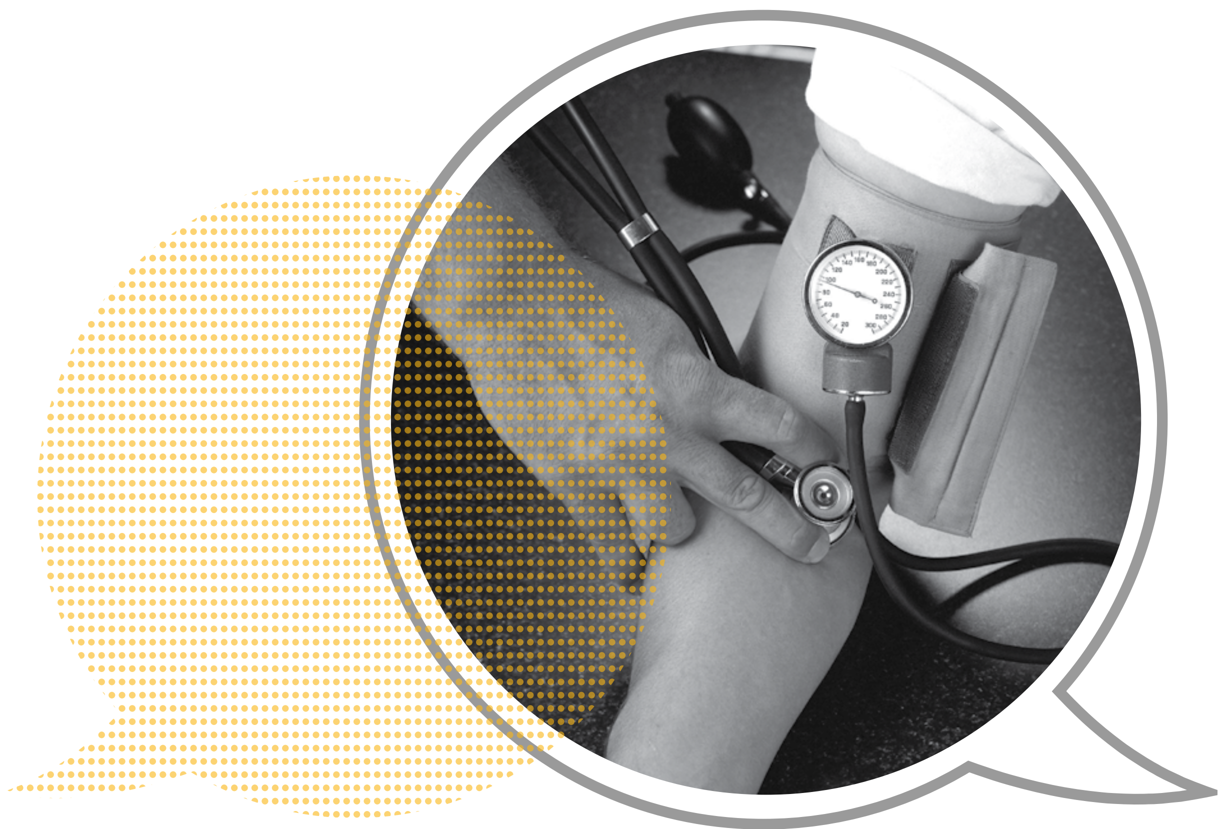
AT HOME PROGRAM GUIDE

For Health Care Professionals and Families

BRITISH COLUMBIA

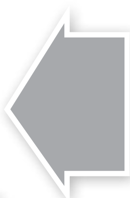
Ministry of Children and Family Development



INTENT *of this* GUIDE

This guide provides detailed information on all aspects of the *At Home Program* and is intended to assist both parents and health care professionals with understanding how the program works. As the guide is updated regularly, please refer to the online guide on the ministry's website for the most current version.

A family can access *At Home Program* Respite and Medical Benefits without having to read through all of the technical information in this guide. However, some information, such as travel reimbursement, only applies to families and should be reviewed.



TO ASSIST IN DETERMINING WHAT INFORMATION IS PARTICULARLY USEFUL FOR FAMILIES, THIS SPECIAL LOGO HAS BEEN ADDED TO SOME SECTIONS.

HERE *to* HELP

The Ministry of Children and Family Development is committed to children with severe disabilities and their families. As always, staff are available to answer questions you may have and provide assistance. Contact information for each section is provided throughout this guide.

Questions about **MEDICAL Benefits:**
TOLL-FREE: 1 888 613-3232
VICTORIA: 250 387-9649

Questions about **RESPITE Benefits:**
Please contact your local MCFD Office

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AT HOME PROGRAM OVERVIEW

The *At Home Program* (AHP) is intended to assist parents or guardians with some of the extraordinary costs of caring for a child with severe disabilities at home. It provides assistance in two main areas:

RESPITE BENEFITS allow parents or guardians to access respite services that best suit their needs. *See page 8, About Respite Benefits*, for more information.

MEDICAL BENEFITS provide a range of basic, medically necessary items and services. *See page 9, About Medical Benefits*, for more information.

A child may be eligible for both Respite Benefits and Medical Benefits, or a choice of one benefit.

WHO *is* ELIGIBLE?

To be eligible for the AHP, a child or youth must be:

- 17 years or younger for Medical Benefits; 18 years or younger for Respite Benefits;
- A resident of British Columbia;
- Enrolled with British Columbia Medical Services Plan;
- Living at home with a parent or guardian or with an Extended Family Program caregiver.

AND one of the following:

- Assessed as dependent in at least three of four functional activities of daily living (eating, dressing, toileting and washing);
- Considered to have a palliative condition;
- Eligible for Nursing Support Services Direct Care; or,
- Diagnosed with one of the following degenerative conditions: Duchenne Muscular Dystrophy; Spinal Muscular Atrophy Type 2.

