# Completing your ACES\$ Service Authorization

## Important:

- Below are instructions for completing your ACES\$ Service Authorization (SA). <u>The form is separate from this guide and can be found on login.mycil.org</u>.
- All sections must be filled out accurately. If the form is not filled out and signed completely and accurately, the SA form may not be processed. This could cause a delay in payroll for the Personal Support Worker (PSW) until the issues are resolved.
- Parents, Step-parents, guardians cannot work as a PSW for a consumer under the age of 18.
- Pay rate changes must be received by the 4th of the month to take effect for that month's payroll. Pay rate changes received after the 4th will take effect the following month.
- If the consumer has a legal guardian they cannot act as their own employer.
- Sample SAs are available at the end of the guide for example purposes only.

#### **Consumer Information**

- Adult HCBS or Children and Young Adults HCBS must be checked at the top.
- **Consumer Number** This is the 4 digit Consumer code.
- Fill in all demographic and address information. We need the Consumer's **Full Name**; please do not write nicknames or abbreviated names.
- The **RIN Number** is the Consumer's 9 digit Medicaid ID#. This must be listed on all New Consumer authorizations.
- Self-Directing Services
  - Select YES if the Consumer is using the self-direction option and <u>NOT</u> using a Self-Directed Assistant. You can skip the Self-Directed Assistant Information section.
  - Select NO if the Consumer is using a Self-Directed Assistant. The Self-Directed Assistant
     Information section must be filled out.

#### Self-Directed Assistant Information

• If the Consumer is using a **Self-Directed Assistant** (formerly known as a Service Facilitator), please list the Self-Directed Assistant here. If the Consumer is choosing to use **Self-Direction**, please leave this section blank.

# **Employer Demographics**

- If the Consumer is also the Employer, select **Consumer Employer**; no need to fill out the rest of the section.
- If someone else is the Employer for the account, select **Someone Else**. Then, complete all of the Employer information.
- Please use the Employer's **Full Name**; do not write nicknames or abbreviated names.

### Service Authorization Information

- For new Consumers, select **New Consumer**. For other changes, select **Change to Services**.
- A Monthly Service Start Date must always be listed to update the budget.
- Budgets can be ongoing, an end date is not required.

- For Temporary budgets, fill in both the Monthly Service Start Date and Monthly Service End Date. Temporary budgets can span multiple months, but cannot end mid-month.
- Adding an end date to this section **DOES NOT** terminate services. Only entering a termination date will
  do so.
- For a **Termination of Services**, please write the last date of service and reason for termination.
- List all Active PSWs in this section who are to be working with the Consumer. If a PSW is not listed, they will be terminated. If there are more than 4 PSWs, please use multiple pages.

#### Fill in all PSW columns:

- PSW Name full name must be listed; please do not write nicknames or abbreviated names.
- **Social Security** # -for activation and verification purposes, the last 4 digits of the PSW's SSN is required.
- Code for Regular Hours the code is 55D; for Crisis Hours the code is 53C.
- Hourly Pay Rate list the PSW's hourly pay rate. This is the rate the PSW will be paid.
- **Unit Rate** this is calculated by multiplying the PSW's hourly pay rate by 1.07. Standard rounding rules apply. (hourly pay rate x 1.07 = unit rate) <u>The unit rate, NOT the pay rate, is used in the maximum monthly dollar amount calculation</u>. A reference chart of common pay rate/unit rate calculations is on the last page.
- **Hours Approved per Month** list the amount of hours the PSW is authorized. If there are multiple PSWs, shared is an acceptable amount of hours as long as the Total Monthly Amount is filled in.
- Maximum Monthly this is calculated by multiplying the <u>hours</u> by the <u>unit rate</u>. (hours approved per month x unit rate = maximum monthly amount)
- **Total Monthly Amount** this is the sum of the maximum monthly amounts listed for the PSWs above. This is the Consumer's total budget amount. <u>This number cannot be more than the DHS maximum</u> budgets.

### **Budgeting Tips:**

- Please consider all billings when setting the budget. The above DHS totals are for <u>all</u> Home-Based Services (i.e. PSW services, day programs, SDA fees, etc.).
- Hours must be listed in 15 minute increments.

*Note:* **.25** = 15 minutes | **.50** = 30 minutes | **.75** = 45 minutes

- If Crisis Funding (53C) is awarded, we also need a copy of the award letter to process timesheets.

