Improving lives THROUGH supports and services THAT FOSTER self-determination.

MISSOURI DIVISION OF DEVELOPMENTAL DISABILITIES

COMMUNITY TRANSITIONS MANUAL

FOR SUPPORT COORDINATORS

AND

COMMUNITY LIVING COORDINATORS

www.dmh.mo.gov/dd MISSOURI DEPARTMENT OF MENTAL HEALTH

History of the Transition Manual

- The manual became effective July 1, 2016.
- This manual replaced Directive 5.010 and Directive 4.270.
- This manual is designed to be a “one stop shop” for everything related to Transfers and Transitions.
- It includes information on (but not limited to):
  - Money Follows the Person
  - Community Transition Services
  - Notification Process for Individuals on the Sex Offender Registry
  - And also a step- by- step process for transferring individual’s files across different regions
  - Guideline 67

Procedures outlined in the Manual Apply to Regional Offices (RO), Senate Bill 40 Boards and other not-for-profit Targeted Case Management (TCM) Entities.

Authorities

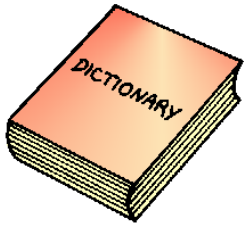
- Missouri Home & Community- Based Waiver
- 79 Fed. Reg. 2947
- U.S Supreme Court Olmstead V L.C Ruling
- Individual Support Plan Guidelines
- Missouri Statute 630.127
- Department Operating Regulation 4.270
- Sections 589.400 to 589.425, RSMo
- Section 552.020, RSMo
- CFR 441.301
- TCM Technical Assistance Manual
- 9CSR 10-5.206
- Division Directive 1.060
- Division Directive 3.090
- Division Directive 4.060
- Division Directive 4.070
- Division Directive 4.170

Glossary

Consumer Referral Database: A Customer Information Management, Outcomes, and Reporting (CIMOR) based referral system which makes referral information for individuals seeking residential services available to providers in the county(ies) where the individual is interested in residing.

Individual Determined Permanently Incompetent to Stand Trial: An individual who has been permanently determined to lack capacity to understand the proceedings against him or her or to assist in his or her own defense under Section 552.020, RSMo, for offenses the individual would otherwise have been required to register as an offender on or after January 1995, under Sections 589.400 to 589.425, RSMo.

Post-Move Review Meeting: A meeting of the individual's interdisciplinary team that is held following an individual's move to a new setting. The purpose of the meeting is to review the current supports, develop outcomes and action steps and set a date for transfer to a Regional Office or Targeted Case Management agency if the individual has moved to service area.



Glossary

Registered Offender: A person who is registered or will be registered by law enforcement upon discharge from a state operated inpatient or correctional facility pursuant to sections 589.400-589.425, RSMo.

Transfer Contact Designee: Staff persons at the Regional Office, Satellite Office, and Targeted Case Management agencies designated to assist with the transfer process.

Transition Coordinator: An employee of either the Division of Developmental Disabilities (DDD) or a Targeted Case Management agency whose role is to facilitate an individual's transition from a habilitation center to the community.

Transition Meeting: A meeting involving the individual's interdisciplinary team to identify and document all of the services, supports, accommodations, etc., that an individual will need once the individual has moved to a new setting.

In this training, we will cover:

- Transfers for individuals living in natural homes
- Transfers for individuals residing in their homes using Developmental Disabilities (DD) paid residential supports
- Administrative file transfer process
- Transitions from Habilitation (Hab) Centers
- Home Modifications
- Money Follows the Person
- Transitions for Individuals on Sex Offender Status
- Community Transition Services

MISSOURI DIVISION OF DEVELOPMENTAL DISABILITIES

Transfers for Individuals Living in Natural Home

Natural Home Transfer Process

- Anytime an individual is moving within or out of his/her current region, the Support Coordinator (SC) will discuss with the individual or guardian the choice to transfer or discharge from services.

- If the individual or guardian chooses to remain in services, the sending Support Coordinator Supervisor (SCS) will send an encrypted e-mail stating that fact to the following staff about the upcoming move:
  - Receiving SCS
  - Transfer Contact designees at the sending/receiving Regional Offices; and
  - Transfer contact designees at the receiving TCM entities

- An electronic copy of the Individual Services Plan (ISP) and demographic page will be attached to the email.

Natural Home
Transfer Process

In addition to the Individual and his/her family and/or guardian, the following people may be involved in a natural home transfer:

- Sending and Receiving:
  - Support Coordinators (SC)
  - Support Coordination Supervisors (SCS)
  - Community Living Coordinators (CLC)
  - TCM and/or Regional Office Transfer Contact Designee
  - Provider Staff

- Others determined important to ensuring a smooth transition

Natural Home
Transfer Process

- The receiving Regional Office Transfer Contact Designee will inform the responsible RO staff person to open a second Episode of Care so that both parties are able to bill and have access to CIMOR during this time of transfer.

- If the individual receives funded services which will need to continue in the new location, the sending SC and/or SCS will work directly with the receiving SC at the receiving TCM agency or RO to ensure that services are set up in advance of the move. An amendment or updated ISP will be completed by the sending SC prior to the individual's move.

- Approval for services will be authorized through the sending Utilization Review Committee (URC) and the sending SC will share the new budget with the receiving SC at the receiving TCM agency or RO.

Is a Transition Meeting Needed for Natural Home moves?

- Complex individual service needs shall require a transition meeting to ensure that all necessary supports and services are in place.
- The need for a transition meeting will be determined by the sending and receiving TCM agencies prior to the move.
- If a formal meeting is not needed then the Sending SC can collaborate with the receiving team.

Transfer Process
Final Steps

- It is the responsibility of the sending SC to provide an up-to-date ISP or amendment to the receiving SC upon transfer.

- Once services are coordinated and authorized, the transfer may occur.

- After review of the Transfer Form, the receiving transfer contact designees or receiving TCM transfer contact will send an encrypted email to the sending TCM and RO transfer contact and transfer contact designees within 3 business days which will contain the following information:
  - Confirmation that they received the transfer information
  - The effective date of transfer
  - An address to mail records

- The Episode of Care will end for the sending RO one day prior to the date of transfer.