Children assessed as dependent in three of four functional activities of daily living are eligible for a choice of either AHP Respite or Medical Benefits. Families may switch between these benefits up to once per year.

Children assessed as dependent in four of four functional activities of daily living are eligible to receive both AHP Respite and Medical Benefits.

The following are circumstances where a child or youth does not require an AHP assessment to receive one or both benefits:

- Children with a palliative condition, as indicated by the child's physician on the *At Home Program* Application form, are eligible for both AHP Respite and Medical Benefits.
- Children who receive direct nursing care through *Nursing Support Services* are eligible for Medical Benefits. The child may continue to receive Medical Benefits for three months following his/her discharge from Nursing Support Services. An eligibility assessment is required to continue benefits beyond this timeframe.
- Children diagnosed with Duchenne Muscular Dystrophy or Spinal Muscular Atrophy Type 2 are eligible for Medical Benefits.

Program eligibility may be reassessed at the discretion of the Ministry of Children and Family Development (MCFD).

How Do I Apply?

Complete the *At Home Program Application form* with the assistance of a physician. The application is available on the *At Home Program forms page* online, at your local MCFD Office, or local health unit. The telephone number of your local health unit can be found in the blue pages of your telephone directory or by calling Health Link BC at 811.

Mail or fax the completed form to your local *At Home Program Regional Contact*.

MCFD At Home Regional Contacts review the completed application, and will arrange for the child to have an assessment if necessary.

What is an Eligibility Assessment?

An assessor will contact the family and arrange to meet with the parent or guardian, and child or youth in their home. An assessment of the child's abilities in four functional activities of daily living (eating, dressing, toileting and washing) will be conducted. The assessor may also contact other health care providers to review the child's needs and abilities or may request to observe the child in an alternative setting.

The assessor provides the parent or guardian with a copy of the completed assessment.

How is Eligibility Determined?

A regional eligibility committee reviews the application and assessment, and makes an eligibility recommendation to MCFD.

The parent or guardian will receive a letter indicating the eligibility decision. If the child is not eligible for the AHP, the parent or guardian may be referred to other supports and services where available.

If the child or youth is eligible for the AHP, a Children and Youth with Special Needs (CYSN) social worker will follow up to discuss the family's needs and other available CYSN services.

What Do I Do If I Disagree With an Eligibility Decision?

If you do not agree with an eligibility decision, please contact your local *At Home Program* Regional Contact. If you have additional medical documentation that was not available during the assessment, submit it for review.

If a satisfactory resolution is not achieved, you may contact the Ministry of Children and Family Development's Client Relations Branch at 1 877 387-7027 (toll-free) or 250 387-7027 (Victoria) and enquire about the *complaint resolution process*.

I Have Received a Settlement or Court Award, Am I Still Eligible for The At Home Program?

The AHP, like most other MCFD services for children and youth with special needs, is subject to the Eligibility for Services following a Third Party Settlement or Court Award policy. Under this policy, children or youth who are in receipt of a settlement or court award related to the child's disability are not eligible for the AHP. *Parents and guardians are responsible for notifying MCFD if a settlement or court award has occurred*.

Please contact your CYSN worker for more information.

ABOUT RESPITE BENEFITS

AHP RESPITE BENEFITS ARE MANAGED LOCALLY THROUGH MCFD OFFICES.

The AHP Respite Benefits provides funding to purchase respite care for eligible children and youth. Families may choose the type of respite services that best suit their needs, either in their home or at another location.

AHP Respite Benefits of up to $2,800 per year may be available dependent on family income. An income test is applied. In some cases, benefits may be enhanced to meet extraordinary need. Respite funding may not be available immediately; families may be waitlisted.

Local MCFD offices assist families to access the AHP Respite Benefits. Working with the local CYSN social worker, a parent or guardian makes a written agreement with the Ministry of Children and Family Development to receive funding, and can choose to receive benefits through a direct monthly payment or to be reimbursed for respite expenses.

The parent or guardian is responsible for arranging respite care, paying caregivers, managing their respite budget and providing a record of respite expenditures.

The program does not cover services that are:

- Required as a result of the parent or guardian's paid or unpaid employment, training or education; or
- Provided by any other MCFD program.

AHP Respite Benefits cease on the last day of the month of a youth's 19th birthday.

For more information about AHP Respite Benefits, contact your local MCFD Office.

For families receiving direct monthly respite payments, the following resources may help in determining tax and employer obligations:

- For individual income tax enquiries, *Canada Revenue Agency* (CRA) at 1 800 959-8281
- CRA specific information on people with disabilities
- *Work Safe BC* (registering for coverage)
- *Employment Standards Branch*

Families are encouraged to contact a tax professional for information specific to their situation.

ABOUT MEDICAL BENEFITS

Medical Benefits are managed centrally by the MCFD Medical Benefits program.

ALL MEDICAL BENEFITS REQUIRE PRE-APPROVAL.

Medical Benefits available to an eligible child or youth may include the following:

- Medical Equipment
- Biomedical Equipment
- Medical Supplies
- Orthotics and Splints
- Audiology Equipment and Supplies
- School-Aged Extended Therapies
- Dental, Orthodontic and Optical Coverage
- Medical Transportation
- Medical Services Plan Coverage*
- Medications and PharmaCare*

* Medical Benefits include MSP Premium Assistance and PharmaCare Plan F. However, the Medical Benefits program does not handle PharmaCare or MSP submissions. These are handled by Health Insurance BC. *See page 33, Medical Services Plan Coverage*, and *page 34, Medications and PharmaCare*, for more information.

Requests for equipment, supplies and services must be recommended in writing by a health professional (all exceptions specifically noted). Certain types of equipment must be deemed "medically necessary" in order to be considered eligible by Medical Benefits. Forms and guidelines for requesting the various medical benefits are available ***online***.

