RESET

PLEASE READ INSTRUCTIONS

COMPLETION INSTRUCTIONS – CAREGIVER EXEMPTION REVIEW FORM (PA 1820)

RESET EXEMPTION

The form PA 1820 is used to verify a caregiver exemption from federal work participation requirements. This form documents a medically verified need for a TANF parent needed in the home to care for a *disabled family member living in the home*.

Who may complete this form?

Section 1 must be completed by the caregiver requesting the exemption. Section 1 is located on page 1 of the PA 1820 and includes providing caregiver information, as well as information for the individual receiving care.

Section 2 must be completed by the licensed, medical provider treating the individual receiving care. This includes a physician, psychologist, physician's assistant, or certified registered nurse practitioner.

Who signs this form?

Section 1 must be signed by the caregiver requesting the exemption.

Section 2 must be signed by a physician, psychologist, physician's assistant, or a certified registered nurse practitioner.

General form completion requirements:

The information on the form must be complete and legible. Questions must be answered fully to enable the county assistance office (CAO) to decide if the individual has an exemption.

Section 1:

If the caregiver completing this section needs more space than provided, attach additional paper or documents to the form when returning to the CAO. If the caregiver has questions, they should contact the CAO for help.

Section 2:

If the medical professional completing this form needs more space than provided, attach additional paper or documents to the form when returning to the caregiver or CAO. If the medical professional has questions, they should contact the CAO for help.

CAO Usage Instructions:

Permanently Disabled: If the individual receiving care is marked as permanently disabled, the exemption will be reviewed annually (at renewal). Reviewing the exemption does not necessarily require contact. A case record review should be conducted to assess if the exemption is still appropriate. The CAO should review the following:

- Is the exempt individual a TANF parent?
- Is the exemption still appropriate?
- Is the disabled/incapacitated individual still in need of care?
- Does the individual needing care still live in the home?
- Is the individual a family member?
- Is there any reason to believe something has changed? If so, does it rise to requiring new verification or contacting the household?

A PA 1820 is required annually (at renewal) if the medical condition may improve, or alternate care may become available. If the disabled individual's condition is not likely to improve or worsen, a new PA 1820 is not required until a change is reported or when the situation is questionable.

Temporarily Disabled: If the individual receiving care is marked as temporarily disabled, the exemption will be reviewed 30 days prior to the disability end date and a new PA 1820 provided if necessary. For the RESET exemption, the caregiver must be a TANF parent and the family member needing care must be disabled and living in the home with the caregiver. If these conditions are met, ETP 54 will be used. This will be reviewed once a year at renewal.

Not Disabled: If the individual is marked as not disabled, the CAO will conduct a partial redetermination, review the household for any other potential exemption or good cause reason, and if found mandatory, update the Agreement of Mutual Responsibility, and refer to the appropriate Employment and Training (E&T) program.

CAO-Use Only: At the bottom of page 2 there is a box that is indicated for CAO-Use Only. The intention of this box is to ensure CAOs have provided as much service and information as possible to individuals required in the home to care for disabled individuals.

For individuals receiving Medical Assistance, they can receive enhanced services and access to resources through their MCO's Special Needs Unit. To access contact information visit https://www.dhs.pa.gov/HealthChoices/HC-Services/Pages/PhysicalHealthChoices-MCOs.aspx.

Additionally, this box can be used to ensure the worker has completed any necessary DAP/SSI referrals, and referrals to potential waiver services through Long Term Care. For more information visit https://www.dhs.pa.gov/Services/Disabilities-Aging/Pages/default.aspx and https://www.aging.pa.gov/aging-services/caregiver-support/Pages/default.aspx.

The CAO should also be aware of how to connect individuals to other resources:

- Resources for Caregivers of Adults
- Resources for Caregivers of Children

Questions: If the CAO has any questions or concerns surrounding the completion of the form, they should contact RA-PWBEP.TANF@pa.gov for assistance.