MISSOURI DIVISION OF DEVELOPMENTAL DISABILITIES

Transitions for Individuals Receiving PAID Services in DD Residential Settings

Guideline 67
Transition Monitoring Guideline

- The CLC at each Regional Office will complete on-going monitoring of the transition process. Specific benchmarks are required for all transitions. One of these benchmarks include placing an individual on the consumer referral database when they are seeking a new residential provider or going into residential services for the first time.

- If the CLC discovers a situation where one or more of the benchmarks has not been implemented as required by the Transition Manual, The CLC will enter each issue into the APTS database. The CLC should work with the Support Coordinator to resolve the issue(s).

- If attempts to resolve the issue regarding the transition process with the Support Coordinator are not effective, the CLC will work with the TCM TAC and Regional Office administration as appropriate, to develop a plan to resolve the issue.

Transitions for Paid Residential Habilitation
Choosing a Provider

All individuals seeking a residential setting shall be entered into the Consumer Referral Database.

- The sending Support Coordinator shall electronically send the Consumer Referral Profile and referral documents to the sending Community Living Coordinator who will place the documents on the referral database. The referral documents include:
  - The ISP
  - Housemate Compatibility Tool
  - and other relevant documents (BSP, HI, current Amendments) if applicable

- The SC will assist the individual and/or their family to gather information about potential residential support providers.

Consumer Profile

Please note: This form is to be used as an aid for the provider to quickly assess the individual's needs. This provides a brief description of the individuals support needs. The consumer Profile form in no way replaces the Individual Support Plan or any additional information that is required for the providers to determine if they can support the individual successfully.

Person Completing Profile and Title:	**Date Profile Completed:**

Consumer Identification

Consumer Name: Date of Birth: Client ID (Statewide ID):
Financial Resources: Source: Amount: $ Spend down amount: $

Diagnosis (list name of diagnosis not just the number)
ICD 10:
Axis I,II,and III:

County Preference

1st Choice: 2nd Choice:

3rd Choice: Statewide: ☐

About the Consumer

Day Activities & Services

Activity / Service	Full Time	Part Time
☐ Day Habilitation	☐	☐
☐ Vocational Training	☐	☐
☐ School	☐	☐
☐ Physical Therapy	☐	☐
☐ Speech Therapy	☐	☐
☐ Occupational Therapy	☐	☐
☐ Competitive Employment	☐	☐
☐ Supported Employment	☐	☐
☐ Sheltered Employment	☐	☐
☐ Volunteer	☐	☐

Daily Living Needs (All That Apply)

Support Needed:	None	Minimal	Moderate	Extensive
Bathing	☐	☐	☐	☐
Dressing	☐	☐	☐	☐
Grooming	☐	☐	☐	☐
Eating	☐	☐	☐	☐
Cooking	☐	☐	☐	☐
Toileting	☐	☐	☐	☐
Money Management	☐	☐	☐	☐
Medication Management	☐	☐	☐	☐

Medical Support Needs (All That Apply)

- ☐ Allergy(s)
- ☐ Ambulatory
- ☐ Bowel Care
- ☐ Braces
- ☐ Catheterization
- ☐ Communicates with Sign Language
- ☐ Mobility - Walker/Cane
- ☐ Mobility - Walks independently
- ☐ Mobility - Walks unaided with difficulty
- ☐ Mobility - Walks with supportive devices
- ☐ Oxygen therapy
- ☐ Seizures

- [ ] Communicates with Sign Language
- [ ] Colostomy
- [ ] Dentures
- [ ] Diabetes, Insulin Dependent
- [ ] Diabetes, Non-Insulin Dependent
- [ ] Dialysis
- [ ] Accessible environment
- [ ] Accessible transportation
- [ ] Hearing - Deaf
- [ ] Hearing - Hearing Aids
- [ ] Hearing - Normal
- [ ] Hearing - Partial hearing loss
- [ ] Hearing - Unknown or undetermined hearing capabilities
- [ ] Illnesses that interfere with daily routine
- [ ] Illnesses that require medical attention
- [ ] Incontinence
- [ ] Mobility - Crawls
- [ ] Mobility - Electric wheelchair independently
- [ ] Mobility - Lift
- [ ] Mobility - Manual wheelchair with assistance
- [ ] Mobility - Manual wheelchair with transfer assistance
- [ ] Mobility - Manual wheelchair without assistance
- [ ] Mobility – Requires total assistance with mobility
- [ ] Seizures
- [ ] Skin Breakdown
- [ ] Special Diet Preparation
- [ ] Speech - Communicates using assisted devices
- [ ] Speech - Communicates using gestures or eye pointing
- [ ] Speech - Communicates using sign language
- [ ] Speech - Difficult to understand
- [ ] Speech - No functional communication
- [ ] Speech - Normal
- [ ] Suctioning
- [ ] Therapeutic Positioning
- [ ] Tracheotomy
- [ ] Tube Feeding
- [ ] Uncontrolled seizures
- [ ] Ventilator
- [ ] Vision - Blind
- [ ] Vision - Impaired but corrected with glasses
- [ ] Vision - Impaired vision
- [ ] Vision - No functional vision
- [ ] Vision - Normal
- [ ] Vision - Travel vision but legally blind
- [ ] Vision - Unknown or undetermined visual ability
- [ ] Wears Depends

Altered Levels of Supervision Needed (All That Apply)

- [ ] Requires RN/LPN oversight on all shifts
- [ ] 24 Hour
- [ ] Moderate Supervision
- [ ] Line of Sight
- [ ] Awake, Overnight Staff
- [ ] Constant Supervision
- [ ] Max Time Alone – Less Than 15 Minutes
- [ ] Max Time Alone – Less Than 1 Hour
- [ ] Max Time Alone – 10+ Hours
- [ ] Unable to Evacuate Without Assistance
- [ ] Max Time Alone – 1-3 Hours
- [ ] Max Time Alone – 3-10 Hours
- [ ] 1:1 Staffing
- [ ] More than 1:1 Staffing

Behavioral Issues (All That Apply)

Monitoring Needed	Protection Needed	
☐	☐	Chemical Abuse
☐	☐	Dishonesty
☐	☐	Elopement
☐	☐	Physical Aggression
☐	☐	PICA
☐	☐	Property Destruction
☐	☐	Self-Abuse
☐	☐	Sexuality - Vulnerability
☐	☐	Sexuality (Predator - Preference Female)
☐	☐	Sexuality (Predator - Preference Male)
☐	☐	Sexuality (Predator - Children)
☐	☐	Social Interactions
☐	☐	Extra Support for Transportation
☐	☐	Verbal Aggression
☐	☐	Stealing
☐	☐	Fire Setting

Sexually Aberrant Behavior

(defined as inappropriate sexual behavior that puts the individual or others at risk of physical or psychological harm and/or causes high level of concern within the community. Examples: criminal sexual behaviors, non-consensual sexual acts, predatory behaviors etc.)

