CHAPTER 4. HEAD INJURY PROGRAM

Sec.

4.1. Scope and purpose.
4.2. Definitions.
4.3. Services eligible for payment.
4.4. Requirements for provider participation.
4.5. Application for enrollment as a HIP client.
4.6. Assessment.
4.7. Enrollment.
4.8. Rehabilitation service plan.
4.9. Rehabilitation period.
4.10. Transition period.
4.11. Case management services.
4.12. Funding limits.
4.13. Payment for HIP services.
4.14. Peer review.
4.15. Administrative review.

Authority

The provisions of this Chapter 4 issued under section 14(e) of the Emergency Medical Services Act (35 P. S. § 6934(e)); and section 2102(g) of The Administrative Code of 1929 (71 P. S. § 532(g)), unless otherwise noted.

Source

The provisions of this Chapter 4 adopted July 27, 2001, effective August 27, 2001, 31 Pa.B. 4064, unless otherwise noted.

§ 4.1. Scope and purpose.

(a) This chapter establishes standards for the Department to administer the Fund.

(b) The Department will use the Fund to administer a head injury program, as set forth in this chapter, to pay for medical, rehabilitation and attendant care services for persons with traumatic brain injury.

§ 4.2. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Agency head—The Secretary or a deputy secretary designated by the Secretary.

Alternative financial resources—

(i) All income subject to tax under section 61 of the Internal Revenue Code (26 U.S.C.A. § 61).

(ii) Funds which are available to the applicant or client by virtue of experiencing a TBI. These include, but are not limited to, court awards,

insurance settlements and other financial settlements made as a result of the TBI and received by any person on behalf of or for the use of the applicant or client.

(iii) Funds which are available to the applicant or client through other State or Federal programs including, but not limited to, Medicaid, Medicare, Social Security Disability Insurance (Title II), Supplemental Security Income (Title XVI), veterans' benefits, workers' compensation insurance and unemployment compensation insurance.

Applicant—An individual for whom a completed application for enrollment in HIP has been submitted to the Department.

Authorized representative—An individual who is authorized by law to make a decision for, or enter into an agreement on behalf of, an applicant or client. The term does not include an employee of the provider unless the employee is appointed by a court to serve as the legal guardian of the applicant or client.

Case management services—Services to be offered by the provider to a client during the enrollment period.

Case manager—An individual who delivers case management services to a client through a provider.

Client—An individual enrolled in HIP.

Day services—Nonresidential services intended to improve the physical, cognitive, behavioral or functional abilities of the client through therapeutic intervention and supervised activities which are provided on an outpatient basis at a facility belonging to a provider.

Department—The Department of Health of the Commonwealth.

Division—The Division of Child and Adult Health Services.

Enrollment period—The period of time, comprised of the rehabilitation period and the transition period, during which a client is enrolled in HIP.

Fund—The Catastrophic Medical and Rehabilitation Fund.

HIP—Head Injury Program—The traumatic brain injury program of the Department.

HIP Peer Review Committee—A committee, composed of professionals and representatives of organizations offering rehabilitation services in this Commonwealth to persons with traumatic brain injury, whose members are appointed by the Department to review rehabilitation plans and services offered to clients and to recommend actions to improve services.

HIP services—Rehabilitation and case management services for which the Department authorizes payment through HIP.

Home facilitation—A formal rehabilitation program which provides a community reentry specialist in the client's home to continue therapy learned by the client and to assist the client in the practice of techniques and strategies for living independently.

 Copyright © 2001 Commonwealth of Pennsylvania

Immediate family—A parent, spouse, child, brother, sister, grandparent or grandchild and, when living in the family household (or under a common roof), all other individuals related by blood or marriage.

Peer review—A review of services and rehabilitation service plans for clients conducted by the HIP Peer Review Committee for the purpose of advising the Department on best practices to be followed in offering services to clients.

