSHS include:

- Cleft Lip/Palate
- Scoliosis/Orthopedic

- Cardiac Care for Children Program
- Metabolic Disorders
- Cerebral Palsy
- Developmental Assessment
- Myelodysplasia
- Diabetes
- Neurorehab
- Asthma

Meeting the complex health needs of children and their families often requires special assistance in the form of care coordination.

The Care Coordination Program helps families access services and resources in their community, and when needed, across multiple service delivery settings. Although the primary focus of the care coordination program is on the health care of the child, this program also attempts to meet the needs of the family.

Care Coordination activities through CSHS vary to some extent by provider but may include:

- Eligibility determination
- Child and family assessment
- Service planning
- Case monitoring and coordination
- Referrals to services and financial resources
- Information and training
- Other: negotiation, support/counseling, systems improvement activities, etc.

County Social Services staff coordinate care for children who are eligible for CSHS treatment services.

Public Health nurses coordinate care for additional children in five eastern ND counties (Cass, Grand Forks, Nelson, Walsh, and Pembina).

Metabolic Food Program:

Children's Special Health Services (CSHS) provides medical food and low-protein modified food products to individuals with Phenylketonuria (PKU) and Maple Syrup Urine Disease (MSUD).

- CSHS provides medical food at no cost to males under age 22 and females under age 45 who are diagnosed with PKU or MSUD, regardless of income.
- CSHS offers for sale at cost medical food to males age 22 and over and females age 45 and over who are diagnosed with PKU or MSUD, regardless of income.
- CSHS provides low-protein modified food products, if medically necessary as determined by a qualified health care provider, to males under age 22 and females under age 45 who are receiving medical assistance and are diagnosed with PKU or MSUD.
- Russell Silver Syndrome Program

Information and Resource Center:

CSHS operates **an information and resource center** that provides the following public information services free of charge:

Toll Free telephone number - An in-state, Toll Free Info-Line (800 755-2714) is available to help parents obtain health and related service information.

Targeted outreach, information and referral efforts - CSHS staff conduct outreach activities to help families locate services to meet their needs.

Resource library - The CSHS resource library includes reference books and other publications, pamphlets, audio/video cassettes, topical packets, and promotional materials. Families frequently request information on the following topics:

- child's medical condition
- special health care services and providers
- typical child development

- financial assistance
- family support services
- well-child health care

Education and consultative services - Services include technical assistance, educational presentations, committee representation, and training.

Other public information activities - Other activities may include news releases, newsletters, publications, informational mailings, resource development, web site, unit e-mail, and display board opportunities.

How to Apply: To apply for Children's Special Health Services an application is made at your County Social Service Office. The phone numbers of County Social Service Offices are listed in local telephone directories under "Government Offices - County."

To contact Children's Special Health Services:

Children's Special Health Services
North Dakota Department of Human Services
600 East Boulevard Avenue, Dept. 325
Bismarck, ND 58505-0269
Phone: (701) 328-2436
Toll Free: (800) 755-2714 (in-state)
TTY: (701) 328-3480 **Fax**: (701) 328-1645
website: dhscshs@state.nd.us

Children's Health Insurance Program/Healthy Steps

According to estimates, about 15,000 children in North Dakota are uninsured. The state's Healthy Steps Children's Health Insurance Plan will provide a healthier future for many of these children.

Healthy Steps insurance is for children who:

- do not have health insurance coverage
- are 18 years of age or younger
- do not qualify for the North Dakota Medicaid Program
- live in families with qualifying incomes

Who is Eligible?

Healthy Steps insurance is intended to meet the needs of working families, who cannot afford health insurance coverage for their children, yet earn too much to qualify for Medicaid. Coverage is available for uninsured children age 18 and younger who live in families with qualifying incomes. Single 18-year-olds with eligible incomes may also apply.

The income guidelines were established by the North Dakota Legislature in May 1999 (SB 2012). To qualify, a family's NET income (after subtracting childcare costs and payroll taxes such as social security tax, Medicare tax, and income tax) must be greater than the Medicaid level, but cannot exceed 140 percent of the federal poverty level.

See next page for income chart

Family Size	Annual Net Income	Monthly Income
1	$13,034	$1,087
2	$17,486	$1,458
3	$21,938	$1,829
4	$26,390	$2,200
5	$30,842	$2,571
6	$35,294	$2,942
7	$39,746	$3,313
8	$44,198	$3,684
9	$48,650	$4,055
10	$53,102	$4,426

For family households over ten people, increase the monthly income amount by $372 for each additional person or increase the annual income amount by $4,452.

Note to farmers and self-employed families: Eligibility for self-employed applicants is based on the average adjusted gross income for the previous three years.

Children who apply for Healthy Steps but are eligible for Medicaid will be referred to Medicaid.

Families may be responsible for modest co-payments for some services.

- **Emergency Room** - $5 per visit
- **Hospitalization** - $50 per hospitalization
- **Prescription** - $2 per prescription

Due to the unique relationship that exists between the federal government and tribal governments, the co-payment requirement has been waived for Native American children.

How to Apply:

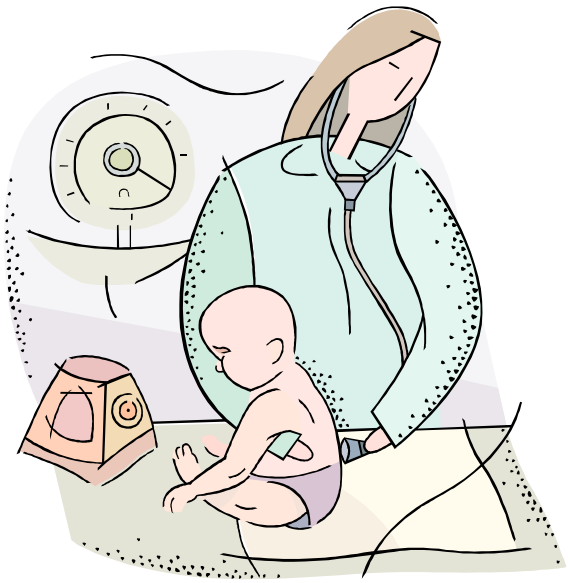
To apply, simply complete the Health Coverage Application, which is available online at:
http://www.state.nd.us/eforms/Doc/sfn00502.pdf

http://www.state.nd.us/humanservices/services/medicalserv/chip/apply.html and return it to Department 325, 600 E. Boulevard Avenue, Bismarck, ND 58505-0250. This application is used to determine if individuals qualify for health coverage under the Healthy Steps children's health insurance program or Medicaid and Caring Program for Children.

