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Title: Transfers

Application: Applies to Regional Offices, Senate Bill 40 Boards and other not-for-profit Targeted Case Management (TCM) Entities.

Purpose: To implement a consistent, statewide process for transfer of individuals, ensuring a smooth transfer that maintains services, with no delay in obtaining new supports and services when a person is moving from one Regional Office area to another, and to/from a TCM provider.

Definitions:

Interdisciplinary Team or Team: Those people (professionals, paraprofessionals, guardian and/or family members) who know the individual well and who possess the knowledge, skills, and expertise necessary to accurately identify a comprehensive array of the individual’s needs and design a program which is responsive to those needs (Person Centered Planning Guidelines and Federal Standards ICF-MR W201 483.440(b)(4)(i), W202 483.440(b)(4)(ii), W203 483.440(b)(5)(i), W204 483.440(b)(5)(i), and W205 483.440(b)(5)(ii)). This includes all appropriate staff who know the individual as well as staff from other agencies who serve the individual, or will serve the individual, the Regional Office, the individual, the legally responsible party (guardian/individual) and other advocates chosen by the guardian or individual.

Individual Support Plan (ISP): A document resulting from a person centered process directed by the individual served, with assistance as needed by a representative, in collaboration with an interdisciplinary team. It is intended to identify the strengths, capacities, preferences, needs, and desired outcomes of the person served. The process may include other people freely chosen by the individual who are able to contribute to the process. The person-centered planning process enables and assists the individual to design a personalized mix of paid and non-paid services and supports that will assist him/her to achieve personally defined outcomes and the training, supports, therapies, treatments, and/or other services that become part of the Individual Support Plan. (4.060 Individual Support Plan and 9-CSR 45 3.010 Individualized Habilitation Plan Procedures and RSMO 633.110)

Transfer Contact Designees: Regional Office (RO) or satellite office staff person(s) designated by the Regional Office Assistant Director to assist with the transfer process.

TCM Transfer Contact: Staff person(s) at the TCM agency designated to assist with the transfer process.

Transfer Process: The work involving the individual's interdisciplinary team to identify and document all of the services, supports, accommodations, etc., the individual will need and to set into motion the plans and actions needed for the individual to move.

TRANSFERS FOR NATURAL HOME INDIVIDUALS

1. Anytime an individual is moving within or out of current region, the Support Coordinator (SC) will discuss with the individual or guardian the choice to transfer or discharge from services.
2. If the individual or guardian chooses to remain in services, the sending Support Coordinator Supervisor (SCS) will send an e-mail to inform the receiving SCS, sending/receiving Assistant Directors (AD) and transfer contact designees. An electronic copy of the Individual Support Plan and demographic page will be attached to the e-mail.
3. The receiving 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.
4. 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 TCM agency or RO to ensure that services are set up in advance of the move.
5. 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 TCM agency or RO.
6. 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 transfer.
7. An amendment or updated ISP will be completed prior to the individual moving. It is the responsibility of the sending SC to provide an up-to-date ISP or amendment to the receiving Support Coordinator upon transfer.
8. Once services are coordinated and authorized, the transfer may occur.

TRANSFERS FOR INDIVIDUALS IN PAID RESIDENTIAL SETTINGS

1. The sending Support Coordinator shall ensure that the referral for an individual 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.
2. Support Coordinators will encourage individuals and families to review profiles of potential support providers available on the Department of Mental Health website at <http://dmh.mo.gov/dd/>.
3. Community Living Coordinators (CLC) will review the list of providers that are on Improvement Plans and Critical Status Plans and inform the SC. (Division Directive 4.080 Integrating Quality Functions).