Provider—An individual, organization or facility that delivers rehabilitation and case management services to clients under a contractual agreement with the Department.

Rehabilitation period—The period of time that a client receives rehabilitation services through HIP.

Rehabilitation service plan—The written plan developed by the provider, which states specific goals to be achieved and expected time frames for achievement of each goal.

Rehabilitation services—Services provided to assist the client to recover from TBI, improve the client's health and welfare, and realize the client's maximum physical, social, cognitive, psychological and vocational potential for useful and productive activity. These services include neuropsychological evaluation, physical therapy, occupational therapy, speech or language therapy, behavior management, home facilitation, therapeutic recreation, prevocational services, case management services and psychological services which may include cognitive remediation.

Secretary—The Secretary of the Department.

TBI—traumatic brain injury—An insult to the brain, not of a degenerative or congenital nature, caused by an external physical force that may produce a diminished or altered state of consciousness, which results in impairment of cognitive abilities or physical functioning or in the disturbance of behavioral or emotional functioning. These impairments may be either temporary or permanent and cause partial or total functional disability or psychosocial maladjustment.

Transition period—The period of time following the rehabilitation period during which a client receives case management services through HIP to guide and assist the client to make the transition out of HIP.

§ 4.3. Services eligible for payment.

HIP will pay for the following:

(1) Assessments of applicants by providers.

(2) Development of rehabilitation service plans by providers.

(3) Rehabilitation services.

(4) Case management services.

§ 4.4. Requirements for provider participation.

(a) Providers of residential, outpatient, day and home-based rehabilitation services shall be accredited by a National accrediting body as approved by the Department. From time to time, the Department will publish a list of approved National accrediting bodies in the *Pennsylvania Bulletin*.

(b) Providers shall provide rehabilitation services in accordance with their contractual agreements with the Department.

(c) Providers shall use forms and procedures as prescribed by the Division in the provision of rehabilitation services.

§ 4.5. Application for enrollment as a HIP client.

(a) *Initial contact*. An individual who is interested in enrolling in HIP or in arranging for another individual to be enrolled in HIP shall contact the Eligibility Specialist of the Division by writing to: Eligibility Specialist, Department of Health, Division of Child and Adult Health Services, Post Office Box 90, 7th Floor East Wing, Health And Welfare Building, Harrisburg, Pennsylvania 17108. Contact may also be made by facsimile or electronic mail.

(b) *Funding*. The Division will accept an application for enrollment in HIP only if the funds designated to HIP from the Catastrophic Medical and Rehabilitation Appropriation exceed projected expenditures in providing HIP services to current clients.

(c) *Waiting list*. If the funds designated to HIP from the Catastrophic Medical and Rehabilitation Appropriation are not adequate to enable the Division to accept an application for an individual for whom enrollment in HIP is sought, the Division will place the individual on a waiting list if the individual so elects. The individual on the waiting list or the authorized representative shall immediately notify the Division of any change in mailing address. The Division will request an individual on the waiting list, or the authorized representative, to submit an application for enrollment as funding becomes available. Except as otherwise provided in this chapter, the Division will request individuals on the waiting list, or their authorized representatives, to submit applications in the order that the requests to be placed on the waiting list were received by the Division. Individuals who are receiving case management services through HIP as of August 27, 2001, but who have never received rehabilitation services through HIP, will be given first priority on the waiting list.

(d) *Application*. When an individual qualifies to receive an application for enrollment in HIP, the Division will send to that individual or the person who sought to enroll that individual in HIP, at the mailing address provided to the Division, information on HIP and application materials. If the individual is on a waiting list, the Division will also request that the individual notify the Division in writing whether the individual is still seeking enrollment in HIP. The notification shall be timely only if it is postmarked within 21 days after the date the

Copyright © 2001 Commonwealth of Pennsylvania

materials were sent by the Division. If the Division receives a timely notification that enrollment in HIP is desired, the Division will proceed with the application process. If the Division is apprised that enrollment in HIP is no longer desired, or if the Division does not receive timely notification of continued interest in enrollment, the Division will remove the individual from the waiting list, contact the next person on the waiting list and repeat the process.