Applications are also available at local County Social Service Offices or by calling (800) 755-2604.

Family Voices of ND has applications available for families:

888-522-9654



Caring Program for Children

The North Dakota Caring Foundation was established in 1989 by Blue Cross Blue Shield of North Dakota as part of its effort to make affordable health care available to all North Dakotans.

With financial support from businesses, community and church groups, and individuals, the Foundation provides Caring for Children, a specially designed health and dental benefit program for eligible children, at no cost to the children or their families.

Blue Cross Blue Shield of North Dakota, in cooperation with the Dental Service Corporation of North Dakota, contributes all administrative costs. That means all funds - 100 percent - are used to provide benefits for the children.

Health and dental benefits include:

- physician office visits & routine physicals
- emergency accident care
- diagnostic tests
- well child care and immunizations
- limited inpatient and surgical services
- mental health & chemical dependency care
- preventive dental services
- limited restorations & extractions (copay)

An important part of the program is the network of participating physicians, dentists, hospitals, mental health and other professionals who accept reduced fees as payment in full for services to enrolled children.

Thousands of North Dakota children do not receive the primary and preventive health and dental care they need. They are from low income working families who cannot afford insurance and do not receive or are not eligible for Medicaid. The children fall through the cracks in terms of receiving basic health and dental services.

How does a child qualify for the program?
A child must be an unmarried natural son or daughter, stepchild, legally adopted child or under the legal guardianship of parents whose household income is within qualifying guidelines. The child cannot be eligible for Medicaid, Healthy Steps or other health insurance. All eligible children in the family must apply. Children are eligible from birth to age 19, provided those of school age remain full-time students through grade 12 and are residents of North Dakota. No child can be turned down for any health reason.

How To Apply

An application can be obtained online at:
http://www.state.nd.us/eforms/Doc/sfn00502.pdf

http://www.bcbsnd.com/about/pdf/27000774.pdf or by calling a BCBSND representative at 1-800-342-4718 or write to BCBSND at 4510 13th Avenue South, Fargo, ND 58121-0001.

Understanding Private Insurance

Many middle income families, you may not qualify for a public program such as Medical Assistance. It is important to know what to look for in your private insurance plans.

BASIC PRIVATE HEALTH INSURANCE

Commercial health plans are sold as a contract. Health plans agree to provide health services either on an individual basis or to a group of employees. Most individuals are covered through employer-based group health insurance. Health insurance is a contract which must meet certain guidelines under state regulations. These guidelines are enforced through a state government agency.

Group Health Coverage

Group health insurance is most often provided through an employer. Health plans usually receive a set amount of money from the employer to cover their employees' heath costs. The employer usually pays on a per employee, per month basis. That money is to cover all the health care costs of all employees covered under the plan for that month. Not everyone goes to the doctor every month. The health plan hopes that there will be more members who stay well during the month. Then the health plan can pocket the money (if it's a for-profit health plan; or reinvest it in health services if it is a non-profit health plan.)

The costs to individual members of these plans are usually lower because the insurance company can spread the amount of risk with a larger pool of those covered. "Risk" refers to the responsibility to pay for the actual cost of providing health services.

Small employers have been cutting back on coverage for their employees. They have smaller risk pools to offer health plans. Small employers usually have to pay a higher rate for their employees to receive the same benefits. These small employers have several choices to make when providing health coverage. They may choose to offer a plan but not provide any assistance in paying for the

coverage. They may offer only employee coverage leaving dependent/family coverage up to the individual employee to purchase. They may restrict the amount of coverage offered. Co-payments, deductibles and premiums are often high for this employer group.

Large employers (those with 50 or more employees) can often provide a better coverage package with less out-of pocket costs for employees. Over the last several years even large employers have struggled with keeping costs at a minimum. Some have even chosen to exclude dependent coverage.

Some employers have turned to managed care to attempt to keep costs reasonable. They have begun to offer "cafeteria" plans which allow employees to choose the types of benefits they need. The co-pays and deductibles often vary among these cafeteria type plans. Traditional fee-for service plans under group employment are becoming less and less frequent even under group-based health insurance. Most employers are reaching out to managed care to try to keep their employee costs at a minimum.

Individual Coverage

When a person has no access to a group health plan, health insurance purchased directly from the health plan (rather than through an employer) is usually available. Essentially, the individual must pay the rate that an employer would pay under group health arrangements. Individual coverage is tailored to one person or family and the health plan usually charges a high premium. In addition, there may be high co-payments and deductibles. Often these forms of "cost-sharing" exceeds thousands of dollars. Insurers use these costs both to cut their own expenses, but also in the hope that it will discourage members from using only the most non-necessary health services. This type of health insurance usually has higher costs and fewer benefits for the health plan member.

Anyone who has to contact their insurance company before entry into a hospital setting is essentially enrolled in a managed care plan. However, there are three main types of managed health care plans.

Understanding Health Maintenance Organization (HMO)

An HMO is a type of managed care plan that provides or arranges for coverage of defined health services needed by plan members for a prepaid premium. Covered services are usually paid for in full through the premium payment or may require a small fixed fee or co-payment for office visits or other benefits, such as prescription drugs. Plan enrollees must use providers in the HMO network or else services may not be covered. There are several different models of HMO plans.

Preferred Provider Organization (PPO)

A PPO is a Preferred Provider Organization. If you use a provider (hospital, doctor or other medical provider) that is a member of the PPO you normally will pay a lower deductible and/or coinsurance amount. The insurance carrier can do this because the carrier and PPO have a written agreement to provide the carrier a discount for services provided to the carrier's customers. The insurance carrier passes on the savings to the customer in the form of lower deductibles and/or coinsurance.

Point of Service Plan (POS)

POS plans (sometimes called open-ended HMOs) permit members to decide at the time services are needed whether to obtain covered services through designated network providers or through non-participating (out-of-network) providers. Members' cost-sharing responsibilities vary, depending on whether they obtain services through in-network or out-of-network providers. If using in-network services, the HMO's cost-sharing requirements apply. However, members may seek out-of-network treatment and receive benefits on a fee-for-service basis, usually at higher cost to the member.