☐ Yes ☐ No

Family Involvement (Check Only One)

☐ Frequent
☐ Infrequent
☐ None

Guardianship:

Name:
☐ Limited ☐ Full

Payee:

Intellectual Skills (All That Apply)

Support Needed (None, Minimal, Moderate, Extensive):

None	Min.	Mod.	Ext.		None	Min.	Mod.	Ext.	
☐	☐	☐	☐	Coping Skills: Does not handle everyday stress	☐	☐	☐	☐	Judgment Impaired: Rational Decisions Health
☐	☐	☐	☐	Coping Skills: Dislikes disruptions in environment	☐	☐	☐	☐	Judgment Impaired: Rational Decisions Financial
☐	☐	☐	☐	Judgment Impaired: Easily Taken Advantage Of	☐	☐	☐	☐	Judgment Impaired: Rational Decisions Safety
☐	☐	☐	☐	Judgment Impaired: Inability to Advocate for Self	☐	☐	☐	☐	Recognize Reality: Paranoia or Delusional Behavior

Rights Restriction:

Rights Restriction:

Brief description of unique or special support needs:
Summary of Current Situation:

Housemate Compatibility Tool

This tool shall be completed by an individual who is seeking a living situation with housemates, and potential housemates who may have someone move in with them. The tool should be completed by the individual with support as needed from someone who knows the individual well. The information is considered by the planning team in determining compatibility of two or more housemates.

Name

Date

Things a potential housemate should know about me: (habits, routines, strong likes/dislikes, supports needs that could affect a housemate's routine, etc.)	**Characteristics I like in a potential housemate:** (personality, common interests, routines, habits, etc.)	**I could not live with someone if they:** (what I find annoying or upsetting, anything that would make it unlikely I could live with another person)

A more comprehensive Housemate Survey can be found in the optional forms section of the Support Coordination Manual at: http://dmh.mo.gov/dd/manuals/scmanual.html

Transitions for Paid Residential Habilitation

Choosing a Provider

The CLC shall check all individuals seeking a residential setting to determine if they are on a sex offender registry.

- For any adult (over the age of 21)- the CLC will only check the Missouri Highway Patrol Sex Offender Registry to determine if the individual is a registered offender .

- For any juvenile (under the age of 21) – the CLC will check both the online Missouri Highway Patrol Sex Offender Registry and the Juvenile Sex Offender Registry via letter to the Juvenile Office in the individual's current county of residence.

Transitions for PAID RES HAB
Choosing a Provider

TO BE COMPLETED BY CLC

Information for Determining Rate

Support Intensity Scale/Vineland Index *(for shared living only):*

Rate Allocation Score *(for group home):*

ISL Rate:

Check if:

☐ New Placement

☐ Move from Current Placement

Sex Offender Registry Check

Community Living Coordinator has checked appropriate sex offender registry for this individual:

For adult, CLC checked Highway Patrol Sex Offender Registry on this date

For juvenile under 21, CLC check Highway Patrol Sex Offender Registry on this date AND letter was sent to Juvenile Office to check Juvenile Sex Offender Registry on this date .

Transitions for Paid Residential Habilitation

Planning the Transition

Once a provider is identified, the sending SC shall notify the following individuals by encrypted e-mail:

- Sending and Receiving:
  - Support Coordinators
  - Support Coordination Supervisors
  - Community Living Coordinators
  - TCM and /or Regional Office Transfer Contacts
  - Provider Staff

- Others determined important to ensuring a smooth transition
- The SC shall attach an electronic copy of the ISP and demographic page to the e-mail.

Transitions for Paid Residential Habilitation
Planning the Transition

- The sending SC and CLC will arrange and co-facilitate a transition meeting far enough in advance of the move to ensure a smooth transition.
    - Remember to invite the RO nurses, and Area Behavioral Analyst (ABA) to the transition meeting when appropriate.
- The sending SC will write the transition plan/ ISP amendment which will outline the plan for the move.
- The sending SC will arrange for the individual to visit the new support location and support persons. If this is not able to happen, use alternative methods such as pictures, video, or other methods.

Transitions for Paid Residential Habilitation

Planning the Transition

- The Sending SC will utilize the Checklist for Community Living Moves
  - Once this is completed, it gets emailed to the entire planning team; the original shall go into consumers file.

- The sending RO URC remains responsible for approving plans and budgets for the individual
  - The sending SC will share the proposed budget with the receiving Regional Office Transfer Contact designee.

- The sending SC will complete a Health Inventory prior to the move or within 10 days, if it is an emergency placement.

Transitions for Paid Residential Habilitation

Planning the Transition –

Logging/ Billing for time

- The receiving Regional Office Transfer Contact Designee will inform the responsible RO staff person to open a second Episode of Care so that both TCM entities are able to bill and have access to CIMOR during this time of transfer.

- During the period of case transfer, there may be billable activities from each TCM entity that are viewed as independent.

- When TCM activities of the sending SC cannot be distinct or independent from that of the receiving SC, only one SC may log billable TCM activities.

Checklist for Residential Community Living Moves

Name: DMH #

Transitioning from: to
(Natural Home/ Residential Name) (Residential Name)

Transitioning from: to Move Date
Regional Office Regional Office

New Address New Phone Number

Initial Transition meeting date: Post Move Transfer meeting date:

Section A. Initial Planning and Provider Selection

Action Step	Date Action Step Completed (or N/A)	Comments
Have checked the Medicaid (ME) code to verify that the individual has active, waiverable Medicaid?		
The individual's waiver eligibility has been determined and Level of Care (LOC) completed.		
Responsible Person(s) has identified the counties they want to consider for a move.		
Has UR approved to proceed with placement?		
If an individual is moving from a Hab Center or Skilled Nursing Facility into the community, has a referral to Money Follows the Person been completed? *Note: Talk to your Community Living Coordinator		
Notify the receiving Area Behavior Analyst if the individual is moving from a Level II facility, nursing home, psychiatric hospital, or jail, or if the individual has been in a psychiatric hospital or jail within the past year.		
Individual's referral has been placed on Consumer Referral Database.		
Individual and responsible parties have been made aware of all provider options and have been provided information and opportunities to visit providers before making informed choice.		
Housemate Compatibility Tool has been completed, and the team has evaluated the level of risk any housemate would present to the other.		