(e) *Request and application for reenrollment*. A request for reenrollment may be filed for an individual who was previously enrolled in HIP. If there is a waiting list, the Division will not accept an application for reenrollment. Instead, it will place the individual on the waiting list. The Division will give priority to individuals on the waiting list who have not previously received rehabilitation services from HIP. The Division will request individuals who have previously received rehabilitation services from HIP who are on the waiting list, or their authorized representatives, to submit applications for reenrollment. The Division's requests for these applications will be made in the order that the requests for reenrollment were received. Except as provided in subsection (c), the Division will only accept a request or application for reenrollment for an individual who is not a client at the time the request or application is made.

(f) *Acceptance of application*. The Division will accept an application for enrollment only from the individual for whom enrollment is sought or from an authorized representative.

§ 4.6. Assessment.

(a) *Eligibility for assessment*. The Division will review an application for enrollment in HIP to determine whether the applicant is eligible for an assessment, as follows:

(1) *General criteria*. An applicant shall be eligible for an assessment only if all of the following requirements are met:

(i) The applicant sustained a TBI after July 2, 1985.

(ii) The applicant is a citizen of the United States and was domiciled in this Commonwealth at the time of the injury and at the time of application for enrollment in HIP.

(iii) The applicant is 21 years of age or older.

(iv) The application is completed and is accompanied by the documentation that is requested to verify the applicant's satisfaction of the eligibility criteria in this subsection.

(v) The applicant's alternative financial resources are at or below 300% of the Federal Poverty Income Guidelines.

(A) The applicant's income will be assessed using the applicant's most recent Federal Income Tax form, which the applicant shall provide. If that form is unavailable, the Division may request other documentation of income. If the most recent Federal Income Tax form is not representative

of the applicant's income at the time of application, the applicant may submit documents to that effect in support of the application.

(B) The applicant shall provide, on forms provided by the Division, information about any court award or financial settlement made or pending as a result of the TBI, and any other funds which are available to the applicant. If all or part of the award, settlement or other funds is unavailable to the applicant to use for HIP services, the applicant may submit documents to that effect in support of the application.

(2) *Condition criteria*. An applicant shall be eligible for an assessment only if the applicant's impairment is not the result of one or more of the following conditions:

(i) Cognitive or motor dysfunction related to congenital or hereditary birth defects.

(ii) Putative birth trauma or asphyxia neonatorum (hypoxic-ischemic-encephalopathy).

(iii) Hypoxic encephalopathy unrelated to TBI.

(iv) Significant preexisting psychiatric, organic or degenerative brain disorder.

(v) Stroke.

(vi) Spinal cord injury in the absence of TBI.

(3) *Symptom criteria*. An applicant shall be eligible for an assessment only if the applicant does not manifest any symptom, such as a comatose condition, which would prevent the applicant from participating in the assessment in a meaningful way or prevent the provider from doing a full and complete assessment.

(4) *Assignment agreement*. An applicant shall be eligible for an assessment only if the applicant or authorized representative completes an assignment agreement which, conditioned upon the applicant's receipt of HIP services, would assign to the Department rights in future court awards, insurance settlements or any other proceeds which have accrued or will accrue to the applicant as a result or by virtue of the applicant's TBI, up to the amount expended for HIP services on behalf of that individual.

(b) *Assessment process*. The Division will refer an applicant who is eligible for an assessment to a provider. The provider shall assess the applicant for the following:

(1) To corroborate the Division's determination that the applicant satisfies the condition and symptom criteria in subsection (a)(2) and (3).

(2) To determine that the applicant has the physical, social, cognitive, psychological and vocational potential for useful and productive activity which can be nurtured by rehabilitation services available through HIP so as to enable the applicant to progress toward a higher level of functioning and transition to a less restrictive environment.