What are eligible expenses?

Eligible expenses are medical expenses incurred by an Insured Member for covered services listed in the health insurance plan that are ordered or prescribed by a Physician for the treatment of a covered Accident or Sickness and are Medically Necessary. In

most health insurance plans, the amount of expenses in excess of the Usual and Customary Charges, as determined by the insurance carrier, in the geographic area where the expenses are incurred are not considered Eligible Expenses.

What is a deductible?

A deductible is the amount of eligible expenses incurred during a Calendar year that an Insured Member must pay before any benefits are payable. In some health insurance plans, eligible expenses incurred after a specific date, which have not been paid because the deductible has not been met, may be used to help satisfy the deductible for the next calendar year.

What is coinsurance?

Coinsurance is the percentage applied to eligible expenses after subtracting the deductible. In many health insurance plans the coinsurance an Insured Member is responsible for is capped after a certain dollar amount of eligible expenses have been incurred.

What is a doctor's office visit co-pay?

A doctor's office visit co-pay is the fixed amount payable by an Insured Member on a per visit/service basis.

What is the difference between an in-network provider and an out-of-network provider?

An in-network medical provider is a provider that is a member of a PPO that is approved by your insurance carrier. An out-of-network provider is not a member of a PPO that is approved by your insurance carrier. The amount you will be responsible for paying will be less if you use an in-network provider than an out-of-network provider.

"Can I be reimbursed for services already provided? Or do I need PRE-AUTHORIZATION in order to be reimbursed?"

Many health insurance and managed care companies will not even consider reimbursing you for services provided and paid for PRIOR to your call. They will require that you receive their authorization

first.

If you are eligible to file claims for reimbursement, then ask:

"What is the rate of reimbursement?"

That is, what percentage of the money that you spend will be reimbursed to you? For example, if you spend $100 out-of-pocket for one hour of individual psychotherapy and then submit a claim for reimbursement, should you expect to get the full $100 reimbursed? Probably not. How much will be reimbursed?

What is a lifetime maximum benefit?

A lifetime benefit maximum is a cap on the amount of benefits available to a policyholder. The cap is designed to keep the cost of benefits affordable and to stabilize potential future costs. Many health plans cap lifetime benefits at $1 million and are most often applied to mental illness, drug and alcohol treatment, or organ transplants.

If a plan has a relatively low lifetime maximum cap, think carefully about how much risk you're willing to assume. Even if you're healthy, the expenses incurred from one severe car accident -- including hospitalization and outpatient physical therapy -- could easily exceed a $100,000 cap.

What do most people worry about?

Pre-existing Conditions: New Federal Law

Many people worry about coverage for ***pre-existing conditions,*** especially when they change jobs. Recent changes in federal law help assure continued health insurance coverage for employees and their dependents. Starting July 1, 1997, insurers may impose only one 12-month waiting period for any pre- existing condition treated or diagnosed in the previous six months. Your prior health insurance coverage will be credited toward the preexisting condition exclusion period as long as you have maintained continuous coverage without a break of more than 62 days. Pregnancy is not considered a pre-existing condition, and newborns and adopted children who are covered within 30 days are not subject to the 12- month waiting

period.

If you have had group health coverage for two years, and you switch jobs and go to another plan, that new health plan cannot impose another pre-existing condition exclusion period. If, for example, you have had prior coverage of only eight months, you may be subject to a four month pre-existing exclusion period when you switch jobs. If you've never been covered by an employer's group plan, and you get a job that offers such coverage, you may be subject to a 12-month pre-existing condition waiting period.

Federal law also makes it easier for you to get individual insurance under certain situations, including if you have left a job where you had group health insurance, or had another plan for more than 18 months without a break of more than 62 days.

If you have not been covered under a group plan and have found it difficult to get insurance on your own, check with your state insurance department to see if your state has a risk pool. Similar to risk pools for automobile insurance, these can provide health insurance for people who can not get it elsewhere.

What Is Not Covered?

While HMO benefits are generally more comprehensive than those of traditional fee for-service plans, no health plan will cover every medical expense.

Few plans cover eyeglasses and hearing aids because these are considered expenses that need to be budgeted for. Very few plans cover elective cosmetic surgery, except to correct damage caused by a covered accidental injury. Some fee-for-service plans do not cover wellness checkups. Procedures that are considered experimental may also not be covered. Some plans cover complications arising from pregnancy but do not cover normal pregnancy or childbirth.

Health insurance policies frequently exclude coverage for pre-existing conditions, but, as explained, federal law now limits

exclusions based on such conditions.

Insurers will not pay duplicate benefits. A husband and wife may each be covered under a health insurance plan at work but, under what is called a coordination of benefits provision, the total you can receive under both plans for a covered medical expense cannot exceed 100 percent of the allowable cost. Also, if neither of the plans covers 100 percent of your expenses you will only be covered for the percentage of coverage (for example, 80 percent) that your primary plan covers. This provision benefits everyone in the long run because it helps to keep costs down.

What Happens to My Insurance if I Lose My Job?

If you have had health coverage as an employee benefit and you leave your job, voluntarily or otherwise, one of your first concerns will be maintaining protection against the costs of health care. You can do this in one of several ways:

- First, you should know that under a federal law (the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly known as COBRA), group health plans sponsored by employers with 20 or more employees are required to offer continued coverage for you and your dependents for 18 months after you leave your job. (Under the same law, following an employee's death or divorce, the worker's family has the right to continue coverage for up to three years.) If you wish to continue your group coverage under this option, you must notify your employer within 60 days. You must also pay the entire premium, up to 102 percent of the cost of the coverage.
- If COBRA does not apply in your case-- perhaps because you work for an employer with fewer than 20 employees-- you may be able to convert your group policy to individual coverage. The advantage of that option is that you may not have to pass a medical exam, although an exclusion based on a pre- existing condition may apply, depending on your medical history and your insurance history.
- If COBRA doesn't apply and converting your group coverage is not for you, then, if you are healthy, not yet eligible for Medicare, and expect to take another job, you might

consider an interim or short- term policy. These policies are designed to provide medical insurance for people with a short-term need, such as those temporarily between jobs or those making the transition between college and a job. These policies, typically written for two to six months and renewable once, cover hospitalization, intensive care, and surgical and doctors' care provided in the hospital, as well as expenses for related services performed outside the hospital, such as X-rays or laboratory tests.

