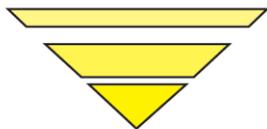


DIVISION OF
**DEVELOPMENTAL
DISABILITIES**



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5.010
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Title: Transfers & Portability of Funds Policy

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 transition 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:

Division of DD Person Centered Planning Guidelines: Describe the philosophy and values that form the foundation of the planning process.

Interdisciplinary Team or Team: Those individuals (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 Service 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 service plan.

Transition Meeting: A meeting involving the individual's interdisciplinary team to identify and document all of the services, supports, accommodations, etc., the individual will need to live in the community, and to set into motion the plans and actions needed for the individual to transition to the community.

PROCEDURES FOR ALL TRANSFERS FROM ONE REGION TO ANOTHER REGION OR FROM ONE TCM ENTITY TO ANOTHER

1. The Assistant Director of the Regional Office will coordinate transfers. Anytime an individual wishes to move, any of the following may initiate that request: the individual or guardian, service coordinator, or the sending or receiving Regional Office. County Boards will send the individual's file back to the Regional Office for the purpose of transfer to another Regional Office or for the purpose of transfer from one TCM provider to another.
2. Immediately upon learning that an individual will be relocating to another region or another TCM provider, the sending service coordinator shall send the following information, electronically if possible, to the Assistant Director of the sending Regional Office:
 - Current Individual Service Plan (ISP).
 - Updated plan/addendum addressing the individual's move and containing current, updated information regarding the individual, his/her situation and support needs
 - Any addendums and other information that impacts placement or other service decisions
 - Other pertinent information that would be helpful to the receiving Regional Office/TCM provider in providing continuity of services.
 - The TCM referral packet (Appendix C) and supporting documentation, if the individual is transferring to a county where the TCM will be provided by a county board TCM entity.
3. Once receiving the above information, the Assistant Director of the sending Regional Office will review and forward information electronically to the receiving Regional Office/TCM Provider as soon as possible after receiving the request, but no more than three (3) working days. Services will commence immediately at a time agreed upon by the individual or guardian, new provider, and Regional Office/TCM Provider.
4. The sending Service Coordinator will provide the sending Regional Office with updated demographic information including address, placement status, and other information necessary to update the individual's computer record and ensure adequate processing of provider billing.
5. If the individual is transferring from one Regional Office to another:
 - a. The sending Service Coordinator will complete the Transfer Information form (Appendix A) and send to the Assistant Director of the sending Regional Office. The Assistant Director of the Regional Office will ensure the information is complete. The Assistant Director of Administration will complete the Allocation Transfer form (Appendix B). Within thirty (30) days of the individual's move, the Assistant Director of the sending RO will forward the Transfer form and the Allocation form, to the Assistant Director of the receiving Regional Office. The funds transfer should be completed within thirty (30) days of the transfer request. Actual transfer of funds will be the responsibility of the chief financial officer. If an exception is needed, the sending and receiving Regional Office Directors must contact the Deputy Director/Assistant Director for the Division of DD covering their area.
 - b. If the transfer is originating from a TCM entity, the sending TCM agency shall forward the individual's file to the sending Regional Office within three (3) days. The Regional Office (RO) shall assure that the records office will prepare the individual's file to be transferred within ten (10) calendar days of the final transfer date set by the person's planning team. In the event the sending TCM agency also provides TCM in the county where the individual is moving, the TCM agency will provide the sending Regional Office with updated demographic information to complete the transfer and will keep the individual file. The sending Regional Office will forward a copy of the skeleton file to the receiving Regional Office, and document that since the original TCM agency will continue to provide TCM in the new county, the TCM entity has retained the file.

- c. If the eligibility of the individual is questioned by a receiving Regional Office or TCM provider, the transfer will be accepted and a review of eligibility will be completed by the receiving Regional Office Intake Team, with formal documentation of the review completed. If the review does not confirm that the individual is eligible for services, then the receiving Regional Office will begin the formal redetermination process.
- d. In the event that an individual moves prior to being determined eligible during the intake process, the Regional Office which completes the intake will transfer the individual to the receiving Regional Office and TCM entity without an ISP being completed. The receiving TCM entity will complete the initial ISP as is done with all new intakes.