 Copyright © 2001 Commonwealth of Pennsylvania

(3) To determine that the applicant has needs that can be addressed by HIP services, that will not be addressed by any other services to which the applicant is entitled.

(4) To determine that the applicant does not manifest suicidal or homicidal ideation, or potentially harmful aggressive behavior, to such a degree that HIP cannot provide the appropriate services through its providers to sufficiently address these ideations or behaviors.

(c) *Forms and procedure*. The provider shall complete the assessment on forms provided by the Division. A provider conducting an assessment shall:

(1) Review the applicant's medical records.

(2) Review all pertinent documentation submitted by physicians on behalf of the applicant.

(3) Evaluate the applicant's ability to benefit from rehabilitation services, performed in accordance with standards prevailing in the field.

(d) *Development of rehabilitation service plan*. If the provider corroborates the Division's initial determination under subsection (a)(2) and (3), and determines that the applicant meets the criteria in subsection (b)(2)—(4), the provider shall develop a rehabilitation service plan for the applicant as specified in § 4.8 (relating to rehabilitation service plan).

(e) *Assessment period*. The provider shall complete its assessment and give written notification of its determination to the Division and the applicant or authorized representative within 14 days after the provider begins to conduct an assessment of the applicant. If the provider determines that the applicant is eligible for enrollment in HIP, the provider shall also complete a rehabilitation service plan for the applicant within that 14-day period.

(f) *Reapplication*. If the Division determines that an individual is not eligible for an assessment or that an applicant is not eligible for enrollment in HIP after an assessment has been completed, the individual may repeat the process for seeking enrollment in HIP when the individual or authorized representative believes that the factors which rendered the individual ineligible for enrollment in HIP have been eliminated.

Cross References

This section cited in 25 Pa. Code § 4.7 (relating to enrollment).

§ 4.7. Enrollment.

(a) *Notification of decision*. The Division will notify an applicant or authorized representative in writing of its decision regarding an application for enrollment within 16 days after receiving from the provider the completed assessment and, if applicable, its decision regarding the rehabilitation service plan. If the Division determines that the applicant is ineligible, the notice will include the reason for that determination and will advise of appeal rights.

(b) *Provider determination that applicant is not eligible for enrollment*. If, after assessing the applicant the provider determines that the applicant does not satisfy the condition and symptom criteria in § 4.6(a)(2) and (3) (relating to assessment), lacks the potential to benefit or the need described in § 4.6(b)(2) and (3) or manifests ideation or behavior which would render the applicant unfit to participate in HIP under § 4.6(b)(4), the provider shall share its findings with the Division and the applicant or authorized representative. The Division will provide the applicant or authorized representative the opportunity to rebut the provider's findings, and then will make a determination as to whether the applicant is eligible for enrollment in HIP.

(c) *Overturning provider determinations*. If the Division determines that an applicant is eligible for enrollment in HIP despite the provider's determination to the contrary, or that a rehabilitation service plan is unacceptable, the Division will direct the provider, or another provider at the Division's discretion, to develop a rehabilitation service plan for the applicant within 14 days of receiving the Division's decision. The Division will act on the revised rehabilitation service plan within 16 days after receipt.

(d) *Commencement of enrollment*. A client's enrollment begins on the first day that a client receives rehabilitation services from a provider after the Division issues its written notification granting enrollment in HIP.

(e) *Duration of enrollment*. The enrollment period of a client shall be specified in the client's rehabilitation service plan. It may not exceed 18 consecutive months, comprised of a maximum rehabilitation period of 12 consecutive months followed by a maximum transition period of 6 consecutive months. A client's enrollment shall end prior to the time designated in the client's rehabilitation service plan when one of the following occurs:

(1) The Division determines that the continuation of HIP services will not enable the client to progress to a higher level of functioning and transition to a less restrictive environment.