For more information about AHP Medical Benefits, please *see page 11 How Do I Contact Medical Benefits?* for more information.

What Does "Medically Necessary" Mean?

Medical Benefits provides a range of basic, medically necessary equipment and supplies to support and assist eligible children and youth in their homes. To be considered "medically necessary," equipment and supplies must be:

- Directly related to the health condition or disability that qualifies the child or youth to be eligible for Medical Benefits, and required for one or more of the following reasons:
  - To sustain life and bodily functions
  - To maintain the child or youth's body in proper alignment
  - To mitigate significant complications related to the condition or disability that qualifies the child or youth to be eligible for AHP Medical Benefits
  - To provide mobility in common indoor and common outdoor settings
  - To safely transfer the child or youth within the home (e.g. bedroom and bathroom transfers)
  - To safely position the child or youth for travel in a vehicle, when vehicle seatbelts and/or commercial car seats and booster seats are not an option based on the current, individual requirements of the child or youth
- Prescribed by a professional who is regulated under the Health Professions Act (all exceptions are explicitly noted)
- Available on the market long enough to be considered common, standard equipment
- The least expensive item that addresses the child's medical needs; funding limits may apply
- Pre-approved by Medical Benefits prior to purchase

Medical Benefits does not cover all types of medically necessary equipment and supplies or the full cost of all equipment and supplies; funding limits may apply.

Equipment and supplies that are not specific to the child or youth's disability or complex health condition are not eligible benefits; this includes equipment designed specifically for caregiver health, caregiver safety, or personal preference. Although some benefits may assist children and youth in gaining independence, equipment or upgrades are not approved when independence is the sole rationale. Costs associated with equipment

upgrades and repairs of upgrades related to caregiver health, caregiver safety, personal preference and environmental factors, as well as over-limit costs, are the responsibility of parents or guardians. Medical Benefits does not cover the cost of replacement due to intentional or negligent damage, loss or theft.

The term "medically necessary" applies to equipment and supplies only. All children eligible for Medical Benefits are eligible to request the school-aged extended therapies benefit, with the recommendation of a healthcare professional. Please *see page 27 School-Aged Extended Therapies* for more detail.

How Do I Contact Medical Benefits?

The following contact information should be used when:

- Seeking more information about this guide, or
- Submitting requests, invoices, or receipts, as described throughout the guide.

TOLL-FREE: **1 888 613-3232**
VICTORIA: **250 387-9649**

FAX: **250 356-2159**

ADDRESS: Medical Benefits
Ministry of Children and Family Development
PO Box 9763 – STN PROV GOVT
Victoria BC V8W 9S5

EMAIL: *MCF.MedicalBenefitsProgram@gov.bc.ca*

If you have a concern about the service provided by Medical Benefits, or about a Medical Benefits decision, contact Medical Benefits at 1 888-613-3232. If your complaint is not resolved, request to speak to a Medical Benefits Supervisor at 1 888-613-3232.

MEDICAL EQUIPMENT

ALL MEDICAL EQUIPMENT MUST BE PRE-APPROVED.

APPROVALS ARE VALID FOR 12 MONTHS FROM THE DATE OF ISSUE. IF EQUIPMENT HAS NOT BEEN DELIVERED WITHIN THE 12 MONTHS, CONTACT MEDICAL BENEFITS.

Medical Benefits may provide the following basic, medically necessary equipment:

- Alternate Positioning Devices
- Bathing and Toileting Aids
- Hospital Beds and Mattresses
- Lifts
- Mobility Equipment
- Seating Systems
- Specialized Car Seats
- Therapeutic Equipment

Please *refer to page 16 for information on requesting medical equipment*.

Alternate Positioning Devices

AHP Medical Benefits may provide the following devices to assist with positioning options for the child in the home:

- Standing frames
- Walkers
- Sidelyers
- Beanbag chairs
- Floor sitters
- Other alternate positioning devices recommended by a therapist

Multiple alternate positioning devices may be provided to a maximum of $3,200. Once the $3,200 maximum has been used, requests for additional alternate positioning devices will not be approved until arrangements have been made for one or more devices to be returned to the *Children's Medical Equipment Recycling and Loan Service*. Additional available funding will equal the total cost of the device(s) returned.

Bathing and Toileting Aids

AHP Medical Benefits may provide basic equipment for bathing and toileting in the home, including:

- Commodes/raised toilet seats
- Toilet frames
- Bath chairs/bath benches
- Bath lifts
- Bath seat component for use with a lifting device ($800 maximum)
- Transfer poles
- Grab bars (maximum 2)
- Step stools ($100 maximum)

The following expenses are not benefits:

- Installation of grab bars
- Typical toilets and bidets
- Home renovations or structural modifications to accommodate new equipment

Hospital Beds

The AHP Medical Benefits may provide funding for a typical electric hospital bed including headboard, footboard and rails as follows:

HOME CARE BED (maximum $2,250) – justification must confirm that a hospital bed is required to facilitate transfers of a child or youth to and from bed or to adjust or maintain positioning in bed.

POSITIONING BED (maximum $3,000) – justification must confirm that a positioning bed is required to adjust or maintain the child or youth's positioning in bed (e.g. Trendelenburg position).

Medically required pressure redistribution mattresses may be approved for use with a hospital bed.

Lifts

AHP Medical Benefits may provide a floor model lift or ceiling track lift for bedroom and/or bathroom transfers, to a maximum of $4,200 for the life of the device (including two slings and installation). Replacement motors for lifts must not exceed $3,060.

AHP Medical Benefits does not fund van modifications, vehicle lifts, or stair or porch lifts.

Removal and reinstallation of a lift when a family moves to new accommodation is not an eligible benefit.