Individual has chosen a provider and the selected provider has been informed.		
For Shared Living-Is there an up to date SIS report available?		
Medicaid Waiver, Provider, and Services Choice Statement completed.		
Individual has met housemates and has had a chance to become acquainted with the home through home visits, photos, videos or alternative methods. What attempts have been made?		
If the home is a new ISL, prior to the move, has the Support Coordinator inspected the proposed new home using the ISL Environmental Site Review form?		
Have verified that the individual has sufficient benefits to cover the room and board costs? If not, have requested RO Business Office review the benefits?		
If moving from one Regional Office to another, have the sending & the receiving ROs, and CLCs been informed?		

Section B. Transition Plan:

Action Step	Date Action Step Completed (or N/A)	Comments
The new TCM agency has been informed of the move and invited to transition meeting.		
Receiving SC has entered their role into CIMOR.		
Initial transition meeting with BOTH sending and receiving teams has been scheduled.		
Document who participated in the initial transition meeting and date of the meeting.		
The team is informed of any pending court actions.		
Does the individual have overdue/unpaid bills? If so, is a plan in place to address the bills?		
Have the sending & receiving business office staff been informed of status of payee?		
Is the end of life plan for the individual documented in the ISP?		

Has the sending SC documented who is going to notify current landlord, post office, Social Security Office/Medicaid Office, bank, etc. of the individual's move/and new address?		
Startup needs (rental/utility deposits, furniture, household set-up, etc.) have been identified and funding source identified prior to the move.		

All medical supports the individual needs are addressed in the ISP Amendment.		
Receiving provider's staff is informed and aware of the individual's medical needs.		
Sending and Receiving RO Nurses have been informed of the individual's move.		
If individual has had a change in health status or this is first move to residential living, Health Inventory has been completed.		
Prior to the move, Provider staff has been trained on any specialized medical supports.		
The individual has all needed durable medical equipment. The source and funding for needed equipment has been identified and obtained.		
Prior to the move, Provider staff has received a copy of the BSP and has been trained on any needed specialized behavioral supports.		
All behavioral support needs are addressed in the ISP/ Amendment.		
If involvement of the Behavioral Resource Team (BRT) in the transition is needed, the BRT has been made aware and will be involved.		
If the individual has a Behavior Support Plan, has it been sent to the receiving Area Behavioral Analyst?		
Is a psychiatrist needed? If so, has a referral been made? Has the need for a psychiatrist been documented in the ISP\amendment?		
Staffing ratio needed has been identified and justified in the plan.		
If the person's rights are restricted, has the plan been reviewed by the Due Process Committee and documentation is in the file?		

If the individual is a registered sexual offender or has been found NGRI (not guilty due to disability or mental illness) for a sexual offense, or was determined incompetent to stand trial for a sexual offense, has the SC notified the sending CLC of the move? Prior to the move, the CLC has sent out notification letters which are required by statute.		
Has the need for Home Modifications been determined?		
If the individual is planning to utilize Community Transition Services and/or Home Modification Services, has the team ensured that the home is not provider owned and/or controlled?		
If utilizing remote supports, agency has been identified and back-up plan is in place.		

Arrangements have been made for transporting the individual and belongings on the move date.		
Transfer of personal funds has been arranged • Spending money in the individual's possession is sent WITH individual or responsible person. • Personal spending money in accounts is returned by the provider to the Regional Office. (If RO is not payee, RO will direct provider to whom to return the funds).		
Has a Tentative move date been discussed? If so, what date?		
Determine which SC will do Service Monitoring during the first 30 days after the move.		

Section C. After Transition Meeting

Action Step	Date Action Step Completed (or N/A)	Comments
Budget submitted by the agency provider.		
Authorizations have been approved by the sending UR and the sending RO Director prior to the move.		
Authorizations have been sent to the new TCM to be entered into the system for billing at the new Regional Office.		
If the move will result in an ISL rate increase, has the ISL budget been approved by sending Regional Office Director prior to the move?		
Sending TCM entity has provided the receiving TCM entity and provider with an approved copy of the budget.		

If applicable, interdivisional or interdepartmental agreement has been completed and signed.		
If home modifications are needed for health and safety, were they approved and completed prior to the move?		
Final UR approval has been received for all services. Has the waiver slot been assigned?		
Upon the move, an inventory of the individual's belongings has been documented during the first 30 days and the inventory is maintained by the Provider Agency.		
The following have provided to the receiving provider at least one week before the individual's move: • Current Individual Support Plan, including any addendums and budget/funding authorizations • Behavior Support Plan • Current specialized medical information • Information regarding diet and allergies		
At a minimum, the following must be provided to the receiving provider no later than the day of the move: • Current Physician's orders • A minimum of a 7 day supply of current medications, with plan in place for renewal • Current physical, vision and dental exams • Medicaid, Medicare, ID card and Social Security cards • Current immunization record • Adaptive equipment • Clothing • Personal care items		
Sending Business Office has been informed of the move.		
If the home is a new ISL and repairs/changes were necessary based on the initial ISL Environmental Site Review form, did the proposed new ISL home pass inspection prior to the move?		
The sending SC will ensure that CIMOR is updated (i.e address, phone number, etc).		

Section D. Follow Up

Action Step	Date Action Step Completed (or N/A)	Comments
The receiving provider has scheduled doctor appointments to ensure continuity of care.		
All APTS entries which occurred prior to the move, including issues noted in the Nursing Review & Health Inventory, have been discussed and resolved or a remediation plan has been developed.		
Post move transition meeting including sending and receiving support coordinators, CLC's, provider's, and any other staff necessary has been scheduled.		
Has the sending SC ensured that his/her role has ended in CIMOR one day prior to transfer?		
Sending SC prints last 6 months' worth of log notes and puts in the master file.		
Upon the move, the personal inventory form is reviewed and signed off by both the sending and receiving home manager or agency provider.		
Community Moves Checklist sent to entire planning team.		
Transfer date finalized. Provider and receiving TCM agency have been notified.		
Transfer Form is completed if moving outside the region/county.		
Has the File Audit Checklist been completed by the SCS prior to the transfer?		
Consumer File sent within 5 business days of the effective transfer date.		