### **DHS Budget Maximums**

Waiver	2024 Total	2023 Total	Notes
Children and Young Adults HCBS	\$1886	\$1828	Consumers on the Children and Young Adults HCBS can bill up to double the monthly allotment in one month, until they reach their yearly cap.
Adult HCBS	\$1886	\$1828	For consumers on the Adult HCBS still attending special education classes. On the Adult HCBS, double spending is not an option.
	\$2829	\$2742	For consumers no longer attending special education classes. DHS must be notified in writing with documentation from the special education district upon completion or discontinuation of classes.

<sup>\*</sup>If you are unsure which waiver the consumer is in, please ask your ISC agency.

CURRENT Hourly Wage/ Unit Rate conversion chart 7.0%

Hourly Wage	Hourly Cost to You	Hourly Wage	Hourly Cost to You	Hourly Wage	Hourly Cost to You
14.00	14.98	17.75	18.99	21.50	23.01
14.25	15.25	18.00	19.26	21.75	23.27
14.50	15.52	18.25	19.53	22.00	23.54
14.75	15.78	18.50	19.80	22.25	23.81
15.00	16.05	18.75	20.06	22.50	24.08
15.25	16.32	19.00	20.33	22.75	24.34
15.50	16.59	19.25	20.60	23.00	24.61
15.75	16.85	19.50	20.87	23.25	24.88
16.00	17.12	19.75	21.13	23.50	25.15
16.25	17.39	20.00	21.40	23.75	25.41
16.50	17.66	20.25	21.67	24.00	25.68
16.75	17.92	20.50	21.94	24.25	25.95
17.00	18.19	20.75	22.20	24.50	26.22
17.25	18.46	21.00	22.47	24.75	26.48
17.50	18.73	21.25	22.74	25.00	26.75

# Signatures

- The SA must be signed by the **Employer** and **the Self-Directed Assistant (SDA).**
- If the Consumer is the Employer for the account, they must sign it.
  - o If the consumer is their own employer, a Power of Attorney/parent cannot sign the SA for the consumer.
- If someone else is listed as the Employer on the account, that person must sign it.
- PSWs cannot sign the authorization for any reason.
- If Self-Directing services, an **SDA** signature is not needed.

After completing the <u>separate</u> ACES\$ Service Authorization form, please email directly to <u>BudgetsIL@mycil.org</u> or fax to 570-558-5570 or 217-528-9849 for processing.

Sample SAs are available on the following pages for example purposes.



SUBMIT SERVICE AUTHORIZATION: Fax: 217-528-9849 or 570-558-5570 Email: budgetsIL@mycil.org

# **ACES\$ ILLINOIS**

#### SERVICE AUTHORIZATION FORM

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Waiver Type*:(check o	ne) Adult HCBS	Children and	Young A	dults HCBS		consun	ners unde	r the a	age of 18.	
Consumer Name : Sky		Blu			Consu	ımer Numb	er: A12	23		
Address: 123 Happy	First	Middle	Lo	ast						
123 Happ	y Road		City	Lincoln			Logan		Zip 626	356
Phone Number: 555	-789-1234	Social Security Nu	ımber 12	23-45-6789		RIN Numb	er 987	6543	321	
Self Directing Services:	Yes	No If no, please fil	ll out the S	elf Directed As	sistant Se	ction Below				
		Self-Directo	ed Assist	ant Informa	tion			and managed		
Self-Directed Assista	ant Name:	***************************************			Agency:					
Self-Directed Assista	ant Email:	Phone Number:								
		Emplo	yer Info	rmation			Name and Address of the Owner, where the Owner, which is the			
Who is designated as	the Employer?:	Consumer	Some	one Else		ship to Co	nsumer	: Gi	uardian	
Employer Name: Mya	а			ВІ	ue					
Firs	· · · · · · · · · · · · · · · · · · ·	Middle			Last			1		
Address: 123 Happy	Road		City L	incoln		County Log	gan	ZI	Р 626	56
Employer Phone Numi	ber: 555-789-1234		Employ	er Email : my	ablue@t	estemail c	om			
Purpose for Authoriza			RIZATION	I INFORMATION Services*	ON					
Monthly Service Start Termination of Service	Date: 01/01/2024 Effective Date: Social	nsumer 4	RIZATION Change to Reason urly	INFORMATION	ervice Ention:		75		Maxim Vonthly I	
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SUBMIT SERVICE AUTHORIZATION: Fax: 217-528-9849 or 570-558-5570 Email: budgetsIL@mycil.org