4. The sending Support Coordinator shall use the Housemate Compatibility Tool (Appendix A) to assist the team in considering individual preferences in the selection of a home. Once a region and/or provider has been identified, the sending CLC will contact the following individuals by e-mail: sending and receiving TCM supervisors or TCM Transfer contacts, receiving CLC, sending and receiving transfer contact designees. An electronic copy of the ISP and demographic page will be attached to the e-mail.
5. The Support Coordinator shall utilize the Checklist for Community Living Moves (Appendix B) as a planning tool throughout the transfer process.
6. Once a home is identified and all staff listed above are notified:
 - The receiving transfer contact designee will inform the responsible RO staff person to open a second Episode of Care. The sending and receiving CLCs will identify the main contacts to assist the Support Coordinator with questions regarding services and resources available in the area where the individual is moving.
 - The receiving CLC will notify their RO nurse of the transfer.
 - A current updated ISP/Amendment is the responsibility of the sending SC. The ISP/Amendment shall include adequate supports for health and safety and to minimize difficulty in adjusting to any changes in his/her life that may occur with the change in living arrangements or supports.
 - The sending SC and CLC will arrange and co-facilitate a transition meeting far enough in advance of the move to ensure a smooth transfer. The sending SC will document the plan for the move in an ISP amendment. The sending SC will arrange for the individual to visit the new support location and support persons.
 - Participants in the transition meeting will include all staff necessary to provide input to the ISP. The sending and receiving RO nurses should be a member of the team when appropriate. A member of the sending and receiving Behavior Resource Team may be included if behavioral challenges occurred in previous support situation.
 - The sending SC has the individual or guardian sign all necessary documents (i.e. Provider Choice of Support Coordination and Services).
 - The sending SC will share the proposed budget with the receiving RO's transfer contact designee. The sending RO will be responsible for seeking budget approval for services through their URC.
 - If the individual has had a significant change in health or is moving from their natural home, the sending SC will complete a Health Inventory prior to the individual moving. (Division Directive 3.090 Health Identification - Planning System Process)
 - The sending CLC will notify sending reimbursement officer and receiving CLC will notify the receiving reimbursement officer of payee status.

7. In the event the individual is moving to a new provider directly from a hospital, the sending SC will ensure the receiving provider is prepared to support the individual's medical needs by;

- contacting the hospital as soon as possible after admission to request participation in discharge planning and,
- ensuring the receiving provider has been provided all written medication orders as well as training and instruction regarding care procedures, techniques, use and monitoring of equipment, and other elements of care.

The sending and receiving RO nurse will be involved in the planning process to assist the team for coordinating needed medical follow-up.

8. For the first 30 days following the move, the following will occur:

- The sending TCM agency and RO will maintain responsibility for the individual and Support Coordination will be co-facilitated with the sending SC as the lead. The sending SC is responsible for completing Support Monitoring. However, due to travel distance, it may be necessary to have Support Monitoring completed by the receiving SC. Every attempt to accommodate a reasonable request for assistance with Support Monitoring due to distance will be made. The sending and receiving support coordination agencies will come to agreement on what is a reasonable distance and will decide who will provide the support monitoring during the first 30 days.
- The receiving provider will bill the sending RO for approved services until the date of transfer is agreed upon.
- 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 (the Event Report Form shall be marked **COPY**) to the sending SC. (Division Directive 4.070 Event Report Processing and 9CSR 10-5.206)

9. A post-move review meeting or call is held within the first month after the move. The post-move review meeting/call is jointly facilitated by the sending SC and CLC to include but not limited to the receiving SC, receiving CLC, and provider. Outcomes and action steps may need to be developed at this meeting. If so, the sending SC will document those in a plan amendment.

10. Following the post-move review meeting, the transfer date is determined. The transfer will be finalized within 30 days of the move.

ADMINISTRATIVE FILE TRANSFER PROCESS

1. The sending SCS or TCM transfer contact will electronically forward a completed Transfer Form (Appendix C) to the appropriate receiving TCM transfer contact and transfer contact designees. Prior to sending the form the SCS or TCM transfer contact will ensure that items on the file audit checklist are included in the file.
2. After review of the Transfer Form, the receiving transfer contact designees, or receiving TCM transfer contact will respond within three business days of receipt via e-mail. The effective date of transfer, along with an address to mail records, will be included in the response to the sending TCM transfer contact and transfer contact designees. Once a transfer date is determined, the Episode of Care is ended for the sending RO.
3. All files from the sending Regional Office and sending TCM entity including current and history (electronic or hard copy) shall be sent to the receiving TCM entity within 5 business days of the effective transfer date. If the sending Regional Office has a manila file with the information listed below it shall be sent directly to the receiving Regional Office. If the receiving RO does not receive a manila file the TCM agency shall forward the following list of original documents to the Regional Office 1.) All legal documents to include: Guardianship letters, Conservatorship letters, court orders and other custody documents, marriage certificates, birth certificates etc. and 2.) All admission documents to include: 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. 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.