- Another possibility is obtaining coverage through an association. Many trade and professional associations offer their members health coverage-- often HMOs-- as well as basic hospital-surgical policies, and disability and long-term care insurance. If you are self-employed, you may find association membership an attractive route.

What is the first thing I should know about buying health coverage?

Your aim should be to insure yourself and your family against the most serious and financially disastrous losses that can result from an illness or accident. If you are offered health benefits at work, carefully review the plans' literature to make sure the one you select fits your needs. If you purchase individual coverage, buy a policy that will cover major expenses and pay them to the highest maximum level. Save money on premiums, if necessary, by taking large deductibles and paying smaller costs out-of- pocket.

One of my medical bills was turned down by the insurance company (or health plan). Is there anything I can do?

Ask the insurance company why the claim was rejected. If the answer is that the service isn't covered under your policy, and you're sure that it is, check to see that the provider entered the correct diagnosis or procedure code on the insurance claim form. Also check that your deductible was correctly calculated. Make sure that you didn't skip an essential step under your plan, such as preadmission

certification. If everything is in order, ask the insurer to review the claim.

Patient Bill of Rights

A Patient Bill of Rights describing the responsibility of health plans to group coverage plans has moved slowly through Congress. But several other federal laws are in place that provide health plan and employer responsibilities. In addition, state laws are enforced by a state insurance commission working closely with the Governor and employers in the state to ensure that health contracts are handled fairly. The state insurance commission also handles any grievances brought about in a dispute between insurance contract partners.

Private Insurance Checklist/Things to Look For

Inpatient Hospital Coverage

- What hospitals are covered under this plan?
- Can you receive home care services in lieu of hospital care?
- What types of services are covered?
- What co-pays are required for each type of service?
- Are there any deductibles?
- Are there prior authorization (approvals) procedures to be followed for needed services not covered? Are there penalties for not following those procedures? If so, can you file an appeal? How is that handled? In emergency (where patients risk pain, suffering or disability) situations, can time frames be accelerated to assure appropriate and timely care?
- How many days of inpatient hospital care is covered?
- Will exceptions be made possible if services are deemed necessary by the primary physician? What procedures must be followed to receive an exception? Can they be approved by phone or

must written approval be received by the primary physician?

- What is the time frame for such approvals? Can services be covered until such time as a decision is made? Who does the company consult with about children with special health care needs? Do their credentials include pediatric experience particularly in developmental pediatrics?
- Are there pre-existing condition clauses limiting coverage? For how long are these conditions denied coverage? Are those spelled out clearly in the contract? By whom?
- Is there an Appeals process? What are the procedures for appeals?

Outpatient Services and Home Care Coverage:

- What types of providers' services will be covered? Is there a list of providers one must use? Are their credentials available and do the credentials document experience in pediatric care?
- How many hours of each service will be covered?
- How many visits are allowed? Please define a visit.
- Is there a minimum or maximum number of hours or dollars in these areas?
- Are there restrictions regarding home care? A) registered nurse only/registered nurse only at eight hour shifts; or B) Medicare-certified home health agency only?
- Must home care start within a designated number of days of hospital discharge and be completed in so many days? Will this be covered 100%? What are the co-insurance requirements?
- What is the family deductible per calendar year?
- What has been paid by our family toward our yearly deductible as of the present date?

- Is there an 80/20, 90/10, 50/50 coinsurance requirement up to a specified dollar amount per calendar year, after which the insurer covers 100% of the charges or costs? What is the dollar amount?
- Is there a lifetime maximum? Does this include hospital coverage or only outpatient services/ home care nursing services, etc? What has been expended toward that lifetime maximum?
- Does the contract include case management services either provided by the insurer or an outside agency? Who has the final decision-making power? How can that person be accessed during an appeal?
- Is there major medical coverage? To what limit?
- What services are included in the major medical coverage? Are there restrictions on providers? Are there exceptions to going outside that list? What are the cost ramifications?
- Does this policy contain a catastrophic illness clause?
- Are there any exclusionary clauses? Are alternative medical procedures covered? Is there an appeals process if procedures are denied? What documentation is required by medical director for such an appeal?
- Can you/or your employer purchase a supplemental benefits package? Can this include services that are not already covered?
- Are the following services available under your current policy or can they purchased under a separate policy?

Adaptive equipment:

- prone standers
- corner tables
- specialized car seats
- bath aids
- van adaptations

- Medications
- trach tubes
- gastrostomy tubes or buttons
- feeding pumps and bags
- catherterization equipment and bags
- wheelchairs - how often can they be replaced _____
- seat adaptations - how often can they be replaced _____
- scooters
- crutches___ walkers____ braces___
- Corrective shoes
- eyeglasses__ lens replacement__ how often can they be replaced_____
- Specialized orthodontia
- Dental braces
- Prosthetic devices

Services:

- Respite care:_____ in-home_____ out-of-home
- Specialized medical day care
- Genetic services
- Hospice
- Speech, language and hearing services
- Physical therapy
- Occupational therapy
- Programs for eating disorders
- Mental health services
    - coverage restrictions _____
    - payment restrictions _____
    - inpatient care _____
    - outpatient mental health services _____
- Homemaker/home health aide services
- Personal attendant
- Nutrition services

- Rehabilitation services
- Habilitation services
- Infant stimulation programs
- High-risk infant follow-up programs
- Early intervention programs
- Counseling programs: parents_____ peers_____ patient_____ restrictions_____
- Case management _____individualized____ benefits managers_____

Durable Medical Equipment:

- Ventilators
- bipap machine
- suctioning
- I.V. stands
- air compressors
- feeding pumps
- nebulizers
- CPT vests____ pacemakers____ phrenic___ heart____ diabetes kits _____

Questions to ask your insurer:

- How does your insurance policy define and how does the company determine what is:
  - usual and customary
  - experimental
  - therapeutic
  - custodial
  - medically necessary?
- When seeking a referral to specialists what are the procedures and restrictions?
- To those affiliated with the contract? To those outside the contract?
- How long does it take to get a decision on a request?
- Who approves such referrals?
- How are denials of referrals appealed?