Mobility Equipment

AHP Medical Benefits may provide the following mobility equipment:

- **CRUTCHES** ($200 maximum plus the cost of basic tips)
- **WHEELCHAIRS:**
  - One manual wheelchair, or
  - One special needs stroller, or
  - One basic power wheelchair and one 'backup' device – either a basic manual wheelchair or a special needs stroller. Funding for a manual backup mobility device is provided to a maximum of $1,500. Parents or guardians are responsible for a $75 deductible charge for special needs strollers provided for children less than three years of age.
  - The minimum replacement period for manual and power wheelchairs is 5 years
  - The minimum replacement period for a stroller is 3 years
  - Limits apply to specific wheelchair and stroller components:
    - $150 for specialized stroller handles
    - $300 for wheelchair trays and $385 for armrests or $685 for swing to side armrests if required for positioning support.
- **SCOOTERS** – a basic scooter may be provided, if the child is not totally wheelchair dependent and is unable to propel a manual wheelchair (due to medical reasons). Funding for a scooter is provided to a maximum of $3,700.
  - The minimum replacement period for a scooter is 5 years

Basic, wheelchairs may be eligible benefits; modifications and upgrades may not be eligible.

A basic manual wheelchair includes the following features:

- Frame with seat depth and seat width adjustability (grow-ability)
- Height adjustable back canes
- Height adjustable armrests and basic arm pads
- Swing away footrest hangers
- Angle adjustable footrests
- Wheel locks with extensions
- Standard wheels and casters
- Anti-tippers
- Transit package
- Seat and back upholstery

All other upcharges for wheelchairs need to be justified by the prescribing therapist.

A basic powered wheelchair includes the following features:

- Power base with Group 22NF batteries
- Battery charger
- Frame with seat width and seat depth adjustability (grow-ability)
- Seat pan
- Height adjustable back canes
- Height adjustable armrests and basic arm pads
- Swing away footrest hangers
- Angle adjustable footrests
- Basic electronics with standard joystick
- Fixed joystick mount
- Standard wheels and casters

All other upcharges for wheelchairs need to be justified by the prescribing therapist.

Medical Benefits does not provide funding for wheelchair ramps, home modifications, or vehicle modifications to accommodate wheelchairs.

Wheelchair Seating Systems

Medical Benefits may provide the following:

- One commercial or custom-made postural control seating system for use in a wheelchair or special needs stroller up to a limit of $6,000.

All requests for custom seating must include a quote showing the itemized costs of components and labour.

Duplicate seating systems or custom seating and cushions for backup wheelchairs are not provided.

A seating system that is not primarily used in a mobility device may be considered as an Alternate Positioning Device (APD).

Specialized Car Seats

Medical Benefits may provide specialized car seats for children who cannot use commercial car seats due to their disability. Parents or guardians are responsible for a $50 deductible for specialized car seats provided for children under age nine and whose height is less than four feet, nine inches (145 cm). All requests for specialized car seats must include the child's height and weight. Replacement will not be considered for the life of the car seat or until the child has outgrown it.

As with all other equipment specialized car seats must be returned to the Children's Medical Equipment Recycling and Loan Service (CMERLS) or disposed of upon authorization of the CMERLS program.

Therapeutic Equipment

Medical Benefits may provide one of each of the following items, as needed for a home-based therapy program:

- Floor therapy mat (1 mat up to a lifetime maximum of $400)
- Therapy roll
- Therapy ball

How Do I Request Medical Equipment?

Before a health care professional requests basic, medically necessary, equipment for a child or youth, the professional must first contact the Children's Medical Equipment Recycling and Loan Service (CMERLS) to determine whether there is suitable equipment to trial. Thirty day trials are typical. If suitable equipment is not available, authorized medical equipment dealers may be able to offer equipment for trial.

If a trial is successful and the equipment will be retained for the child's use, or if the purchase of new equipment is required, a health care professional must submit a *Request for Medical Equipment form* and/or a *letter of justification* to Medical Benefits, which outlines the following:

- The nature of the child's condition and need for medical equipment;
- Current equipment and successful/unsuccessful trials;
- A description and rationalization of the equipment; and
- A quote from an approved dealer (a list of approved dealers is available from Medical Benefits).

For more information, see the *AHP Guidelines for Writing Justification Letters for Medical Equipment*.

Requests must be submitted to Medical Benefits for review, please *see page 11 How Do I Contact Medical Benefits?*

Is My Medical Equipment Under Warranty?

All new wheelchairs provided by an approved dealer have a two year limited warranty including:

- Six-month maintenance checks;
- All repairs due to normal wear and tear (including tires and batteries); and
- Equipment loaned to the child during warranty repairs.

Most other medical equipment is covered under manufacturer warranties.

For more information, contact the medical equipment dealer.

What if My Medical Equipment Requires Repairs?

Medical equipment must be returned to the original dealer for any necessary repairs during the two-year warranty period.

After the two-year warranty period, requests for repairs should be forwarded to the Children's Medical Equipment Recycling and Loan Service (CMERLS) run by the Canadian Red Cross Society. For more information about CMERLS, call 1 800 565-8000 or visit the *CMERLS website.*

Funding for repairs is limited to normal wear and tear on equipment purchased through AHP Medical Benefits. If new replacement equipment has been approved, repairs to old equipment will not be considered.

What if My Medical Equipment Requires Modifications?

APPROVALS ARE VALID FOR 12 MONTHS FROM THE DATE OF ISSUE. IF MODIFICATIONS HAVE NOT BEEN COMPLETED WITHIN THE 12 MONTHS, CONTACT MEDICAL BENEFITS.

Medical equipment modifications must be directly related to the child's disability or medical condition. Funding for modifications is only available for equipment purchased through AHP Medical Benefits.

Requests for medical equipment modifications must include a letter from a health care professional, outlining:

- The nature of the child's condition and need for medical equipment modifications;
- A description of the modifications; and,
- A quote from an approved dealer.