CAO NAME AND ADDRESS	
RETURN BY:	CAO FAX:

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CASE IDENTIFICATION				
CO	DIST	RECORD NUMBER	CAT	CSLD
RECORD NAME				

CAREGIVER EXEMPTION REVIEW FORM

The Caregiver Review Form (PA 1820) is used by the county assistance office to determine if a TANF parent is required to participate in an Employment and Training Program or if the **TANF parent** has a medically documented need to remain in the home to provide care to a disabled *family member residing in the household*.

SECTION 1
THIS SECTION MUST BE COMPLETED BY THE CAREGIVER

PART 1: IDENTIFYING INFORMATION OF CAREGIVER

CAREGIVER NAME:

CAREGIVER ADDRESS:

CAREGIVER TELEPHONE NUMBER:

PART 2: IDENTIFYING INFORMATION OF INDIVIDUAL RECEIVING CARE

NAME OF INDIVIDUAL REQUIRING CARE:

AGE: RELATION TO CAREGIVER:

DOES THIS PERSON RESIDE IN THE SAME HOME? ☐ YES ☐ NO

PLEASE DESCRIBE IN DETAIL WHAT YOU DO FOR THE DISABLED INDIVIDUAL AND WHY IT STOPS YOU FROM WORKING OR PARTICIPATING IN WORK-RELATED ACTIVITIES. PLEASE INCLUDE INFORMATION ON OTHER HOUSEHOLD DUTIES AND HOW YOU MAKE TIME TO CARE FOR YOURSELF:

By signing this form, I certify that the above statements are true and correct. I also understand that this information must be reviewed at each renewal of benefits.

CAREGIVER SIGNATURE _____ DATE _____

SECTION 2

THIS SECTION MUST BE COMPLETED BY THE LICENSED MEDICAL PROVIDER TREATING THE INDIVIDUAL RECEIVING CARE

INSTRUCTIONS TO MEDICAL PROVIDER: This form may be completed a counselor, social worker, or mental health therapist, but **must** be agreed upon **and** signed by a physician, psychologist, physician's assistant, or certified registered nurse practitioner.

The caregiver [identified in **Section 1, Part 1**] reports they are unable to participate in work or work-related activities because they are required to be in the home to provide care for a disabled individual [identified in **Section 1, Part 2**]. Please provide the information requested below to verify that the individual is a patient of your practice, and if appropriate, explain the circumstances surrounding the caregiver's need to be in the home to provide care to your patient due to disability.

PLEASE CHECK ONLY ONE

☐ My patient, identified in Section 1, Part 2, is temporarily disabled, and requires a caregiver in the home.
This disability is expected to end:_____

☐ My patient, identified in Section 1, Part 2, is permanently disabled, and requires a caregiver in the home.

☐ My patient, identified in Section 1, Part 2, is disabled but does not require a caregiver in the home.

PLEASE EXPLAIN:

☐ My patient, identified in Section 1, Part 2, is not disabled, and does not require a disability caregiver.

PLEASE PROVIDE ANY ADDITIONAL COMMENTS REGARDING MEDICAL DOCUMENTATION TO SUPPORT THE NEED FOR THE CAREGIVER TO REMAIN IN THE HOME TO CARE FOR THE DISABLED INDIVIDUAL.

MEDICAL PROVIDER INFORMATION

NAME OF MEDICAL PROVIDER:

MEDICAL LICENSE NUMBER:

ADDRESS:

PHONE NUMBER:

NPI NUMBER:

By signing this form, I certify that information above, regarding the need for an in-home caregiver is true and correct.

_____ _____

MEDICAL PROVIDER SIGNATURE DATE

NOTE: Signature of the medical provider must be original, or the form is invalid. Rubber stamps, labels, or other reproductions are not acceptable.

CAO USE ONLY

Is the disabled individual open in Medical Assistance?	Yes ☐ No ☐
If yes, has a referral been made to the disabled individual's Managed Care Organization (MCO), Special Needs Unit?	Yes ☐ No ☐
If yes, and disability is permanent, and no SSI is received, has the individual been referred to the Disability Advocacy Program?	Yes ☐ No ☐
Has a referral been made on behalf of the disabled individual for waiver services?	Yes ☐ No ☐
Have resources been provided to the individual to ensure the caregiver has options and information?	Yes ☐ No ☐