(2) The client fails to cooperate or exhibits unmanageable behavior so that HIP cannot provide the appropriate services to meet the client's needs under § 4.6(b)(4).

(3) The maximum funds available for allocation to the client under § 4.12 (relating to funding limits) are exhausted.

(4) The client becomes eligible for other services offered as a result of the TBI, which services will meet the client's needs or duplicate HIP services so that HIP services are rendered unnecessary.

(f) *Notification of discharge from HIP*. The Division will notify a client or authorized representative in writing of its decision to terminate the client's participation in HIP. The notice will include the reason for the decision and will advise of appeal rights.

(g) *Grandfather clause*. Clients who are receiving rehabilitation services as of August 27, 2001 are eligible for the maximum enrollment period, beginning on

Copyright © 2001 Commonwealth of Pennsylvania

August 27, 2001. Clients who are receiving only case management services as of August 27, 2001 are eligible for the maximum transition period.

Cross References

This section cited in 28 Pa. Code § 4.15 (relating to administrative review).

§ 4.8. Rehabilitation service plan.

(a) *Development of rehabilitation service plan*. The provider shall collaborate with the applicant or authorized representative, and may collaborate with other individuals identified by the applicant, to develop a rehabilitation service plan for the applicant.

(b) *Goal*. The primary goal of the rehabilitation service plan shall be to enable the client to progress to a higher level of functioning, which will, in turn, enable the client to transition to a less restrictive environment.

(c) *Requirements*. The initial rehabilitation service plan shall contain the following:

(1) A description of desirable goals and the anticipated outcomes in objective and measurable terms, including the expected time frames for the achievement of each goal and outcome, for the entire enrollment period.

(2) A specification of the HIP services necessary to attain the agreed-upon goals.

(3) A specification of any other services to which the applicant is entitled and a description of the impact of those services upon the attainment of the agreed-upon goals.

(4) Beginning and ending dates of each HIP service.

(5) The terms and conditions for HIP service delivery.

(6) The specific responsibilities of the applicant and service provider relative to implementation of each HIP service.

(7) The extent of financial responsibility of the applicant, HIP and any third party.

(d) *Quarterly review*. The rehabilitation service plan shall include a procedure and schedule for quarterly review and evaluation of progress towards the specified goals. These written reviews shall be submitted to the Division.

(e) *Modifications*. The provider shall make modifications to the rehabilitation service plan as often as necessary, and in accordance with subsections (a)—(d). Modifications shall indicate whether previously set goals were met. When goals were not met, modifications shall address the reasons why, and modify or change goals appropriately.

Cross References

This section cited in 28 Pa. Code § 4.6 (relating to assessment).

§ 4.9. Rehabilitation period.

(a) *Provision of rehabilitation services*. During the rehabilitation period a provider shall coordinate the provision of rehabilitation services to a client to ensure achievement of goals consistent with the rehabilitation service plan, and as appropriate to the needs of the client to improve the client's health, welfare and the realization of the client's maximum physical, social, cognitive, psychological and vocational potential for useful and productive activity.

(b) *Supervision*. Rehabilitation services shall be provided or their provision shall be supervised by a physician or other appropriate health professional qualified by training or experience to provide or supervise these services.

(c) *Purpose*. If authorized under the rehabilitation service plan, rehabilitation services may be provided for the following purposes:

(1) Helping a client develop behaviors that enable the client to take responsibility for the client's own actions.

(2) Facilitating a client's successful community integration.

(3) Assisting a client to accomplish functional outcomes at home and in the community.

(4) Teaching a client skills to live independently.

(5) Supervising a client living in a home setting through the following:

(i) Home facilitation.

(ii) Physical rehabilitation.

(iii) Cognitive remediation.

(iv) Life-skills coaching.

(v) Assisting the client in maintaining independence.