GUIDELINES FOR TRANSFER OF ALL INDIVIDUALS IN NATURAL HOMES

1. As soon as the Service Coordinator becomes aware that an individual is moving, the sending Service Coordinator and/or Service Coordination Supervisor will contact the Assistant Director of the sending Regional Office.
2. In the event the individual moves without contacting the Service Coordinator and as a result, the ISP is out of date, the receiving entity providing Service Coordination will contact the individual and update the plan.
3. If the individual receives funded services which will need to continue in the new location, the sending Service Coordinator and/or Service Coordination Supervisor will work with the Assistant Directors of the sending and receiving Regional Offices, and the receiving Service Coordinator to ensure that services (employment services, transportation, personal assistance, etc.) are set up in advance of the move if possible. The receiving Assistant Director/designee will be the contact person to assist the sending Service Coordinator and/or Service Coordination Supervisor with questions regarding services and resources available in the area where the individual is moving. The need for a transition meeting will be determined by the sending and receiving Assistant Director of the Regional Office and TCM provider if applicable. Complex individual service needs shall require a transition meeting to ensure that all necessary supports and services are in place.
4. The sending Service Coordinator will inform the individual/guardian of any current funding that will not transfer with the individual, such as SB 40 funds and will seek and advocate for services to meet needs that have been covered by funds that will not transfer. The sending and receiving Regional Office Assistant Directors will determine how needs that have been provided through the Partnership for Hope Waiver in the sending county will be met if the receiving county does not participate.
5. If the individual receives Self-Directed supports, the sending and receiving Self Directed Supports Coordinator (SDSC) must maintain communication and follow up closely during the transfer process to ensure a smooth transition.
 - The Service Coordinator and/or Service Coordination Supervisor will notify the Regional Office and the current SDSC of the individual's plan to move.
 - The sending SDSC will notify the SDSC at the receiving RO of the transfer, and forward the SDSC file.
 - The sending and the receiving SDSC's will collaborate to ensure all timesheets and billing are in place and that the current services are ended in CIMOR correctly under the sending RO and authorized under the receiving RO's services beginning on the correct date.
 - The sending SDSC and receiving SDSC will coordinate who will notify the Fiscal Management Service (FMS) regarding change of address and other needed information.
 - The receiving SDSC will notify FMS of the updated Service Coordinator and Service Coordinator Supervisor and is responsible for ensuring that FMS receives all updated and current information.
 - The receiving SDSC will work closely with accounting office to ensure that the authorization is transferred, and the units are entered immediately.

GUIDELINES FOR ALL TRANSFERS INVOLVING INDIVIDUALS IN PLACEMENT

1. As soon as an individual is identified as wanting or needing to move, the sending Service Coordinator and/or Service Coordination Supervisor will contact the Assistant Director of the Regional Office at the sending Regional Office. The Assistant Director will inform the sending Community Living Coordinator of the pending move. The referral information for all individuals seeking to move to a new placement will be entered into the Consumer Referral Database.
2. The Assistant Director of the sending Regional Office will contact the Assistant Director at the receiving Regional Office to inform him/her of the move. The sending Community Living Coordinator will ensure that critical information about the individual's support needs is shared with the Community Living Coordinator and TCM agency at the receiving Regional Office, including the individual's updated individual service plan, behavioral plans, and face sheet. The individuals serving as main contacts at each involved agency will be identified, including the main contact person to assist the sending Service Coordinator and/or Service Coordination Supervisor with questions regarding services and resources available in the area where the individual is moving.
3. The Community Living Coordinator at the sending Regional Office will inform the Community Living Coordinator and the Service Coordinator at the receiving Regional Office of any providers who express interest in supporting the individual, and of the progress made toward choosing a provider. The sending Service Coordinator will inform the guardian of all the placement options available to the individual. The sending Service Coordinator will work with the guardian and receiving Community Living Coordinator to gather more information for the guardian/individual about potential providers, and to set up meetings/visits between the provider, individual, and potential housemates. The sending Service Coordinator will respond to all providers who express interest in supporting the individual.
4. Once the provider has been chosen, the sending Service Coordinator will send the provider a detailed packet of information regarding the individual including but not limited to the ISP, behavior plan if applicable, medical information, list of current medications, list of immunizations, etc.
5. When the individual has chosen a provider:
 - The sending Service Coordinator will arrange and facilitate a transition meeting to ensure a smooth transition.
 - The Community Living Coordinator at the sending RO will ensure that this meeting occurs.The following individuals will participate in the transition meeting:
 - The guardian and any other family member, friend, or advocate that the guardian or individual invites to attend.
 - The individual (if team agrees this would be in their best interest)
 - The receiving Provider agency with their staff (lead staff at the home, agency RN)
 - The sending Provider agency
 - Sending Regional Office staff as necessary (Community Living Coordinator, Service Coordinator, RN, Quality Enhancement staff assigned to the provider, Behavior Resource Team Member, Provider Relations Team Member)
 - Receiving Regional Office staff as necessary (Community Living Coordinator, Service Coordinator, RN, Quality Enhancement staff assigned to the provider, Behavior Resource Team Member, Provider Relations Team Member)
 - Sending Service Coordinator/TCM Entity (if applicable)
 - Receiving Service Coordinator from SB 40 Board/TCM Entity (if applicable)
6. At the transition meeting, the team will identify all of the services and supports the individual needs when moving to his/her new home. If service gaps are identified, the receiving Service Coordinator or Placement Coordinator will inform the Provider Relations team member at the Receiving RO of the need for service development. Specific details of the move will be planned including transfer of critical