- What hospitals are available under my plan?
- Are their primary care physicans who specialize in children? Children with special needs? Experience in children's mental health?
- How many patients must a primary care provider, under this plan, see?
- Is the time frame for each visit restricted under this plan? How long can the primary care physician visit with patients?
- If I decide to change primary care physician are there procedures I must follow? What financial incentives (bonuses or penalties) are used to encourage the physician to control utilization and cost of services?
- Will the plan pay for a second opinion from a physician outside this plan?
- Are all providers within a reasonable geographic location or must we travel to another city or area?

General Tips to Follow When Working with Health Plans:

- Get information about your insurance policy, HMO contract or PPO contract in writing from your insurance company, HMO or PPO.
- Always know your insurance agent or employee benefits representative and where he or she can be reached.
- Know where a copy of your policy is located. Read through it carefully as soon as you receive it.
- Know your policy number and enrollment code and include them with any inquiry, whether in written correspondents, by phone or email.
- Keep a record of all phone calls, including date, time, name of the person you spoke with and content of the conversation.
- Make a clear and concise presentation of any information. Always speak to your child's medical

needs and how long they are expected to last. Demonstrate how paying for a particular service or item will improve the your child's health outcomes or prevent further disabling conditions.

- Be willing to negotiate. Propose payment of a service or item which may not be covered in your plan for a period of time to demonstrate cost savings or improved health outcomes.
- Always remember the bottom line is cost savings or improved health outcomes. Be sure the person that negotiates for your coverage understands you and your child's needs. Share your child's success with your boss, your benefits manager and other employees so they may feel a part of doing what is right for your child and family.

Understanding Medical Necessity

Medical necessity refers to the basis by which a health plan determines if a particular procedure, product, treatment, or other service will be covered by the plan. This is one way for the health plan to limit costs.

Case managers play a key role in determining first what procedures are covered according to the contract (benefits package). If a procedure is deemed "not covered" by the case manager, an appeals process is available. The health plan's medical director must use all available information to determine whether a medical procedure being submitted for payment is necessary for the health and well-being of a patient. It is during this appeals process that the medical director for the insurer examines the information provided and determines whether it meets the qualifications for medical necessity.

Defining Medical Necessity

Many states have a definition for medical necessity, the following statement is taken from (*Defining Medical Necessity, Strategies for Promoting Access to Quality Care for Persons with Developmental Disabilities, Mental Retardation and Other Special Health Care Needs)*

Specifications for Defining Medical Necessity Include:

A covered service or item is medically necessary if it will do, or is reasonably expected to do one or more of the following:
Arrive at a correct medical diagnosis
Prevent the onset of an illness, condition, injury, or disability
Reduce, correct or ameliorate the physical, mental, developmental, or behavioral effects of an illness, condition, injury or disability.
Assist the individual to achieve or maintain sufficient functional capacity to perform age-appropriate or developmentally appropriate daily activities.

2. The insurer must determine medical necessity on the basis of the health information provided by the following persons: the individual (as appropriate for his or her age and communicative abilities), the individual's family, the primary care physician, and consultants with appropriate specialty training, as well as other providers, programs, multidisciplinary teams, educational institutions, or agencies that have evaluated the individual.

3. The determination of medical necessity must be made on an individual basis and must consider: The functional capacity of the person and those capacities that are appropriate for persons of the same age or developmental level

4. Available research findings, health care practice guidelines, and standards issued by professionally recognized organizations or government agencies.

5. Final determinations will be made by a physician in concert with the following persons: the individual's primary care physician; a consultant with experience appropriate to the individual's age, disability, or chronic condition; and the individual and/or family.

Medically necessary services must be delivered in a setting (e.g., an individual's home, school, child care center, workplace, or community based agency) that is appropriate to the specific health needs of the individual.

Advocating for Coverage

A health plan must be responsible to its consumers. There are all kinds of avenues for recourse, if a health plan treats their members unfairly. These are some things you need to know, so that you can take charge of your health care, or advocate on behalf of others.

It will be important for individuals and advocates who work with clients to identify key players within a health plan. Several individuals and departments have already been identified but let's recap.

Claims Department-these people are the first to respond to a claim. They begin the history of the claim. Their number appears on the explanation of benefits (EOB) you receive.

Medical Director-the person with ultimate responsibility to assure payment for your claim.

The Case manager-a person who may be hired directly by the health plan or who is contracted by the plan to monitor claims and assure that beneficiaries are using the most cost efficient methods to monitor their health status. Case managers are to respond directly to the Medical Director of the health plan.

Benefits manager-the person at your place of employment who is responsible for negotiating the contract with the insurer.

It is critically important to keep good records of any conversations with these people. Always note the person's name, the date and time contacted and the information they provided. Ask the benefits manager and/or the insurance company to fill out the questionnaire provided in the resource list. This questionnaire will enhance your understanding of services available under the health plan; and, the amount, duration, and scope of the services allowed. It will also explain your plan's reimbursement procedures.

Member Responsibility

It will be important to do good record keeping about the health care services received. Know how to read an explanation of benefits. Match your records to those of the health plan. Know how to appeal a claim denial. Most importantly, know what the future medical needs might be for everyone in the family, or for those you are helping. Learn to evaluate choices based on current health needs or reasonably expected needs in the future. Use a physician to help assess the kind of future health needs family members may have. Consistent and coordinated care helps anticipate long-range health care needs. This is why establishing a medical home is especially important for people with special health care needs.

Helping Partners

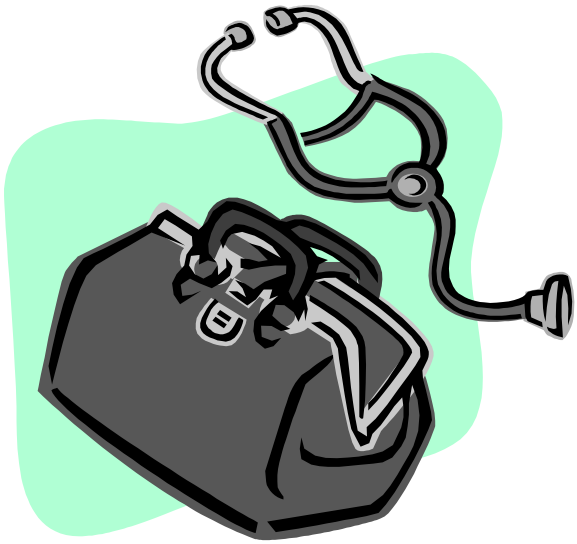
People with special health care needs have several partners who act as advocates for them. Previously we mentioned the state insurance commissioner or the state commission on insurance. These members of the state government are appointed by the governor to monitor how insurance policies are written within the state, and assuring that the laws of the state are followed. One such important law prohibits insurers from denying a claim based on the claimants eligibility for Medicaid. If a citizen believes that he/or she has been denied benefits that are stated to be covered by an insurer the commissioner or his department is bound to review the contract to settle this dispute. If other discrepancies are found, the health plan

may not get additional Medicaid contracts from the state government.