Additional Comments:

Signature of sending SC completing form and date (Required)

CC: Entire Planning Team
Consumer file

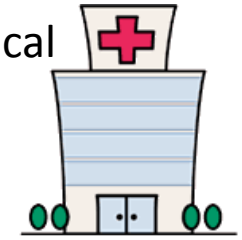
8/30/2017

Transitions for Paid Residential Habilitation

Planning the Transition

If the individual is being discharged from a hospital and he/she is transitioning directly into Res Hab Placement, the sending SC will ensure the receiving provider is prepared to support the individual's medical needs by:

- Getting the hospital to participate in discharge planning.
- Ensuring that the provider has all written medication orders, training and instruction regarding care procedures, techniques, use of monitoring equipment, and other elements of care.
- The sending SC will ensure that the sending and receiving RO Nurses are involved in the planning process in order to coordinate necessary medical follow up.



Transitions for Paid Residential Habilitation

Post Move Follow Up

- The sending TCM agency and RO are responsible for the individual's support coordination for the first 30 days; after the move, the individual's support coordination will be co-facilitated with the sending SC as the lead.

- Service Monitoring will be done by the sending SC unless it has been discussed and agreed up by both the sending and receiving TCM agencies/or Regional Office Team that the receiving SC will complete the service monitoring.

Transitions for Paid Residential Habilitation

Post Move Follow Up

For the first 30 days:

- The Receiving Agency Provider will bill the sending RO for approved services until the effective date of transfer.
- Event Report Forms will be sent by the provider to the receiving RO and SC where they will be entered into CIMOR. The receiving RO will send a copy of the Event Report Form to the sending SC.

Transitions for PAID RES HAB
Post Move Follow Up

- A post move meeting or call will be held within the first 15 - 30 days after the move. This will be co-facilitated by the sending SC and CLC. Transfer date will be determined during this meeting. Transfers will be completed within 30 days.

- Outcomes and Action Steps shall be reviewed; if new ones are to be developed, then the sending SC will provide an up to date ISP amendment to the receiving SC upon transfer.

- If additional service requests need to be completed after the post move meeting, the transfer still occurs and the new SC will complete the requests for new services through their UR.

Transitions for PAID RES HAB
Post Move Follow Up

- The sending SCS or TCM transfer contact will electronically forward a completed Transfer Form to the appropriate receiving TCM transfer contact, sending and receiving RO transfer contact designees. Prior to sending the record, the sending SCS or TCM transfer contact will verify that all items on the file audit checklist are contained in the file.

- After review of the Transfer Form, the receiving transfer contact designees or receiving TCM transfer contact will send an encrypted email to the sending TCM transfer contact and transfer contact designees within 3 business days which will contain the following information:
    1. Confirmation that they received the transfer information
    2. The effective date of transfer
    3. An address to mail records

- The Episode of Care will end for the sending RO one day prior to the date of transfer.

Administrative File Transfer Process

Administrative File Transfer Process

All files from the sending RO and sending TCM entity, including current and historical (electronic or hard copy), shall be sent to the receiving TCM entity within 5 business days of the effective transfer date. If the sending RO has a manila file with information listed below, it shall be sent directly to the receiving RO. If the receiving RO does not receive a manila file, the TCM agency shall forward the following list of original documents to the RO:

- All legal documents including Guardianship letters, Conservatorship letters, court orders and other custody documents, marriage certificates, birth certificates, etc.; and
- All admission documents including eligibility determination and admissions information, assessments and reports used to determine eligibility, application information, client rights receipt, client choice documents, diagnosis sheet, and supporting documentation.

Administrative File Transfer Process

Any paper records being forwarded need to be hand-delivered or mailed by USPS certified with return receipt. Please refer to Division Directive 1.060 for storage, retention, and destruction information on records.

Transfers from Habilitation Centers

Transfers from Habilitation Centers
List of Habilitation Centers & Transition Coordinators

SC Transfer Contacts Brochure

Transfers from Habilitation Centers
Choosing a Provider

- At least quarterly, the team for an individual residing in a state-operated program will review and assess supports that would be necessary for that individual to live in a less restrictive setting.

- If the team identifies that an individual could live successfully in the community, or the individual, the legally responsible party or other person close to the individual advocates for transition to the community, then process for transition from a Habilitation Center will begin.

Transfers from Habilitation Centers
Choosing a Provider

Transitions from Habilitation Centers are facilitated by a Transition Coordinator. The Transition Coordinator works with the individual, family, and responsible party to:

- Research the community living options available to the individual in the community.
- Identify the location where the individual prefers to live.
- Submit the individual's referral information to the referral database.
- Explore the supports available through providers that respond to the individual's referral.
  - May include assisting the individual, family and responsible party to visit the potential provider agencies.

Transfers from Habilitation Centers
Planning the Transition

Once an agency has been chosen by the individual and the legally responsible party, the Transition Coordinator:

- Notifies the receiving RO CLC that the individual will be transitioning to an agency in the receiving RO's area.
- Notifies the receiving TCM entity and the provider of the transition.
- Ensures the team gives careful consideration to potential housemates.
  - The Housemate Compatibility Tool may be used in considering the compatibility of potential housemates.

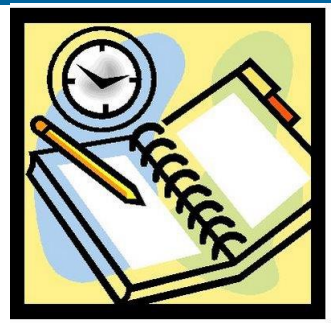
Transfers from Habilitation Centers
Planning the Transition

The Transition Coordinator also:

- Schedules and facilitates a transition meeting including all the individuals necessary to plan the supports that will need to be in place for the individual to successfully transition to the community.
  - More than one meeting may be needed.

- Uses the Initial Transition Meeting Discussion Guide to plan the steps for a successful transition.
- Uses the Risk Assessment Guide or similar tool to ensure that risk mitigation is part of the transition planning.
- Develops a transition plan.