documentation, medications, clothing, and belongings to the new provider. At a minimum, the following must be provided to the receiving provider no later than the day of the move:

- Current Individual Service Plan, including any addendums and Behavior Support Plan
- Current physician's orders
- A minimum of a 7 day supply of current medications
- Current physical, vision and dental exams
- Current specialized medical information
- Information regarding diet and allergies
- Medicaid, Medicare and Social Security cards
- RN summary
- Current immunization record
- Adaptive equipment
- Clothing
- Personal care items
- Personal property inventory
- Documentation of guardianship
- Documentation of payee
- Spending money
- Funding authorization

7. In the event the individual is moving to a new provider directly from a hospital, the team will follow the hospital discharge process. The receiving Regional Office QE nurse and the receiving community RN must be informed as soon as possible of the individual's pending move. If needed, training of staff for delegated medical duties, increased RN oversight, medical/adaptive equipment, special diets, and appointments for medical follow up must be in the place before the individual moves. The sending Service Coordinator must complete a new Health Inventory if the individual has experienced a significant health change, and for all initial placements.
8. The sending and receiving Service Coordinators will review the proposed budget to ensure the services being proposed are within the individual's existing budget. The sending Service Coordinator will determine who will be payee and make sure receiving and sending reimbursement offices are aware. No UR approval is required for the individual to move and for current budget funds to be used if the move is cost neutral. However, the sending Service Coordinator will submit the cost neutral budget to the receiving RO who must review and approve the ISL budget before the individual moves. Any increase in service cost must be approved by the sending RO's Utilization Review Committee and added to the transfer allocation. The final approved budget will be signed by the provider, sending Service Coordinator, Service Coordination Supervisor, and Regional Office Director/designee, and sent to the receiving Regional Office. The receiving Regional Office Director/designee will sign the budget to authorize the budget through the end of the plan year.
9. The sending Service Coordinator will inform the individual/guardian of any current funding that will not transfer with the individual, such as SB 40 funds and will seek and advocate for services to meet needs that have been covered by funds that will not transfer.
10. Prior to the move, the transition team will meet again to ensure that all necessary supports are in place, and to finalize the plan and arrangements for the move.
11. For the first 30 days, the sending Regional Office and TCM agency maintain responsibility for the individual. However, the receiving RO will open an episode of care in CIMOR for the individual as soon as the individual moves. The provider will continue to bill the sending RO until the actual date of transfer occurs. The sending RO will authorize services on the IPC and budget for the new provider through their system until transition takes place. Incident reports will be sent by the provider to the receiving RO where it will be entered into the EMT system, reviewed by the Service Coordinator, with a copy sent to the sending RO. Service coordination will be co-facilitated by the TCM providers for up to 30 days, with the sending

Service Coordinator as the lead. At the transition meeting, the sending Service Coordination provider will work with the receiving Service Coordinator provider to determine who will complete Service Monitoring during the first 30 days. The sending Service Coordinator will get a completed Choice of Provider form for TCM from the individual/guardian (if applicable). The receiving Service Coordinator will accept responsibility for the individual upon the effective date of transfer.

12. A thirty-day review meeting is jointly facilitated by the sending and receiving service coordinators. The ISP is amended by the receiving Service Coordinator as needed. The transfer will be finalized upon completion of the thirty-day review meeting. All transfers must be completed within 30 days of the move date. If an exception is needed, the sending and receiving Regional Office Directors must contact the Deputy Director/Assistant Director for the Division of DD covering their area.
13. The Transfer Information form is sent to the Assistant Director of the receiving Regional Office by the Assistant Director of the sending Regional Office. When transfer is completed, the individual's files will be forwarded from the sending RO to the receiving RO, who forwards them to the receiving service coordination entity. When possible, basic documents will be forwarded electronically: ISP, Behavior Plan, ICF/MR. The receiving Service Coordinator will authorize services through the Individual Plan of Care (IPC) starting the date of funding allocation or date of transition acceptance.