A list of approved dealers is available from Medical Benefits.
Please call 1 888 613-3232 (toll-free) or 250 387-9649 (Victoria) for more information.

How Do I Recycle Medical Equipment I No Longer Use?

The Canadian Red Cross Society operates the Children's Medical Equipment Recycling and Loan Service (CMERLS) on behalf the Ministry of Children and Family Development to provide recycled, durable medical and therapeutic equipment to children and youth who are eligible for Medical Benefits.

Medical equipment purchased through Medical Benefits is the property of the Canadian Red Cross Society. Families or clinicians are to return equipment that is no longer needed to CMERLS; it will be repaired, cleaned and recycled for the benefit of other families.

Please note that CMERLS is not responsible for uninstalling ceiling track, grab bars, or floor to ceiling poles, and may authorize local disposal of medical equipment in some cases.

For more information about CMERLS, including how to arrange for pickup of equipment that is no longer needed, call 1 800 565-8000 or visit the *CMERLS website*

FAMILIES MAY CHOOSE *to use their private extended health benefit plans to purchase or upgrade medical equipment. Equipment can be partially funded with personal or charity funds, or private extended health benefit plans, however, equipment partially funded through MCFD is the property of CMERLS and must be returned to CMERLS when it is no longer needed.*

BIOMEDICAL EQUIPMENT

ALL BIOMEDICAL EQUIPMENT MUST BE PRE-APPROVED.

APPROVALS ARE VALID FOR 12 MONTHS FROM THE DATE OF ISSUE. IF EQUIPMENT HAS NOT BEEN DELIVERED WITHIN THE 12 MONTHS, CONTACT MEDICAL BENEFITS.

Medical Benefits may provide medically necessary, specialized biomedical equipment to assist with life-sustaining functions, such as breathing or feeding. Examples include:

- Oximeters
- Ventilators
- Bi-pap machines
- C-pap machines
- Nebulisers
- Suction machines
- Feeding pumps

Health care professionals submitting requests for biomedical equipment are responsible for ensuring that parents or guardians receive training in the use of the equipment. Parents or guardians in turn are responsible for ensuring that other caregivers receive training in the use of the equipment.

EVERY FAMILY IS RESPONSIBLE *for emergency preparedness. Parents or guardians should consult with their child's health care team to develop an emergency plan which includes accessing a power source for biomedical equipment during an extended power outage or other emergency situations.*

OXYGEN *is not a benefit of Medical Benefits. For information on oxygen and oxygen equipment, please contact your local health authority and ask about the Home Oxygen Program.*

How Do I Request an Oximeter?

To request an oximeter, a health care professional must complete a *Request for Oximeter* form. A letter of justification may also be required. For more information, see the *Request for Oximeter* form and the *AHP Guidelines for Writing Justification Letters for Biomedical Equipment*.

How Do I Request All Other Biomedical Equipment?

To request any other biomedical equipment, a health care professional must provide a letter of justification, outlining:

- The nature of the child's condition and need for specialized medical equipment; and
- A description of the equipment being requested.

For more information see the *AHP Guidelines for Writing Justification Letters for Biomedical Equipment*.

Requests must be submitted to Medical Benefits for review, please *see page 11 'How Do I Contact Medical Benefits?'*

What If My Biomedical Equipment Requires Repairs?

REPAIR REQUESTS MUST BE PRE-APPROVED.

Biomedical equipment must be returned to the original dealer for any necessary repairs during the warranty period. After the warranty period, requests for repairs should be forwarded to the Canadian Red Cross Society at 1 800 565-8000.

Funding for repairs may be available for equipment purchased by Medical Benefits.

How Do I Recycle Biomedical Equipment I No Longer Use?

The Canadian Red Cross Society operates the Children's Medical Equipment Recycling and Loan Service (CMERLS) on behalf of the Ministry of Children and Family Development.

Biomedical equipment purchased through Medical Benefits is the property of the Canadian Red Cross Society. Families or clinicians are to return equipment that is no longer needed to CMERLS. Equipment will be repaired, cleaned and recycled for the benefit of other families. Equipment can be partially funded with personal or charity funds, or private extended health benefit plans, however, equipment partially funded through MCFD is the property of CMERLS and must be returned to CMERLS when it is no longer needed.

For more information about CMERLS, call 1 800 565-8000 or visit the *CMERLS website*.

MEDICAL SUPPLIES

ALL MEDICAL SUPPLIES MUST BE PRE-APPROVED.

Medical Benefits may provide medical supplies, including:

- Bandages and dressings
- Catheters, syringes, tubing, connectors
- Diabetic supplies not covered by PharmaCare
- Feeding system or gastrostomy supplies including bags, feeding adapters, tubing, buttons, and connectors
- Specialized feeding formulas
- Some supplements and supplies required for a Ketogenic diet
- Incontinence supplies including diapers, pull ups, diaper pads and wipes (for children three years of age and older)
- Oxygen masks and supplies
- Special shampoo for treatment of a diagnosed condition
- Special ointments, salves and lotions for the treatment of specific conditions
- Burn-treatment garments when related to the child or youth's disability

Medical Benefits does not provide trials or samples of formulas. Parents or guardians may want to request trials of formulas from their child's dietician.

How Do I Request Medical Supplies?

To request medical supplies, the health care professional (e.g., registered nurse, physician or registered dietician/nutritionist) must complete a *Request for Medical Supplies form*.

Requests must be submitted to Medical Benefits for review, please *see page 11 How Do I Contact Medical Benefits?*

How Are Medical Supplies Delivered?

After a request for medical supplies has been approved, a monthly order can be placed through the Product Distribution Centre.

For more information about the Product Distribution Centre, call:

TOLL-FREE: 1 877 927-2234
LOWER MAINLAND: 604 927-2910

Is There Direct Funding Available For Purchasing Incontinence Supplies?