# **ACES\$ ILLINOIS**

### SERVICE AUTHORIZATION FORM

Waiver Type*:(check one)	n and Young Adults: Parents/S Guardians cannot work as PSV 's under the age of 18.
Consumer Name: Jane Smith Consumer Number: First Middle Last Children and Young Adults HCBS Consumer Number: First Middle Last Consumer Number: 555-777-1111 Social Security Number 111-22-3333 RIN Number Self-Directing Services: Yes No If no, please fill out the Self Directed Assistant Section Below Self-Directed Assistant Information  Self-Directed Assistant Name: Mary Green Agency: The Happy Agency: The	
Address: 45 Blue Street  Phone Number: 555-777-1111  Social Security Number 111-22-3333  RIN Number Self-Directing Services: Yes No If no, please fill out the Self Directed Assistant Section Below  Self-Directed Assistant Name: Mary Green Agency: The Happy Agency:	
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Phone Number: 555-777-1111 Social Security Number 111-22-3333 RIN Number Self Directing Services: Yes No If no, please fill out the Self Directed Assistant Section Below Self-Directed Assistant Name: Mary Green Agency: The Happy Agency: The Happy Agency Information Self-Directed Assistant Email: Mary Green Agency: The Happy Agency: The Happy Agency: The Happy Agency: The Happy Agency Information Someone Else Relationship to Consumer Someone Else Relationship to Consumer Someone Else Information Below Employer Name:    First	
Self-Directed Assistant Section Below  Self-Directed Assistant Information  Self-Directed Assistant Name:  Self-Directed Assistant Email:  Mary Green  Self-Directed Assistant Information  Self-Directed Assistant Email:  Mary Green  Self-Directed Assistant Email:  Employer Information  Who is designated as the Employer?:  Consumer  Someone Else  Solat  Solat  Solat  Solat  Middle  Last  County  County  Femployer Email:  Service End Date:  Termination of Service End Date:  Termination of Service End Date:  Total Monthly Service  Total Monthly Amour  poyroll. Poy rate changes must be received by the 4th of the month to take effect for that month's  Total Monthly Amour  poyroll. Poy rate changes received ofter the 4th will take effect the following month.  Total Monthly Amour  poyroll. Poy rate changes received after the 4th will take effect the following month.  Total Monthly Amour  poyroll de budget could result in the interruption of payroll for the direct support worker(s) until on  resolved.	
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Self-Directed Assistant Name:  Self-Directed Assistant Email:  mgreen@testagency.org  Phone Num  Employer Information  Who is designated as the Employer?:  Consumer  Someone Else  Relationship to Consumer  Someone Else  City  County  Employer Information  Who is designated as the Employer?:  Employer Name:  First  Middle  Lost  Addresss  Employer Phone Number:  Employer Email:  SERVICE AUTHORIZATION INFORMATION  Purpose for Authorization:  New Consumer  Change to Services*  Monthly Service End Date:  Termination of Service Effective Date:  Reason for Termination:  First  Monthly Service End Date:  Reason for Termination:  Forward  For	
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I hereby authorize this service authorization and understand it is my responsibility to monitor and approve the individual consumer's service plan and monthly service maximum. I fully understand that far provided budget could result in the interruption of payroll for the direct support worker(s) until over resolved.	unt = \$ 1792.25
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SDA Signature Mary Great Date 10	128/23
ACES\$ USE ONLY	



SUBMIT SERVICE AUTHORIZATION: Fax: 217-528-9849 or 570-558-5570 Email: budgetsIL@mycil.org

# ACES\$ ILLINOIS

#### SERVICE AUTHORIZATION FORM

Waiver Ty	A THE RESIDENCE	SOUTH THE PARTY OF	OR SHEET WATER STREET													
waiver i			74444	DO [			SUMER INF				-	-parents	/Gua	ordians c	annot	lts: Parents/ work as PS
			Adult HC	BS	Childr	en a	and Young	g Adu	Its HCBS	7.			- 0	mder the	age o	f 18.
Consumer	Name :	Jane Fire	st		Middle		Smith	Last		Consu	ımer	Numbe	er: A	4124		
Address:	45 Bl	ue Street							Chicago			County	Cod	ok	Zip	60007
Phone Nu	mber:	555-777	-1111	s	ocial Se	curit	y Number	111	-22-3333		RIN	Numbe	er 1	23456	3789	
Self Direct	ing Serv	rices:	Yes	■ N	o If no,	plea	se fill out th	ne Self	Directed Assi	stant Se			l			
					Self	-Dir	ected Ass	sistan	t Informati	ion					MARKATON TO	
Self-Dir	rected A	ssistant N	lame: M	lary G	reen					Agency:	The	Нарру	/ Ag	gency		
		Assistant E			n@testa	iger	icy.org			gy-[	7			Process of	5-33	3-7777
Who is de	esignate	ed as the E	mployer?:		Consi		nployer In	form		Relation	ship	to Con	sum	ner:		
Employe	r Name							Employe	r Information Bel	ow.						
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