Transfers from Habilitation Centers
Planning the Transition



- The Transition Coordinator will schedule times for:
  - The staff at the new provider agency to visit and shadow the individual at the habilitation center.
  - The individual to visit the new home and meet potential housemates.
  - The individual to visit the home overnight if that is in the best interest of the individual.

- Staff at the habilitation center will:
  - Assist with planning visits to the new home and preparing the individual for the visits.
  - Provide training to the new provider's staff on the individual's behavior support plan (if applicable.)

Transfers from Habilitation Centers
Planning the Transition

The Transition Coordinator schedules and facilitates a final transition meeting at which:

- The team confirms that all supports needed by the individual, including employment referrals, doctor's appointments, adaptive equipment needs, etc., are in place.
- The tentative move date is set.
- Post-move review dates are set up for 30, 60, and 90 days following the move.

Transfers from Habilitation Centers
Planning the Transition

The Transition Coordinator:

- Submits the Transition Plan, budget information, and all necessary waiver paperwork (ICF-DD Level of Care Statement, service authorization documentation, the Medicaid Waiver, Provider, and Services Choice Statements) to the sending RO's URC for approval.

- Completes the Health Inventory.

- Confirms the final move date once the URC and Regional Director have approved the transition plan and budget.

Transfers from Habilitation Centers
Planning the Transition

The Sending RO will:

- Request a waiver slot for the individual.
- Transfer the individual to the Receiving RO effective the date of the move.

The Receiving RO/ TCM will:

- Be responsible for support coordination the day the individual moves.
- Accept transfer the day the individual moves.

Transfers from Habilitation Centers
Planning the Transition

On the day of the move:

- The current Medication Administration Record, current medications and/or medication orders to provide at least a 15 day supply of medication, current physician's orders, current lab results, current annual physicals, current ISP, current BSP, and information regarding upcoming doctors' appointments will go with the individual to the home.

- A completed Inventory Checklist accompanies the individual to the new home.

- The individual's file is transferred from the sending Habilitation Center to the receiving RO.
  - If the individual will receive support coordination from a TCM entity other than the RO, the receiving RO will transfer the file to the TCM entity within 5 days of the move.

MISSOURI DIVISION OF DEVELOPMENTAL DISABILITIES

- **Transfers from Habilitation Centers**

Post Move Follow up

The **Transition Coordinator** will:

- ❖ Facilitate the 30, 60, and 90 day post-move review meetings where any additional support needs and adjustment concerns will be discussed and the frequency of future home visits will be determined.
- ❖ Complete the Post-Habilitation Center Transition Review Form and send it to all team members.
- ❖ Schedule additional monthly follow up meetings if there are concerns or issues at the 90 day meeting.

- **Transfers from Habilitation Centers**

Post Move Follow up

The receiving **Support Coordinator** will:

- ❖ Make weekly visits to the individual for the first 30 days.
- ❖ Monitor purchases made for the individual through the Community Transition service and discuss any additional items or changes in items needed with the transition team
- ❖ Approve the Post-Habilitation Center Transition Review form by signing the form or documenting approval via encrypted e-mail to the Transition Coordinator.
- ❖ Complete an addendum to the ISP which includes objectives for implementation in the community.
  - **The date of the annual ISP does not change.**

Transfers from Habilitation Centers
Post Move Follow up

If the individual has a behavioral support plan, the individual will have behavioral services ongoing in the community and will be referred to the Regional Behavior Support Review Committee.

The Behavior Resource Team will:

- Assist the SC and support provider to utilize positive, proactive, and preventative strategies that have the best chances of supporting the individual with a good quality of life.

- Provide at least weekly onsite visits and consultation for the first month and at least bi-weekly onsite visits and consultation for the next 60 days to assist with consistent utilization and adjustment of strategies of support recommended by the Transition Team.

Transfers from Habilitation Centers
Transition Rate and Provider Reimbursement

- The daily rate for individuals who transition from a habilitation center is determined utilizing the individual's current Rate Allocation Score.

- Providers can be reimbursed for administrative costs necessary to the process to transition someone from a habilitation center, such as:
  - Staff training, nursing consultation, locating housing, cost associated with visit, etc.

Transfers from Habilitation Centers
Transition Rate and Provider Reimbursement

When new residential services are developed, planned, and implemented, the usual administrative fee for the first month may be increased by an amount not to exceed $1,500 to reflect provider administrative costs required to develop new services.

- This increase is added as a line item to the ISL budget or written in as a separate item on the shared living budget for the first month of service.

- Future ISL and shared living budgets must reflect the provider's usual administrative fee within ISL and shared living guidelines.

- The combined cost for residential and reimbursement for increased administrative costs is not to exceed the cap for the daily rate of ISL or shared living arrangement for that initial month.

Transfers from Habilitation Centers
Transition Rate and Provider Reimbursement

If an individual is moving to a group home where there is an existing vacancy, an existing ISL or shared living home, transition administrative costs may be negotiated up to an amount, not to exceed $500 for that person.

- If transition administrative costs are approved for group home service providers, they will be reimbursed under “res hab transition” code T2016 TG, for the first month of service only.

Transfers from Habilitation Centers
Home Accessibility Modifications

- Waiver environmental accessibility adaptations/home modification services (up to $7,500), as well as specialized medical equipment and supplies (up to $7,500), may be accessed in advance of a person moving to the community. Only adaptations as per the service definition are covered when the specific need is documented within the transition plan.

Transfers from Habilitation Centers
Home Accessibility Modifications

- Home accessibility modifications may be authorized in the waiver up to 180 consecutive days in advance of the individual's transition from Title XIX-funded facilities (e.g. ICF/ID, SNF).

- The home modification started while the person is living in the facility is not considered complete, and may not be billed, until the date the individual leaves the facility and enters the waiver.

- The claim for reimbursement must indicate the date the individual leaves the institution and enrolls in the waiver as the date of service for allowable expenses incurred during the previous 180 days.

Money Follows the Person (MFP)

Money Follows the Person (MFP)

It is a grant that supports efforts to:

- Provide Medicaid Eligible people with choice of where they live and receive services.
- Allow qualified people living in nursing facilities or habilitation centers to move to the community.
- Promote a system that is person centered, based on needs, and ensures high quality services in the community.