(6) Providing transitional living services to assist a client with community reentry skills.

(7) Maximizing a client's physical potential.

§ 4.10. Transition period.

(a) *Provision of case management services*. Following the rehabilitation period, HIP will provide case management services to assist the client in making the transition out of HIP.

(b) *Commencement of transition period*. The transition period will commence immediately following the end of the rehabilitation period.

(c) *Duration of transition period*. The transition period may not exceed 6 consecutive months, and shall end when the maximum funds available for allocation to the client are exhausted under § 4.12 (relating to funding limits).

§ 4.11. Case management services.

Case management services shall be provided by a case manager who has a minimum of 1 year of experience in TBI case management, and shall include the following activities by the case manager:

Copyright © 2001 Commonwealth of Pennsylvania

(1) Monitoring the client's progress with respect to the rehabilitation service plan and collaborating with the client or authorized representative, the client's significant others and the rest of the treatment team in the development and modification of the rehabilitation service plan.

(2) Assisting the client in gaining access to services from which the client may benefit and for which the client may be eligible.

(3) Monitoring and evaluating the client's progress in transitioning to living in a home or community setting and ensuring that any necessary supports are in place, or facilitating placement of the client in a long-term care facility.

(4) Determining that the client has fully transitioned to the home or community or has been referred to the appropriate long-term care facility.

§ 4.12. Funding limits.

(a) HIP will provide no more than $100,000 for case management and rehabilitation services for a client during a rehabilitation period. This amount will be reduced by any client share of costs under § 4.13(b) (relating to payment for HIP services).

(b) HIP will provide no more than $1,000 for case management services for a client during a transition period. This amount will be reduced by any client share of costs under § 4.13(b).

(c) The Division will notify an applicant of these maximum funding limits when it accepts the applicant as a client.

Cross References

This section cited in 28 Pa. Code § 4.7 (relating to enrollment); 28 Pa. Code § 4.10 (relating to transition period); and 28 Pa. Code § 4.15 (relating to administrative review).

§ 4.13. Payment for HIP services.

(a) *Written authorization*. The Division will provide written authorization, to the client and to the provider, as to HIP services for which the client is eligible and the maximum available funding and time limits for those services.

(b) *Client responsibility for payment*. If the Division determines that a client is responsible to pay for any part of HIP services, the client will be informed of that fact, and of the amount for which the client is responsible, as follows:

(1) The client shall be assessed a share of the cost of HIP based upon alternative financial resources between 185% and 300% of the Federal Poverty Income Guidelines. The patient's share of the cost shall be determined using the Patient Share of Cost Table in Appendix A, as periodically updated and published in the *Pennsylvania Bulletin*.

(2) The client will be responsible to pay for HIP services up to the amount of alternative financial resources which exceed 300% of the Federal Poverty Income Guidelines.

(c) *Notification of discontinuance of HIP funding*. The Division will notify a client in writing of any discontinuance of funding. The notice will include the reason for the discontinuance and advise of appeal rights.

(d) *Duty to update financial information*. A client shall immediately report to the Division all changes in availability of alternative financial resources.

(e) *Preexisting conditions*. HIP will not pay for services to address conditions existing prior to the TBI.

(f) *Services funded through other benefit programs*. HIP will not pay for services available through other publicly funded programs. The provider will coordinate HIP with other public and private programs to assist clients to access benefits for which they may be eligible.

(g) *Reimbursement*. The Department may seek reimbursement for payments made with HIP funds on behalf of a client from an insurer that provides coverage to the client or from the proceeds of any litigation arising out of the injury which led to eligibility for enrollment in HIP.

Cross References

This section cited in 28 Pa. Code § 4.12 (relating to funding limits).

§ 4.14. Peer review.

(a) *Purpose*. The Department will appoint a peer review committee to conduct a review of services and rehabilitation service plans for clients. The HIP Peer Review Committee (Committee) shall advise the Department on best practices to be followed in offering services to clients.

