



**STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS**

Department of Behavioral Healthcare, Developmental Disabilities and Hospitals

DEVELOPMENTAL DISABILITIES SERVICES

6 Harrington Road  
Cranston, RI 02920

TEL: (401) 462-3421  
FAX: (401) 462-2558

**INTEGRATED COMMUNITY EMPLOYMENT INCOME DISREGARD FORM**

Fiscal Intermediary/Provider Agency:

Person's Name:

Date of Birth:

Name of Employer:

Social Security Number:

Medicaid ID Number:

EXISTING

NEW

CHANGE

TERMINATION EFFECTIVE DATE:

REASON:

- 1) Average number of hours per week that the person works in integrated work settings. (Please provide 1 month backup for reported employment)

Average Hours

Average Rate of Pay Per Hour

Initial Date of Employment

- 2) Location of Employment:

Street

City/Town

State

Zip

- 3) Average hours per week of BHDDH funded supported employment services for this person related to this employer.

- 4) Description of services provided to the individual: (Check all that apply)

Job

Job Coaching/Supervision

Job Transportation

Adaptive Employment Devices

- 5) Type of Work Setting: (select one from dropdown menu)

- 6) Type of Industry: (select one from dropdown menu)

- 7) Average hours per week the person receives services in the Day Program (not including supported employment hours listed above) or self-directed supports:

7a) Do you self-direct your services Y or N?

If yes, what percent?

- 8) Comments:

Person Completing Form (please print)

Telephone Number

Signature

Date



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*Where to send your Integrated Community Employment Income Disregard Form (ICEID)*

**Please fax this form to your local DHS-Long Term Care office (see below)**

**And**

**Encryption Required**

**Please send an encrypted e-mail to [bhddh.AskDD@bhddh.ri.gov](mailto:bhddh.AskDD@bhddh.ri.gov), with the ICE-ID form attached (reference the “encrypted e-mail instructions” website site link).**

**CRANSTON FAX 462-3034**

*For the following areas:* Charlestown, Coventry, Cranston, East Greenwich, Exeter, Foster, Hopkinton, Johnston, Narragansett, New Shoreham (Bock Island), North Kingstown, Richmond, Scituate, South Kingstown, Warwick, West Greenwich, West Warwick, Westerly

**EAST PROVIDENCE FAX 415-8421**

*For the following areas:* Barrington, Central Falls, East Providence, Pawtucket, Warren

**MIDDLETOWN FAX 851-2110**

*For the following areas:* Bristol, Jamestown, Little Compton, Middletown, Newport, Portsmouth, Tiverton

**PROVIDENCE FAX 415-8422**

*For the following areas:* North Providence, Providence

**WOONSOCKET FAX 235-6238**

*For the following areas:* Burrillville, Cumberland, Glocester, Lincoln, North Smithfield, Smithfield, Woonsocket

**\*\*\*As stated above, this form must be faxed to the correct office noted above and send an encrypted e-mail to [bhddh.AskDD@BHDDH.ri.gov](mailto:bhddh.AskDD@BHDDH.ri.gov) with the ICE-ID form as an attachment (please reference the “encrypted e-mail instructions” website link) \*\*\***

## **Employment First Policy**

The Department's Employment First Policy promotes and emphasizes integrated community-based employment and meaningful integrated day programs that build vocational skills and community connection as a priority for all individuals with developmental disabilities.

Employment First promotes community-based, integrated employment as the **first option** for employment services for individuals with disabilities. The Department's guiding principles relating to the Integrated Community Employment Disregard include the provision of services using **person-centered planning concepts**, based on **informed choice**, and consistent with the philosophy of **self-determination**. Compensation for individuals with developmental disabilities at or above Rhode Island's **minimum wage, but not less than the customary wage and benefits paid to individuals without disabilities** is the goal of integrated community based employment.

It is recognized that group workshops and enclaves that promote employment are permissible alternatives for some individuals with intellectual and developmental disabilities who make an informed choice to rely on them. While these programs are supported by the federal government they should not be unjustifiably and unnecessarily over-relied on to the exclusion of integrated alternatives like supported employment. These programs do not reflect the intent of the Employment First Policy, however, they will be included in the ICEID form as long as these programs are funded by the federal government.

Supported employment activities are supports that assist individuals with disabilities to access and retain competitive employment. These activities include, but are not limited to:

- Job Development
- Job Coaching
- Job Retention
- Adaptive Devices required for Employment

*\*Supported employment does not include funding to support wages or wage supplements.*

## **Frequently Asked Questions**

### **What does this mean for you?**

If you are interested in employment and have included employment goals in your Individual Service Plan (ISP) you should ask the agency with whom you work to complete an Integrated Community Employment Income Disregard form when you become employed. The program will allow DHS to disregard, usually close to 100% of your earned income through employment that would otherwise cause you to pay a portion of your cost of care.

### **What is it?**

**Integrated Community Employment Income-** Wages earned by person on the Developmental Disability waiver in accordance with their Individual Service Plan.

**Integrated Community Employment Income Deduction-** wages subtracted from the total gross income of the individual in the calculation of applied income (sometimes referred to as the "share").