GUIDELINES FOR ALL EMERGENCY PLACEMENTS

Every possible attempt to follow the process above will be made, but at a bare minimum, the sending Service Coordinator will ensure that basic health and safety information will be sent to the provider before the individual moves. Emergency placement conference calls will be utilized to ensure that necessary supports and services are in place and all involved parties are aware of the move. When necessary, Regional Offices will arrange respite services for the individual until necessary supports and services to safely support the individual are in place at the new home. In the event that a move occurs without prior planning described in the above guidelines, the sending Community Living Coordinator and Service Coordinator will ensure that a transition meeting is arranged as soon as possible, but no later than 2 weeks following the placement. The sending Regional Office and TCM agency will maintain responsibility for the individual until a transition meeting can be held.

GUIDELINES FOR THE INDIVIDUAL'S BUDGET

1. Funds transferred to the receiving Regional Office will be the DMH cost identified in the personal plan and budget. Current fiscal year and cost to continue funds will be transferred.
2. Amounts for one-time expenditures already provided will not be included in the transfer amount.
3. Regional Offices cannot be responsible for transferring funds provided through community support efforts. The team will work with the person to address all his/her support and service needs through the PCP. Other resources may need to be identified to meet any further needs identified beyond the person's personal budget.
4. Amounts for home modifications will not be transferred.
5. Under Shared Unit Agreements, Regional Directors will notify Central Office of the need to deduct funding from the agency.
6. Funding from a Senate Bill 40 County Board is not portable. If services are provided by SB40 match dollars, the sending Regional Office is obligated to notify the receiving Regional Office of the amount from the SB40 on the individual's budget. The sending Service Coordinator will inform the individual/guardian of any current funding that will not transfer with the individual.
7. Waiting lists are considered to be not funded.
8. When the person ages out of the Lopez waiver at age 18, future use of the slot will be determined by the Central Office Review Committee within the Federal Programs Unit.

9. Funding agreement between the Children's Division and DMH will be reviewed and appropriate notifications will be made to each agency. Inter-agency slots are transferred. When the person ages out of the Children's Division, use of additional slots will be jointly determined by Children's Division and Division of DD, Central Office.

PROCEDURES INVOLVING CHILDREN'S DIVISION

1. Children under the custody of Children's Division are sometimes placed in counties other than the child's originating county.
2. The Regional Office serving the location of the Children's Division placement will be asked to provide TCM service coordination while the child is living in Children's Division placement. The case shall be opened or transferred so that the local Regional Office/TCM Provider can provide, and bill for, case management; however, this should not be considered the final decision regarding Regional Office responsibility after the child leaves Children's Division custody. If a child is placed in a very short term placement (eg. 30 to 60 days) with intention of returning to his/her home area, the sending and receiving Regional Offices will determine on a case by case basis if a transfer will be completed or if the sending Regional Office will maintain responsibility.
3. Transfers involving children in the custody of Children's Division will follow the transition procedures outlined in the Procedures for Placement section to ensure that planning, communication occurs, and all necessary supports and services for the health and safety of the child are in place. Providers accepting children through child-specific contracts are responsible for informing their Service Coordinator and Regional Office of the placement before it occurs to allow the teams for other individuals in the home an opportunity to consider roommate compatibility and adjust the budgets as needed.
4. When a child reaches 18 or 21 years of age, or is otherwise released from Children's Division custody, the Regional Office/TCM Provider will determine the need for ongoing services and supports through the Utilization Review Process. The individual, his/her family, or other legal guardian may have preferences as to where the person calls "home." Some individuals may return to their home county, in which case the Regional Office/TCM Provider serving the home, or originating county will assume case management responsibility. Some individuals may choose to stay in the town or county where they have been living under Children's Division placement. If this decision is made, then the Regional Office/TCM Provider serving that county remains responsible for case management.
5. Funding for continued supports/residential placement will be accessed through caseload growth.
6. If any DMH funds are a part of the person's budget, along with Children's Division, those funds will continue to be a part of the individual's personal budget after he/she leaves Children's Division care and custody assuming that the person continues to need comparable services.