The state insurance commissioner's office works closely with the state Attorney General to monitor activities of those operating businesses within the state. The Attorney General can provide legal assistance to citizens of a state who have been denied covered benefits if the insurance commission believes it is warranted.

Two other agencies can provide legal assistance to citizen of a state:

- Legal Services who work on behalf of the poor have assisted in numerous cases involving denial of services and coverage.
- Protections and Advocacy is the legal organization for persons with disabilities. Most often their background is in special education law but there have been state programs who have involved themselves with denial of benefits claims.



Social Security Income

WHAT is it?

- Supplemental Security Income (SSI) is a federal program for people with disabilities administered by the Social Security Administration. Under SSI, a child is defined as being under age 18 and unmarried.
- If your child is found eligible for SSI then he or she is may be eligible for Medicaid.
- Your child, if eligible, would also receive a monthly check from the Social Security Administration. The amount of the check will depend on the income and resources of the child and/or the child's household.

How do I QUALIFY for it?

Eligibility is based on

- a determination that the child is disabled
- The family's (including the child's) earned and unearned income, resources, and assets.

How do I APPLY for it?

Families can either call or visit their local Social Security Administration (SSA) to begin the application process. The local SSA office will send the claim to the Disability Determination Service (DDS) for a medical decision.

☎ (800) 772-1213 Federal

💻 http://www.ssa.gov/

☎Bismarck- 701-250-4200

☎Devils Lake 701-662-6290

☎Dickinson 701-250-4200

☎Fargo 701-239-5607

☎Grand Forks 701-772-5518

☎Jamestown 701-252-6024

☎Minot 701-852-0604

☎Williston- 701-572-0682

You can also call toll free **1-800-772-1213** to the Federal Social Security Administration to begin the application process.

- A face to face interview is NOT required. The application can be completed by phone and mailed to the family for their signatures.

Financial Eligibility

The Social Security Administration (SSA) determines a family's financial eligibility based on the following:

- **Earned Income**: Earned income is money from wages, tips, or self-employment.

- **Unearned Income**: Unearned income is money from child support, alimony, bank interest, unemployment compensation, Reach Up, disability trust income etc.

- **Resources and Assets**: Resources are things that families own such as cash, bank accounts, stocks, bonds, houses, cars, and boats. Farm equipment, rental property, furniture and personal belongings may be resources. Parents may have $3,000 in countable resources if two parents live in the home, or $2,000 if one parent is in the household. SSA considers any amount above that as belonging to the child. This is called "deeming". If the amount deemed to the child, combined with any resources the child has, is under $2,000, the child is eligible for SSI.

Some resources are NOT counted by the Social Security Administration, such as the house that you live in, one car of any value which is used for employment and/or medical appointments. (If the car is not used for these purposes, its value cannot exceed $4500

Many factors are considered when determining financial eligibility. All families are encouraged to apply even if they

feel they are slightly over the income/resource guidelines. SSA will determine whether you meet the income/resource guidelines.

OR

- **Waiver of Parental Deeming:** This is another way for a child to be found eligible for SSI. Under Section 1614(f)(2)(B) of the Social Security Act, when a child lives with his/her parent(s), a parent's income and/or resources are NOT counted if ALL of the following conditions are met:
  - the child is under age 18 years and disabled; **and**
  - at any time in the child's life the child previously received SSI, at the personal needs allowance level, while in a medical institution, for one calendar month or more; and
  - the child would be found ineligible for SSI benefits because the parent's income and resources are over the limit set by the Social Security Administration.

The child who fits into these eligibility rules would be eligible to receive SSI benefits based solely on the eligible child's income and resources. Payments to the child would be based on the personal needs allowance, currently $47.66/month.

Disability Eligibility

The Disability Determination Service (DDS) determines if a child's disability meets eligibility requirements based on information provided by medical providers, therapists, counselors, schools, and parents.

- A child is considered to be disabled by the Disability Determination Service (DDS) if: 1) the child has a physical or mental condition which results in severe functional limitations, and 2) the condition is expected to last at least 12 months or result in death.

- The family will be asked to list professionals who can provide information about their child's disability. This list should include ANYONE who can help document facts about a child's disability, including letters from physicians, therapists, teachers, day care providers, as well as family, friends, relatives, and/or others. Letters that describe the child's limitations are most helpful.

The Disability Determination Service (DDS) determines the functional abilities and disabilities of the child.

Appeals Process

The Social Security Administration denies applications for children's SSI benefits where the medical evidence in the claim does not meet the requirements for eligibility. A large number of initial applications are turned down.

These denials can be appealed and benefits may be approved after an appeal is decided. Benefits are retroactive to the date of the original application.

Health Insurance - Glossary of Terms

Allowable Fee, or Usual and Customary Reimbursement (UCR): The maximum amount a health insurer will pay for a service or procedure.

Assignment: The legal transfer of one person's interest in an insurance policy to another person.

Balance Billing: A billing practice in which you are billed for the difference between what your insurer pays and the fee that the provider normally charges.

Coinsurance: Some insurance coverage requires you to pay a percentage of the cost of covered medical services, usually 20-30 percent. For example, you pay 20 percent of the cost, and your insurance pays 80 percent of the cost. Your portion of the cost is the coinsurance.

Commercial Insurers: Health insurance can also be written by life insurers, property/casualty insurers and other types of insurers. These insurers offer products similar to those provided by nonprofit indemnity insurers. (See non-profit indemnity insurers.) Policyholders are subject to deductibles and significant out-of-pocket costs unless they use a preferred provider network.

Complaint: A complaint occurs whenever a consumer or provider complains to the State of North Dakota about a health insurer or Health Maintenance Organization (HMO).