Money Follows the Person (MFP)

Eligibility Criteria :

- Individual has lived in a state habilitation center or nursing facility for a period of 90 days
- Currently receiving MO Healthnet benefits in the care facility prior to transition
- Transition to a home that is leased or owned by the participant or participant's family, or move to a residential housing with no more than four individuals living in the home.

MFP is a 365 day program.

Typical Waiver Services are split at 60/40 –When an individual participates in the MFP program the split becomes 80/20. The State saves 20%.

Contact your CLC if you have someone looking to participate or they might be eligible for this program.

NON-HAB CENTER TRANSITIONS MFP

Support Coordinator

- Informs the CLC of the proposed move and provides information the CLC needs to determine if the person qualifies for MFP.
- Writes the individual's transition plan (ISP amendment or ISP) and submits it to the Utilization Review Committee to obtain pre-approval for the services the person will need to make the move. ***UR preapproval must be obtained in order to access MFP.***

Community Living Coordinator

- Determines if the individual qualifies for MFP.
- Gives a copy of the MFP Participation Agreement to the Support Coordinator.

NON-HAB CENTER TRANSITIONS MFP

Support Coordinator

- Talks with the Legally Responsible Person(s) about MFP.
- Obtains the signed MFP participation agreement from the Legally Responsible Person(s).
- Scans/emails or faxes the signed Participation Agreement to the CLC.
- Obtains all the necessary information from the Nursing Home and any other source necessary for the MFP Level of Care and Application process.

Community Living Coordinator

- Completes electronic application for MFP via MFP web-based referral system.
- Provides MFP Staff with the signed Participation Agreement.
- Sends an email to MFP Staff informing them when the move is planned to occur. The MFP staff will then schedule a Quality of Life Survey.

Money Follows the Person (MFP)

The following statement must be maintained in an individual's ISP during the period they participate in the MFP program:

As __Name__ is moving into a number person ISL/group home, he/she is eligible for the Money Follows the Person demonstration. Name's legally responsible party has been notified of this option and has signed the agreement for their participation for one year. During this time, surveys will occur prior to discharge from _institution_, at one year and again at two years. If ___name___ is hospitalized or placed in an inpatient setting, regardless of the amount of time, the MFP project director must be contacted. This will be the responsibility of __Support Coordinator name__, Support Coordinator. The ___area___ Regional Office provides a 24 hour call-in number for emergency back-up assistance if needed. ___Name___ and his/her legally responsible party have been provided this number in the event that emergency back-up is needed.

MISSOURI DEPARTMENT OF MENTAL HEALTH
MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

MONEY FOLLOWS THE PERSON PARTICIPATION AGREEMENT

PARTICIPANT NAME	
MO HEALTHNET NUMBER	COUNTY OF RESIDENCE

SUMMARY

The Money Follows the Person Demonstration is designed to assist individuals who wish to transition from institutions into the community. The Money Follows the Person Demonstration's intent is to eliminate barriers to receiving services and to ensure delivery of quality services.

AGREEMENT

I understand that I must be eligible for MO HealthNet in order to participate in the Money Follows the Person Demonstration.

I understand that my participation in the Money Follows the Person Demonstration is for a period of one year from the date of my transition into the community. My home and community based services will continue uninterrupted and without reduction following the demonstration period, as long as there is a continued need and all eligibility requirements are met.

I understand that the Federal Government will pay for a larger portion of my home and community based services during the one year that I participate in the demonstration.

I understand that any HCBS MFP demonstration services I receive to aide in transition, such as utility deposits or home modifications, are not ongoing and will terminate after my year of participation in the demonstration.

I agree to participate in the Money Follows the Person Demonstration. I understand there will be ongoing surveys and follow-up regarding my transition into the community. I understand that I am encouraged, but not required, to participate in the survey that will help demonstrate the success of the project.

I understand that I have the right to end my participation in the demonstration at any time during the one year period.

I have reviewed this form and understand that my signature acknowledges agreement in participation in the Money Follows the Person Demonstration.

I understand that the Federal and State laws will be followed regarding the sharing of my personal health information.

I agree to participate in the Money Follows the Person Demonstration requirements as set forth herein.

PARTICIPANT	DATE

As guardian, I agree to facilitate successful participation of _____ in the Money Follows the Person Demonstration.

GUARDIAN SIGNATURE	DATE

If at any time you have questions call Department of Health and Senior Services Information Hotline: 800-235-5503 or Department of Mental Health: 800-364-9687.

MFP
for
HABILITATION CENTER TRANSITIONS

- If an individual is transitioning from a habilitation center, the Transition Coordinator will take the lead to plan the transition and enroll the individual in MFP.

THE DAY THE MOVE OCCURS

Support Coordinator

- ***INFORMS THE CLC THE MOVE HAS OCCURRED.***
- If paid DD Residential Services are involved, the SC informs the receiving Provider that the Provider must report to the SC any time the person leaves the DD Residential Service for a temporary stay at a hospital, nursing home, rehab, crisis unit, etc.

Community Living Coordinator

- Enters the actual move date into the web based system. ***THIS IS THE FINAL ACTION THAT STARTS MFP.***

DURING THE 365 DAYS OF PARTICIPATION IN MFP

Support Coordinator

- Provides follow up information required by CMS to the CLC.
- This is done through a monthly report the SC completes and sends to the CLC.

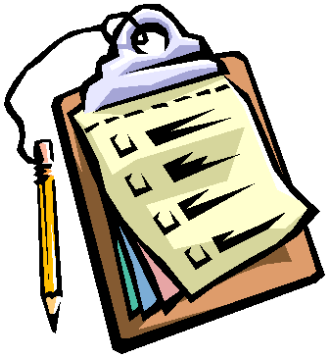
Community Living Coordinator

- Pulls data report to gather follow up information available in our data systems.
- Gathers monthly report from the SC to collect information not available through data system reports.
- Submits required follow up information into the MFP web-based system.

We only ask the SC to provide information that cannot be tracked through data systems.

MISSOURI DIVISION OF DEVELOPMENTAL DISABILITIES

Transitions for Individuals on Sex Offender Status



Notification Procedures for Individuals on Sex Offender Status

Communication between the SC and CLC is key to ensuring all forensic notification procedures are followed. The SC should contact the CLC any time an individual is seeking a residential setting who:

- Is required to register on the Highway Patrol Sex Offender Registry;
- Is required to register on the Juvenile Sex Offender Registry in the county where he/she resides; or
- Has been determined permanently incompetent to stand trial for a sexual offense.