(b) *Procedures*.

(1) The Committee shall meet quarterly and review selected client charts, including charts for at least one client from each provider providing services at the time of the quarterly meeting, to evaluate the appropriateness of provision of services and client progress.

(2) Within 30 days after it completes its review, the Committee shall provide to the Department, in writing, recommendations regarding the provision of services by each provider.

(3) A member of the Committee may not participate in a review conducted by the Committee that presents a conflict of interest for that member. Examples of conflicts include, but are not limited to, participating in a review conducted by the Committee for one of the following:

(i) A service provided to a client of that member, that member's employer or that member's immediate family.

(ii) A service provided by a person who is in the immediate family of the member.

(4) The Division will notify the Committee of any actions taken on the recommendations of the Committee.

 Copyright © 2001 Commonwealth of Pennsylvania

§ 4.15. Administrative review.

(a) *Reconsideration by Division*.

(1) An applicant, client or authorized representative may file with the Division a request for it to reconsider any of the following decisions made by the Division:

(i) An applicant is not eligible for an assessment.

(ii) An assessed applicant is not eligible for enrollment.

(iii) A disapproval or revision of a rehabilitation service plan.

(iv) A client is to be discharged from HIP prior to the date specified in the client's rehabilitation service plan.

(v) Alternative financial resources are available so that the client must pay for HIP services.

(2) At the time a decision is made, the Division will notify the applicant, client or authorized representative in writing of the right to seek administrative review. The letter will advise the recipient to seek assistance from legal counsel, family and others who may serve in an advisory role, and include contact information for a HIP representative to answer questions.

(3) An applicant, client or authorized representative shall file a request for reconsideration within 15 calendar days after the mailing date of the Division's determination. The request shall meet the following standards:

(i) State the specific legal and factual reasons for disagreement with the decision.

(ii) Identify the relief that is being sought for the applicant or client.

(iii) Include supporting documentation, if any, to support the factual averments made.

(4) The Division will notify the applicant, client or authorized representative in writing of its decision within 30 days after receiving the request for reconsideration.

(b) *Administrative appeal*.

(1) An applicant, client or authorized representative may file an administrative appeal to the Agency Head within 30 days after the mailing date of the Division's decision on the request for reconsideration. An applicant, client, or authorized representative may not file an administrative appeal unless reconsideration has been sought and the requested relief has been denied.

(2) A hearing will be held only if a material issue of fact is in dispute.

(c) *General rules*. The General Rules of Administrative Practice and Procedure, 1 Pa. Code Part II, apply except when inconsistent with this section.

(d) *Status of clients and applicants*. A client shall continue to receive HIP services until the client's right to administrative review has been exhausted, and until the maximum funds available to a client under § 4.12 (relating to funding limits) are exhausted, or the maximum duration for enrollment under § 4.7(e) (relating to enrollment) has expired. An applicant, including one who has com-

pleted the assessment period, will not receive HIP services pending the disposition of the administrative review.