Co-payment: A flat fee for specified medical services required by some insurers. For example, you pay a $10 co-payment for a doctor visit or a $50 co-payment for a hospital stay.

Deductible: The amount you must pay each year for your medical expenses before your insurance policy starts paying. Deductibles are common in fee-for-service coverage and PPOs.

External Appeal/External Review: You may request an independent external review when you are denied health care services on the basis that those services are experimental, investigational, or not medically necessary. The review is conducted by an external review organization that is not affiliated with your insurer, your doctor, or your family.

Fee-for-Service (FFS): Also known as indemnity insurance, FFS is a type of health coverage that typically allows you to go to any doctor or provider. Your insurance company will reimburse your provider for each covered service provided. Deductibles and coinsurance usually apply in FFS coverage.

First-level Internal Appeal Process: Once you have received a decision on your utilization review appeal, you have completed the

first-level internal appeal process. If the decision is not in your favor, you are entitled to request an external review. If you and your insurer waive the first level review, you are then permitted to proceed directly to an external review. (See utilization review appeal and external review.)

Grievance: A grievance is a complaint to an HMO by a member or provider about an action or decision. Decisions regarding the medical necessity of a service are not considered grievances. They are handled as utilization review appeals. (See utilization review appeal.)

Health Maintenance Organization (HMO): The HMO arranges for, or contracts with, a variety of health care providers to deliver a range of services to consumers who make up its membership. All HMOs employ managed care strategies that emphasize prevention, detection and treatment of illness. HMOs use primary care physicians as the coordinator of patient care needs. An HMO may offer consumers an HMO plan or POS plan. (See health maintenance organization plan and point of service plan.)

Health Maintenance Organization (HMO) Plan: A type of coverage that provides comprehensive health services to members in return for a monthly premium and co-payment. In an HMO plan, members may choose a primary care physician (PCP) who coordinates each assigned member's care. The PCP refers patients to specialists and provider services as needed. Although many HMOs require their members go to the doctors and other providers in the HMO provider network, some HMO plans offer the option to go out-of-network (for example in a POS plan). HMO plans often require members receive a referral from their PCP before seeing a specialist. (See primary care physician and point of service plan.)

Non-profit Indemnity Insurers: Non-profit indemnity insurers employ managed care strategies but offer a more traditional approach to coverage than HMOs. Non-profit indemnity insurers reimburse policyholders, physicians and hospitals. Non-profit policyholders are subject to deductibles and out-of-pocket costs that are considerably higher than those required by HMOs unless they use a preferred provider network.

Out-of-pocket maximum: The amount of co-insurance a member must pay before out-of network claims will be paid at 100% of the allowed amount.

Participating Provider: A health care provider (e.g., doctor, psychologist, hospital) who agrees to accept the terms, conditions and allowable payments of an insurer.

Point of Service (POS) Plan: A type of managed care coverage that allows members to choose to receive services either from participating HMO providers or from providers outside the HMO's network. Members pay less for in-network care. For out-of-network care, members usually pay a deductible and coinsurance.

Preferred Provider Organization (PPO): A type of managed care coverage based on a network of doctors and hospitals that provides care to an enrolled population at a prearranged discounted rate. PPO members usually pay more when they receive care outside the PPO network.

Preferred Care Provider (PCP)-practitioner, or in some instances an obstetrician/gynecologist. If you are enrolled in an HMO, you usually must choose a PCP from a list of participating providers. The PCP coordinates your care and makes referrals to specialists as needed.

Prompt Pay Complaint: A complaint from a consumer or provider to the North Dakota State Insurance Department about the late payment of claims.

Referral: Authorization from your primary care physician or health insurer to see a specialist or receive a special test or procedure. HMOs often require that you obtain a referral for most specialty care. It is important to know what your health insurer's rules and procedures are for referrals.

Schedule of Allowances: The set dollar amount the insurance policy covers for each procedure.

Self-Insured Health Plan: In this type of plan, an employer will pay

for employees' health care costs out of a fund that the company has set aside for medical expenses. Employers may contract with an outside organization, often an insurance company, to administer the plan. Under a federal statute known as ERISA, the U.S. Department of Labor has authority over self-insured employer health plans.

Specialist: A doctor who has been specially trained in and practices a specific type of medicine other than primary care (e.g., cardiologists, dermatologists, gastroenterologists). If you are enrolled in an HMO, you usually will need a referral from your primary care physician to see a specialist.

Utilization Review (UR) Appeal: A UR Appeal occurs when a consumer asks an insurer to reconsider its refusal to pay for a medical service the insurer considers experimental, investigational, or not medically necessary. (See first-level internal appeal process.)

Advocacy and Legal Resources

North Dakota Protection and Advocacy System

☎ Bismarck office (701) 328-2950/ (800) 472-2670
☎ Region 1: Williston (701) 774-4345
☎Region2: Minot (701) 857-7686 Belcourt (701) 477-5066
☎Region 3: Devils Lake (701) 662-9026
☎Region 4: Grand Forks (701) 795-3800
☎ Region 5: Fargo (701) 239-7222
☎Region 6: Jamestown (701) 253-3295
☎ Region 7: Bismarck (701) 328-2950
☎Region 8: Dickinson (701) 227-7444
💻 www.ndpanda.org

- Help protecting your child's rights
- Legal help and information
- Find people who help with legal problems

☎ARC State Office (701) 223-5349

☎The ARC of Upper Valley (701) 772-6191

☎ARC of Bismarck (701) 222-1854
☎ ARC of Bowman (701) 523-5254
☎ARC of Dickinson (701) 483-4272
☎ARC of Cass County (701) 293-8191
☎ARC of Valley City (701) 845-2117

- Help for children with developmental disabilities
- Help with your child's education and health
- Help when you have a problem getting services for your child

Legal Assistance of North Dakota

- Serves low income or elderly individuals

☎ Bismarck (701) 258-4270 or 800-932-8882
☎ Devils Lake (701) 662-6560 or 800 726- 8980
☎ Fargo (701) 232-4495 or 800-342-4696
☎ Grand Forks (701) 777-2932 or 800-752-0312
☎ Minot (701) 852-3870 or 800-342-4409
☎ New Town (701) 627-4719 or 877-627-4122

Independent Living Centers (ILC'S)