Parents or guardians may choose to receive direct funding for pre-approved incontinence supplies and make purchases directly from a supplier of their choice.

Direct funding for incontinence supplies involves payments to families that are provided every three months, based on the child's age and weight. These payments are a contribution towards the cost of incontinence supplies for children aged three and older, and may not cover all costs.

Direct funding may only be used for the purchase of incontinence supplies (diapers, pull-ups, liners and wipes).

Parents or guardians are responsible for:

- Keeping receipts for incontinence supplies for three years, and providing them on request;
- Providing an updated *Request for Medical Supplies form* on request (to confirm the child's continued need for incontinence supplies); and
- Returning unused funds to Medical Benefits (make cheques payable to the Minister of Finance).

How Do I Request Direct Funding for Incontinence Supplies?

Accessing direct funding for incontinence supplies is a two-step process:

1. A health care professional must first complete a *Request for Medical Supplies form* if incontinence supplies have not previously been approved.
2. Once the request for incontinence supplies has been approved, the parent or guardian may request an Incontinence Supplies Direct Funding application package by calling Medical Benefits and returning the application once it is completed.

For Medical Benefits contact information, please *see page 11 How Do I Contact Medical Benefits?*

The first payment will be provided approximately six weeks after the completed application package is received and approved.

ORTHOTICS

ALL ORTHOTICS MUST BE PRE-APPROVED.

APPROVALS ARE VALID FOR 12 MONTHS FROM THE DATE OF ISSUE. IF EQUIPMENT HAS NOT BEEN DELIVERED WITHIN THE 12 MONTHS, CONTACT MEDICAL BENEFITS.

Medical Benefits may consider requests for the following orthotic devices:

- **CERVICAL COLLARS**
- **UPPER-EXTREMITY DEVICES**
  - Wrist-hand resting orthotics
  - Wrist orthotics
  - Wrist-hand orthotics
  - Hand orthotics
- **LOWER-EXTREMITY DEVICES**
  - Ankle-foot orthotics (made from low-temperature material)
  - Foot orthotics
  - Bilateral twister cables
  - Therapeutic boots and brace

For a description of each device, see the *Ministry of Children and Family Development Glossary of Orthotic Devices*.

Orthotic devices that are made from high-temperature material must be fitted and manufactured under the direct supervision of an orthotist or podiatrist.

Orthotic devices that are made from low-temperature material must be fitted and manufactured under the direct supervision of an orthotist, podiatrist, occupational therapist or physiotherapist.

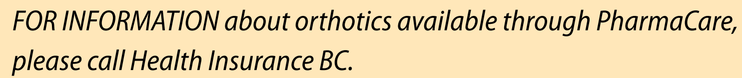
Medical Benefits does not provide orthotic devices that are available through PharmaCare. This includes:

- Certain lower-extremity devices (e.g., ankle-foot orthotics made from high-temperature material); and
- Body braces.

Certified orthotists should forward requests for PharmaCare benefits to PharmaCare.

How Do I Request Orthotics?

To request orthotics, an orthotist, occupational therapist, physiotherapist, podiatrist or physician must complete a *Request for Orthotics form*.



FOR INFORMATION about orthotics available through PharmaCare, please call Health Insurance BC.
TOLL-FREE: 1 800 663-7100
LOWER MAINLAND: 604 683-7151

AUDIOLOGY EQUIPMENT *and* SUPPLIES

ALL AUDIOLOGY EQUIPMENT AND SUPPLIES MUST BE PRE-APPROVED.

APPROVALS ARE VALID FOR 12 MONTHS FROM THE DATE OF ISSUE. IF EQUIPMENT HAS NOT BEEN DELIVERED WITHIN THE 12 MONTHS, CONTACT MEDICAL BENEFITS.

Children who are under three and a half years of age and have a permanent hearing loss receive their first set of hearing aids and bone anchored hearing devices through the BC Early Hearing Program. For more information, including contact information for local audiology clinics, visit the *BC Early Hearing Program website*.

Cochlear implants are funded by the Ministry of Health. For more information, including contact information, please visit the *Cochlear Implant Program website*.

Medical Benefits may provide audiology equipment and supplies for eligible children with a documented hearing loss (audiogram required). Equipment and supplies are to be used primarily in the home setting. Equipment and supplies specifically intended for school use are not funded by the *At Home Program*.

Audiology equipment includes:

- Hearing aids
- Bone anchored hearing devices
- Cochlear implant specific equipment
- Remote hearing assistance technology

Audiology equipment is provided to a maximum of $3,000 for all devices combined in a four year period. The minimum replacement period is four years.

Reasonable repairs for audiology equipment will be covered by Medical Benefits. Repair warranties on audiology equipment must be for a minimum of 6 months, with preference given for a 1-year repair warranty.

The *At Home Program* provides essential accessories and supplies required for effective operation of hearing aids, bone anchored hearing devices, remote hearing assistance technology, and cochlear implants.

How Do I Request Audiology Equipment and Supplies?

To request audiology equipment or supplies, or cochlear implant supplies an audiologist must complete a *Request for Audiology Benefits form*.

Requests must be submitted to Medical Benefits for review, please *see page 11 How Do I Contact Medical Benefits?*

SCHOOL-AGED EXTENDED THERAPIES

ALL SCHOOL-AGED EXTENDED THERAPY SERVICES MUST BE PRE-APPROVED.

INVOICES RECEIVED MORE THAN SIX MONTHS FROM DATE OF SERVICE DELIVERY WILL NOT BE ACCEPTED.

Medical Benefits may provide extended occupational therapy (OT), physiotherapy (PT), speech-language pathology (SLP), chiropractic and massage services for children of school age. These School-Aged Extended Therapies (SAET) are made available to children aged five or older and who are eligible for AHP Medical Benefits.

These direct therapy services are intended to:

- Assist in the maintenance or improvement of functional skills; and
- Address post-surgical rehabilitation needs.