Appendix A

BUREAU OF FAMILY HEALTH
DIVISION CHILD AND ADULT HEALTH SERVICES

PATIENT SHARE of COST (PSC) TABLE

PSC	$0	$0	$50	$250	$400	$550	$700	$850	$1000	$1150
% of Poverty	0 to 100%	>100 to 185%	>185 to 225%	>225 to 250%	>250 to 275%	>275 to 300%	>300 to 325%	>325 to 350%	>350 to 375%	>375 to 400%
Size of Family Unit	Income Ranges						Use these columns only for clients who were in DCAHS programs prior to 1/1/97 and have continuous participation without a lapse in eligibility.			
1	0	8,591	15,893	19,329	21,476	23,624	25,771	27,919	30,066	32,214
	8,590	15,892	19,328	21,475	23,623	25,770	27,918	30,065	32,213	34,360
2	0	11,611	21,480	26,124	29,026	31,929	34,831	37,734	40,636	43,539
	11,610	21,479	26,123	29,025	31,928	34,830	37,733	40,635	43,538	46,440
3	0	14,631	27,067	32,919	36,576	40,234	43,891	47,549	51,206	54,864
	14,630	27,066	32,918	36,575	40,233	43,890	47,548	51,205	54,863	58,520
4	0	17,651	32,654	39,714	44,126	48,539	52,951	57,364	61,776	66,189
	17,650	32,653	39,713	44,125	48,538	52,950	57,363	61,775	66,188	70,600
5	0	20,671	38,241	46,509	51,676	56,844	62,011	67,179	72,346	77,514
	20,670	38,240	46,508	51,675	56,843	62,010	67,178	72,345	77,513	82,680
6	0	23,691	43,828	53,304	59,226	65,149	71,071	76,994	82,916	88,839
	23,690	43,827	53,303	59,225	65,148	71,070	76,993	82,915	88,838	94,760
7	0	26,711	49,415	60,099	66,776	73,454	80,131	86,809	93,486	100,164
	26,710	49,414	60,098	66,775	73,453	80,130	86,808	93,485	100,163	106,840
8	0	29,731	55,002	66,894	74,326	81,759	89,191	96,624	104,056	111,489
	29,730	55,001	66,893	74,325	81,758	89,190	96,623	104,055	111,488	118,920
9	0	32,751	60,589	73,689	81,876	90,064	98,251	106,439	114,626	122,814
	32,750	60,588	73,688	81,875	90,063	98,250	106,438	114,625	122,813	131,000
10	0	35,771	66,176	80,484	89,426	98,369	107,311	116,254	125,196	134,139
	35,770	66,175	80,483	89,425	98,368	107,310	116,253	125,195	134,138	143,080
11	0	38,791	71,763	87,279	96,976	106,674	116,371	126,069	135,766	145,464
	38,790	71,762	87,278	96,975	106,673	116,370	126,068	135,765	145,463	155,160

Copyright © 2001 Commonwealth of Pennsylvania

PSC	$0	$0	$50	$250	$400	$550	$700	$850	$1000	$1150
% of Poverty	0 to 100%	>100 to 185%	>185 to 225%	>225 to 250%	>250 to 275%	>275 to 300%	>300 to 325%	>325 to 350%	>350 to 375%	>375 to 400%
Size of Family Unit	Income Ranges						Use these columns only for clients who were in DCAHS programs prior to 1/1/97 and have continuous participation without a lapse in eligibility.			
12	0	41,811	77,350	94,074	104,526	114,979	125,431	135,884	146,336	156,789
	41,810	77,349	94,073	104,525	114,978	125,430	135,883	146,335	156,788	167,240
13	0	44,831	82,937	100,869	112,076	123,284	134,491	145,699	156,906	168,114
	44,830	82,936	100,868	112,075	123,283	134,490	145,698	156,905	168,113	179,320
14	0	47,851	88,524	107,664	119,626	131,589	143,551	155,514	167,476	179,439
	47,850	88,523	107,663	119,625	131,588	143,550	155,513	167,475	179,438	191,400
15	0	50,871	94,111	114,459	127,176	139,894	152,611	165,329	178,046	190,764
	50,870	94,110	114,458	127,175	139,893	152,610	165,328	178,045	190,763	203,480
16	0	53,891	99,698	121,254	134,726	148,199	161,671	175,144	188,616	202,089
	53,890	99,697	121,253	134,725	148,198	161,670	175,143	188,615	202,088	215,560

Note: This table is revised each year based on the release of HHS Federal Poverty Income Guidelines by the United States Department of Health and Human Services. The figures above were published in the *Federal Register*: February 16, 2001 (Volume 66, Number 33) Notices: (pages 10695—10697).

[Next page is 5-1.]

Copyright © 2001 Commonwealth of Pennsylvania