ILC's work toward equality and inclusion for people with disabilities through programs of
empowerment, community education, and systems change.
☎Dakota Center for Independent Living/Bismarck (701) 222-3636
☎Freedom Resource Center for Independent Living/Fargo (701) 478-0459
☎Independence/Minot (701) 839-4724
☎Options/East Grand Forks (218) 773-6100

Local Social Security Offices

Extra money for your child's medical care if your child has a disability. Based on family income and child's disability
☎ (800) 772-1213 Federal
💻 http://www.ssa.gov/

☎Bismarck- 701-250-4200
☎Devils Lake 701-662-6290
☎Dickinson 701-250-4200
☎Fargo 701-239-5607
☎Grand Forks 701-772-5518
☎Jamestown 701-252-6024
☎Minot 701-852-0604
☎Williston- 701-572-0682

Health Services

Medical Services Division: ND Department of Human Services

☎ (800) 755-2604 or 701-328-2321
💻 http://www.nd.us/childrenshealth

🕮 Look in the Blue (Government) section of the phone book under County, then under Social Services

- Food stamps
- Help finding a place to live
- Help applying for Medicaid /Healthy Steps
- Respite or therapeutic day care

Children Special Health Services (CSHS)

☎ Bismarck 701-328-2436 or 800-755-2714
Provide services for children with special health care needs and their families and promote family-centered, community-based, coordinated services and systems of health care. A complete list of conditions that qualify for financial help is available through the state office. **To apply for CSHS, you may apply at your County Social Service Office**

- The Multidisciplinary Clinic Program is a resource to help families manage their child's chronic health condition. Most clinics supported by Children's Special Health Services (CSHS) provide multidisciplinary team evaluations where families have an opportunity to see many different providers in one place at one time.
- The Care Coordination Program through Children's Special Health Services (CSHS) helps families access services and resources

in their community, and when needed, across multiple service delivery settings
- Specialty Care
- Diagnostic Treatment Services
- Russel Silver Program
- Provides medical food and low-protein modified food products to individuals with Phenylketonuria (PKU) and Maple Syrup Urine Disease (MSUD).
- Operates a resource center that provides the following public information services free of charge: 1) toll free numbers to assist in locating resources; 2) targeted outreach information and referral efforts; 3) resource library; 4) education and consulting services; 5) other public information activities.

CHIP: Children's Health Insurance Plan/Healthy Steps

☎ (800) 755-2604
- Low cost health insurance for your child
- You may apply even if your income is too high for Medicaid

Covering Kids & Families

(ND Health Coverage Programs)
☎877-KIDS-NOW OR 877-543-7669

Caring Program for Children

Privately-funded Coverage Program
☎ 800-342-4718

Prescription Programs

Prescription Connection (Low Cost Prescriptions
Prescription Connection for ND is a program of the North Dakota Insurance Department that connects qualified people with discount drugs, direct from the manufacturer.

If you are currently taking prescription medication, and do not have health insurance or do not qualify for other prescription assistance,

you may be eligible for this assistance.

Each individual pharmaceutical company has its own eligibility criteria. The criteria may include one or more of the following: Income guidelines, Asset guidelines, Citizenship status, Veterans benefits status, and Prescription benefits currently received through other programs, such as Medicaid

We are always looking for individuals who are interested in helping people in their communities. If you are interested in becoming a volunteer counselor for the program, please contact us.

ND Insurance Department
600 East Boulevard Avenue
State Capitol, Fifth Floor
Bismarck, ND 58505
701.328.2440 - phone
701.328.9610 - fax
☎ 888-575-6611

Public Health Departments in your District or County

📖 Look in the blue (Government) section of the phone book or ask your health care provider.
💻 http://www.health.state.nd.us/localhd/
They help you find:

- Food
- WIC
- Immunizations
- Nurses and other people to help with your child's care

☎ 1-800-472-2286/ND Department of Health

Community Health Centers in North Dakota

☎Northland Community Health Center-Rolette (701) 246-3391

☎Valley Community Health Center/Larimore (701) 343-6418

☎Valley Community Health Center/Northwood (701) 587-6000

☎Family Health Care Center/Fargo Clinic (701) 239-7111

☎Family Health Care Center/ Fargo Homeless Health Services (701) 298-9245

☎Family Health Care Center-Fargo Native American Program (701) 235-6036

☎Northland Community Health Center-McClusky (701) 363-2296

☎Northland Community Health Center-Turtle Lake (701) 448-9255

☎Coal Country Community Health Center-Halliday (701) 938-4464

☎Coal Country Community Health Center-Beulah (701) 873-4445

☎Coal Country Community Health Center-Center (701) 794-8798

Family Support Organizations

Family Voices of North Dakota

☎ 888-522-9654 or (701) 493-2634
💻 http://www.familyvoices.org (National)
💻 http://www.geocities.com/ndfv/ (State)

- Assistance in locating resources, assistance in navigating private and public systems for children with special health care needs
- Assistance driven by family need/Health Information and Education Center

Federation of Families for Children's Mental Health

Dedicated exclusively to helping children with mental health needs and their families achieve a better quality of life
☎Bismarck State Office (800) 492-4951 or (701) 222-3310
☎Fargo Regional Office (701) 235-9923

ND Family to Family

F2F support network based on the philosophy that parents who have successfully adapted to their children's disabilities or special health care needs, are the best support for other parents of children with special needs.
☎888-434-7436 or (701) 777-2359
💻http://www.med.und.nodak.edu/depts/rural/family/contact/index.html

Pathfinder Family Center

Provides information, training, resources in meeting the education needs of children with disabilities
☎ (701) 837-7500 or 800-245-5840
💻http://pathfinder.minot.com/index2.html

Notes: _____

FAMILY VOICES OF NORTH DAKOTA®

Other publications from FVND:

Care Notebook-a recordkeeping guide for families

New Beginnings-A resource directory offering general resources and support information.

Accessing and Understanding Health Services
ND Children and SSI

Fact Sheets:
EPSDT/Medicaid
Medical Home
Emergency Preparedness for children with special health needs
Vocational Rehabilitation
COBRA
Health Insurance Laws
Meeting Your Child's Health Needs
Paying the Bills
And many others…….

FVND has a variety of workshops and trainings available for families and providers.

For more information contact FVND at 888-522-9654
Or fvnd@drtel.net