Notification Procedures for Individuals on Sex Offender Status

Missouri Statute 630.127 requires the following notification procedures:

- When an individual who is a registered sex offender will be living in a setting with other individuals who receive DMH funded placement, those individuals with whom the registered offender will reside must be notified of the registered offender's status.

- When an individual who has been found permanently incompetent to proceed to trial on an offense which would have required registration as a sex offender if he or she been found guilty will be living in a setting with other individuals who receive DMH funded placement, DMH is required to contact the individual's legally responsible party to request permission to notify individuals with whom the individual will live of the charges for which the individual was found incompetent to proceed.

Notification Procedures for Individuals on Sex Offender Status

Missouri Statute 630.127 requires the following notification procedures:

- The notification procedures also apply if an individual who currently receives residential placement becomes required to register or is found permanently incompetent to proceed on a charge covered by the statute.

Notification Procedures for Individuals on Sex Offender Status

- Whenever an individual is referred for residential placement, the sending CLC will determine if the individual is on either the Highway Patrol Sex Offender Registry or the Juvenile Sex Offender Registry in their county of residence, as appropriate, before placing the individual's referral information on the Consumer Referral Database.

- If the individual seeking residential placement is a juvenile, the SC will assist the CLC in getting a signed consent from the juvenile's parent/legally responsible party for the CLC to send to the juvenile office for the purpose of determining if the juvenile is on the Juvenile Sex Offender Registry.

Notification Procedures for Individuals on Sex Offender Status

- If the individual (adult or juvenile) is required to register on the Highway Patrol Sex Offender Registry, the sending CLC will send notification letters to other housemates who receive DMH funded placement, or their legally responsible party, before the individual moves into the home.

- If the individual has been found Incompetent to Proceed to Trial on an offense for which he/she would have been required to register had he/she been found guilty, the sending CLC will seek permission from the individual/ legally responsible party to disclose information about the offense to potential housemates before the individual moves in to the home.
    - Refusal to grant consent will not automatically stop the placement, but may require additional discussion by the individual's planning team.

Notification Procedures for Individuals on Sex Offender Status

- If a juvenile is required to register on the Juvenile Sex Offender registry in their county of residence, consent to disclose information regarding the juvenile's legal status to other individuals receiving DMH funded placement with whom the juvenile will live will be requested from the parent/legally responsible party.

- If parental consent is obtained, the sending CLC will send the appropriate notification letters.
  - Refusal to grant consent will not automatically stop the placement, but may require additional discussion by the individual's planning team.

Notification Procedures for Individuals on Sex Offender Status

- Specific procedures for planning appropriate residential supports for juveniles who are registered offenders are also covered under the Department Operating Regulation 4.270.

- The CLC can also provide technical assistance to an individual's support team regarding housing and planning specialized supports for registered offenders and other individuals who display aberrant sexual behaviors.

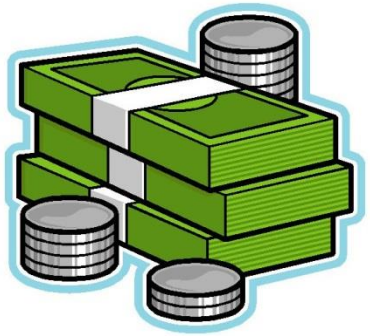
Community Transition Services

Community Transition Services

Transition Services are one-time, set-up expenses for individuals who transition from an institution (ICF/ID or Title XIX Nursing Facility, or other congregate living setting) to a less restrictive community -based living arrangement such as a home, apartment. These community based living arrangements are not provider-owned or controlled; however, they include homes where waiver participants own or rent, with or without housemates, and/or receive ISL services.

Community Transition Services

- Congregate living settings include any provider-owned residential setting where MO HealthNet reimbursement is available; examples of such living settings include:
  - Intermediate Care Facilities for Individuals with Intellectual Disabilities
  - Nursing Facilities
  - Residential Care Facilities
  - Assisted Living Facilities
  - DD Waiver Group Homes



- This service is available in the following Waivers:
  - Comprehensive, Community Support, and Partnership for Hope

- Waiver Code – T2038

Community Transition Services

Examples of expenses that may be covered include:

- Expenses to transport furnishings and personal possessions to the new living arrangement;
- Essential furnishing expenses required to occupy and use a community domicile;
- Security deposits that are required to obtain a lease on an apartment or home that does not constitute paying for housing rent;
- Utility set-up fees or deposits for utility or service access (e.g. telephone, water, electricity, heating, trash removal);
- Health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy.

Community Transition Services

Examples of expenses that may be covered include:

- Essential furnishings include items for an individual to establish his or her basic living arrangement, such as a bed, a table, chairs, window blinds, eating utensils, and food preparation items.

- Community transition services **DO NOT** cover monthly rental or mortgage expenses, food, regular utility charges, and/or household appliances or items that are intended for purely divertive or recreational purposes such as televisions, cable TV access or VCRs or DVD players.

- Total Transition Services are limited to $3,000 per individual.

Summary

- Please notify your local Community Living Coordinator (CLC) whenever you have an individual who is:
  - Moving and they will require a new TCM entity and/or a new Regional Office
  - Seeking Residential Placement for the first time or seeking a new Residential provider
  - Eligible for MFP
  - Eligible for Community Transition Services
  - On the sex offender registry
  - Needing home modifications
  - Having difficulty adjusting to the new transition/ move from the Hab Center

- The Transition Manual is your friend and can be found at the following web address https://dmh.mo.gov/dd/manuals/ - click on "Community Transition Manual"
- Please check the FAQ in the Transition Manual or consult with your local CLC for further assistance.

Final Thoughts

- Communication is vital when it comes to transitions and transfers. Please make sure your are talking with the entire transition team which includes, but is not limited to:

  - The Sending and Receiving:
    - Support Coordinators
    - Support Coordination Supervisors
    - Community Living Coordinators
    - TCM and /or Regional Office Transfer Contacts
    - Provider Staff
    - Others – QERN, Area Behavioral Analysts, etc.

MISSOURI DIVISION OF DEVELOPMENTAL DISABILITIES

Who are you going to call??

CLC Contact List

QUESTIONS?

If you have questions, please submit them via email to
ddmail@dmh.mo.gov