Each therapy service should be:

- Goal-directed;
- Based on practical, meaningful outcomes and an identified family priority; and
- Responsive to the child's individual and changing needs.

Therapists are responsible for ensuring that adequate insurance is in place for the delivery of services and that all relevant employer-employee obligations are met. Medical Benefits cannot provide advice regarding employer-employee obligations.

Please note that physiotherapy, occupational therapy, speech and language pathology, chiropractic and massage services may also be available through the Medical Services Plan.

OT, PT and SLP Services

School-Aged Extended Therapy services enhance the primary OT and PT services made available through the *School-Aged Therapy Program*, and school district SLP services. For more information on how these services are to be coordinated, see the *School-Aged Therapy and the At Home Program's School-Aged Extended Therapies Benefit Info Sheet*.

The services must:

- Complement, and be consistent with, the child's existing therapy plan; and
- Not duplicate school based therapy services.

Services may be delivered on a one-to-one or group basis by a:

- Therapist; or
- Therapist assistant, under the supervision of a therapist.

The use of therapist assistants must be done in accordance with the ***At Home Program Guidelines: Use of Therapist Assistants***.

In partnership with the parent or guardian, the therapist requesting the SAET benefit is expected to consult and coordinate services with the school-/community-based therapist(s) or school designate.

A maximum of $3,840 per twelve month period may be approved for any one of occupational therapy, physiotherapy, or speech-language pathology services (including therapist assistant services). Exceptions to this maximum will be considered for children requiring post-surgical rehabilitation services.

Therapists may bill up to a combined total of $480 (within the maximum of $3,840) for consultation, report writing and travel purposes within the twelve-month period. This is intended to support a coordinated therapy plan across multiple environments and professional disciplines.

The maximum hourly billing rates are as follows:

- Services delivered directly by a therapist: $80 per hour
- Services delivered by a therapist assistant: $40 per hour

Both the therapist and the therapist assistant's rates may be billed during the same billable hours when the therapist provides child-specific instruction to the therapist assistant.

Services lasting less than one hour must be prorated.

Chiropractic and Massage Services

A maximum of $1,920 may be provided for any one of chiropractic or massage services, per twelve-month period. Exceptions to this maximum will be considered for children requiring post-surgical rehabilitation services.

The maximum billing rates are:

$40 per session for chiropractic services; and

$40 per hour for massage services (massage services lasting less than one hour must be prorated).

How Do I Request School-Aged Extended Therapies?

To request School-Aged Extended Therapies, the occupational therapist, physiotherapist, speech-language pathologist, chiropractor or massage therapist must complete an *At Home Program Request for School-Aged Extended Therapies form*.

Part 5 of the request form requires identification of the intended functional outcomes of the service for the child. It is recommended that therapists assist families to prioritize outcomes and address a limited number of outcomes at a given time. Sequential, rather than simultaneous, therapy services are preferred – with each outcome having distinct services, frequency and intensity. For more information, see *Writing Functional Outcomes – Guidelines for Therapists.*

Requests must be submitted to Medical Benefits for review, please *see page 11, How Do I Contact Medical Benefits?*

How Does Payment for Approved School-Aged Extended Therapies Work?

Invoices for approved services should be submitted in a format similar to the *School-Aged Extended Therapies Sample Invoice*. Please note that therapists may submit invoices on a different form, provided that it contains all of the required information. Failure to provide this information may result in delayed processing.

Invoices are submitted to Medical Benefits; please *see page 11 How Do I Contact Medical Benefits?*

DENTAL, ORTHODONTIC *and* OPTICAL BENEFITS

DENTAL, ORTHODONTIC AND OPTICAL BENEFITS MUST BE PRE-APPROVED.

DENTAL, ORTHODONTIC AND OPTICAL BENEFITS MUST BE PURCHASED WITHIN 6 MONTHS FROM THE DATE THE APPROVAL IS ISSUED, AND MUST BE APPLIED FOR YEARLY.

Medical Benefits may provide dental, orthodontic and optical benefits for eligible children, if the need for benefits is:

- Required due to the child's disability; and
- Not met through another program or insurance plan.

The following maximum benefit limits apply:

- Dental: $700 per year for restorative procedures
- Orthodontic: $5,000 lifetime
- Optical: Prescription lenses and frames up to $150 per year

Routine dental care is not eligible.

For more information, please contact Medical Benefits.

OTHER OPTICAL AND DENTAL RESOURCES

The Healthy Kids Program delivered through the Ministry of Social Development and Social Innovation (SDSI) provides basic optical and dental benefits for families who qualify for Medical Services Plan premium assistance. Some children are eligible for both the Healthy Kids Program and the At Home Program.

For more information about the Healthy Kids Program, visit the Healthy Kids Program website.

The Children's Dental Program at UBC provides free basic dental and preventative services for school-aged children and youth from the lower mainland who meet their eligibility criteria. Visit Children's Dental Program website for more information.

How Do I Request Dental, Orthodontic and Optical Benefits?

To request dental or orthodontic benefits, a physician, dentist or orthodontist must complete a *Request for Dental Benefits form*.

To request optical benefits, a physician must complete a *Request for Optical Benefits form*.

Requests must be submitted to Medical Benefits for review, please *see page 11 How Do I Contact Medical Benefits?*

MEDICAL TRANSPORTATION

Non-Emergency Medical Transportation is handled through Medical Benefits. The BC Ambulance Service provides reimbursement for Emergency Ambulance services for children who are enrolled in Medical Benefits, *see page 32* for more details.

Is Non-Emergency Medical Transportation covered?

ALL NON-EMERGENCY MEDICAL TRAVEL MUST BE PRE-APPROVED.

Medical Benefits may assist with transportation costs to therapy, medical or clinic appointments, if:

- The service is not available in the child's home community; and
- The round trip exceeds 80 kilometres.