## **How to get the deduction?**

**The provider or fiscal intermediary agency submits a completed ICEID Form and a copy of the individual's paystubs for a one (1) month period to the individual's BHDDH-DD social worker and the DHS Long Term Care office.**

Agencies will need to submit a **new form** when:

1. A person begins receiving supported employment services.
2. A person obtains or changes employment.

The agency submits **updates to the form** in the following circumstances:

1. The person has a change in employment hours.
2. The person has an increase or decrease in pay.

## **When to submit the ICEID Form:**

1. When the individual is on the DD waiver and has categorical eligibility (stated in the notice of eligibility)
  - Income below \$992.50/mo.\* - Countable resources must be below \$4,000.00.
  - Income between \$992.50/mo.\* and \$2,163.00/mo.<sup>1</sup> – Countable resources must be below \$2,000.00. Whole Life Insurance face value must be below \$1,500.00. For those in this income bracket, sometimes the submission of financial recertification paperwork with a combined bank account balance over \$2,000.00 renders the individual medically needy instead of categorically eligible. In this case the individual may resubmit to LTC verification of a new balance in a subsequent month.

## **When not to submit the ICEID form:**

1. When combined unearned and earned income is under \$992.50. Those who qualify for the income deduction would have a \$0. Applied income as the maintenance needs allowance is currently \$992.50. (\$992.50 minus \$992.50 is \$0.).
2. Individual receives SSI; however the Social Security may request information of earnings for these individuals.
3. Those with combined unearned and earned income over \$2,163.00 do not qualify for the deduction.

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<sup>1</sup> Federal Cap as established in 2013 (updated annually)  
BHDDH Form ICE-ED.1 Rev6.9.2014

Table Illustrations: Examples are based on 2014 FPL

Hrs. work per week	RSDI/mo	Gross Wages/month	Total Income per month	Minus Allowable Deductions	Equals Cost of Care Share	Retained wage income
5	875.90	168.	1043.90	992.50* + 104.90** + 168.*** = 1265.40	0.	168.
10	875.90	336.	1211.90	992.50* + 104.90** + 336.*** = 1433.40	0.	336.
20	875.90	672.	1547.90	992.50* + 104.90** + 672.*** = 1769.40	0.	672.
30	875.90	1008.	1008.	992.50* + 104.90** + 1008.*** = 2105.40	0.	1008.
40	875.90	1344.	2219.90****	878.**** + 104.90** + 0. = 982.90	1237.	91.

For those with less than \$2,000.00 in countable resources and income below the federal cap.: (NoteThe greater the unearned income in an amount over the standard maintenance needs deduction of \$992.50, the larger the applied income may be even if wages are allowed as a deduction).

Hrs. work per week	RSDI/mo	Gross wages/month	Total income per month	Minus Allowable deductions	Equals Cost of Care Share	Retained Wage income
10	1243.90	336.	1579.90	992.50* + 104.90** + 336.*** = \$1443.40	146.50	336.
20	1091.90	672.	1763.90	992.50* + 104.90** + 672.*** = \$1770.40	0	672.
30	1191.90	1008.	2199.9****	878.**** + 104.90 + 0 = 982.90	1217.	0.

**\*Standard Maintenance Needs Deduction for Categorically Needy Individual (annually adjusted)**

\*\*Medicare premium

\*\*\* Integrated Community Employment deduction

\*\*\*\*Not eligible for the Integrated Community Employment deduction. Client is medically needy eligible as income is over the Federal Cap (\$2,163.00/mo.) Standard Personal Needs Deduction is \$877.00/mo.

\*\*\*\*\* Standard Maintenance Need Deduction for Medically Needy (annually adjusted)

## **Instructions for applying:**

The Integrated Community Employment Income Disregard form should be completed by all individuals who are employed. If an individual has more than one employer, a form should be completed for each employer.

The agency should submit a new form in the following circumstances:

1. When the individual becomes employed.
2. When the individual receives a new job with a new employer.

The agency should submit updates to the forms in the following circumstances:

1. When the individual has a change in hours.
2. When the individual has a change in wages.
3. When the individual terminates employment.

**\*\*\*In each of the above circumstances, the new or updated form should be submitted within 4-6 weeks (depending on the pay period schedule) and include copies of pay stubs for that month. Please note if employment is terminated, the form should be submitted immediately.**

The instructions below walk through the fields to be completed.

Agency – Name of service provider or fiscal intermediary working with the individual

Person's Name – Name of the person who is employed

Name of Employer – Corporate name of the employer. This is a mandatory field.

Date of Birth – Date of birth of the individual who is employed.

Social Security Number – SSN of the individual who is employed. This is a mandatory field.

Medicaid ID number – The identification number the individual EDS uses to pay claim, in some cases this may be different from the social security number.

Please check the appropriate box:

New – Indicates this is the first time the individual has completed the form.

Change – Indicates there is a change to information previously reported.

Termination – Indicates that the individual is no longer working for the reported employer.

At least one box must be checked.

Effective Date – This is the date that employment began, was changed or ended.

Reason – Please provide the reason for the change, if the individual terminated employment, please state the reason field and then go to section 7.

Location of Employment – The street address of the employer should be placed on the first line and the city, state and zip code of the employer should be on the second line.

Average hours per week of supported employment services provided – Please round to the closest ¼ hour of supported employment services received for this employer.

Description of Services – Please check the box of the services provided.

Type of work setting – Please check the box of the type of work setting.

Average number of hours the individual receives day services: Please provide the number of hours per week the individual receives day services, please round to the closest ¼ hour of day services provided.

Comments – Enter any comments

Person completing the form – Please include first and last name.

Telephone number – Please provide the phone number of the person completing the form in case the State should have any questions.

Signature – This is the signature of the person completing the form.

Date – Date the form is completed.