Allowable transportation costs include:

- The least costly mode of car, bus, train, ferry or air transportation for the child and one other person from the family home (car transportation is reimbursed at 40 cents per km);
- Accommodation (to a maximum of $150 per night, $15 per night for parking at the hotel);
- Highway tolls; and
- Parking at the appointment.

Examples of costs that are not reimbursed include:

- Transportation to medical or dental appointments that are not related to the child's disability;
- Transportation within the city where the child's appointment is; and
- Meals.

SOME TRAVEL DISCOUNTS ARE AVAILABLE *through the Travel Assistance Program (TAP BC). Families should apply to TAP BC before accessing medical transportation benefits through AHP Medical Benefits.*

Families are encouraged to refer to the TAP BC website for a listing of private transportation carriers who provide discounts to patients and families. The TAP BC website also includes links to other medical travel and accommodation programs.

For more information about the Travel Assistance Program visit the TAP BC website or call:
TOLL-FREE: 1-800-663-7100

How Do I Make a Request for Non-Emergency Medical Transportation?

Requests must be pre-approved and include a letter from a health care professional or clinic, which indicates:

- The purpose and date of the appointment; and
- Confirmation that the service is not available in the child's home community.

After the request has been submitted, parents or guardians should contact Medical Benefits to make arrangements for air travel and/or accommodation.

How Can I Get Reimbursed for Non-Emergency Medical Transportation Costs?

Contact Medical Benefits for a Request for Reimbursement of Approved *At Home Program* Medical Expenses form:
TOLL-FREE: 1 888 613-3232
VICTORIA: 250 387-9649

Submit the following to Medical Benefits:

- A completed *Request for Reimbursement of Approved At Home Program Medical Expenses form*; and
- Original receipts
- Confirmation of appointment

REIMBURSEMENTS RECEIVED MORE THAN SIX MONTHS FROM DATE OF SERVICE DELIVERY WILL NOT BE ACCEPTED.

What if I Need Ambulance Services?

Emergency ambulance service is available at no charge for children who are enrolled in Medical Benefits.

If you receive a bill for ambulance services, forward it to the following address (include the child's Personal Health Number on the bill):

BC AMBULANCE SERVICE – Ambulance Billing
Ministry of Health Services
PO Box 9676 STN PROV GOVT
Victoria BC V8W 9P7

Or call BC Ambulance at:
TOLL-FREE: 1 800 665-7199
VICTORIA: 250 356-0052

MEDICAL SERVICES PLAN COVERAGE

Children enrolled in Medical Benefits receive premium-free Medical Services Plan (MSP) coverage. MSP coverage is administered by Health Insurance BC.

For more information about MSP, visit the Ministry of Health *Medical Services Plan website*, or contact Health Insurance BC via telephone at:

TOLL-FREE: 1 800 663-7100
VANCOUVER: 604 683-7151

NOTE: Medical Benefits does not assist with MSP services or claims. Please contact Health Insurance BC directly.

MEDICATIONS *and* PHARMACARE

Children enrolled in Medical Benefits receive benefits through the PharmaCare program (Plan F). PharmaCare coverage is administered by Health Insurance BC. Plan F benefits may include:

- Prescription medications prescribed by a physician and approved by PharmaCare
- Orthotics and prosthetics
- Needles and syringes for insulin-dependent diabetics
- Blood glucose testing strips for individuals with a certificate of training from a recognized Diabetic Training Centre

NOTE:

- MCFD Medical Benefits does not process PharmaCare claims. Please contact Health Insurance BC directly.
- There may be a short delay between eligibility determination and active PharmaCare coverage. Please contact Health Insurance BC if you are unsure whether or not coverage is active.
- PharmaCare benefits are not in effect when a child is temporarily out of the province.

For more information about PharmaCare benefits, visit the ***PharmaCare website***, or contact Health Insurance BC via telephone at:

TOLL-FREE: 1 800 663-7100
LOWER MAINLAND: 604 683-7151

TRANSITION *to* ADULT SERVICES

Medical Benefits come to an end on the last day of the month of a youth's 18th birthday.

Premium-free Medical Services Plan (MSP) coverage and PharmaCare benefits provided through Medical Benefits also end on the last day of the month of the youth's 18th birthday. Parents or guardians who wish to reinstate their son or daughter as a dependent on their MSP coverage should contact Health Insurance BC at:

TOLL-FREE: 1 800 663-7100
LOWER MAINLAND: 604 683-7151

AHP Respite Benefits come to an end on the last day of the month of a youth's 19th birthday.

Transition to Adult Disability Assistance

Young people with disabilities who are 18 years of age or older may qualify for adult disability assistance, including financial and supplementary health assistance, through the Ministry of Social Development and Social Innovation (SDSI). The application process for these services should begin six months before their 18th birthday.

Young people enrolled in Medical Benefits have access to a streamlined application process for disability assistance made available through SDSI. For more information on the application process, please visit the SDSI website: *17 Year Old Disability Assistance Applicants*.

Transition to Community Living BC

Young people who are 19 years of age or older and have a developmental disability, Fetal Alcohol Spectrum Disorder (FASD), or Autism Spectrum Disorder (ASD) and significant limitations in adaptive functioning, may qualify for Community Living BC (CLBC) services. CLBC funded supports are delivered through service agencies and help eligible adults meet their disability-related needs and participate in meaningful ways in the community. The application process for these services typically begins on the youth's 16th birthday.

For more information on eligibility and application process, please visit the CLBC website.

Home and Community Care

Young people who are 19 years of age or older may qualify for Home and Community Care services through their local health authority. Home and Community Care services provide a range of health and support services to people who have acute, chronic, palliative or rehabilitative health care needs.

For more information on eligibility and the application process, contact your health authority.

BRITISH COLUMBIA

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Children and Family
Development